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EDITOR’S PERSPECTIVE

The Challenges of Research & EBP
doi: 10.13178/jnparr.2014.0402.0516

With research and evidence-based practice (EBP) now being more and more an integral part of nursing, it is only timely to examine the challenges that health care organizations (HCOs), nursing management, nursing staff, and patients face along with its integration into practice, as well as appropriate strategies to address these concerns.

Research is a methodical and scientific manner of finding legitimate and valid solutions to clinical problems and concerns employing specific and meticulous means. On the other hand, EBP is the use of the best-proven evidence, integrates clinical experience, and incorporates patient values and preferences in the process of providing professional nursing care in response to identified patient needs and concerns. Melding research and EBP into the day-to-day practice of nursing creates the potential for better quality of care and enhanced patient outcomes.

Many factors brought on this heightened focus on quality and improved outcomes of care. Some of these elements include: (1) the emphasis on the essential role of nurses in healthcare (IOM, 2010; IOM, 1999); (2) the aim by HCOs to achieve designation or re-designation as a Magnet facility (ANCC, 2013) or be accredited as a Pathways to Excellence organization (ANCC, 2012); (3) strict requirements by third party payers of health care for payment and non-reimbursement of services, i.e., payment for performance, bundled payments for care improvement (CMS, 2013), etc.; and, (4) the push to promote and enhance standards of care in nursing.

Nurses are doing more research and EBP initiatives in their respective practice settings. Yet, there are hurdles when it comes to implementing research and EBP findings. Some of these obstacles have been identified to be process, nurse, and organization-related. The process of research and implementing evidence into clinical practice can be quite involved; EBP literature about clinical topics contain too much information and results of the synthesis of research studies can be non-conclusive or sometimes contradictory. Some nurses lack the knowledge and skill in research and EBP, while a few are unenthusiastic, apathetic, or indifferent. There are nurses who claim that incorporating research and EBP activities along with their myriad professional responsibilities can be daunting. Daily patient care workload is already quite substantial that reading and reviewing research literature for implementation can be overwhelming. In terms of organizational issues, some nurses contend that management is unsupportive—whether in terms of providing dedicated time allotted to research, allowing appropriate staffing to lighten the load, supporting their needs to gain better knowledge and skill in the process, streamlining the protocol for clinical implementation of research outcomes or best practices, or aligning the organizational values and priorities with that of patient care needs (Houser, 2012).

As nurses, we are all responsible for promoting what is best for our patients. Research and the integration of the best evidence into our practice will only facilitate the attainment of this end. We need to address these obstacles to enhance the quality of patient care and improve outcomes. It is our professional responsibility to remain current in best practices, as well as obtain continuing education and training on critical areas where knowledge gaps or deficits have been identified. We need to also align our values, priorities, and interests with that of the HCO that we choose to practice for. The same way that organizations need to parallel its strategic approaches with its mission and vision, every member of the staff needs to conform and be one with the goals and aims of the facility. A critical assessment of the fundamental barriers that are specific to the HCO needs to be completed so that a targeted plan of action can be drafted and implemented. Included in the action plan is the identification of key staff, frontline managers, and administrators who will serve as champions and act as role models, mentors, and facilitators to foster an
environment conducive to research and EBP. It is crucial that these individuals provide the motivation and opportunity for nurses to appropriately and readily apply research outcomes in their practice. EBP implementation protocols and guidelines need to be streamlined for nurses not to be discouraged with complex and long-winded processes. Opportunities for education and scientific inquiries should always be fostered. A simple tactical approach, e.g., Research Rounds, is easy to implement. This can be unit-based and scheduled once a week, with the goal of identifying clinical issues and concerns relevant to one’s department and accessing data warehouses for appropriate evidence to address them. Holding regular Journal Club sessions, another customary and established strategy, can be made more interesting. Some units conduct their Journal Club during their lunch hour. Nurses take turns reporting on a journal article that reports research outcomes that might be applicable to their patients’ needs. The staff of a particular unit can also organize a Research Group where members share their ideas and skill to conceptualize and implement research and EBP studies. This can be held during a particular time of the day when most will be available to attend. Research and EBP projects can be presented to the entire hospital staff during a Research Day, not only to share outcomes but also to showcase one’s work and motivate other staff members to participate in future projects. Organizational support can also be extended to the nurses by way of meeting their resource needs. Scientific information is now readily available in the Internet or accessed through electronic databases. Most HCOs subscribe to many information sources and services. These should be open for use whenever staff need to. Patient care units should be equipped with computers that are not blocked to allow access to these resources. Some facilities have created their own EBP portals that provide direct and secure sign-on for staff to avail of these information resources. Better yet, mobile devices should be made available to nurses that can be signed out during their respective shifts. These portable tools should provide direct link to information sources as necessary.

There are many other creative ways to facilitate the focus on research and EBP activities expected of nurses. There will always be challenges and obstacles along the way, but these only make our professional practice more rewarding as we continue to course our energies adapting to the demands of the changing healthcare market. For nurses to continue to be valued, we must always base our care decisions on the best available evidence.

REFERENCES


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The Holy Trinity: Clinical Care, Research and Teaching
doi: 10.13178/jnparr.2014.0402.1613

The Christian theological concept of the Holy Trinity, first described by Tertullian in the early third century, explains that the Father, the Son, and the Holy Spirit are “one in essence—not one in Person.” One God in three persons—the three persons are distinct, yet one in “substance, essence or nature” (The Holy See, 2014). In this context, “nature” is what one is, while “person” is who one is.

The Holy Trinity means that they are co-equal, co-eternal and consubstantial, i.e., defined as identical in essence or substance though different in aspect. Simply put, one cannot exist without the other. This concept describes the three core elements of leading institutions of health care and learning. In prime academic medical centers, the triad of clinical care, teaching and research is the cornerstone of the establishment and is always included under their mission statement. Clinical care and teaching have always co-existed until research also became an integral part of this triad. In order to deliver the best quality care requires excellent educational training of clinicians and scientists, while scientific discoveries through cutting-edge research inform the direction and standard of clinical care and teaching. Evidence-based practice is standard and fundamental. This framework is the theme of this current issue of JNPARR. The articles published in this journal demonstrate the essential nature of how these three elements interrelate to create the whole or the best patient experience.

As nurses, we are experts and specialists in clinical care, teaching, and research. The scope and extent of our involvement in any one or all three components vary from one nurse to another, depending on our professional responsibilities at any one particular time and place. Regardless of the circumstance, we often find ourselves involved in these three core elements. For instance, when evaluating patient outcomes we rely on our education and our knowledge of evidence. As we do research, we look into clinical care and teaching for knowledge gaps to formulate our research statement. When we design educational programs, we delve into the current status of a clinical topic and look for evidence in the literature for best practices. The consubstantiality of the three elements transforms patient care, beyond merely practicing the profession of nursing.

A quote from a leading academic medical center aptly sums it up. “Much of what we take for granted in medicine today – from the rigorous training of physicians and nurses, to the emphasis on research and the rapid application of that research to patient care – emerged from innovations launched at Johns Hopkins. Here, patient care, teaching, and research have always been the intertwined foundational principles” (JHM, 2014).

As I conclude my term as the 17th President of the Philippine Nurses Association of America (PNAA), I wish to recognize and acknowledge the efforts and tireless energy of JNPARR Editor-in-Chief Edmund Pajarillo, Editorial Board & Staff, Advisory Council, and contributing authors, realizing the intricate linkages of clinical care, teaching, and research in very article published. They have taken JNPARR to the next level. We will continue to course our transcending trajectory in order to accomplish and capture the essence of our profession and map our future courses of action. The publication of scholarly articles will afford PNAA the opportunity to seek and obtain funding to continue to elevate and sustain our status as a strong and viable national and international professional organization. We must aim and do the best we can for our members and the patients we care for, and we have done and will continue to.
REFERENCES


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Using Narratives of Individuals and Couples Living with Early Stage Dementia to Guide Practice

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Abstract

Introduction: Most of the research on dementia has focused on care of persons with middle to late stage disease and on caregiver stress and burden. Less is known about the experience of persons with early stage dementia or the shared experience of the person and their spousal caregiver.

Objective: The purpose of this study was to explore the experience of living with early stage dementia from multiple perspectives, namely, the individual, spouse, and the dyad of the person and spouse.

Method: A descriptive phenomenological approach was used to understand the experience of living with early stage dementia.

Method: Six couples agreed to participate in the study with a mean age of 79 years and a Mini-Mental State Examination (MMSE) score of 23 for people with dementia. Seven themes were identified from the data: 1) one theme emerged from those who were actually experiencing Dementia Alzheimer’s Type (DAT); 2) five themes were evident from the spouses of those with DAT; and, 3) one theme was singled out in interviews with the couples (the person with DAT and their caregiver spouse).

Conclusion: The results provide insight into the experience from multiple perspectives. There were several implications for support and services offered to people with early stage dementia, as well as recommendations for future directions for research.

Keywords: Narratives, dementia, older adults, couples, Alzheimer’s

Funding
The authors did not receive a grant from any funding agency in the public, commercial, or not-for-profit sectors.

Conflict of Interest
The authors declare that there is no conflict of interest.
Introduction
Dementia of Alzheimer’s type (DAT) is a slowly progressive neurodegenerative disease. With increasing knowledge of DAT, better diagnostic procedures, and recent advances in available medication, people are being diagnosed and treated much earlier in the disease process. Living with dementia can be disabling and burdensome for many older adults. An aging population and early diagnosis with a longer disease trajectory can also add to the challenges experienced by spouses who often function in the role of caregiver (Alzheimer’s Association, 2012; Alzheimer’s Disease International, 2012).

People with early stage dementia and their caregivers may present different care needs from those in later stages and further research is needed to determine what interventions may be most helpful to them (Burgener et al., 2008). Many of the issues addressed in health programs offered to this population are designed for those with moderate to late stage disease. Sometimes, these services may not be relevant to those with early stage dementia and may not even be of interest to them at that stage of their condition. In addition, people may not be ready to learn about what the future may hold because this stage of dementia can be frightening to them and to many people (Adams, 2006; Dijkhuizen, 2008; Ducharme, Beaudet, Legault, Kergoat, Lévesque, & Caron, 2009; Harman & Clare, 2006; Quinn, Clare, Pearce, & van Dijkhuizen, 2008; Zabalegui et al., 2008).

Several studies have noted that caregivers of those with early stage DAT receive little information about the condition and are often disappointed at the lack of support provided during the time of initial diagnosis (Cummings, 1997; Hain, Touhy & Engstrom, 2010; Laakkonen et al., 2008; Nichols et al., 2008; Robinson, Clare, & Evans, 2005; Quinn et al., 2008). Problems not addressed early in the caregiving trajectory may have long-term implications for psychosocial outcomes such as burden and depression. The lack of evidence describing the person with DAT, experiences of caregiving in early stage dementia, and the couple (DAT individual and the caregiver-spouse) most likely contributed to the paucity of interventions aimed at helping this population.

There is growing awareness of the importance of understanding the experience of dementia from multiple perspectives in order to understand the “complexity of the caregiver-care recipient relationship” (Hellstrom, Nolan, & Lundh, 2007, p. 406) and to help develop strategies to enhance quality of life for both parties in the relationship (Braun, Scholz, Bailey, Perren, Hornung, & Martin, 2009; Clare, 2002; Davies, 2011; Hellstrom et al., 2007; Hellstrom, Nolan, & Lundh, 2005). There has been little investigation of the experience of either spouse-caregivers of persons with early stage dementia or of the experience of the couple together. In a review of the literature, only three studies were identified that explored the experience of the couple living with early stage dementia that involved interviewing them together (Daniels, Lamson, Hodgson, 2007; Davies, 2011; Robinson et al., 2005). It is increasingly important for health care providers to recognize that when Alzheimer’s disease enters the life of an individual, it also “enters the intimate bond between a husband and wife” (Daniels et al., 2007, p. 162).

The purpose of this study was to explore the experience of living with early stage dementia from multiple perspectives: the individual with early stage dementia of the Alzheimer’s type; the spouse of the person; and the dyad of the person and spouse. It is hoped that the findings of this study will support future research initiatives and the development of programs and services to assist the caregiver and hopefully improve health outcomes for people with dementia.

Method
A descriptive phenomenological approach was used to understand the experience of living with early stage dementia.

Institutional Review Board (IRB) approval was obtained before a convenience sample of participants was recruited from existing clients at a nurse-managed memory disorder clinic in Southeastern Florida.
Inclusion criteria were a medical diagnosis of early stage dementia of Alzheimer’s type (as reported by caregiver), Mini Mental State Examination (MMSE) (Folstein, Folstein & McHugh, 1975) score 20 or higher, able to speak and understand English, and willing to be audiotaped. Those with an MMSE score between 20 to 23 were asked to tell the interviewer in their own words what the study was about, what risk they would be taking, and what they should do if they changed their minds (Agency for Healthcare Research and Quality [AHRQ], 2009). Individuals were informed that participation in the study was voluntary and that withdrawal at any time would not jeopardize the care they received at the center.

Data Collection
Semi-structured interviews were conducted in a private office at the center at a time that was convenient for the participants. The following questions and statement guided dialogue about the experience of living with early stage dementia: (a) Tell me about the experience of living with dementia; (b) What matters most to you right now?; (c) What have been the hardest points along the way?; (d) What has helped you along the way?; and (e) What do you hope for the future?

Two of the authors of this article (TT and DS) who were experienced in caring for this population interviewed the spouses and the person with early stage dementia separately in different rooms. One week after the individual interviews, the couples were interviewed together. These meetings lasted from thirty(30) minutes to one hour. Interviews were audiotaped, transcribed verbatim, and were de-identified. Data were stored in a locked cabinet at the memory disorder clinic.

Data Analysis
Giorgi’s Descriptive Phenomenological Method (Omery, 1983) was used to analyze the data. The analysis involved searching for common patterns or themes. The authors repeatedly read the interview notes as the first step in the data analysis process. Transcription notes from the three respondent sets—the person with early stage dementia, the spouse, and the couple—were read and analyzed separately. In the next step, redundancies were eliminated and the meanings of the remaining constituents were clarified and elaborated on to form more general statements. Each transcript was analyzed and similarities and differences between interview notes were observed until a pattern of understanding emerged. The concrete language was transformed into a higher level of abstraction by summarizing the data in detail.

Themes were validated by returning to the original data and were then extracted from summaries and clustered with similar ones. Finally, themes were integrated and synthesized into a descriptive structure of the experience of living with the challenge of early stage dementia from the perspective of the individual and the couple. Illustrative quotes were added to provide for better understanding and richness. Constant reflexive discussions among the authors were part of the analysis until consensus was reached about the themes presented.

The researchers used the criteria for trustworthiness formulated by Lincoln and Guba (1985), e.g., credibility (truth value), dependability (consistency), confirmability (neutrality), and transferability (applicability). Credibility was demonstrated through peer debriefing and member check. The researchers established dependability by independently conducting the analysis, comparing findings, and using reflective consensus to assure the outcome mirrored what participants said. Confirmability was achieved by assuring that findings demonstrate the voice of the participants and not the researchers’ bias, motivation, or perspectives. A thick description of the findings that includes exemplars provides other researchers evidence that may be applied to clinical practice and future research.

Results
Six couples agreed to participate in the study, i.e., five men and one woman with early stage DAT, and five women and one male spousal caregiver. The age of the participants with early stage dementia ranged from 71-85 years of age (mean = 79.3). MMSE scores ranged from 20-25 (mean = 23.3). Spousal caregivers ranged in age from 61-81 (mean = 73.6) and number of years married ranged from 22-60 (mean = 44.8).

Themes that emerged from the data are presented as individual with DAT theme, spousal themes, and couple theme. One theme that emerged from interviews of those with early stage dementia was trying to do the best I can. Five spousal themes were identified: (1) living with frustration; (2) living with losses; (3) everything on my shoulders; (4) hoping against hope; and, (5) one day at a time. One theme resulting from interviews with the couples was trying to do things that help.

Theme from Interviews with Individuals with Dementia

Trying to do the best I can. The theme emerging from interviews with participants experiencing early stage dementia focused on their awareness of their waning abilities and the effort to maintain their physical, cognitive, and social skills. They were concerned about the stress on their spouses and were trying to find ways to continue to participate in activities they usually enjoyed while attempting to do things to improve their cognitive and physical function. One individual said:

“I forget words. Sometimes it doesn’t mean much and other times it means a great deal. I have learned ways to avoid mistakes like shaking hands when I don’t remember the person’s name, joking, looking at their faces for a reaction.”

Another said,

“I try to make things normal and appear OK. I don’t want to upset my spouse or look abnormal to other people.” One participant stated, “I do understand why the painting and pictures and playing of cards and doing all of these different things are to keep my brain going.”

The individuals interviewed with early stage dementia also expressed hopes that they could improve their memory, their functional ability, and enjoy every day as illustrated by the following quotes:

“The hope is that I’ll be able to improve with my walking and my memory and our relationship. I don’t want to be pushed around in a wheelchair. I am eighty-six. I just have to be patient.”

“I hope I can take care of myself, keep active, not be bedridden, and a burden.”

“What you do is hope you had an easy day that’s all and there are a lot of things that we want to go to, have both children married and we have grandchildren so you have to think about that.”

The person with early stage dementia also discussed the importance of doing all they could to stay as good as they could was evident in the following quotes:

“I am trying as much as I can to improve my memory.”

“I am beginning to learn more about myself and I guess the fact that if I am going to hang around, I may as well have fun doing it.”

Involvement in the memory disorder clinic day program was seen by the individuals with early stage dementia as something that helped them do the best they could. Particularly important to them was being in a program where they are treated with respect and valued for the person they are. One participant stated:

“They (memory disorder clinic staff) are very good, they don’t knock you down. They make you feel like a real person. One thing I kept saying is that they never say ‘dearie’ or ‘honey’ to me, that’s not right. I wear a name tag and I think it’s wonderful in any place that you wear a name tag.”

Using Narratives of Individuals and Couples Living with Early Stage Dementia

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Themes from Interviews with Spousal Caregivers
Consistent with results of many other studies, the role of a caregiver of a person with early stage dementia can be complex and very demanding. Five themes captured the essence of the experience of living with a person who has early stage dementia.

Living with frustration. Frustration related to behavioral issues and communication is often accompanied by feelings of guilt because the caregiver is unable to do more. As expressed by one participant, “Sometimes it’s very frustrating and sometimes its ok…I’m feeling guilty sometimes that I can’t do more for you now.”

Another conveyed frustration related to repetitive statements made by his wife: “She’ll ask me the same question a thousand times…and the answer just doesn’t go in. She hears it, but it doesn’t sink in. So, she’ll ask me the same question again. Then if I am frustrated, I turn around and try to bite my tongue.”

One day at a time. The spouses evidenced a strong preference for living in the present and avoided looking into the future. One participant disclosed: “I guess it is just sort of a day to day thing because you don’t know what the future is going to be.”

And another stated, “I can’t worry about what’s going to happen in a year or two.”

They deal with the events of the day as they occur, as expressed by another caregiver: “We live each day... whatever happens down the road you live with it.”

Although looking into the future may be difficult, some communicated that they looked forward to good days: “When it’s over, tomorrow we’ll be better...yesterday was a wonderful day and I put out of my mind completely that anything could be wrong.”

Hoping against hope. Even though caregivers realize the person will most likely get worse, they continue to hope for a meaningful and pleasurable life without too much suffering for their loved one. One participant disclosed: “We are just praying that whatever it is will advance slowly: it shouldn’t get too much worse. We’re hoping that for as many good days, months, years that he’s got left, he can get pleasure out of it and enjoy and be able to inter play with the children and the grandchildren and our friends. If he goes with a heart attack in the middle of the night, well, we’ll just put the money in the whiskey jar and say thank you. This is our attitude.”

Living with losses. Emotional losses that caregivers experience often are related to changes in the established relationship. Perhaps the most profound was the lost sense of coupleness. One wife put it this way: “Hardest is the loneliness because you know we’re not a couple anymore...there’s just not that communication that there used to be”.

Another said, “I miss the old B very much but I am grateful for the one I have.”

The lost sense of coupleness seemed closely related to a lost sense of mutuality particularly in communication. Communication seemed to be affected in multiple ways. The persons with cognitive impairment...
were neither as expressive nor as receptive as had been in the past. One spouse said:

“He doesn’t talk much and sometimes I don’t think he is listening to me, but he says he is. Just the other day I said you know I felt like I was talking to a blank wall.”

Another said,

“He doesn’t have empathy for me anymore.”

Yet another spouse indicated that she felt compelled to alter her own communication patterns saying,

“I have to be very careful with what I am saying and how it affects him. It should be spontaneous if you know what I mean, and it’s different.”

Additionally, spouses were mourning the loss of their previous ways of life particularly with regard to social activities. This aspect was evident in statements such as:

“He doesn’t want to socialize and he really doesn’t have much interest in things.”

Examples of lost pleasures included activities ranging from vacations to sex.

“I feel really bad for him. We always enjoyed a good sexual relationship; we always had one but I really feel badly for him if he can’t perform, he can’t. I can’t help it.”

One spouse summed it up succinctly stating, “I miss the old B very much.” Yet, another participant stated, “at times I feel my life is lost.” Another said, “I don’t have freedom anymore.”

**Everything on my shoulders.** Caregivers evidenced a clear sense of increased responsibility. From partnerships that once involved well-defined divisions of labor and substantial independence, responsibilities had shifted to the shoulders of one party. Responsibilities included doing all of the driving and taking care of the finances, household chores, and medical care management. One spouse said:

“The fact that he can’t drive is difficult. I am now his chauffeur and I have to worry where he’s going to be, and what he is going to be doing every day, and find a way to get him there and that’s difficult.”

Spouses took the role of insuring proper care for their loved one very seriously. This included monitoring medications and symptoms, arranging medical appointments, seeking the best sources of care and services, and trying to maintain or improve cognitive and physical function. One respondent described shifts in relationships stating:

“We have never spent so much time together as we do now. He had a car, I had a car. I had a life; he had a life.”

One spouse summed it up this way:

“I feel like I am a widow with a husband because everything is on my shoulders.”

**Theme from Couple Interviews**

**Trying to do things that help.** In the couple interviews, the participants expressed how they were trying to do things that may help in maintaining and improving function and in making the best of the difficult situation they faced as a couple. This was supported by the following two quotes from spouses:

“We want to keep the level he’s at and that’s why I get the help.”

“I am trying to keep you far away from what your mother experienced.”

Both the caregiver and the individual with dementia viewed participation at the memory disorder clinic as a very positive experience. One wife said,

“He would not be able to live with me if not for the M &W Center.”
Spouses tried hard to do the right things for their husband or wife with memory loss and expressed that their journey is easier when their partner is doing well. In the words of one wife, “I would be better if he were better.”

While experiencing challenges of living with early stage dementia was often difficult, several expressed that their love and commitment to each other was a driving force in their ability to cope. One participant stated:

“She is my life, so it is something we live with, take each day as it comes, one day at a time and we’ll bear with it.”

The couple acknowledged that as people age, many face health challenges and, even if it is not easy, life continues and you do the best you can. In the words of one spouse:

“Do the best you can with what you have and pardon the expression, bitchin don’t help.”

Discussion
The findings of this study contribute to the growing body of knowledge of how challenging living with early stage dementia can be for the individual and the spouse-caregiver. Although evidence-based assessments and standardized instruments are available for clinicians to use in practice, these often fail to capture the uniqueness of the experience of living with dementia (Clare, 2003). Gleaning from the narratives in the perspectives of individuals with DAT, spousal caregivers, and couples provide insight into the complexity of living with early stage dementia and enhance the understanding of what matters most to the individual with DAT and the spousal caregiver.

The themes that emerged from the caregivers narratives indicated that they are trying to do the best they can to ensure that their loved ones receive optimal healthcare and that life can be as pleasurable as possible. Similar to other studies, caregivers often do not focus on their personal needs; instead, they attempt to deal with the psychological roller coaster of living with someone with a neurodegenerative progressive disease (Auclair, Epstein & Mittelman, 2009; Clare, 2002; Cummings, 1997; Daniels et al., 2007; Hain et al., 2010; Hellstrom et al., 2007).

Communication difficulties with a loved one can be a major source of stress for caregivers. The current study indicated that individuals with early stage dementia also experience frustration in trying to communicate effectively and, most importantly, they were quite aware of their own difficulties. For both the person with dementia and the caregiver, opportunities to express their frustration and anger over communication difficulties and receive validation of their feelings are important aspects of clinical practice. Old communication and coping patterns often need re-evaluation. Effective strategies to maintain and enhance communication and deal effectively with stress can be taught and role-modelled. Williams (2009) described CARE (Communicating About Relationships and Emotions) as an innovative approach. CARE involves working with the couple in their home to assist them to maintain their relationship despite declining verbal communication on the part of the person with dementia. Couples learn strategies on how to respond to communication challenges and the person with dementia gets an opportunity to practice conversation with a nurse who serves as a role model for the caregiver.

Living with losses is also described in other studies (Adams, 2006; Chan, Livingston, Jones, & Sampson, 2013; Garand et al., 2012; Hain et al., 2010; Robinson et al., 2005; Quinn et al., 2008). The ongoing process that couples experiencing early stage dementia engage in has been described as making sense and adjusting to loss. This entails “acknowledging current difficulties and losses while also recognizing resilience and coping strategies” (Robinson et al., 2005, p. 343). With dementia, losses are subtle, incremental, and occur over a period of years. Examples may be loss of a confidante, loss of driving ability,
loss of social roles, and loss of relationship. Spousal caregivers need opportunities to share their losses, express their sadness and other emotions, and develop strategies for coping with changing relationships.

The individual with early stage dementia in this study also expressed losses. Many expressed awareness of the loss of the previous relationship with their spouse, the loss of their former roles, and the burden placed on the spouse as a result of the disease. Other studies exploring the experience of the individual with early stage dementia reported similar findings (Koppel & Dallos, 2007; Langdon, Eagle & Warner, 2007; Noyes et al., 2010; Robinson et al., 2005). Losses and grief reactions can manifest in behavior changes, frustration, and depression that can go undetected (Langdon et al., 2007). This has been largely unexplored in the literature and illustrates the importance of including the individual with dementia in research as well as assessing for grief and depression in persons with early stage dementia.

When caring for individuals with DAT and their caregivers, it is important to involve the person living with the illness. The couples in this study could tell their stories and express their thoughts and feelings. Too often, assessments and interventions focus on the needs of caregivers and while important, the voice of the individual with dementia should not be ignored. Obtaining a history from people with dementia during a clinical evaluation or when conducting an interview for research is often viewed as challenging. Dewing (2002) suggested that interviewing people with dementia “is often seen as being fraught with problems of credibility because of memory change, and perceptual language and other communication changes…the real issue is around accessing the meaning of what is being communicated and interpreted. Both issues need to be more clearly described in the context of dementia research” (p. 166).

Living day to day and trying to stay positive while hoping for a slower decline in cognitive function and for continued enjoyment of life is a way of coping that has been noted in other studies of individuals, caregivers, and couples experiencing early stage dementia (Adams, 2006; Hellstrom et al., 2007; Hellstrom, 2005; Robinson et al., 2005; Quinn et al., 2008). The future was seen as frightening, depressing, uncertain, and unpredictable, so they chose not to worry about it and instead enjoy what they could by living one day at a time. This way of coping was reflected in this study by the participants with dementia, the spouses, and the couple together. Hellstrom et al. (2005; 2007) suggest that constructing an awareness of dementia and how to live with it is a dynamic and purposeful process that involves considerable emotional work. Sustaining uncertainty may be helpful. This can create a space to exist where there is mutual acknowledgment of the condition but a failure to let it dominate daily existence. These authors challenge the notion that promoting active open awareness in which people discuss the future is not necessarily the most desirable outcome.

Taking an approach that considers individual desires to live day to day rather than learn what the future may hold can help caregivers avoid becoming overwhelmed by anticipating too many problematic futures at once. On the other hand, this can prevent them from engaging in proactive planning. Frequently, healthcare professionals, in an effort to avoid catastrophic events, stress the importance of planning for the future. One of the reasons for early diagnosis is to facilitate planning for upcoming needs of the person with a cognitive disorder while the individual is still able to participate in the process. Further exploration of this phenomenon is important so that healthcare professionals can more appropriately and effectively prepare for the management and care of the individual while the dementia is still in its early stage.

The theme of trying to do the best I can that emerged from the interviews with the participants with early stage dementia suggests the need for opportunities to function in social and relational situations in ways that preserve normal functions and roles to the maximum extent possible. Several other studies (Harman & Clare 2006; Langdon et al., 2007; O’Connor et al., 2007; Sørensen, Waldorff & Waldemar, 2008) reported similar findings that suggest that the individual with dementia “actively engages in a preservation of their self” (O’Connor et al., 2007, p. 60).
Of great importance to the individuals with dementia was participation in programs that enhance cognitive and physical functioning and slow the progression of the disease. Feeling competent and capable in learning new things, participating in stimulating activities, socializing with people who have similar interests, and feeling respected rather than patronized, were noted as valued components of day center programs that contributed to self-preservation. Perry and O’Connor (2002) also suggest the importance of avoiding patronizing and belittling approaches when planning care as this may increase reluctance to seek formal support services.

Creating an environment where the person with early dementia and their spouse feel free to express their thoughts and feelings individually before the couple was interviewed together was crucial in this research, an important element that was also noted by Snyder, Quayhagen, Shepherd & Bower (1995). This allows their unique needs and challenges to be heard and validated before the couple engages in shared discourse. This also helps provide the needed support for pressing caregiver concerns so that they do not overshadow the couple dialogue and stifle the expressions of the individual with dementia.

Interventions to enhance couple relationships are important and may promote more positive outcomes for the individual with dementia and for the caregiver (Norton et al., 2009). Couples appear to want activities aimed at helping the person with early stage dementia maintain maximum cognitive and physical function for as long as possible—understanding this as being beneficial to both parties.

**Conclusion**

The face of dementia is changing and models of support services and programs also need to change. As healthcare providers strive to achieve the best health outcomes for people diagnosed with DAT, it is important to consider the needs of people at the early stage of this medical condition as well as the needs of their caregivers. Hearing the whole story is essential; the stories of the person with early stage dementia, their caregiver, and the couple vary from each other and call for different responses and interventions. Tailoring interventions based on their specific needs will assist in promoting positive outcomes based on the unique story rather than expecting a one-size-fits-all approach to be of value to everyone. It is no longer adequate to provide only day programs and support groups for caregivers of individuals in middle to late stage disease at memory disorder clinics.

A challenge for the future is to develop evidence-based programs that reflect the needs of individuals with dementia and their caregivers during the course of the illness and during the stages of the caregiving process for those serving in the caregiver role. In a review of exemplar programs for early stage dementia, Burgener et al. (2008) suggest that multimodal interventions, though complex to evaluate, hold promise and need further investigation. They also suggest that the approach to interventions be “broad based to include all potentially promising intervention strategies until sound research provides evidence to the contrary” (p. 304). Telephone interventions (Connell & Janevic, 2009; Mason & Harrison, 2008), technology-based support (Hanson et al., 2005), home-based interventions (Nichols et al., 2008), couples counseling (Auclair et al., 2009), communication enhancement (Williams, 2009), participation in shared social activities, and family and community involvement are some novel approaches that require further investigation as we continue to develop evidence for practice.

We know that this is “not your grandmother’s Alzheimer’s disease” (Guidance, 2008, p. 3) and we suggest that the research, clinical practice, and support and services must change to reflect the changing faces and experiences of those living with this growing health challenge.

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A Culturally Congruent Education Group: An Evidence-Based Approach to Improve Prenatal Care Utilization

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Abstract

Introduction: This report describes a culturally congruent education group that addressed disparities in prenatal care utilization among Pacific Islanders. Inconsistent compliance with maternal care guidelines despite awareness of their importance, late entry to prenatal care, and poor birth outcomes provided solid evidence to support a practice change.

PICO Question: “Would implementing a culturally congruent education group increase the utilization of prenatal care among Pacific Islander women?” The population refers to Pacific Islander women who were at least 18 years old, not pregnant, of child-bearing age, and living in a southwestern state county. The practice change integrated preferred teaching methods by Pacific Islanders, involved resource persons and ecclesiastical leaders of Pacific Islander heritage, and provided food and prize incentives during the educational sessions. Before and after knowledge and motivation levels were compared. Intended outcomes referred to increased knowledge and improved motivation to utilize prenatal care.

Methods: A 15-item self-report questionnaire was utilized to measure two outcomes: increased knowledge of prenatal care concepts and improved motivation to utilize prenatal care. Pretest and post-test were conducted to measure the knowledge and motivation levels before and after the intervention program. The Theory of Culture Care and Diversity guided the organizational framework which integrated the values and practices of the Pacific Islanders. The PARIHS (Promoting Action on Research Implementation in Health Sciences) guided implementation.

Implementation: There were four educational sessions that discussed physiological changes, access to care, nutrition, lifestyle, and complications in pregnancy. The topics were based upon systematic reviews of pertinent issues in prenatal care. The one-hour sessions were conducted every Sunday after church meetings at a chapel among members of a church congregation.

Evaluation & Discussion: Findings indicated that the education group met the intended outcomes and confirmed certain areas influenced by cultural values. The culturally congruent education group was an effective mode of instruction for the Pacific Islander women and could be utilized in a population-based nursing practice to promote health, mediate healthcare disparities, and address various health concerns common among minority groups congregating within a faith-based structure or in community-based settings.

Keywords: prenatal care, Pacific Islanders, utilization, culturally-congruent, education
Introduction

Prenatal care is essential in monitoring maternal and child health during pregnancy. It is linked to improving birth outcomes because early entry and regular prenatal care visits increase the chances of a healthy pregnancy by reducing the risks for maternal and infant complications (American Congress of Obstetricians and Gynecologists, 2012; Eunice Kennedy Shriver National Institute of Child Health & Human Development, 2012). Inadequate and inconsistent prenatal care utilization among women from different racial and ethnic backgrounds has been documented (Cox, Zhang, Zotti, & Graham, 2011; Benjamin, Capitman, & Ruwe, 2009; Park, Vincent, & Hastings-Tolma, 2007), including Pacific Islanders (PI), whose rate of prenatal care utilization ranks way below those of the other minority groups living in a southwestern state (Utah Department of Health, Office of Vital Records, 2011; Korinek & Smith, 2008).

With the national health agenda’s overarching goal to eliminate disparity in healthcare coverage and to provide health equity to all ethnic and racial groups (Healthy People 2020), it is imperative for advanced practice nurses to address these issues by reducing or eliminating barriers to health and wellness among all groups of people. The paper describes this project designed to implement a culturally congruent evidence-based education group to improve prenatal care utilization among Pacific Islanders (PI) and thus reduce healthcare disparity in this area.

Background

Studies from Utah’s health department and state summary reports point to the inadequate utilization of prenatal care (Utah’s Indicator-Based Information System for Public Health (IBIS), 2013) and high incidence of infant mortality and preterm births among this population (Utah Department of Health, 2013; Utah Department of Health, Office of Vital Records, 2011; Korinek & Smith, 2008). Although this population comprises only about two percent of the state population (U.S. Census Bureau, 2013), the consistent record of low prenatal care in this group compared to the other groups residing in the state and the resulting major emotional and financial burden warrant a more focused look into why the problem persists even if there is access to prenatal care. Using prenatal care in the first trimester as an indicator to assess disparities in health care, Pacific Islanders participated the least among others groups of people residing in the state (2011). Despite widespread awareness of specific maternal health guidelines, Pacific Islanders do not comply with the protocol consistently (Utah Department of Health, Office of Health Disparities, 2012). They would often seek counsel from female relatives and cultural elders whose advice they seriously consider.

Significance

Inadequate prenatal care utilization among Pacific Islanders is a very relevant problem in clinical practice because it can deeply impact birth outcomes. Although there is no study encountered to date by the project leader about the direct correlation of low prenatal care utilization and poor birth outcomes specific to Pacific Islander women, it has been established that prenatal care is crucial in monitoring maternal and child health. Women who do not utilize prenatal care increase their risks of having babies who are three times more likely to have low birth weights or having infants who are five times more likely to suffer from mortality (U.S. Department of Health and Human Services, Office on Women’s Health, 2009). The emotional toll of infant demise or personal strain from taking care of infants who are born preterm could be very challenging for the mother, father, and the entire family due to the increased demand in time, effort, and family resources. Added to these stressors is the serious economic burden of preterm births, averaging $60,000 for an infant born preterm in Utah, compared to an average of $2,400 for a full-term infant (Utah Department of Health, 2013).
PICO Question (Problem, Intervention, Comparison, & Outcome)
The PICO question for the identified clinical problem is:

“Among Pacific Islander women, would implementing a culturally congruent education group increase the utilization of prenatal care?”

The population of focus were women of Pacific Island descent who were at least 18 years and older, not pregnant, of child-bearing age, and lived in a southwestern state county. The women were able to access prenatal care in different health care settings such as private clinics and community centers. The intervention program was a preconceptional education group to improve prenatal care utilization within a faith-based structure. The comparison was grounded on a pretest/posttest design that assessed knowledge of prenatal care and motivation to utilize it before and after the educational intervention. The intended outcomes were increased knowledge of the different components of prenatal care which included physiological changes of pregnancy, access to prenatal care coverage, nutrition and vitamin supplements, complications, and lifestyle during pregnancy. The second outcome was improved motivation to access prenatal care early and follow the recommended number of prenatal care visits during the pregnancy period.

There was evidence from the literature review of disparity of prenatal care utilization among minority groups nationwide, including Pacific Islanders. Empirical data gathered from 2006-2012 by the clinical experts from the Utah Department of Health consistently established solid evidence of inadequate prenatal care and unsatisfactory birth outcomes among Pacific Islanders. There is strong evidence that supports a practice change and the use of a culturally congruent education group due to inconsistent compliance with health guidelines despite widespread awareness of their importance (Utah Department of Health, Office of Health Disparities, 2012). Women preferred to seek counsel from their female relatives who may not necessarily be aware of evidence-base maternal child health practices.

Theory & Evidence-Based Practice Conceptual Model
The Theory of Cultural Care Universality and Diversity (Leininger & McFarland, 2005) was used as the framework in designing a culturally congruent education group to improve prenatal care utilization among Pacific Islanders. The theory’s component of “cultural care accommodation” (George, 2011) considered the use of this population’s preferred teaching methods (Utah Department of Health, Office of Health Disparities, 2012) to implement a practice change that improved knowledge about prenatal care and increased motivation to utilize it. The PARIHS (Promoting Action on Research in Health Services) framework’s three dimensions of evidence, context, and facilitation (Rycroft-Malone, 2004) pulled in the different components of the PICO question and rated “high” in the continuum as described in each category. It guided the successful implementation of the culturally congruent education group among the Pacific Islander women.

Project Pre-Implementation
Pre-implementation planning required thorough inquiry into the different components to increase the chance of successful implementation of the practice change project. It is not sufficient to just “have the knowledge of the best evidence to guide clinical practice; that knowledge must be translated into clinical practice to improve patient care and outcomes” (Melynyk & Fineout-Overholt, 2011, p. 205). The intended outcome was to increase the respondent’s knowledge by at least 75% after participating in the prenatal care education group. The intended outcome to increase motivation was above 43%, as it has already been established that only 43% of Pacific Islander women utilized prenatal care in their first trimester of pregnancy (Utah Department of Health, Office of Vital Records and Statistics, 2011).

Project Implementation
The regional and local church leaders granted permission for the group to be held at the chapel every Sunday at 4:15 P.M. after the three-hour church meeting. The meetings started on October 13 and ended
on November 3, 2013. There was a designated topic for each session and food was served every meeting. The participants belonged to one of the 12 Pacific Islander church groups in the region. There were 11 women who participated during the first meeting and five of them completed the educational sessions.

Meeting 1: Physiological Changes and Access to Care
The Pacific Islander female physician reported the data from the Utah Department of Health which revealed the late entry to prenatal care and the high rate of infant mortality among this population group. She discussed the physiological changes during pregnancy and the importance of prenatal care in taking care of both the mother and the baby. She demonstrated the cardiovascular demands and temperature changes in a pregnant woman by having a participant’s husband carry an 18-pound backpack containing canned goods on the front of his body. He was also asked to put a jacket on and competed with his wife in spooning the water from one container to another. He had a more difficult time with the task and attributed this to his load and feeling warmer from wearing the jacket. The project leader discussed “Access to Care” which focused on finding ways to avail of prenatal care coverage and programs, including the “Baby Your Baby” program, sponsored by the Utah County Department of Health.

Meeting 2: Nutrition, Healthy Snack Preparation and Use of Supplements
The lesson was taught by a Japanese-Hawaiian woman who is an elementary school teacher and was trained in nutrition and healthy snack preparation. She discussed the role of nutrition, the importance of a healthy diet even prior to pregnancy, and the benefits of vitamins, minerals, calcium and folic acid for fetal development. She prepared smoothies with spinach and other fruits and vegetables and made “sushi” with brown and white rice and other healthy condiments. She discussed the importance of appropriate weight gain during pregnancy and the recommended weight gain of 25-35 pounds. She also taught alternatives to high caloric food and condiments which have high sodium content, e.g. soy sauce, used frequently by Pacific Islanders.

Meeting 3: Lifestyle-Exercise for Stress and Weight Management, Seat Belt Use, Abstinence from Alcohol, Smoking, and Drugs
The resource person was a female Pacific Islander pre-medical student who also majored in Dance. She discussed the importance of exercise to relieve stress, other stress management skills, the benefits of sleep, and allocating time for relaxation. She demonstrated the use of the large exercise ball, tennis balls, round pillow, and balancer that could be integrated into daily exercise routine. She underscored the use of different body techniques that women could do while doing simple household chores. She also demonstrated meditation and discussed simple strategies to integrate exercise in daily activities. The project leader discussed the importance of seat belt use and the harmful effects of drugs, alcohol, and tobacco to the mother and the baby.

Meeting 4: Complications of Pregnancy
In the final meeting, the Pacific Islander physician discussed potential complications of hypertension, diabetes, and eclampsia during pregnancy. She also discussed probable problems associated with short interpregnancy interval which was cited as one of the problems among Pacific Islander women (Utah Department of Health Office of Health Disparities, 2012). Post-test was given to the five participants who completed the education group.

Evaluation and Outcomes
Knowledge. Knowledge increased in five of the nine areas and met the 75% benchmark related to important concepts in pregnancy. The five areas where the education group successfully met the intended outcomes based on the respective p values at 0.10 and below were:

1. the importance of prenatal care for the mother and the baby,
2. the use of prenatal care to assist the mother take care of herself and the baby,
3. the use of prenatal care to reduce the risk of pre-term births,
(4) knowledge that prenatal care can reduce the risks of babies with low birth weights, and (5) lifestyle which included weight management, seat belt use, and abstinence from alcohol, drugs, and tobacco. Knowledge about (1) nutrition, (2) complications during pregnancy, (3) reliance upon relatives to take care of themselves and their babies, and (4) exercise did not increase after the education group was implemented.

**Motivation.** Motivation increased to 100% in five out of six areas related to utilizing prenatal care and far exceeded the 43% benchmark of prenatal care utilization. Questionnaire items that measured motivation in utilizing prenatal care showed statistically significant increases in five areas based on the \( p \) values: (1) accessing care, (2) following the recommended prenatal care schedule, (3) seeking support from family members to obtain prenatal care, (4) seeking a health practitioner when pregnant, and (5) availing prenatal care as soon as knowledge of pregnancy occurs. Motivation to overcome barriers to get prenatal care was not impacted by the education group.

**Effectiveness of the Practice Change**
The practice change effectively met the intended outcome to increase knowledge in lifestyle, birth outcomes, and role of prenatal care, suggesting that these concepts be included in teaching prenatal care classes. Although knowledge about reliance upon relatives to teach the woman about taking care of herself and the baby during pregnancy, nutrition, complications, and exercise did not increase, these findings actually confirmed that Pacific Islanders were aware of maternal healthcare guidelines and their importance, but compliance was inconsistent (Utah Department of Health, Office of Healthcare Disparities, 2012). The practice change effectively met the intended outcome to improve motivation to utilize prenatal care as it successfully improved the participants’ motivation in five out of six areas. However, motivation to overcome barriers in obtaining prenatal care was not impacted and suggested of ingrained values that hindered motivation to utilize it. Education helped the women feel that they can make a choice, but this did not offset the cultural value of depending upon relatives for healthcare guidelines. Knowledge and motivation findings suggest that there are health practices embedded within the Pacific Islander culture which are difficult to change.

**Implications for Nursing**
Implications for this practice change were explored within the context of three domains to which the practice change mostly spoke to in the Quad Council of Public Health Nursing Organizations Core Competencies for Public Health Nurses (Quad Council Competencies for Public Health Nurses, 2011). **Cultural competency skills** considered the cultural dimension of inadequate prenatal care utilization among Pacific Islanders (PI) to design the education group. It could also be used to tackle health diabetes, hypertension and cardiovascular diseases prevalent among the PIs (Utah Department of Health, Office of Health Disparities, 2012). It is a primary level of prevention strategy, suggesting that cultural competency skills are needed to drive a population-based initiative. **Community dimensions of practice skills** were used to establish relationships with various stakeholders. Partnerships were forged with the state health department’s Office of Health Disparities, Pacific Islander Coalition Task Force, resource persons from the Pacific Islander community, and a faith-based group where majority of PIs belonged. It also gave the opportunity for the project leader to be a part of the Pacific Islander Coalition Task Force, a group of PIs who volunteer their time and effort to promote the health and well-being of the Pacific Islander community. This would be the basis of future public health nursing initiatives that this project leader planned to pursue to address health issues in the PI community. **Leadership and system thinking skills** drove communication and collaboration with the Director of the county health department and the state health department’s Office of Health Disparities, local and regional ecclesiastical leaders and resource persons. Ethical practice in delivering public service called for a trusting relationship between the various stakeholders and the project leader who was not a Pacific Islander but was basically allowed to introduce change within the PI culture.
Limitations of the Project
The first limitation was the restricted time frame to conduct the education group according to the availability of the participants. There was no other time to meet with them at the chapel except on Sundays after they have already attended the three-hour church service and would have normally gone home. The education group meeting after church was difficult for most of the participants who needed rides with their families. The second limitation was that the solicitation letter was not allowed to be put up in the chapel’s bulletin board where people usually looked for announcements because the activity was not church-related. However, the letter was downloaded in Facebook and announced in the church’s meeting for women.

Recommendations for Practice and Education
The education group was a pilot project to target a specific problem in prenatal care utilization in the Pacific Islander community. Recommendations for nursing practice include a system level change through collaborations with church leaders in the regional level to increase awareness of inadequate prenatal care utilization among their local Pacific Islander congregations. Prenatal care teachings could be integrated in church newsletters and in women’s monthly church meetings. One of the participants who successfully completed the education group meetings and was positively impacted by the project suggested prenatal education sessions be conducted during “Ladies Night,” an informal event. Church leaders are also usually the community leaders who should be tapped to help promote public health initiatives (Patterson, Grenny, Maxfield, McMillan, & Switzler, 2008). It is also recommended that partnerships be created between schools with public health nursing students and the Pacific Islander community. This collaboration will afford the opportunity for students to perform health screening programs to identify those at risk for diabetes, cardiovascular diseases, and other chronic illnesses that are common among Pacific Islanders (Centers for Disease Control & Prevention, 2013). A similar education group can be used as a platform for primary level of prevention by increasing the participants’ knowledge and motivation to pursue healthy lifestyles and dietary changes. The community-based participatory research (CBPR) approach is also recommended so that Pacific Islanders can become active participants in addressing health issues afflicting their own community (National Institutes of Health, n.d.).

Conclusion
Health behavior is intrinsic and culturally-based, making it difficult to change health practices that lead to negative outcomes. It is therefore crucial to implement culturally-congruent healthcare strategies not only for individuals and families, but also for population-based health initiatives. The education group harnessed the strengths of Pacific Islanders in driving change within their community, a very significant component in promoting health teachings and influencing behavior in a culture that values relationships in their day-to-day activities.

The education group met its intended outcomes for the Pacific Islander women to increase knowledge of prenatal concepts and improve their motivation to utilize prenatal care. The outcomes showed that although compliance may be inconsistent with knowledge of healthcare guidelines (Utah Department of Health, Office of Health Disparities, 2012), a culturally-congruent education group can potentially improve prenatal care utilization when embedded within a population’s faith-based social structure. The same platform can also be utilized to implement primary, secondary, and tertiary levels of prevention to address chronic health issues common among Pacific Islanders.

References


“What new or validated nursing or health topic resulting from research, EBP, or quality management can potentially impact or has influenced your practice as a nurse, educator, manager, researcher, or administrator? What are the benefits to its intended recipients including patients, nursing students, population-specific groups, and the global community?”

Close-up is a regular feature section of the JNPARR. In every issue, we post a question that is of relevance to nursing. We encourage the readers to send in their comments, thoughts, and recommendations in response to the question. The intent is for all of us to have a venue wherein we can express our opinions and get a sense of the sentiments of where we stand on relevant, critical issues.

As a nurse educator and simulation faculty, a very helpful and comprehensive publication that has influenced my practice is the two-part Association for Medical Education in Europe (AMEE) Guide on simulation in healthcare education. This provides practical guidance in effectively using simulation as a bridge between classroom learning and real-life clinical experience for our hospital staff — the first Guide and the AMEE Guide No. 82. The first Guide focuses on building a simulation program and discusses operational topics such as types of simulators, simulation center structure and set-up, fidelity management, scenario engineering, and faculty preparation; the AMEE Guide 82 focuses on the educational principles that lead to effective learning and includes topics that are central to simulation efficacy, e.g. feedback and debriefing, deliberate practice, and curriculum integration (Motola, Devine, Chung, Sullivan, & Issenberg, 2013). With a new paradigm of education in healthcare that increasingly involves technology and innovative ways to provide a standardized curriculum and program, these simulation guides have the following potentials: (1) provide valuable information on how to be a better simulation faculty and assist the educator in achieving one’s goals and objectives in tackling issues like increased demands on training hours, limited patient encounters, providing safe patient care and increased patient satisfaction during clients’ hospital or clinic encounters, and obtaining real life learning experience for hospital staff including novice to expert nurses; (2) can be very useful when preparing to offer scheduled, valuable “simulated” learning experiences in any clinical situation that are difficult to obtain in real life settings; these learning opportunities can be scheduled at convenient times and locations and can be reoffered to local and global communities as necessary; and (3) are great healthcare simulation tools for assessment, education, research, and health system integration in facilitating patient safety and satisfaction.


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Nursing intellectual capital theory is nursing knowledge that is translated into nursing and organizational performance which leads to improvements in patient outcomes associated with quality of patient care, such as reduction in adverse events (hospital-acquired infections, patient falls, and medication errors). This theory can help researchers generate specific and nursing-relevant research questions or even modify questionnaires in order to obtain a better correlation between nursing intellectual capital, nursing practice, and outcome (patient care). The theory implies that some units with higher human capital have better patient care quality and incur less adverse events. This would suggest that the organization, managers in particular, would be more inclined to encourage, mandate, and support the staff in acquiring continuing education units (CEUs), performing annual skill check-offs, attending seminars or conferences, obtaining practice certifications, provide tuition or conference fee reimbursements, grant schedule requests to attend professional development programs, etc. This theory has likewise influenced nursing education with the development of such programs as the accelerated BSN, accelerated BSN to MSN, and accelerated BSN to PhD educational pathways. Hiring preferences and requirements have also significantly changed for both hospital entry-level positions (preference given to experienced nurses or those with BSN degrees) and management (those with a BSN and MSN degree with management experience are more likely to be hired).

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Early progressive mobility has been validated many times and supported by robust evidence in actual clinical practice. Together with Awakening and Breathing Coordination, and Delirium Management (ABCDE Bundle), it has been shown to improve patient outcomes such as shortened length of stay, decreased hospital acquired infections, and enhanced wound healing. For almost a year now, the unit where I work has adopted an Early Progressive Mobility Program that relies heavily on proper body mechanics, overhead lifts, portable lifts, and intensive care unit (ICU) beds with low air loss mattress and continuous lateral rotation capability. Everyone in the ICU is enthralled as we see a patient evolve from being heavily sedated and intubated and ultimately being extubated, off sedation, sitting up, awake, alert, fully oriented, ambulating, and transferred to a regular hospital unit. Nurses, doctors, physical therapists, and of course, the patient and the entire family are happy, relieved, and satisfied.

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The use of evidence-based practice (EBP) has proven to result in best patient outcomes both in terms of improved clinical condition and enhanced patient experience. In today’s changing health care environment, EBP is becoming the new normal (not anymore as “nice-to-have” but a “must-have”). This inspires me to always challenge the status quo and introduce novel, EBP-supported learning-applications in everyday practice. I frequently and passionately encourage our nurses to transform health care delivery practices through the use of nursing care approaches that are strongly and appropriately supported by evidence. I look at EBP as a gift for us to describe or redefine the value of nursing and nurses as true partners in care!

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Our research site participated in a prospective, randomized clinical trial to compare schizophrenia medications within the context of many “real world” issues including some of the most challenging circumstances—recent incarceration and substance abuse. The study yielded positive results which indicated that treatment with once-monthly INVEGA® SUSTENNA® significantly delayed relapse time, as well as reduced overall relapse compared to the most commonly used atypical antipsychotic treatments. The findings of our study align with initiatives at finding cost-effective health care solutions for an underserved population. We are pleased to have been part of such landmark study and hope to embark on more of these.

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Cultural competency and diversity is an important nursing and health topic that has been validated with many research studies for many years now. This has been incorporated by schools of nursing in their curriculum and has been a frequent topic in continuing education (CE) offerings. The concept has greatly influenced the professional practice of nurses and other health care practitioners. Members of the health care team integrate this in terms of their approach when treating patients coming from different cultural backgrounds who often have distinct health beliefs and practices that are barriers for successful treatment outcomes. Cultural competency not only gives health care practitioners the social knowledge to understand their patients. It also makes them aware of their own cultural biases that can affect the way they practice when dealing with a diverse group of people. Understanding where a patient is coming from allows the practitioner to consider strategies that can work better to achieve the desired outcome.

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One of the initiatives that we are diligently implementing in our Intensive Care Unit is the reduction of urinary tract infections. Tracking appropriate use and proper management of indwelling urinary catheters are incorporated in daily care plans, as well as in medical-surgical team rounds that nurses actively participate in. As a charge nurse, I see to it that these protocols are adhered to. We have moved away from the days when use of catheters was considered standard practice. It is more commonplace for nurses and patients working together to determine its need and patients are encouraged to use the bedpan or urinal so that the catheter can be removed. This is such a rewarding experience that demonstrates patient advocacy and team collaboration at work.

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Pressure ulcer development is one of the major risks in relocating 228 very high risk (ventilator and totally-dependent) patient-residents of a nursing facility. This was particularly challenging when the actual physical move happened during a two-day time frame. When Goldwater Specialty Hospital and Nursing Facility in Roosevelt Island decided to close its doors and open Henry J. Carter Specialty Hospital Nursing Facility located in northern Manhattan, the relocation of patients occurred without any negative patient outcomes. This required intense collaboration & team development between nursing and the ambulance transport services that included specific steps and strategies such as the use of air overlay mattresses on stretchers and how to reduce transport & travel time to a minimum. The facility devoted months in crafting its comprehensive plan which included identifying transfer routes, developing teams responsible for sending and receiving patients, tracking actual team performance, improving communication networks, and creating the transfer schedule down to the minute. The outcome was an amazing success. There were no patient incidents related to pressure ulcer development 72 hours after relocation.

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My DNP practice change project using a culturally congruent education group to improve prenatal care utilization to impact birth outcomes is a big influence in my career trajectory. The project enabled me to become a change agent utilizing evidenced-based practice (EBP) to drive change in population-based settings. The education group was established with strong collaborations within a faith-based structure, consideration of the values and practices of Pacific Islanders (PIs), outcomes from systematic reviews, and expert opinion from health department officials and key PI resource individuals. This framework can be used to address health issues prevalent among various minorities who tend to have strong affinities with their spiritual or religious groups, including those from developing countries, such as the Philippines, to enhance compliance with health guidelines and improve outcomes. This EBP project inspired me to create “Blue Zone in Quezon” (Philippines), with “Blue Zone” referring to an area where there is longevity because of healthy lifestyle and strong social networking among people in the community.

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Mentorship can help new nurses adjust to the demands and professional responsibilities involved in nursing. Some nurses cite heavy workload and workplace bullying as factors that make for a difficult integration into the profession. Novice nurses require mentoring to develop their confidence, skills, and expertise and assist in their transformation and professional growth. We should be helpful and nurturing to them as they ease their way into becoming expert nurses.

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I have been a case manager for over five years at one of the Medicaid managed care plans of Arizona, Mercy Care Plan (MCP). In 2010, the concept of Integrated Case Management (ICM) was introduced to us to integrate a holistic approach in meeting the physical and mental needs of our members. Around that time, we had over 16,800 MCP members enrolled in the Medicare Advantage (those who are dually-eligible for both Medicare and Medicaid and require acute, long term care, and pharmacy services). About twenty-three per cent of these patients were receiving high cost long-term care and five percent were developmentally disabled. Case managers attended weeks of intensive training on the concept and philosophy of ICM, motivational interviewing techniques, and electronic documentation and client tracking. Members were assisted in coordinating their care by instructing them to establish a good working relationship with their primary care provider (PCP) and empower them to be involved in their medical and behavioral health treatment plan. The interdisciplinary approach involving physicians, behavioral health providers, pharmacists, and other community resources have been a success for those who engaged themselves in the program. Avalere’s recent analysis based on the 2012 Healthcare Effectiveness Data and Information Set (HEDIS) suggested that MCP’s ICM Program has been successful in lowering readmission rates, fewer days spent in the hospital, lower average length of stay, fewer emergency room visits, and higher proportion of members accessing preventive and ambulatory services.

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In order to meet the current challenges in healthcare, Massachusetts General Hospital developed innovative approaches for improvements and overall patient satisfaction. Nursing administration believes that an experienced staff nurse is in a great position to orchestrate the necessary connections between the interdisciplinary team and the patients and their families. With the goals of improving care that is safe, timely, efficient, equitable, effective, and tailored to the needs of the patients and families, the Attending Nurse position was created. The Attending Nurse can support the plan of care by closing system-related gaps and providing aspects of care that may normally not be completed due to workload or time constraints. The Attending Nurse is the consistent contact for the patient, the families, and the health care team supporting the staff nurse, the attending physician as well as all of the members of the team. These coordinated efforts are continuous throughout the patient’s hospital stay.

My role has taken several months to develop and I feel that the most impact I make is on interdisciplinary rounds where I am able to help develop comprehensive plans of care on a consistent basis. I support and encourage discussions about all issues pertaining to each patient’s plan of care.

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High-fidelity simulation is widely used in educational and clinical settings. Among the drivers that are pushing the use of simulation are hospital closures and limited clinical facilities, increased accountability, and focus on student outcomes and patient safety. Simulation provides the opportunity for the students to demonstrate knowledge and skills learned, the capability to practice rare and critical events, and be able to practice decision making and critical thinking. Students, new nurses, and even seasoned nurses who are frontline caregivers in healthcare industries benefit from simulation as it allows them to enhance knowledge, technical, behavioral, and social skills to become competent and culturally-sensitive nurses.

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I learned from a recent pediatric consult for my daughter’s flu-like symptoms that administration of oseltamivir, an antiviral drug, for influenza is determined by the duration of time since the onset of symptoms. Based on the current guideline, oseltamivir is most efficacious in decreasing illness duration when initiated within 48 hours of illness onset in children. This experience led me to question whether oseltamivir would significantly decrease illness duration if given after the recommended 48-hour period. I was inspired to conduct a literature review on the topic for my graduate research class. The literature supports that the timing of therapy in relation to the onset of symptoms influences the efficacy of oseltamivir for influenza. Administration of oseltamivir in children less than 24 and 48 hours following symptom onset reduced illness duration by 3.5 days (Whitley et al., 2001) and 36 hours (Wang et al., 2012), respectively. A more recent study (Fry et al., 2014) showed that the administration of oseltamivir 48 to 72 hours after illness onset significantly reduced illness duration by 1 day. This reduction may significantly affect the child’s condition in lieu of the severity of symptoms and other co-morbidities. Hence, practitioners should take into consideration the timing of oseltamivir treatment for influenza both prior to and after 48 hours since illness onset, especially if the patient’s condition warrants it, until further research provides strong evidence that would negate its use 48 hours after illness onset.

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A Plan to Reduce Polypharmacy in a California State Prison
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Objective. The study is designed to determine whether the creation of a Polypharmacy Committee and utilization of clinical tools to support healthcare practitioners will decrease the adverse effects of polypharmacy and lead to cost-efficiency.

Significance and Background. Polypharmacy results in increased adverse drug reactions, costs, morbidity and mortality rates, and poor compliance among elderly patients in the United States. It was estimated that the cost of polypharmacy to the U. S. healthcare system is at 50 billion dollars per year (Bushardt, 2008). Data from a California State Prison revealed that 12% of its total population were prescribed greater than or equal to ten medications, and among inmates 65 years and older, this number jumped to 50% (Grattet & Hayes, 2013).

Design and Methods. The study will be conducted using a quasi-experimental design (two-group posttest only), employing the Iowa Model of evidence-based practice (Titler, 2001). Potential subjects will be selected from the Chronic Care Master Registry who meet the inclusion criteria. From those selected, the sample population will be randomly assigned to either experimental or control group. A Polypharmacy Committee will use the Beer’s criteria and Epocrates software to review medications of patients. Intervention and monitoring will be conducted for 3 months. Results will be interpreted using t-test and one-way ANOVA.

Results. It is expected that results will show a decrease in the number of medications being prescribed to inmates and will show improvement in their care.

Implications. The elderly population in the California State Prison mirrors the population of the U. S. Adverse effects of polypharmacy result in much more unnecessary pressure on society, institutions, and government. Safely reducing the number of prescribed medications on the elderly can result in improved healthcare quality and outcomes and cost-effective care.
Significance and Background. Patient non-attendance known as “no-shows” at scheduled oral surgery and minor procedure clinic appointments represented a major problem in this particular clinic. There was a 25% rate of “no-shows,” resulting in significant reduction in staff productivity and inefficient use of clinicians’ time. Additionally, “no-show” patients eventually accessed emergency services resulting from their worsening condition.

Purpose of the study. The project aimed to reduce the rate of “no-shows” for oral surgery patients requiring moderate sedation and minor procedures, alleviating the concomitant negative impact on the patient’s condition, staff productivity and clinicians’ time.

Interventions. Best practice recommendations used to address the issue included personal phone calls, i.e., calling the patient one-week before the procedure, and repeating the call one-day prior to the procedure. These calls were made to 200 patients over a period of 4 months.

Evaluation. Ninety per cent (180 of 200 patients) showed up for their scheduled procedures. Three per cent (6 of 200 patients) called and cancelled their procedure, while seven per cent (14 of 200) were no-shows.

Discussion. Applying the best practice recommendations were highly significant in reducing the no-show rate from 25% to 7% for oral surgery procedures requiring moderate sedation and for those requiring minor procedures. This resulted in increased productivity and enhanced utilization of staff and clinician time.

Awareness and Acceptance of a Municipal Ordinance Prohibiting Home Deliveries Among Women of Reproductive Age
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Objective. This study was conducted to determine awareness and acceptance of the municipal ordinance in a small town in the Philippines (Leganes, Iloilo) prohibiting pregnant mothers from delivering their babies at home.

Significance and Background. Despite the existence of the ordinance, 227 out of 609 women opted to deliver their babies at home in 2012. The Department of Health has heightened its campaign to encourage mothers to access obstetric care in the hospital to deliver their babies to improve maternal and child health status and reduce morbidity and mortality rates.

Purpose. The aim of the study was to determine if there was a relationship between the pregnant mothers’ awareness and their acceptance of the ordinance. Additionally, other variables were examined, such as age, civil status, parity, educational attainment, and family income, to ascertain any effect these might have on their awareness and acceptance.

Conceptual or Clinical Model/Philosophic or Theoretical Framework. This study was anchored on Pender’s Health Promotion Model (HPM) (Tomey and Alligood, 2002). Individual characteristics and experiences can influence behavior-specific cognitions and affect the behavioral outcome.
Method and Analysis. This was a descriptive correlational study conducted in September 2013. The study had 373 randomly selected women who completed a three-part validated and reliability-tested researcher-developed questionnaire translated into the dialect (Hiligaynon) spoken in that geographic area. Results were described using frequency distributions, means and standard deviations. T-test, One-Way Analysis of Variance and Product Moment Correlation were used to analyze the data inferentially.

Findings and Implications. There were no demonstrable differences in awareness and acceptance of the municipal ordinance prohibiting home deliveries when respondents were grouped according to age, civil status, parity, educational attainment, and family income. There was a significant relationship between awareness and acceptance of the ordinance, indicating that behavior-specific cognition and affect had an influence on the respondents’ behavioral outcome.

Children’s Day (Araw Pambata)
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Objective. To raise the health status of the children in Magsaysay Village and Nabitasan, La Paz, Iloilo City through health education.

Significance and Background. Children are the cornerstones of a healthy society; this requires that they be nurtured. Many parents, however, lack the appropriate health promotion and disease prevention behaviors including personal and dental hygiene, diet, rest, sleep, and exercise. The challenge is to meet the children’s health needs to empower them, as well as their parents, through health education.

Purpose. The aim of this project was to educate the parents and their preschool children (n = 107) on health and health-related concerns through health education involving collaborators and partners in health and development.

Interventions. The project utilized the principles of community organization participatory action research and the nursing process. Bi-monthly health education classes were conducted between October 2012 through March 2013 employing various approaches including storytelling, skits, picture analysis, puppetry, and using relevant educational materials.

Evaluation. The project was evaluated in March 2013 using the inventory of health practices interview schedule.

Discussion. One hundred percent (n = 107) of the preschool children showed evidence of good health habits after the series of health activities were implemented. Parents diligently supervised their children in performing 22 health activities including gargling water upon waking up, washing hands after using the toilet, taking a bath with soap and water, washing hair with shampoo, wearing clean underwear, cleaning nails, using own towel, combing hair, wearing clean clothes, wearing clean footwear, washing hands before eating, eating from “Go”, “Grow” and “Glow” food groups, drinking at least 6-8 glasses of water, washing hands after eating, brushing teeth after eating meals (three times a day), using clean handkerchief/hand towel, performing weight bearing activities for 15 minutes, and sleeping for at least eight to ten hours.
Lost Fatherhood: The Other Half of the Induced Abortion Story
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Fatherhood is a result of pregnancy, which is the essence of being a man. But the dilemma begins when the pregnancy is suddenly terminated by induced abortion. For every pregnancy that ends up in abortion, a man was involved at some point and to some degree. Literature has overemphasized the role of women in abortion issues, with very little research examining whether and how men contribute to the decision to abort a pregnancy, as well as how abortion affects both of them.

This research was conducted at Vintar, Ilocos Norte, Philippines, using descriptive phenomenological approach to explore the lives of fathers whose wives had induced abortion. Seven (7) participants were recruited as co-researchers by purposive sampling using the following preset criteria: 1) fathers whose wives experienced induced abortion, and 2) are able and willing to articulate, share, participate, and describe their lived experiences. Unstructured interviews and storytelling were approaches used to gather and collect data from co-researchers of their experiences. Narratives were transcribed and analyzed using the Collaizi-inspired phenomenological method of inquiry (Martinez, 2013).

Through reflective analysis, three themes emerged: (a) Shattered Trust: Rage of theConsciously Forgotten, (b) Wounded Heart: Lament for Ruined Chances, and (c) Toughened Self: Beyond the Dusk.

The findings of this research will contribute to better understanding of the experiences of fathers whose wives had induced abortion. Nurses will be able to assist other men who have undergone a similar experience. The knowledge gleaned from this research will help nurses develop a more holistic plan of care, incorporating interventions that address the physical, physiologic, emotional, social, and spiritual needs of the patient.
Robert Wood Johnson Foundation Nurse Faculty Scholar Program for Junior Nurse Faculty: It Takes a Village for a Successful Application
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Accepted for Publication December 2013 doi: 10.13178/jnparr.2014.0402.0402

Abstract

Introduction: Nursing education programs across the United States regularly report denying entry of qualified student candidates due to faculty shortage. The Robert Wood Johnson Foundation (RWJF) established the Nurse Faculty Scholars Program to develop the next generation of national leaders in academic nursing through career development and mentoring of outstanding junior nursing faculty.

Objective: This paper provides highlights of the RWJF Nurse Faculty Scholars Program and offers first-hand information on how to develop a competitive and successful application to this illustrious scholarship program.

Description of the Endeavor: Descriptive reflection served to provide information about the program, including the decision to apply, developing and submitting the required scientific proposal and personal narrative, preparing for the semi-final interview, and what to expect once chosen in the final stage, and the responsibilities after actually being named one of 2013 RWJF Nurse Faculty Scholars.

Outcomes: Intra- and interprofessional collaboration by all key players (the ‘village’) provided the essential structure and support for the development of the application materials and the preparation for the semi-final interview, and the culmination of a successful RWJF Nurse Faculty Scholar application.

Conclusion: It takes a village to achieve a successful grant application. The Robert Wood Johnson Foundation provides funding opportunities that support the nursing profession.

Keywords: Robert Wood Johnson Foundation, Nurse Faculty Scholars Program, funding, nurse educator
Introduction
The nursing shortage continues to be a major concern in the United States (U.S.) for years, resulting in negative consequences on the quality of care. The newly-enacted U.S. healthcare reform will only escalate this issue as it heightens the focus on improved quality of care for all. Tied to the nursing shortage is the scarcity of nursing faculty. Nursing education programs throughout the country are unable to adequately provide the needed number of professionally-educated nurses to join the workforce. Nursing education programs across the U.S. regularly report turning away program applications of qualified student candidates because of faculty shortage (National League of Nursing, 2010; Nally, 2008). Recognizing the shortage of academic nursing faculty and its negative impact on the health and healthcare of Americans, the Robert Wood Johnson Foundation (RWJF) created the Nurse Faculty Scholars program in 2008 (Conn, 2013). The program aims to develop the next generation of national leaders in academic nursing through career development and mentoring of outstanding junior nursing faculty (Robert Wood Johnson Foundation, n.d.). In line with the Robert Wood Johnson Foundation’s mission to help all Americans live healthier lives and obtain the quality care they need, the program embraces diversity and inclusion across all its programs, applicants, and scholars in multiple dimensions such as race, ethnicity, gender, age and disadvantaged socioeconomic status.

The Nurse Faculty Scholars program is especially significant for nurses in academia, particularly those who are on a tenure-track position in research-focused academic settings. These nurses must demonstrate a high level of competence, seek extramural funding, publish regularly in high-quality journals, master teaching skills and engage in purposeful and meaningful service (Kaufman, 2007; Poronsky, Doring, Mkandawire-Valhmu, & Rice, 2012). They are also expected to apply and be successfully awarded tenure within approximately five to six years from the start of their tenure-track clock. The Nurse Faculty Scholars Program aims to facilitate this process by providing opportunities to promising junior faculty for extramural funding, expert mentoring, and training required to be successful in their academic role. With sources of funding from the Federal government becoming scarce, foundations and other non-profit organizations are especially significant as alternative sources for tenure-track faculty.

This paper will describe the RWJF Nurse Faculty Scholars Program and provide first-hand information about the creation of a competitive application. This paper was written from the perspective of a minority nurse faculty (first author) who was a successful applicant in this program. It underscores the important role of intra- and interdisciplinary collaborations, with input from mentors (the co-authors) and the entire “village” for an application to be successful. It is the aim of this paper to inform and encourage other nursing faculty from diverse backgrounds to also apply and compete with the other interested applicants for the Nurse Faculty Scholars Program.

RWJF Nurse Faculty Scholars Program: The Details
The full details of the RWJF Nurse Faculty Scholars program are available at www.rwjfnfs.org. In 2013, the program granted 12 awards of up to $350,000 each over three years. The award includes a 60% release time for the faculty as well as research support. To meet eligibility requirements, applicants should be registered nurses who are U.S. citizens or permanent residents, have a research doctorate (PhD) in nursing or related discipline, and be in a tenure-track junior faculty position (instructor or assistant professor) for at least two years and no more than five. Candidates must identify at least one senior leader in their school of nursing to serve as a primary (nursing) mentor. They also need at least one research mentor, a senior researcher from a discipline outside of nursing in the same university as the applicant with similar or complementary research interests (Coffman, Goodman, Thomas, & Roberson, 2013).

The selection process is managed by the RWJF Nurse Faculty Scholars Program Nursing Advisory Committee. The program guidelines indicate that the committee will be looking for evidence of potential and strong commitment as a leader in academic nursing; institutional support; availability and commitment
of qualified mentors and academic resources; potential to become a national leader in a scholarly focus area; and commitment to teaching excellence and to diversity in nursing. The quality of the candidate’s research proposal must serve as a foundation for the candidate’s academic career and contribution to nursing science, for interdisciplinary knowledge in a focus area, and for improvement of health and health care in the United States.

Application Preparation
To receive timely information about the Nurse Faculty Scholars Program and related processes, nursing faculty are encouraged to register online and create an account at the Robert Wood Johnson Foundation (www.myrwjf.org). The Robert Wood Johnson Foundation offers, in addition to the Nurse Faculty Scholars program, a number of funding opportunities that invest in nursing and the development of nurses.

For the Nurse Faculty Scholars Program, a nursing school can recommend only one candidate at a time but it may have up to two scholars simultaneously (Robert Wood Johnson Foundation, n.d.). Hence, it was recommended that at the outset, a potential applicant should begin meeting with the dean or director of the college or school of nursing to discuss the program and the importance of institutional support (Coffman et al., 2013). This process may vary depending on the structure of the school’s administration. In the primary author’s experience, she initially consulted with the Department Chair. The result of the consultation was confirmation of eligibility and endorsement of the application. Other faculty from the department was interested in applying. The Chair determined that the primary author best met the eligibility requirements and should be the one to apply. The Department Chair, an alumna of the RWJF Executive Nurse Fellows Program, another RWJF investment in nursing, was able to assist all interested faculty in determining eligibility and potential to develop a strong application. She provided insights on the RWJF application and its process. She highlighted how to strategically address the objectives of the Nurse Faculty Scholars Program and the importance of having clear research and leadership goals. The candidate then consulted with the Associate Dean for Nursing Research, who also endorsed the application. The Associate Dean for Nursing Research provided further guidance on the candidate’s proposed program of science as well as the next steps towards application. The candidate then sought the approval of the Dean of the school of nursing, whose strong letter of institutional support was an integral and critical component of the application.

Some schools of nursing may have more eligible junior faculty who are interested in applying for the program. These schools may develop a formal internal screening procedure for prospective applicants. Some deans have shared that, as part of the internal selection process, the interested applicants were given the opportunity to present their program of science and explain how it fits the aims of the Nurse Faculty Scholars program. Following assurance of support from the dean, the candidate would have to identify the required mentors, including both the primary nursing mentor and the research mentor.

Selection of Mentors
The importance of formal mentorship that is accomplished through the pairing of junior faculty with established mentors is widely recognized in academic research as a means for improving research expertise and productivity (Byrne & Keefe, 2002; Cohen et al., 2012; Miller et al., 2006). Mentoring is an essential component of the Nurse Faculty Scholars Program. The program assumes that a faculty member will most likely reach potential with one-on-one support from those who have successfully negotiated senior academic challenges, including development of a vibrant and robust research program (Robert Wood Johnson Foundation, n.d.). Hence, as part of the application process, the candidate must identify at least one primary nursing mentor and at least one research mentor. These mentors should be available for guidance and direction but do not manage the applicant’s project or budget (Coffman et al., 2013). The candidate and the mentors can negotiate on the compensation. They may be financially remunerated as consultants for the research project, if the budget allows it. They may also opt to donate time and
effort as a service to the university and the profession. They can also be co-authors of manuscripts and conference presentations.

In the selection of mentors, the applicant should consider (a) their availability for meetings during the award period, (b) physical proximity to the applicant, (c) knowledge of resources and the working environment in the school of nursing and the university, and (d) the ability to help the applicant learn and develop (Coffman et al., 2013). Hence, it is important that the selection of mentors be accomplished early in the process, allowing time to secure the mentors’ support and solicit the required mentor letters of support for the application. The applicant needs to review each potential mentor’s curriculum vitae, history of research funding, and experience in the mentor role (Coffman et al., 2013). The interdisciplinary network and working relationships of the potential mentors should also be explored. Once the mentors are identified, the candidate should interview the mentors and provide them with information and an explanation of the Nurse Faculty Scholars Program. The candidate should also provide a description of his or her program of science and specific career goals (Coffman et al., 2013). It is important to note that the quality of mentors is considered in the selection process.

The primary nursing mentor has to be a senior faculty member in the school of nursing who is able to advice on academic planning. The RWJF Nurse Faculty Scholars Program expects this mentor to assume the primary responsibility for ensuring that the scholar learns how to juggle the three-pronged mission of the academic institution, i.e., teaching, research, and service to both the profession and the institution (Robert Wood Johnson Foundation, n.d.). For example, the primary nursing mentor is expected to ensure that the scholar is well-prepared for a successful promotion and tenure review. The research mentor is expected to provide the scholar access to organizations, programs, and colleagues who will be helpful to the candidate’s work as a scholar. The primary mentor must be able to help the scholar obtain the maximum benefit of his or her relationship with other mentors, particularly research and national mentors (Robert Wood Johnson Foundation, n.d.).

With these responsibilities in mind, the nursing mentor should be a senior faculty member in the school or department of nursing who is a nurse and has demonstrated the ability to mentor (Coffman et al., 2013). The nursing mentor need not be an expert in the applicant’s program of science. In this particular experience, the author chose the Associate Dean for Nursing Research as her primary mentor. She took into consideration their history of having worked together in an informal mentor-mentee role, as well as the Associate Dean’s successful funding history, extensive intra- and extramural network, time, and accessibility. An important criterion in her choice is the accessible open communication channel with the primary nursing mentor.

The University research mentor should be from a discipline other than nursing and is selected based on common research interests or research methods (Coffman et al., 2013). Disciplines may include public health, medicine or any other discipline relevant to the candidate’s program of science. Individuals who are not in fields directly related to health care may offer new perspectives and knowledge of relevant methods to the candidate, thereby facilitating interdisciplinary research (McBride, 2010). The Nurse Faculty Scholar Program expects the research mentor to help the scholar make interdisciplinary connections within the university and beyond in the area of interest (Robert Wood Johnson Foundation, n.d.).

In this example, the author’s program of science is on biomarkers for posttraumatic stress disorder (PTSD). She chose as her research mentor the director of the South Texas Research Organizational Network Guiding Studies on Trauma and Resilience (STRONG STAR). She considered the research mentor’s successful funding history, extensive intra- and extramural network, time and accessibility. More importantly, they had an existing formal mentor-mentee relationship as part of the author’s previous Clinical and Translational Science Award Career Development (KL2). STRONG STAR is a multi-
disciplinary and multi-institutional research consortium funded by the U.S. Department of Defense and Veterans Affairs. Its mission is to develop and evaluate the most effective early interventions possible for the detection, prevention, diagnosis, and treatment of combat-related PTSD and related conditions in active-duty military personnel and recently discharged veterans (STRONG STAR, n.d.). The author’s research proposal was developed as an add-on to a clinical trial that will be conducted under the STRONG STAR infrastructure. The author’s research proposal is supported and facilitated by the research mentor, who also provides administrative access to STRONG STAR resources and serves as an excellent role model in the management of a huge research consortium.

Once mentors were identified, the author worked closely with both of them to articulate their role in the Nurse Faculty Scholar proposal and letters of commitment. This candidate provided an initial draft of the mentors’ letters of commitment to make sure that all aspects of the goals of the Nurse Faculty Scholars Program were articulated and the formatting requirements were followed. The mentors based their letters on the draft provided.

**Developing the Written Proposal**

An application is completed and submitted by the candidate, the deadline of which is typically around February. The call for proposal includes a schedule of important dates related to the application process, including information on Web conferences or webinars. The webinars, which are often scheduled in December prior to the application period deadline, allows prospective applicants to ask questions related to the process. Interested candidates must register on the program’s website to be able to participate in these webinars.

Applications are submitted electronically via the RWJF online system. Prospective scholars create an account in their online system in order to upload the Nurse Faculty Scholar Program application. The application template outlines specific requirements, including the pertinent information for each section, as well as formatting requirements such as font style, margins, page numbering, and spacing. The guidelines must be strictly adhered to. Applications that do not follow technical instructions, exceed page limits, add extra letters of support, or fail to include required information are generally not reviewed (Coffman et al., 2013). All applicants should therefore familiarize themselves with the online submission requirements early on in the process. The Nurse Faculty Scholars Program office (rwjfnfs@jhu.edu) is available for any clarifications. Prior to the final submission, the mentors and the research office, where applicable, can help make sure that the guidelines are followed.

The application packet requires applicants to provide a career goal statement and research proposal narrative. The career goal statement should include the applicant’s academic career objectives and personal goals for the program, along with a description of the proposed research and scholarly development plan and how this will enhance one’s career in academic nursing. Although the requirements for the written proposal may vary, the applicant must be able to describe the research project, identify the mentors’ roles in the project, provide evidence of leadership potential, address how scholarship will translate into teaching and service, and outline professional goals for the program and beyond (Coffman et al., 2013). The required research proposal narrative has the following sections: the statement of the research problem and specific aims of the project, background, previous studies and preparation for conducting research, methods, and summary (Robert Wood Johnson Foundation, n.d.). A sample of a statement of research problem and specific aims section is provided below.

Research measures, permissions, and letters of support from study sites and collaborators are not allowed. Therefore, applicants must use the proposal to assure reviewers that they are capable of conducting the proposed research (Coffman et al., 2013). The study should fit within a three-year time frame. Proposed project costs should be approximately $20,000 to $30,000 annually. The portion of the budget...
dedicated to research covers the costs of a substantive study, is considerably more than a pilot study, and is comparable to a R21 or K award in National Institutes of Health equivalencies (Coffman et al., 2013).

Developing a clear, well-written, and organized proposal with rigorous research methods takes time. The applicant should seek feedback from mentors (Chung & Kowalski, 2012) and others to ensure a substantive, innovative research study proposal. The applicant should try to have the written proposal critiqued by a number of colleagues in nursing and perhaps in other disciplines, when available. In this example, the author not only addressed all the required sections, but also made sure that the selection criteria as outlined above were being addressed. She sought input from her mentors as well as colleagues in the school of nursing. The research proposal, in a previous form, was submitted for a K08 application at the National Institute for Mental Health (NIMH). In the K08 application preparation, the author received extensive feedback from colleagues across the university as she was a Clinical and Translational Science Award (CTSA) Career Development (KL2) Scholar. The CTSA KL2 mechanism provided an interdisciplinary support team that provided feedback to the candidate. The review from NIMH on the K08 application, which was not funded, was also considered during the development of the revised research proposal for the RWJF Nurse Faculty Scholars Program. Where feedback was contradictory across parties, the author consulted both primary and research mentors for inclusion or changes in the proposal.

While the research proposal is being reviewed internally or externally, candidates can work on the biosketch. There is also a prescribed format under the RWJF online submission system. It is comparable to the NIH formatting. The mentors’ biosketch should also be solicited. All information pertinent to the program of science and roles proposed in the application should be included in the narrative. This is especially true when the applicant and mentors may have diverse research interests. There should be focus on the program of science proposed in the application.

Letters of commitment are required from the university provost or president, the school of nursing dean, the nursing mentor, and the research mentor. An additional letter from a faculty member or colleague who can attest to the applicant’s strengths is also required. These letters are important to the proposal. The applicant should provide ample guidance to mentors and others who are writing letters. Each of the mentors’ letters should demonstrate great familiarity with the applicant’s research, teaching, leadership, and service qualifications. The mentors’ letters can also be used to elaborate on key elements of the proposal which could not be included due to page limitation. An additional letter can be written by a previous mentor who can discuss the applicant’s development and ability to be mentored (Coffman et al., 2013). In this example, the author provided drafts of the letters of commitment to make sure that each followed the prescribed format and addressed the key issues as identified in the selection criteria of the Nurse Faculty Scholar Program. The drafts were considered very useful. When the official letters were submitted, they were double-checked for formatting and content, as outlined by the guideline. The Department Chair was requested to write the required additional recommendation from a colleague. Aside from providing information about the applicant’s track record, the Department Chair also confirmed that the applicant will be given a 60% teaching workload release upon receipt of funding by RWJF.

Applications need to be submitted early to avoid technical issues with RWJF’s online submission system. Both the applicant and research office should verify that the proposal has been uploaded correctly and is complete before sending. The call for application also indicates the expected date of when successful applications will move forward to the semifinal round. In 2013, this notification e-mail was sent in mid-April.

Sample Research Problem Statement and Specific Aims
The Grant Application Writer’s Workbook - National Institutes of Health (NIH) emphasized how the specific aims section is critical to writing a first-class NIH grant application (Russell & Morrison, 2010). This section should be considered as the template or master plan of the research plan. It must include ev-
everything about the research plan that is important and exciting, but with less detail (Russell & Morrison, 2010). A similar approach was used in the development of the one-page problem statement and specific aims page for the Nurse Faculty Scholars Program. The development of a well-written specific aims page takes time and may take several iterations. From experience as an early career grant reviewer for NIH, the author appreciated the importance of this page towards a successful grant application. The problem statement and specific aims page submitted for the Nurse Faculty Scholars Program is provided below.

An estimated 20-45% of military personnel returning from deployments to Iraq and Afghanistan develop PTSD (Helmer et al., 2007; Lapierre, Schwegler, & Labauve, 2007). Cognitive Processing Therapy (CPT) is one of the leading evidence-based treatments for combat-related PTSD. The mechanism on how CPT works is not fully understood. CPT is a brief cognitive therapy that consists of 12 one-hour sessions. However, the standard 12 sessions may not be applicable for all patients (Galovski, Blain, Mott, Elwood, & Houle, 2012). A clinical trial funded by the Department of Defense (DoD) aims to provide a personalized variable length CPT therapy to active-duty military personnel with PTSD until they reach good end-state functioning. The proposed study will piggyback on the DoD clinical trial. It aims to determine the role of cognitive and neurotrophic markers for PTSD and the speed of response to CPT treatment.

Increasing evidence supports a dysfunction in the prefrontal executive system in PTSD (Aupperle et al., 2012), especially cognitive flexibility (CF). CF is the capacity to shift one’s train of thought and action according to the changing demands of the environment (Eslinger & Tranel, 2005). It may include the ability to inhibit information that is incorrect. CF is influenced by brain-derived neurotrophic factor (BDNF), a factor known to modulate higher order cognitive function (Felmingham, Dobson-Stone, Schofield, Quirk, & Bryant, 2013). At the molecular level, a functional single nucleotide polymorphism (SNP) of the BDNF gene at codon 66, which leads to a valine to methionine substitution (Val66Met), has been shown to influence BDNF function and cognition (Klein et al., 2009). PTSD risk is associated with BDNF Val66Met SNP and increased BDNF (Zhang et al., 2013). The nature of the relationship between CF and BDNF function in PTSD as well as its influence on the speed of response to CPT is not well understood. Hence, this study aims to:

**Aim 1:** Determine the relationship of performance in tests for CF, presence of Val66Met SNP and peripheral BDNF levels on the speed of response to CPT treatment in active-duty military service members with PTSD. It is hypothesized that poor performance in tests of CF, presence of Val66Met SNP and increased peripheral BDNF levels will be associated with delayed treatment response to CPT.

**Aim 2:** Determine the relationship between the change in performance in tests for CF and peripheral BDNF levels with the change in symptom severity following CPT in active-duty military members with PTSD. It is hypothesized that the magnitude of PTSD symptom reduction will be associated with changes in CF performance and BDNF levels.

Understanding of cognitive and neurotrophic mechanisms in PTSD and following CPT will potentially inform the development of more effective strategies to treat or prevent PTSD.

**Preparation for Semifinalist Interview**

Twenty-one (21) semifinalists were chosen for face-to-face interviews for the 12 available scholar slots in 2013. The semifinalists were given detailed information on the next steps in the process. They were invited to participate in a panel interview with members of the National Advisory Committee. For the interview, the semifinalists were instructed to prepare a brief five-minute presentation regarding their research project and professional goals as they relate to research, teaching and service.

Guidelines on how to prepare for the interview are sent to the semifinalists and must be followed carefully. A very detailed description of the preparation for a successful interview is available elsewhere (Coffman et al., 2013). These include understanding the funding source, knowing the interviewers, preparing a comprehensive yet succinct presentation, and practicing delivery skills.

To illustrate the process, the author created the five-minute presentation on the basis of the proposal.
submitted. She then sought feedback on the presentation from colleagues in nursing and from the CTSA group across the university. She also presented to nursing student scholars, where the presentation was timed. It was advised that the presentation should be around 4.5 minutes to allow for slower pace during the actual interview if necessary due to feelings of nervousness. She had several mock interview sessions which offered opportunities to improve not only the presentation but also the interview process. Along with the critique of the presentation content and delivery, input was also given on how to present oneself professionally at the interview. In this example, the author tried out various smart business attires at these presentation sessions, and had colleagues choose the best look for the interview. She paid special attention to the guidance of the Department Chair and the Dean of the school of nursing. The Chair highlighted professional image, enthusiasm and confidence. The Dean emphasized arriving early (i.e., at least 30 minutes before) and wearing appropriate conservative business attire with no overstated jewelry. She encouraged confident posture and eye contact as well as good listening skills. She advised that responses to questions should be thoughtfully delivered using concise and concrete examples. If uncertain with the question, she encouraged re-phrasing the question. She encouraged the author to light up the room with her smile and interact with everyone with respect. She also highlighted major trends and future opportunities for nursing education and nurses.

The Call for Application listed the members of the National Advisory Committee. Members are typically renowned nursing educators, leaders, researchers, and academic administrators. The author searched the profiles of the committee members to prepare for possible questions that might be aligned with the member’s past or current work. The Nurse Faculty Scholars Program website also has biographies of these committee members. Knowledge of their work allowed for better interaction at the interview.

The author also revisited the RWJF and the RWJF Nurse Faculty Scholar Program websites to further familiarize herself with the mission and vision of the foundation and the program. Through the distribution list, she gained information of the names of other semi-finalists who were interviewed the same day. She researched the profiles of the other semi-finalists and their programs of science. This facilitated interaction with fellow semi-finalists at the time of interview.

The Program Office sent each of the semi-finalists travel details and a schedule of the interviews. For 2013, the schedule included a reception on the evening prior to the interview. Semi-finalists should choose airline flights that allow for ample time prior to the reception, taking into consideration possible delays. This will help eliminate additional stress prior to the interview.

**The Semifinalist Interview**

Days prior to the scheduled interview, the semifinalist is sent the agenda for the interview. In 2013, the 21 semi-finalists were divided into two interview days. Prior to the day of their assigned interview, the scholars had the opportunity to meet with the members of the National Advisory Committee at a reception and dinner. During the actual interview day, three or four candidates were assigned into blocks of interview time by a panel of committee members. The semi-finalists presented to two committee panels and were rotated between the two. The author arrived early to allow time to relax and socialize with the other semifinalists. The five-minute timing was strictly observed. The presentation was followed by a series of questions from the committee members including questions on author’s research plan, career history and trajectory, leadership development, role of mentors, benefits from being in the program, nursing education and diversity, among other topics.

**Finalist Stage**

After the interview, the National Advisory Committee decides on the new cohort of Nurse Faculty Scholars or the finalists. The selected scholars may be notified within the week by the program director. Several processes followed including the submission and approval of the budget, approval of the scholars...
from the National Program Office, selection of the national mentor, official notification of the award, and issuance of a press release. Following official notification, the successful applicant is now considered a Nurse Faculty Scholar. Funding begins on September 1.

Unsuccessful Applications
For applicants who are not successful, the Nurse Faculty Scholars Program office offers a teleconference, but not individual feedback. Reapplication during the next round of Call for Proposal is encouraged for those applicants who are still eligible. Several scholars have been successfully funded after submitting a second application (Coffman et al., 2013).

Conclusions
The RWJF aims to help all Americans live healthier lives and get the care they need. As part of its 20 Human Capital programs, the Foundation developed the Nurse Faculty Scholars Program to help address the shortage of nursing faculty, which has negative consequences to the nursing workforce and the quality of care. The program provides the much-needed support to junior nursing faculty with a doctorate (PhD) degree who are in a tenure-track position. It provides the necessary funding support that allows 60% release time for the faculty to engage in their program of research, actual research support, mentorship and other opportunities needed for junior faculty to advance to become academic leaders, well-funded researchers, leaders in their fields, future nursing deans, and health policy experts. This type of support is unparalleled and competition is tough. However, when potential applicants team with and gather input from all key players and the school of nursing as a whole, they can produce a competitive application that could potentially produce the next Nurse Faculty Scholar. PhD-prepared and eligible nurse faculty must consider applying and are encouraged to engage their “village” towards this lofty aspiration.

Authors’ Update on the RWJF NFS Program (April 2014)
In February 2014, the Robert Wood Johnson Foundation announced the plan to conclude ten RWJF Human Capital programs including the Nurse Faculty Scholars Program (RWJF, n.d.). Table 1 shows the complete list of the affected programs and their closing dates. Applications for the last cohort of nurse faculty scholars were accepted in February 2014, with the program to officially close in Spring 2017.

The underlying approaches to develop a competitive and successful application detailed in this article are useful for any grant funding mechanism. This guide becomes especially critical as RWJF aims to create “new health-focused leadership programs that connect people across sectors as well as disciplines, capitalize on technology to promote networking and mentoring, and reach and help many more individuals” (RWJF, n.d.). This signals a shift from a more discipline-specific focus to a more multi-disciplinary approach. The proposed interdisciplinary nature of these programs means that nurses will compete for the same funding resources with individuals from other disciplines. This increases the pressure for an even more competitive application. The selection process may be comparable to the Nurse Faculty Scholar Program described in this article. The details of future RWJF Human Capital initiatives will soon be available. To receive updates of funding announcements, sign up at www.myrwjf.org.

### Table 1: List of Concluding Robert Wood Johnson Foundation (RWJF) Human Capital Programs

<table>
<thead>
<tr>
<th>Closing Year</th>
<th>Name of Program</th>
</tr>
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<tbody>
<tr>
<td>2015</td>
<td>New Careers in Nursing</td>
</tr>
<tr>
<td>2016</td>
<td>RWJF Health &amp; Society Scholars</td>
</tr>
<tr>
<td>2016</td>
<td>RWJF Scholars in Health Policy Research</td>
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<tr>
<td>2017</td>
<td>RWJF Clinical Scholars</td>
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<tr>
<td>2017</td>
<td>RWJF Executive Nurse Fellows</td>
</tr>
<tr>
<td>2017</td>
<td>RWJF Investigator Awards in Health Policy Research</td>
</tr>
<tr>
<td>2017</td>
<td>RWJF Nurse Faculty Scholars</td>
</tr>
<tr>
<td>2018</td>
<td>RWJF Center for Health Policy at Meharry Medical College</td>
</tr>
<tr>
<td>2018</td>
<td>RWJF Center for Health Policy at the University of New Mexico</td>
</tr>
<tr>
<td>2018</td>
<td>RWJF Nursing and Health Policy Collaborative at the University of New Mexico</td>
</tr>
</tbody>
</table>
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Russell, S. W., & Morrison, D. C. (2010). *The grant application writer’s workbook- national institutes of health*. California: Grant Writers’ Seminars and Workshops, LLC.


Healthy Transitions from Hospital to Skilled Nursing Facility Post-CABG
María Ordóñez & Debra Hain

Abstract

Introduction: As people age, the risk of coronary heart disease (CHD) that may require cardiac surgery increases. Older adults undergoing surgery are susceptible to post-op complications. To reduce the risk of potential complications, many people are discharged to skilled nursing facilities (SNF) for rehabilitation before returning home. Older adults are vulnerable to poor health outcomes during the transition from a hospital to a SNF.

PICO Question: The authors examined the effect of a gerontological nurse practitioner (GNP) care coordination model on healthy transition and 30-day rehospitalizations among older adults discharged from a hospital to a SNF for rehabilitation following coronary artery bypass grafting (CABG) surgery.

Method: A quality improvement project was conducted to evaluate the effectiveness of this model.

Implementation: The GNP care coordination project involved an interprofessional collaborative approach to the care of older adults as they transitioned from the hospital post CABG to SNF for rehabilitation. The care process began in the hospital and continued throughout rehabilitation. Older adults, their family members, and the healthcare team established mutually-agreed upon goals and the GNP was the coordinator of care.

Evaluation and Discussion: Findings from the project support the effectiveness of the GNP care coordination model in reducing the risk of 30-day rehospitalization and promoting the development of realistic and attainable goals. As hospitals struggle to reduce 30-day rehospitalizations, it is important to include the patient, family, and significant others in developing a collaborative plan of care.

Keywords: Transitions, Cardiac Surgery, Older Adults, Rehospitalization, Skilled Nursing Facility
Introduction

Over the past several years coronary artery bypass grafting (CABG) has become a common treatment for older adults with coronary heart disease (CHD). In 2006 almost half a million CABGs were performed in the United States (American Heart Association, 2010). From 2000 to 2007 about 91,000 CABGs were performed among Medicare beneficiaries (Jacobs et al., 2010). While CABG can be lifesaving and improve the quality of life for many older adults, it is not without risk. Even though intraoperative and post-operative risks for complications exist, a patient continues to be vulnerable after discharge from a hospital.

Many factors complicate the prognosis of a CABG patient after discharge from the hospital, including age, multiple co-morbidities, and functional and cognitive decline, often leading to rehospitalization within 30 days of discharge. To avoid potential complications, many older adults are discharged to a skilled nursing facility (SNF) for in-patient rehabilitation before returning home.

Older adults are susceptible to poor health outcomes during transitions of care between and among healthcare settings (Edwards, Maurer, & Wellner, 2003; Meleis, 2010). When a patient moves from one healthcare setting to another and receives care from more than one health care provider, changes in clinical status must be readily recognized (NTOCC, 2008) and appropriate interventions must be implemented in a timely fashion. Care coordination from an advanced practice nurse that focuses and integrates transitions of care can be an effective way to reduce the risks that older adults face as they move from one healthcare location to another (Bootwell, Griffin, Hwu, & Shannon, 2009; Naylor, Aiken, Kurtzman, Olds, & Hirschman, 2011; Melies, 2010). There is, however, a lack of evidence evaluating care coordination for post-CABG older adults who transition to skilled nursing facilities (SNF) for rehabilitation.

Lett, Remus, & Bryan (2010) explained that focusing on readmission opens a quality improvement opportunity with emphasis on providing care at the right place and at the right time. In addition, current health care reform that includes legislation, rules, and regulations have two crucial areas affecting both hospitals and SNFs. These are in relation to bundled payments for acute and subacute care (e.g. SNFs and home care) and the reduction of payments for readmissions. The Florida Hospital Association (FHA) developed a Readmission Collaborative among hospitals and other health care organizations to jointly reduce the number of hospital readmissions in Florida within 15 and 30 days after discharge. The targets for the collaborative include the reduction of readmission rates for CABG to less than eight percent by December 31, 2010 (Lett et al., 2010). The identification of best practices to reduce readmissions is also part of the FHA Readmission Collaborative.

The purpose of this quality improvement project was to evaluate the effectiveness of care coordination by a Gerontological Nurse Practitioner (GNP) on transitions of care and reducing the risk of 30-day rehospitalizations of older adults post CABG who were discharged to a SNF from the hospital for rehabilitation.

The National Quality Forum (NQF) describes care coordination as “a function that helps ensure that the patient’s needs and preferences for health services and information sharing across people, functions, and sites are met over time” (NQF, 2006). The U.S. Agency for Healthcare Research and Quality (AHRQ) defines it as “the deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient’s care to facilitate the appropriate delivery of health care services” (AHRQ, 2011, p. 189).

The aim of professional nursing practice is to achieve effective and high quality patient-centered care. Care coordination promotes improved quality, safety, and effectiveness in care, resulting in improved healthcare outcomes. A GNP, who is educated and trained in the care of older adults, is an expert in coordinating the care within the complexity of the health care system encountered during the transitional care...
setting. The term transitional care encompasses a wide range of time-limited services and environments intended to ensure health care continuity and avoid preventable poor outcomes among at-risk populations, such as the post-CABG older adult who require one level of care to another, from among multiple providers, and across settings (American Geriatrics Society, 2003).

This quality improvement project specifically explored the following PICOT focus:
Did a gerontological nurse practitioner (GNP) care coordination model affect healthy transition and 30-day rehospitalizations among older adults discharged from a hospital to a SNF for rehabilitation following coronary artery bypass grafting (CABG) surgery?

Theoretical Framework
Meleis’ Transition Theory was the theoretical framework that guided this project. Meleis (2007) explains that the person’s lived experience becomes the central area of nursing interest, particularly in terms of the individual’s response to a constantly changing environment and the unique resulting effects during transitions (p. 214). Meleis’ Transition Theory is relevant and appropriate in providing the framework for gerontological nursing practice. Based on this theory, the nurse practitioner is an expert in assessing, describing, and understanding the older person’s transition patterns, processes and process indicators, as well as in identifying additional tools for measurement and providing ongoing refinement or evaluation of nursing interventions (Schumacher, Jones, & Meleis, 1999).

Using this theoretical framework helped provide a better understanding of the challenges and needs during transitions in care for older adults, resulting in the development of better and more effective interventions (Schumacher et al., 1999). Meleis (2007) speaks of health as being the outcome of healthy transitions, and vulnerability and risks as the result of unhealthy transition processes. Patient-centered interventions can facilitate an optimal transition environment benefitting the patient and family, health care, and society.

Literature Review
Potentially avoidable rehospitalizations exhaust a substantial portion of the health care budget. In 2007, thirty-three per cent of all hospitalizations were adults over 65 years of age (Edwards et al., 2003). Furthermore, approximately 20% of Medicare fee-for-service older adults admitted to an acute hospital is rehospitalized within 30 days of discharge (Stephen, Williams, & Coleman, 2009).

There are many successfully implemented transition models of care that parallel the current health care reform effort to improve quality of care. These transition models resulted in optimum health outcomes in older adults while reducing health care costs. Naylor (2004) developed a Transitional Care Model for older adults that proved to be a cost-effective intervention aimed at improving the patient’s quality of life and reducing re-hospitalizations. Resource utilization was compared between intervention and control groups and included acute care visits, home care visits, and hospital readmissions over a 52-week period of time post index (initial) hospital discharge. The cost savings were substantial for the intervention group after being cost adjusted for unequal follow-up. The intervention group was about $7,500, while the control group was $12,500, a savings of about $5,000. Naylor (2004) said that “older patients who transition from hospital to home are particularly vulnerable, with many of these patients having multiple health problems that continue beyond discharge” (p. 675).

One of the most significant points supported by the body of evidence is the awareness that older adults have complex needs often dealt within a fragmented system, especially during healthcare transitions and making the older patient even more vulnerable throughout this experience. A patient-centered model of care with an emphasis on an interprofessional approach is a crucial aspect of improving transitions of care (Coleman, Parry, Chalmers, & Min, 2006; Godfrey & Townsend, 2008; Cheek et. al, 2006; Lie, Arnesen, Sandvik, Hamilton, & Bunch, 2006; Theobald, Worrall-Carter, & McMurray, 2005). None of the existing evidence supporting transition models of care deals with the older adult population transi-
tioning from a non-teaching hospital to a skilled nursing facility for rehabilitation. Transitions of care are considered an essential component of care coordination (NTOCC, 2008). A collective theme perceived from the body of research was a critical need for care coordination in this vulnerable population.

Knowledge Gap
A non-teaching hospital and SNF were chosen as the clinical sites for this project. The GNP has a collaborative practice with a physician in the SNF where many of the patients have been admitted after being discharged from this particular hospital after undergoing CABG surgery. This hospital performed about 223 CABGs from November 2010 through October 2011. Of these, five to eight percent of patients were rehospitalized within 30 days of hospital discharge. In light of restructuring in CMS reimbursement, this hospital is challenged like many other healthcare organizations to explore ways to reduce their 30-day rehospitalizations. This author, a gerontological nurse practitioner, has first-hand experience in a preponderance of fragmented care among patients who transition across health care settings and identified this as a quality improvement opportunity to improve care coordination, quality of care, and patient outcomes.

Methods
Project Design
A quality improvement project was conducted after receiving hospital and university IRB approval. The project period was July 2011 to March 2012. A purposive sampling design was used to select older adults who met inclusion criteria. Once discharged to the SNF the participants were assigned to the GNP who had staff privileges at the SNF. Patients were free to refuse to participate in the project and expect to receive the same standard of care for an older adult who is discharged from an acute care facility to a SNF for rehabilitation.

Population
Inclusion criteria: Patients who were eligible to participate in this project were older adults >65 years old status post-CABG, Medicare beneficiaries who received care at a non-teaching hospital and were discharged to the SNF in Southeast Florida, can read and speak English, have a telephone, and agreed to participate in the project. Exclusion criteria: Patients who had a diagnosis of moderate to severe dementia as determined by their healthcare provider or medical records were excluded from the intervention.

Intervention
The proponent of the project was a board-certified GNP with over five years of professional experience working with older adults in the SNF. The GNP implemented the project with supervision from faculty and in collaboration with the staff and administration of the SNF.

Steps Involved in the Process
The cardiothoracic surgeon or nurse practitioner in collaborative practice notified the GNP of any potential participant of the project from among those who had CABG surgery and had a planned discharge to the SNF within the next 24 to 48 hours. The GNP then established the initial encounter with the potential participant while still in the hospital and prior to the SNF discharge. This was the opportunity to explain the project and a full disclosure of the details were provided to help the prospective project participant make an informed decision and provide written consent to participate. Baseline data collection was also initiated during this first GNP visit. Socio-demographic and health data were obtained from the medical record and the patient, family, and significant other. The GNP did not see the participant again until after being transferred and admitted to the SNF.

The nurses notified the GNP upon arrival of the participant at the SNF. The GNP would conduct initial contact during the SNF admission which included verifying all the patient’s medications and providing the initial orders. Within 24-48 hours, the GNP followed up with other data collection activities, e.g.,
completing the patient’s history and physical examination, reviewing the medical records, and establishing the mutually-agreed upon plan of care (POC). This POC included the patient care goals and preferences, which is an important aspect for optimal transitions of care. Goals were established using a valid and reliable tool, the Goal Attainment Follow-up Guide (GAS) (Table A).

### Table A: GOAL ATTAINMENT FOLLOW UP GUIDE (GAS)

<table>
<thead>
<tr>
<th>LEVEL OF ATTAINMENT</th>
<th>SCALE 1</th>
<th>SCALE 2</th>
<th>SCALE 3</th>
<th>SCALE 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Control of Signs and Symptoms</td>
<td>Functional Status</td>
<td>Depression</td>
<td>Sense of Integrity</td>
<td></td>
</tr>
<tr>
<td><strong>Much less than expected outcome</strong></td>
<td>Moderate to severe surgical wounds’ pain or discomfort. Dyspnea at rest + moderate to severe DOE*. (&gt;2+ lower extremities edema. Presence of more than one sign/symptom of surgical wounds infection (increased incisional pain, malaise, chills, temperature of 99F or greater, leukocytosis).</td>
<td>Not able to ambulate at least 50 feet once a day.</td>
<td>Continually depressed. Unable to participate in any daily activities (unable to eat, sleep, and participate in rehabilitation activities).</td>
<td>Generally negative feelings about personal meaning of transitional experience.</td>
</tr>
<tr>
<td><strong>Somewhat less than expected outcome</strong></td>
<td>Mild to moderate surgical wounds’ pain or discomfort. No dyspnea at rest + mild to moderate DOE*. (1-2+ lower extremities edema. Presence of one sign/symptom of surgical wounds infection (increased incisional pain, malaise, chills, temperature of 99F or greater, leukocytosis).</td>
<td>Able to ambulate 50 feet once or twice a day.</td>
<td>Depression often interferes with daily activities (unable to eat, sleep, and participate in rehabilitation activities).</td>
<td>More negative feelings than positive about personal meaning of transitional experience.</td>
</tr>
<tr>
<td><strong>Expected level of outcome</strong></td>
<td>Mild surgical wounds’ pain or discomfort. No dyspnea at rest + mild DOE*. Trace or non-existing lower extremities edema. Absence of sign/symptoms of surgical wounds infection (increased incisional pain, malaise, chills, temperature of 99F or greater, leukocytosis).</td>
<td>Able to ambulate 50 feet three times a day.</td>
<td>Depression occasionally interferes with daily activities (unable to eat, sleep, and participate in rehabilitation activities).</td>
<td>Uncertainty about positive or negative feelings of personal meaning of transitional experience.</td>
</tr>
<tr>
<td><strong>Somewhat more than expected outcome</strong></td>
<td>Minimal or no surgical wounds’ pain or discomfort. No dyspnea at rest + no DOE*. Absence of lower extremities edema. Absence of sign/symptoms of surgical wounds infection (increased incisional pain, malaise, chills, temperature of 99F or greater, leukocytosis).</td>
<td>Able to ambulate 50 feet four times a day.</td>
<td>Infrequent periods of depression that do not interfere with daily activities (unable to eat, sleep, and participate in rehabilitation activities).</td>
<td>Verbalizes more positive than negative feelings of personal meaning of transitional experience.</td>
</tr>
<tr>
<td><strong>Much more than expected outcome</strong></td>
<td>No surgical wounds’ pain or discomfort. No dyspnea at rest + no DOE*. Absence of lower extremities edema. Absence of sign/symptoms of surgical wounds infection (increased incisional pain, malaise, chills, temperature of 99F or greater, leukocytosis).</td>
<td>Able to ambulate 50 feet more than four times a day.</td>
<td>Absence of depression</td>
<td>Generally verbalizes positive feelings of personal meaning of transitional experience.</td>
</tr>
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</table>

**COMMENTS**

Post-CABG older patient and/or Valve Repair or Replacement Surgery

DOE: Dyspnea on exertion
The GNP attended weekly interprofessional team care coordination meetings with the unit staff. During these meetings the GNP would discuss and provide updates on the patient’s preferences and goal progression as established and indicated in the GAS. Members of the team and the GNP would review rehabilitation goals with the patient and family to determine best options to achieve the provisions of the POC. The GNP would then discuss the outcomes of the meeting with the patient and family (if patient agreed to have a family member involved) to evaluate any discrepancies and collaborate on exploring other appropriate interventions. The essential component in this process was shared decision-making between the patient and the GNP. Any changes in the patient’s condition and plan of care were discussed with the cardiothoracic surgeon and nurse practitioner from the primary hospital.

The GNP acted as care coordinator by being the single point of contact, providing pertinent information and education to the patient, family, and significant others, and assuring that the POC was adhered to and communicated between the patient and the health care professionals. In addition, the GNP performed the role of the patient’s primary healthcare provider while in the SNF.

Outcome Measures

Health Outcomes

The clear metric for this quality improvement project was the reduction in potentially preventable 30-day rehospitalizations. This was measured by contacting project participants within 30-days of hospital discharge as a face to face visit in the SNF, or as a telephone call if discharged home from the SNF. The Goal Attainment Scaling (GAS) was used to develop and evaluate goal attainment of healthy transition processes. This tool measures individual change as specifically determined for this project (Becker, Stuifbergen, Rogers, & Timmerman, 2000; Kiresuk, Smith & Cardillo, 1994). The GAS was reviewed at strategic transition points (STPs) during the duration of the project: initial SNF visit, within two weeks of SNF stay, after one week of the patient’s discharge from SNF, and approximately 30 days post hospital discharge.

Schlosser (2004) recommends that content validity of the GAS be assessed on a case-by-case basis due to the differences among disciplines, disorders, and even clinicians. At the same time, the construct validity of GAS is also best tested on a project-by-project basis (Schlosser, 2004). According to Marson, Wei, & Wasserman (2009), GAS composite scores were found to be a reliable instrument for monitoring patient’s progress over time. The GAS has good interrater reliability at 0.83 (Marson et al., 2009). Furthermore, in the area of rehabilitation, Malec (1999) reported outstanding interrater agreements with inter-class correlations of 0.90 or above. Finally, Marson et al. (2009) described sensitivity as the ability of a method, in this case GAS, to “detect change when change did in fact take place” (p. 230). Marson et al. (2009) affirm that GAS is sufficiently sensitive to capture these changes.

Results

A total of 10 older adults participated in this project from July 2011 through March 2012. Participants’ ages ranged from 67 to 87 with a mean age of 78.70, standard deviation of 7.86 years. The type of open heart surgery was classified as 1 for CABG, 2 for valve repair or replacement, and 3 for CABG and valve repair or replacement. Six participants underwent CABG and four of them had both CABG and valve repair and replacement surgery, with a standard deviation of 1.03. The length of stay at the SNF ranged from 6 days to 39 days, with a mean length of stay of 14.80 days and a standard deviation of 11.34 days. The length of hospital stay ranged from 5 to 21 days, with a mean hospital stay of 10.7 days and a standard deviation of 4.90 days (Table B). None of the older adults participating in this project were readmitted to the hospital within 30 days of hospital discharge. These results indicate a five to eight percent more effective rate than the standard of care.
Goal Attainment
Four process indicators or scales were chosen and translated into goals to measure how transition is progressing based on Meleis Transition Theory (2010). Inferential statistics was used to look at individual improvement and goal attainment across time (Figures 1 - 4). A total or composite score was used to illustrate overall goal attainment (Figure 5).

The findings support that over time there was a progressive improvement on reported symptoms, function, depressed mood, and integrity as measured at four data collection points: initial SNF visit, within two weeks of SNF stay, after one week of the participants discharge from the SNF, and approximately 30 days post hospital discharge. The total composite score for all four variables indicates that a GNP care coordination model is an effective intervention in promoting a healthy transition of older adults as they move from a hospital to a SNF for rehabilitation (p < 0.001).

Results

<table>
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<tr>
<th></th>
<th>N</th>
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<th>Maximum</th>
<th>Mean</th>
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<td>11.34</td>
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<tr>
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<td>21.00</td>
<td>10.70</td>
<td>4.90</td>
</tr>
</tbody>
</table>

Table B: Socio-Demographic Profile of Project Participants

There were no 30-day avoidable re-hospitalizations

Goal Attainment
Four process indicators or scales were chosen and translated into goals to measure how transition is progressing based on Meleis Transition Theory (2010). Inferential statistics was used to look at individual improvement and goal attainment across time (Figures 1 - 4). A total or composite score was used to illustrate overall goal attainment (Figure 5).

The findings support that over time there was a progressive improvement on reported symptoms, function, depressed mood, and integrity as measured at four data collection points: initial SNF visit, within two weeks of SNF stay, after one week of the participants discharge from the SNF, and approximately 30 days post hospital discharge. The total composite score for all four variables indicates that a GNP care coordination model is an effective intervention in promoting a healthy transition of older adults as they move from a hospital to a SNF for rehabilitation (p < 0.001).

Figure 1: Control of Signs and Symptoms: F (3, 27) = 15.167; p<0.001; N^2 = 0.628.
Time accounts for 62.8% of the variance in symptoms on the scale of -2 to +2.
Figure 2: Functional Status: $F(3, 27) = 30.0; \ p < 0.001; \ N^2 = 0.769$. Time accounts for 76.9% of the variance in function as measured by the -2 to +2 rating.

Figure 3: Depression: $F(3, 27) = 36.95; \ p < 0.001; \ N^2 = 0.803$. Time accounts for 80.3% of the variability in depression as measured by the -2 to +2 scale.

Figure 4: Sense of Integrity: $F(3, 27) = 19.137; \ p < 0.001; \ N^2 = 0.680$. Time accounts for 68% of the variability in integrity as measured by the -2 to +2 scale.
Transition of care as part of care coordination is something that nurses have been doing as a fundamental standard and competency for professional practice. Emphasizing the important role of nursing in care coordination, the American Nurses Association describes the best nursing care coordination model as “one in which the patient experiences primary care as delivered by an integrated, multidisciplinary team that explicitly includes at least one care coordinator staff person” (ANA, 2012). The value of advanced practice nurses in patient-centered care coordination roles have been demonstrated in numerous transition care models across patient populations and health care settings (Coleman et al., 2006; Naylor, Aiken, Kurtzman, Olds, & Hirschman, 2011). Few of the existent evidence supporting transition models of care have investigated the older adult population transitioning from a community hospital to a skilled nursing facility for rehabilitation. A collective theme perceived from the body of research was the critical need for translation of the evidence into practice, something that was done in this project.

A patient-centered model of care with an emphasis on an interprofessional approach was unveiled as indispensable to improve transitional care (Coleman et al., 2006; Godfrey & Townsend, 2008; Cheek et al., 2006; Lie et al., 2006; Theobald et al., 2005).

Implications for Practice
The findings from this project provide preliminary evidence of a successful GNP care coordination approach for post-CABG older adults who transition from an acute care facility to a SNF for rehabilitation. Even though the results from this quality improvement project are not generalizable, there are nursing practice implications.

First, it is essential to take an individualized approach to care by mutually establishing goals with patients and their families. Older adults have varying cognitive, physical, and cultural healthcare needs that can be addressed in care coordination. The nurse practitioner conducting this project was able to effectively communicate and collaborate with other healthcare professionals involved in the care of participants. This allowed for open dialogue with other healthcare professionals involved in the care regarding established patient and family goals. The participants in this project expressed gratitude for having a voice in their care and achieving the goal of returning home as soon as possible with the least complications (Box 1 Exemplar). One year after this project ended the cardiothoracic surgeon contacted the DNP asking if she would join his practice. He stated that since the project ended there has been an increase in the number of patients rehospitalized within 30-days of discharge. The physician valued the role of a doctorally-prepared nurse practitioner in managing the potentially-complex transition of care.
Limitations

Although this quality improvement project provides baseline data for future work, there were several limitations. First, the results are not generalizable. Second, the sample included a small number of participants. Third, there is a lack of formal cost-effectiveness analysis. In addition, this project was conducted only in one healthcare institution and participants were restricted to Medicare beneficiaries. A randomized clinical trial of a larger sample involving a few geographically-dispersed health settings will provide valuable insights into the relevance of a GNP-led transition model of care. A cost-benefit analysis can also help determine the financial benefits of this model, which can support future reimbursement for nurse practitioners who provide care coordination to older adults. Finally, financial implications to the healthcare organization for improving quality of care and diminishing the number of 30-day rehospitalizations will be more evident.

Conclusion

The application of a gerontological nurse practitioner guided model of care for post-CABG older adults transitioning from the hospital to a skilled nursing facility ought to be considered as a timely and necessary endeavor of high clinical and financial importance that may impact, transform, and reduce the increased costs associated with these types of patients, as well as improve health outcomes.

Improving transition processes and care coordination at the interfaces between care settings require dynamic leadership, collaboration, and excellent interpersonal skills, which are key components of the GNP role. Healthy transition is possible with effective care coordination managed by a gerontological nurse practitioner.

References


Healthy Transitions from Hospital to Skilled Nursing Facility Post-CABG


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