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## **A Community Health Outreach Project Focused on Developing and Implementing a Culturally Competent Tobacco Cessation Education Toolkit**

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## **Executive Summary**

### **Introduction of the Problem**

The economic and devastating health impacts of smoking have been extensively researched and documented. Our society needs to stop smoking. Smoking cessation education is not a new concept. Many patients expect their clinicians to ask them about their smoking status, educate them about quitting, and track their records in the quitting process. Unfortunately, these expectations are seldom met, partly due to a lack of appropriate training for the clinicians to start the smoking cessation conversation. The omission of educational resources to concisely guide the process has also been shown to contribute to this issue. The challenge of engaging in smoking cessation conversations has become more evident with specific vulnerable populations such as the underserved community of East St Louis. Smoking has a negative generational impact due to the predominant culture within this community.

The East St Louis community is also plagued with racial, economic, and health access disparities that have subsequently normalized certain practices such as smoking. This has created many health concerns in this community. In addition, the existing culture where smoking is perceived as a norm continues to deepen the economic deprivation within the community. For this reason, it is essential to engage in a community-based project that tackles smoking cessation by holistically considering this population's cultural, economic, health, racial, and educational background.

We CARE clinic, located in East St Louis, has served the community for years by providing affordable access to care. They have also engaged in community improvement educational projects on different health topics and in championing specific preventative health

campaigns. However, they need a culturally competent educational toolkit to help them engage the community in discontinuing smoking. Therefore, a program to train the staff at the We CARE clinic to become smoking cessation ambassadors was needed. In addition, the need to screen every patient that comes into the clinic for smoking status, including secondhand smoking exposure, and use available resources to guide, refer and follow up on intended quitters was necessary.

### **Literature Review**

An extensive review of existing literature sheds some light on the gaps in the existing smoking cessation strategies. Smoking and nicotine addiction were popular public health topics. As a result, smoking cessation education has been a widespread and ongoing discussion, with tens of thousands of articles published within the last ten years. However, the literature also reviewed that although smoking cessation education is widespread, culturally competent smoking cessation education resources were not that popular as there were far fewer articles published under this domain, with one such being the We Can Quit (WCQ) protocol among pregnant women.

Reviewed literature did not only reveal the gap in culturally competent smoking cessation educational resources. However, it showed how vital clinicians' training in smoking cessation education could impact the entire cessation program outcomes. Literature evidence also suggests disparities among cultural, racial, and educational backgrounds. They played a role in who got screened for smoking, provided quitting resources, and were given referrals by clinicians, as Caucasians are 2.39 times more likely to be urged to quit smoking and provided resources to quit by their clinician than other minorities.

## **Project Methods**

Our project created an educational toolkit for the staff at the We CARE Clinic in East St. Louis. Our extensive literature review developed this toolkit. We focused on developing the toolkit using best practice research and incorporating cultural competence. Our group met in person with the staff of the We CARE Clinic. We gave the staff a presentation on culturally competent smoking cessation education at this meeting. Role-playing examples were performed to help the staff visualize a culturally competent smoking cessation conversation between a staff member and a patient. In addition, they gave a pamphlet to provide to their patients to aid in smoking cessation conversations. The focus of the pamphlet was using the five A's framework to start and guide smoking cessation conversations with their patients. The Five A's include asking, advising, assessing, assisting, and arranging.

## **Evaluation**

The project was evaluated by using the Plan-Do-Check-Act or PDCA cycle. This cycle works by planning out the project by using research. The next step is incorporating or implementing the project during the do phase. The check phase entails looking at the outcomes of the implementation. The last phase is called act, which includes adjusting and improving the project based on the findings found in the check phase. The PDCA cycle generally ensures that the project is well formulated and effectively achieves its goals.

Pre-education and post-education surveys were used to test the effectiveness of our presentation on the staff's knowledge of smoking cessation education strategies. The pre-survey was used to assess the staff's knowledge of strategies to engage patients in smoking cessation

discussions before the presentation. The post-survey was used to evaluate the staff's understanding of the Five A's framework and their confidence in starting a smoking cessation conversation after the presentation. Finally, the results were compared to evaluate the effectiveness of our project in aiding the staff to start the conversation and feel comfortable speaking about culturally competent tobacco cessation.

Our results showed that education on the five A's framework was successful. Each of the five items asked on the survey showed that participants understood the framework to approach the conversation of smoking cessation. Item one showed positive feedback in that more users will use the 5 A model to initiate a smoking cessation conversation after the presentation. Question two covered the clinicians' comfort level with starting a difficult smoking cessation conversation, and question three revolved around awareness of the 5 A model. Both questions showed positive results. Question four asked survey takers if they screened for smoking status. On item four, 40% of respondents stated they never screened for smoking status. Post survey results on this item were 60% sometimes screen for smoking status and 40% always screen. The last item on the survey evaluates comfort level regarding cultural competence. On the post-test, 100% of respondents agreed they feel comfortable initiating a culturally competent conversation compared to 40% on the pre-test. While limitations included a small respondent pool of five, this data shows positive outcomes the culturally competent smoking cessation program can have. Implementing this program with patients is the next step to keep moving forward to put this program to the test truly.

### **Impact on Practice**

The We CARE Clinic was established in a community that experiences many health disparities, so this smoking cessation program was implemented to minimize the effects of these inequalities. The immediate impact of this project was to inform providers and practitioners at the We CARE Clinic of the community outreach program developed and to provide education about implementing the smoking cessation toolkit. The toolkit was formulated around the five A method; Ask, Advise, Assess, Assist and Arrange. Through extensive research, it was found that this five A method was a helpful strategy to begin the conversation revolving around smoking cessation. The predicted long-term outlook of this project would be for employees of the We CARE Clinic to use the five A method with every patient at every visit to aid in smoking cessation habits. For the ongoing implementation of this project, the 5 A method can be incorporated into the clinic's charting as a required documentation piece. The recommendation is for the charting to populate follow-up questions as the provider asks each portion of the five A model.

### **Conclusions**

Overall, we achieved the goals we set out for with this project. The staff at the We CARE Clinic found the information we provided beneficial in starting smoking cessation conversations with their patients. They also stated that they would incorporate our education and pamphlet into their discussions on smoking cessation with their patients. Future projects could look at staff adherence to see if they use the information we provided or measure patient outcomes with culturally competent smoking cessation education. We hope our project has a lasting effect on the staff and the patients at the We CARE Clinic.

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