

Introduction

- Tobacco use is a risk factor that leads to preventable diseases, disability, and deaths (CDC, 2019).
- The US DHHS, WHO and CDC recommend the 5A's and 5R's of smoking cessation as a clinical practice guideline

5 A's	
1. Ask	
2. Advise	
3. Assess	
If patient is willing to quit then,	If patient is not willing to quit then,
4. Assist	5 R's
5. Arrange	1. Relevance
	2. Risk
	3. Rewards
	4. Roadblocks
	5. Repetition

Background and Significance

- The United States Preventive Taskforce (2015) rates the 5 As and 5 Rs of smoking cessation to adults who are not pregnant a grade A recommendation.
- In primary care, the CDC reported that during a 3-year period 62.7% of smokers were screened, of those, only 20.9% received tobacco counseling and 7.6% received a prescription medication for tobacco dependence (Patnode et al., 2015).

Theoretical Framework

The Consolidated Framework for Implementation Research (CFIR) is a meta-theoretical framework that promotes and explains the implementation of evidence-based guidelines into multiple contexts integrating 19 implementation theories to improve the translation of evidence-based theories to practice (Damschroder et al., 2009).

Research Question

1. In primary care, how does the implementation of multimodal non-pharmacological and pharmacological smoking cessation interventions using the 5 A's and the 5 R's, affect the uptake of screening and smoking cessation interventions in practice?
2. What are the barriers, facilitators, and unique findings pertaining to this practice that influence the implementation of smoking cessation interventions?
3. In what manner has the potency and amenability of the CFIR constructs changed throughout the project?
4. What personal lessons have been learned by the DNP student investigator via 1st person inquiry done before and throughout the implementation process of smoking cessations?

Setting

The DNP project will be conducted in a primary care physician's office located in Bayonne, New Jersey. The healthcare team in this setting includes: A medical doctor (MD), nurse practitioner (NP), two medical assistants (MAs) and a billing assistant (BA).

Methods

This study was conducted by using a mixed methods participatory inside action research (PIAR) approach to implement multimodal smoking cessation interventions in a primary care setting.

The principles of PIAR emphasize that the process for implementation is not linear, but iterative

Research Procedures and Data Collection

Learning Circle.	LC#1. Training and education LC #2 –Implementation planning LC #3&4 –Barriers, Facilitators, and Adaptation of the implementation plan. LC #5 –Barriers and Facilitators to Implementation, Adaptation Plan, and Sustainability Plan LC #6 –Presentation of results to the team
Chart Review.	Assessed the uptake of the screening and smoking interventions weekly after initial implementation
First-person inquiry.	Assisted the researcher in uncovering any perspectives or opinions that might negatively affect her role as facilitator and researcher
CFIR Force Field Analysis.	Analyzed each of the constructs of the CFIR for their potency and amenability to change.

Data analysis

Learning Circle.	Narrative data analysis constant comparison and open coding.
Chart Review Data.	Quantitative data obtained from using descriptive statistics to measure the rates of implementation of the 5As & 5 Rs of smoking cessation.
First-person inquiry.	15 entries of reflective data as first-person inquiry to study the personal lessons learned related to knowledge development, process adaptation, and organizational politics implementation
CFIR analysis	Force field analysis to rate constructs potency and amenability to change.

Results

Learning circles.	<ul style="list-style-type: none"> • Barriers (1) Time (2) Other patient needs, (3) prescribing medications • Facilitators. (1) brief and simple interventions, (2) routine • Unexpected findings (1) self-disclosure of use of substances, (2) resignation of NP • Adaptation of implementation (1) simplifying actions, (2) customizing referral sheet, (3) new interventions co-exist with existent workflows, (4) increasing uniformity of interventions 												
Chart Review.	5A's highest adherence: Asking 100%, Assistance 72% 5R's highest adherence: Discussion of risks 21%												
First Person Inquiry.	(1) input from multiple sources avoids blind spots, (2) resistance that lessens with iteration, (3) organization hierarchy had a positive effect on implementation but might have also had led to the resignation of the NP.												
CFIR.	<table border="0"> <tr> <td>Potency:</td> <td>Amenability:</td> </tr> <tr> <td>(1) Design quality and packaging L→H</td> <td>1) Patient needs and resources L→H</td> </tr> <tr> <td>(2) Goals and feedback L→H</td> <td>2) Goals and feedback L→H</td> </tr> <tr> <td>(3) Available resources L→H</td> <td>3) Available resources L→H</td> </tr> <tr> <td>(4) Planning L→H</td> <td>4) Engaging L→H</td> </tr> <tr> <td></td> <td>5) Champion L→H</td> </tr> </table>	Potency:	Amenability:	(1) Design quality and packaging L→H	1) Patient needs and resources L→H	(2) Goals and feedback L→H	2) Goals and feedback L→H	(3) Available resources L→H	3) Available resources L→H	(4) Planning L→H	4) Engaging L→H		5) Champion L→H
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Discussion

- This project had a significant impact on screening with smoking status and assisting patients with smoking cessation. The primary facilitator of these smoking cessation interventions (asking and assisting) was making the delivery of these interventions brief, straightforward, and uniform.
- In contrast, the intervention that required a higher skill level, were more time consuming had the lowest adherence. These were the 5R's of smoking cessation because they required the use of motivational interviewing.
- Reimbursement of services may influence the time for-service practices choose to allot to the prevention of diseases. Hence, there is an increased need for value-based reimbursement which support preventative care practices.

References

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