



Robert Wood Johnson Foundation

Robert Wood Johnson Foundation
New Careers in Nursing

NCIN Round 6 Poster Development

Monday, June 24, 2013

2 p.m. EDT



American Association
of Colleges of Nursing

Webinar Troubleshooting

- The call-in number is **1-800-273-7043**
- The attendee access code is **811509**
- Event number: **578 065 542**
- Event password: **NCINR6**
- If you are still having trouble with the phone or online aspects of this webinar, please contact Christine Downing in the text box, at **Cdowning@aacn.nche.edu**, OR at **(202) 463-6930 ext. 266**

Quick Reminders

Reduce background noise

- Silence your cell phone
- Close your office door
- To mute your line *6

Participation

- Q/A and Chat on the right
- Ask a question at anytime

Trouble with the system

- 1-866-229-3239
- Info Tab for more details

PURPOSE

- Review the NCIN6 call for Poster Abstracts
- Discuss the timeline
- Discuss best practices

NCIN6 POSTER SUB COMMITTEE

2013 Members

- Lori A. Escallier*, PhD, RN, CPNP
- Dr. Cecil Holland, RN, BSN, APRN, MSN, MEd, EdD, PhD
- Denise M. Tate*, EdD, APRN, WHNP-BC, ANP-BC
- Susan Ward, PhD, RN

*Committee co-chairs



TIME LINE

- *Call released to past and current grantees 5/30/13
- *Web Meeting 6/24/13 (2pm EST)
- *Deadline for abstract submissions 8/1/13 (Noon EST)
- *Peer Review 8/1/13-8/8/13
- *Email Notification of acceptance or rejection 8/9/13
- *Deadline for camera-ready poster 9/13/13 (Noon EST)
- *Washington DC Conference 10/10/2013- 10/12/2013

TOPICS

- Leadership development activities for accelerated students;
- Successful recruitment and retention strategies to yield/ retain ethnically diverse or underrepresented students;
- Program evaluation of accelerated programs;
- Innovative program design for accelerated students;
- Successful mentoring programs;
- Career Trajectory (overview of your graduates' 1) employment, 2) transition to graduate program, and 3) demonstrated leadership activities post-graduation);
- Hot Topics/ Other (Amazing in- progress or completed projects such as challenges faced, unexpected accomplishments/successes, Scholars leveraging previous skills etc...);
- Cultural Competence Initiatives.

POSTER CONTENT

- Each poster should include the following information:
 - The purpose and goals of the work.
 - Any background and information needed to understand the work.
 - Methods used to complete the work.
 - A summary of the contribution and/or results, in sufficient detail for a viewer to understand the work and/or results; especially key details, results and contributions, or the anticipated contributions if the work is at an early stage.
 - Where to find additional information. This should include but is not restricted to:
 - a web site with additional information about the work
 - author contact information, including email addresses
 - citations for any papers, books, or other materials that provide additional info.

SPECIAL GUEST

Corrine Jurgens PhD RN ANP-BC FAHA
Associate Dean for Research
Clinical Associate Professor
Stony Brook University
School of Nursing

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New Careers in Nursing



QUESTIONS?



Submit questions in your chat window at anytime.

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Stony Brook University



Developing Effective Posters

NCIN Webinar

Corrine Y. Jurgens PhD RN FAHA

Associate Dean for Research



Stony Brook University

Communicating a message







- Develop a strong abstract
- Review prior accepted abstracts
- Peer review abstract prior to submission
- Adhere to abstract & poster guidelines
- Identify resources for printing
- Peer review poster presentation



- Summary of your paper / project
- Background *to* Conclusion
- General format (varies depending on organization)
 - Background
 - Purpose
 - Method
 - Results
 - Conclusions



- Put the findings in your title
- Majority of text reserved for results
- Move important message to beginning of sentences
- Use tables judiciously
- A ‘word’ about word counts
 - Do not write to the word count
 - Put everything you want in first, then edit

Improving Heart Failure Self-Care: A responder analysis of an educational intervention

Background/Purpose: The most effective method of improving heart failure (HF) self-care is unknown. The purpose of this study was to assess a 4-part self-care intervention to identify the most effective component.

Method: We performed a responder analysis of data from a randomized controlled trial of 99 HF patients randomized to a self-care intervention or usual HF care. All participants received a weight scale and HF self-care booklet. The intervention group also received interactive symptom recognition training using a 6-minute walk test and training in use of a daily symptom graph with reinforcement during a home visit or call one week later. HF self-care was measured using the Self-Care of HF Index (SCHFI) maintenance scale at baseline and 6 months; scores range 0-100, higher scores indicate better self-care. Each of the 4 intervention components (scale and booklet, 6-minute walk test, visit or call, symptom graph) was assessed in terms of effectiveness in improving self-care with chi square, paired t tests and repeated measures ANOVA. The effect of combining components was then examined. As both groups received an intervention, the groups were combined for this analysis.

Results: The sample was 67.7 years, SD 12.1, 32% female, 89% White and functionally compromised (85% NYHA III-IV). Providing a scale and booklet significantly increased self-care maintenance scores (60.8 to 74.3, $p=.048$). Providing a scale and booklet plus a home visit further improved self-care maintenance scores (60.8 to 80.9, $p=.048$). The 6-minute walk test did not contribute to improvements in self-care (72.7 vs 74.9, $p=.31$) nor did training in use of symptom graphs (73.7 vs 75.2, $p=.96$).

Conclusions and Implications: Providing both a weight scale and follow-up was sufficient to improve self-care in this sample. Although conceptually appealing as an approach to improving symptom recognition, the 6-minute walk test and symptom graphing were not important elements of this intervention.

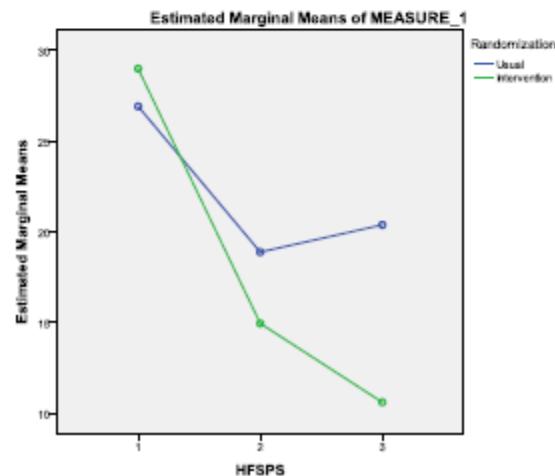
Effect of Symptom Awareness Training on Heart Failure Self-Care and Symptom Burden

Symptom severity is associated with timely care-seeking among patients with heart failure (HF). Delay in responding to symptoms frequently results in escalating symptom severity by the time they seek care. The study purpose was to test the effect of an interactive symptom training protocol on self-care, symptom burden and contact with health providers.

Method: Using a randomized controlled trial design, 46 HF patients were randomized to a symptom training protocol or usual HF education. All received a weight scale and self-care booklet. Intervention group patients received interactive symptom recognition training and use of a daily symptom graph. HF self-care was measured using the Self-Care of HF Index (SCHFI) at baseline, 3 and 6 months. SCHFI scores range 0-100 with higher scores indicating better self-care. HF symptom severity was measured with the HF Somatic Perception Scale (HFSPS). Scores range 0-90 with higher scores indicating higher HF symptom burden. Emergent calls to health providers were documented by telephone interview at 1, 3 and 6 months, recorded as a binary variable and summed from baseline to 6 months. Self-care and symptom severity was assessed with repeated measures ANOVA.

Results: The sample mean age was 71.4 years, *SD* 10.9, 39% female, 87% White and functionally compromised (78% NYHA III-IV). Both groups had clinically relevant improvement in SCHFI maintenance and management scores at 3 months and some further improvement in maintenance scores at 6 months. There were no statistically significant differences in SCHFI scores between groups. Despite similar SCHFI scores at 6 months, the mean HFSPS score was 50% lower in the intervention group (10.6 vs 20.4) ($t=2.2$, $p=.033$). The intervention group initiated more contacts with health providers than the usual care group (10 vs 8).

Implications: Patients receiving symptom training demonstrated an improvement in symptom recognition ability although self-care scores were no different than those of the control group. Better symptom recognition may be responsible for the increase in contact with health providers by those in the intervention group.





- Use a readable font (e.g. Arial vs Times New Roman)
- Use an appropriate size font
Should be able to read 6 feet away
- Delete extra words (e.g. 'the')
- Delete unnecessary commas, periods, colons, underlining
- Include figures, graphics as appropriate



Prepare your elevator speech

- Punch line comes first
 - Diversity among nursing students is important, therefore...
- Easy to understand: NO jargon
- Concise
- One big point
- Sum it up – Be clear about take home message
 - The 'ask'



- Who is your audience?
- What is your message?
- Use format and design to highlight message and key points
- Edit the text mercilessly
- Proof your work; have others proof, too
- Let your figures do the talking
- Practice, practice, practice



- It's not a mini paper: it's a poster
- It is about dialogue
- Highlight your findings
- Make it accessible to everyone
- Demonstrate your skills
- Credit institution and funding sources
- Email trail: Business cards & handouts

What would strengthen the clarity of this poster?

Designing Disease Management Programs for Hispanics with Heart Failure

Purpose

Background: Hispanics are a growing population and heart failure (HF) is prevalent in this population. Disease management improves outcomes in the general population but little is known about how to design effective interventions for Hispanics with HF.

Purpose: To identify the characteristics of Hispanic patients needing a relatively more intense disease management intervention.

Design

Design

- Secondary analysis

Data sources

- Data from a randomized controlled trial (RCT) of telephone case management:
 - (2006) Riegel et al. Randomized Controlled Trial of Telephone Case Management in Hispanics of Mexican Origin with Heart Failure. *J Cardiac Fail*, 12(3), 211-219.

Sample

- N = 134 Hispanic persons with HF
 - 69 randomized to intervention group
- **Demographic & Clinical Characteristics**
 - 72.6 ± 10.8 years of age
 - 58.0% female
 - 56.5% married
 - 80.7% annual family income <\$15,000
 - 79.7% grade school education or less
 - 82.6% NYHA class III/IV
 - 37.5% newly diagnosed with HF (≤ 2 mo)

Methods

- Enrolled during a HF hospitalization
- Intervention group received 6-months of telephone case management by Mexican-American bilingual/bicultural registered nurses
- Total number contacts with patients, family members, and others (e.g., physicians) summed and used as a measure of intervention intensity
- Multiple regression analysis used to identify intervention group patients needing the highest intensity of care. Hypothesized predictors were:
 - Demographic (age, education)
 - Psychological (quality of life, depression)
 - Clinical (comorbidity, functional status, cardiologist care, ability to communicate with provider)
 - Cultural (barriers to care score, level of acculturation)

Results

- Using an **enter** method, a model of 8 (all except comorbidity and functional status) variables explained 33% of the variance in intervention intensity ($F=3.2$, $df\ 8,52$, $p=.005$)
- Using a **forward** stepwise approach, only education and quality of life were significant, explaining 16% of the variance in intervention intensity ($F=5.4$, $df=2,58$, $p=.007$)
- Using a **backwards** deletion approach, 5 predictors remained, explaining 29% of the variance ($F=4.4$, $df\ 5,55$, $p=.002$):
 - Depression (PHQ-9)
 - Barriers to care scale score
 - Education level (3 categories)
 - Quality of life (EQ-5D visual analog scale)
 - Age (years)

Final Solution Using Multiple Regression, Backwards Deletion

	Unstandardized Coefficients		Standardized Coefficients	t	Sig.
	B	Std. Error	Beta		
Depression (PHQ Score)	.409	.243	.193	1.682	.098
Barriers to Care Scale Score	1.018	.493	.255	2.063	.044
Education 3 groups	-8.777	3.244	-.349	-2.705	.009
Quality of life (EQ5D - VAS)	-.166	.070	-.291	-2.365	.022
Age in years	-.269	.141	-.254	-1.911	.061

Conclusions

- Intervention group patients needing the highest intensity were those who were depressed, poorly educated, low in quality of life, and younger age, and who perceived barriers to care.
- Culturally specific issues were education and barriers to care:
 - Most of the sample had less than a grade school education—not typical in the U.S.
 - Barriers to care scale addresses access to care, language, finances, immigration status

Limitations

- Secondary analysis
- Small sample, limited statistical power
- Single ethnic/racial group in this sample

Implications for Practice & Research

- When designing interventions for special populations, assessment of these characteristics may improve the match between staffing and patient needs.
- Research into effective ways of caring for special populations is greatly needed.

Discussing Physician-Assisted Dying (PAD): A Qualitative Study of Doctors' Experiences in the US & the Netherlands

WHAT WE LEARNED

Whether or not a physician chooses to participate in PAD, exploring a patient's initiation of the topic can serve as a gateway to addressing end-of-life issues important to patients. PAD discussions strengthen and intensify doctor-patient relationships. PAD discussion can be an emotional experience for physicians. Where PAD is legal, physicians turn to others for support and have open and honest conversations about PAD with patients and with colleagues.

BACKGROUND

Physician-assisted dying (including euthanasia and assisted suicide) is requested by patients throughout the world. The US and the Netherlands are developed Western nations with high standards of medical care, yet varying legal/ethical environments surrounding the end of life and PAD. Little is known about how physicians experience these discussions in various settings.

AIMS

- To further understand physicians' experiences of *discussing* PAD with their patients in different settings
- To understand the role of the doctor-patient relationship as it affects and is affected by PAD discussions
- To explore the emotional impact of discussing PAD
- To understand how physicians discuss these patient interactions with others

QUALITATIVE METHODS

- Semi-structured one-on-one interviews conducted in person by a single interviewer
- Purposive sampling using snowball method to obtain a diverse range of experiences from different types of physicians, with different beliefs, in different settings
- On-going inductive analysis of interview data to guide sampling and data collection
- Multiple coders of different disciplines contributed to development and application of hierarchical coding tree
- Utilization of NVivo software to facilitate further analysis across various codes and demographic factors

RESPONDENTS

	Sex		Age (yrs)			Region	Specialty		
	Female	Male	<40	40-50	>50		Primary Care*	Oncology/Hematology	Other** specialties
US	6	12	2	6	10	8	3	7	
Dutch	9	9	3	9	6	7	4	7	

*Defined as family medicine or general internal medicine (US); huisarts or nursing home medicine (NL)
**Includes anesthesiology, cardiology, geriatrics, hospice/palliative medicine, otolaryngology, psychiatry, pulmonology, neurology, radiation oncology, rheumatology, surgical oncology

RESULTS

PAD DISCUSSIONS AS A GATEWAY

- PAD discussions were an opportunity to clarify, to explore fears, to address end-of-life concerns, and to reassure patients

It was rather clarifying for her... When people are informed... they're more comfortable knowing that there are options, and that there's always the possibility to... discuss it again when it's really appropriate. Because there are very many people who start talking about euthanasia like... a kind of insurance. They want to know that when it really... would be that bad that they couldn't live anymore, that there is someone who's out there to help them. NL

Theoretical PAD Question

Actual PAD Request

Opportunity to address concerns

When patients bring up questions about physician-assisted death [they] are also opening the door to discussions about their care and about their symptoms and about their situation... Physicians always need to be able to talk about all of those things. US

INTENSE PHYSICIAN EMOTIONS

- Discussing PAD evoked both positive and negative--as well as frankly ambivalent--emotions in physicians

Those two patients were very, very, very determined in their wish and were really grateful that I was willing to talk to them about it and was willing to consider it... I thought it was very rewarding. NL

Literally I felt as though the blood had frozen in my veins. I just felt totally cold all over. I had no idea what to do. I realized there was no help I could get from anywhere... I felt... impotent to help them. US-OR

This feeling that maybe I was letting him down... given the circumstances of ALS. US

STRONG DOCTOR-PATIENT RELATIONSHIPS

- Relationships set the stage for PAD discussions to occur and were strengthened by discussing matters important to patients

It's a strange topic to talk about but it's a way to come close to the patient... You really get to know what this person thinks about his or her complaints. Why, why is this person considering this symptom as too painful or too distressing to live with? The other one is not. Then you get to learn the real motivations of patients. NL

Doctor-Patient Relationship

PAD Discussion

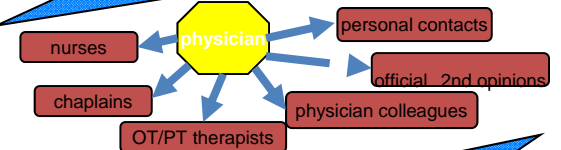
I've never had a relationship end over this... When you've had a long-term relationship... there's enough trust... and respect there that people are willing to respect your point of view. US

- Even when patient and physician did not ultimately agree about PAD, the relationship was not necessarily negatively affected

SUPPORT WITH PAD DISCUSSIONS

- Discussing PAD requests with others was helpful to physicians; where legal, these discussions were inherent to the process of a

It starts with the patients, the family, the nurses... in the nursing home... therapists, and that's part of the process... not all disciplines of course... but some are close to the patient. In one case it might be the [physical] therapist. Other times... someone from activities or the [chaplain]... He's... one of the first persons you ask... after the patient has brought it up. NL



I actually called a couple of colleagues and just... ran it by them again because... I knew I was being pulled so far towards... "Well maybe we can just try. What harm can it do?" They were just like, "Look, you don't want this to go bad on you or the patient, and it's not fair and it sounds like he is declining quickly." So with that I did decline. US-OR

What is wrong with this picture? Proofing the proof...

Symptom Clusters Predict Functional Status in Patients with Heart Failure



Corrine Y. Jurgens PhD RN¹ Debra K. Moser DNSc RN² Cheryl Hoyt Zambroski PhD RN²
 Terry Lennie PhD RN² Beverly Carlson MS RN CNS CCRN³ Barbara Riegel DNSc RN CS FAAN³



¹Stony Brook University, Stony Brook NY ²University of Kentucky, Lexington KY ³Sharp HealthCare, San Diego CA ⁴University of Pennsylvania, Philadelphia PA

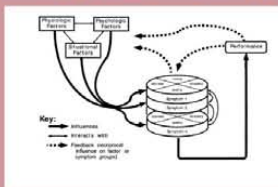
BACKGROUND

- Persons with heart failure (HF) have great difficulty recognizing and labeling their HF symptoms
- Symptom recognition is complicated by:
 - Comorbid illnesses
 - Expectations about symptoms and aging
 - Nonspecific insidious nature of HF symptoms
- Perhaps if groups or clusters of HF symptoms were known, patients would recognize their symptoms more easily

PURPOSE

- To describe the number, type, and combination of HF symptoms as clusters
- To examine the importance of HF symptom clusters by assessing their impact on functional status

THEORY OF UNPLEASANT SYMPTOMS



HiCN
 How I appear like a heart failure
 feeling or other cardiac nursing capacity

METHOD

- Factor analysis of 4 unique data sets
- 2 samples with acute HF
- 2 samples with chronic HF
- Instruments used to identify symptom clusters
 - HF Somatic Awareness Scale
 - 12-item Likert HF specific somatic awareness scale
 - Minnesota Living with HF Questionnaire
 - 21-item Likert quality of life scale (physical & emotional factors)
 - HF Symptom diary
 - 7 HF symptoms rated 1 (best experienced) to 10 (worst experienced)
- Physical Functioning
 - New York Heart Association Classification
 - Specific Activity Scale

DEMOGRAPHICS & SYMPTOM MEASUREMENT

- Sample 1
 - N = 201 acute HF patients hospitalized for symptom management 44% female, mean age 70 ± 12, 95% non Hispanic white
 - HF Somatic Awareness Scale
- Sample 2
 - N = 231 acute HF patients hospitalized for symptom management 49% female, mean age 72 ± 12, 82.6% non Hispanic white
 - Minnesota Living with HF Questionnaire
- Sample 3
 - N = 69 chronic HF patients recruited from HF clinic 42% female, mean age 62 ± 14, 71% non Hispanic white

HF Symptom Diary

- Sample 4
 - N = 53 chronic HF patients recruited from HF clinic 34% female, mean age 56 ± 9.8, 88% non Hispanic white
 - Minnesota Living with HF Questionnaire

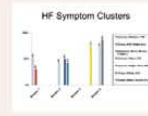
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SYMPTOM ITEMS SELECTED FROM THE MINNESOTA LIVING WITH HF QUESTIONNAIRE

1. Cause swelling in your ankles, legs, etc.? (swelling)
2. Making you sit or lie down to rest during the day? (fatigue)
3. Making your walking about or climbing stairs difficult? (dyspnea on exertion)

4. Making your sleeping well at night difficult? (sleep difficulties)
5. Making you short of breath? (dyspnea)
6. Making you tired, fatigued, or low on energy? (fatigue)
7. Making you worry? (worry)
8. Making it difficult for you to concentrate or remember things? (memory)
9. Making you feel depressed? (depression)



Cluster	Sample 1	Sample 2	Sample 3	Sample 4
Cluster 1	15%	12%	10%	18%
Cluster 2	20%	18%	15%	22%
Cluster 3	18%	16%	14%	20%
Cluster 4	12%	10%	8%	15%
Cluster 5	10%	8%	6%	12%
Cluster 6	8%	6%	4%	10%
Cluster 7	6%	4%	2%	8%
Cluster 8	4%	2%	1%	6%
Cluster 9	2%	1%	0%	4%

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Cluster 5	10%	8%	6%	12%
Cluster 6	8%	6%	4%	10%
Cluster 7	6%	4%	2%	8%
Cluster 8	4%	2%	1%	6%
Cluster 9	2%	1%	0%	4%

CONCLUSIONS

- Physical and psychological symptom clusters predicted functional status
- Fatigue was common and clustered with symptoms reflecting volume overload

IMPLICATIONS

- Knowledge of symptom clusters may improve recognition of compromised HF status

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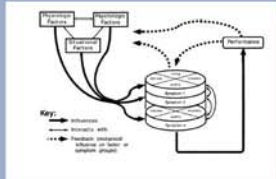
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THEORY OF UNPLEASANT SYMPTOMS



HF-NSI
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 Bentley, Anderson, University of Pennsylvania

METHOD

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- 2 samples with acute HF
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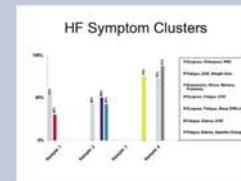
SYMPTOM ITEMS SELECTED FROM THE MINNESOTA LIVING WITH HF QUESTIONNAIRE

- Cause swelling in your ankles, legs, etc.? (swelling)
- Making you sit or lie down to rest during the day? (fatigue)
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- Making your sleeping well at night difficult? (sleep difficulties)
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- Making you feel depressed? (depression)

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 - Minnesota Living with HF Questionnaire

METHOD



Cluster	Physical	Emotional	Mean	Std. Dev.
1	100	100	100	100
2	100	100	100	100
3	100	100	100	100
4	100	100	100	100
5	100	100	100	100
6	100	100	100	100
7	100	100	100	100
8	100	100	100	100
9	100	100	100	100
10	100	100	100	100

Cluster	Sample 1	Sample 2	Sample 3	Sample 4
Cluster 1: Physical & Emotional	100	100	100	100
Cluster 2: Somatic Awareness	100	100	100	100
Cluster 3: Memory/Worry	100	100	100	100
Cluster 4: Depression	100	100	100	100

CONCLUSIONS

- Physical and psychological symptom clusters predicted functional status
- Fatigue was common and clustered with symptoms reflecting volume overload

IMPLICATIONS

- Knowledge of symptom clusters may improve recognition of compromised HF status



Elders Experience Fewer Heart Failure Symptoms and Lower Symptom Distress

Corrine Y Jurgens PhD RN CS ANP
Barbara Riegel DNSc RN CS FAAN

School of Nursing, Stony Brook University, Stony Brook, New York
School of Nursing, University of Pennsylvania, Philadelphia, PA



PURPOSE

To describe the incidence of early, acute heart failure symptoms in relation to age, comorbidity, and symptom distress in patients seeking care for acute heart failure.

METHOD

- Heart Failure Symptom Awareness Scale
 - Number of symptoms
 - Symptom distress
- Charlson Comorbidity Index
- Structured interview
 - Symptom duration prior to hospitalization

Sample Sociodemographics N=201

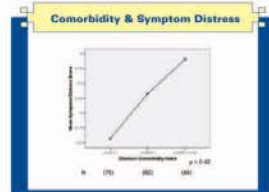
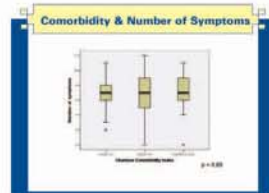
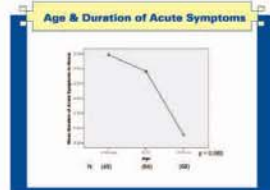
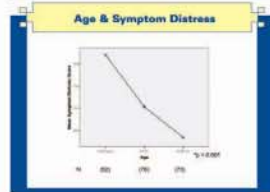
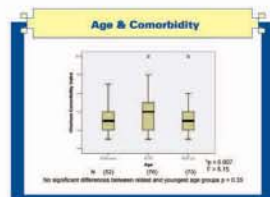
AGE (years)	Mean 70 (Range 27-97 years)
Age 27-40	62 (31.3%)
Age 41-50	76 (38.3%)
Age 51-70	73 (36.5%)
SEX	115 (57.2%)
ETHNICITY	
White	80 (40.3%)
Black	42 (21.4%)
Hispanic	46 (23.2%)
EDUCATION	
Less than 12 years	50 (25.1%)
High School Diploma	80 (40.3%)
Some college/Associate Degree	40 (20.2%)
Bachelor's Degree	15 (7.5%)
Graduate Degree	6 (3.0%)
Marital Status	
Married	38 (19.4%)
Widowed	44 (22.4%)
Divorced, separated, never married	46 (23.2%)
Insurance	
Medicaid	7 (3.5%)
Medicare	79 (39.3%)
Private	73 (36.5%)
Other	32 (16.0%)

Duration of Heart Failure Symptoms prior to Hospitalization

SYMPTOM	n	%	Median Duration (days)
Dyspnea	191	96	6
DOE	156	78	7
Acute dyspnea	149	75	6.2
Fatigue	142	71	7
Orthopnea	120	60	6
PND	104	52	6.1
Cough	103	51	7
Edema	100	50	7
Increased girth	88	44	7
Weight gain	53	26	7
Puffiness	43	21	7
Shortness	41	20	7
Recovery	41	20	7

PND = paroxysmal nocturnal dyspnea DOE = dyspnea on exertion

■ acute symptoms ■ prodromal/early symptoms



SUMMARY OF RESULTS

- Oldest patients reported fewest symptoms, least amount of symptom distress, and shortest duration of acute symptoms
- Comorbidity had no influence on number of symptoms reported, symptom distress and recognition, or duration

CONCLUSION

- Elders appear less sensitive to early heart failure symptoms, which may impair their self-management ability

IMPLICATIONS

- Research is needed to determine if there is a physiologic reason for less symptom sensitivity or if elders attribute symptoms to aging and therefore do not report them

Grant Support: American Heart Association, Heritage Affiliate
Sigma Theta Tau, Kappa Gamma Chapter
John A. Hartford Foundation

Results of the OH-PONHE I* Study

*Oral Health—Positive Outcomes for Nursing Home Elders

Rita A. Jablonski, PhD, RN, ANP; Cindy Munro, PhD, RN, ANP, FAAN; Mary Jo Grap, PhD, RN, ACNP, FAAN;

R. K. Elswick, Jr, PhD; Mary Ligon, PhD(c)

Background

- The National Institute of Dental and Craniofacial Research (NIDCR) recognizes frail and functionally dependent elders who reside in nursing homes as a group with significant health disparities in the area of oral health
- There is emerging clinical evidence demonstrating associations between poor oral health and systemic diseases
- For the past 10 years, oral health has declined for frail, functionally dependent, and institutionalized elders
- Reasons for this decline include limited access to preventive dental care at a time when more elders are arriving in nursing homes with their own teeth

Purpose

This pilot study, the first of the Oral Health--Positive Outcomes for Nursing Home Residents (OH--POHNE) studies, examined the oral health of 39 nursing home residents who resided in 2 nursing homes

Setting

• Autumn Woods**

120 beds
Rural
For-profit facility
Primary reimbursement:

Medicare/Medicaid

• Crawford Meadows**

250 beds

Suburban
Non-profit facility
Primary reimbursement:
Private pay

**All NH names are pseudonyms

Sample

Inclusion criteria:

- Female
- Dentate OR edentate with at least one set of dentures OR mixed dentition
- IRB approval; informed consent obtained from legally responsible party or elder

Subjects:

39 NH Residents
20 from Autumn Woods
19 from Crawford
* 87% white, 13% AA
* Mean age = 81 years
* 58% diagnosed with moderate dementia

Data analyzed using data from 38 subjects due to incomplete information

No statistical difference between subjects in either facility

Procedures

- Liquid disclosing agent placed on teeth and/or dentures
- Plaque measured on 10 surfaces per tooth/denture using the University of Mississippi Oral Health Index
- Decayed, missing, and filled teeth counted
- Functional and cognitive status were measured using the Katz ADL Index and subscales of the Functional Abilities Checklist
- Dementia was quantified using the Global Deterioration Scale

Analysis

- Descriptive statistics
- T-tests for group differences

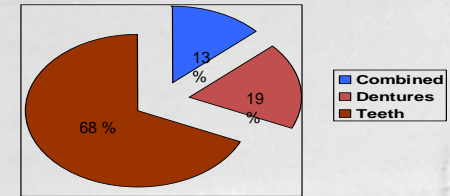
Results

Number of Teeth

- Range, 0-25
- Mean, 8.1
- SD, 7

DMF

- Mean, 17.4
- SD, 8.7



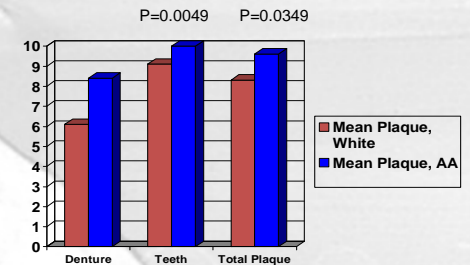
Cognition

- GDS: Mean, 3.9; SD 2.0
- FAC Cognitive Status: Mean, 2.3, SD 0.9
- FAC Agitation: Mean, 1.21, SD 0.36
- AA residents exhibited less agitated behavior than white residents, $p=0.0013$

Functional Status

- Katz: Mean, 14.3, SD 2.1
- FAC Self-care: Mean, 3.0; SD 0.47

- No relationship between cognitive status, functional status, agitation, or disruptive behavior and the total amount of plaque
- No relationship between cognitive status, functional status, agitation, or disruptive behavior and plaque on teeth or dentures



Conclusion and Implications

- These findings support the growing evidence of poor oral health among frail and functionally dependent elders in nursing homes
- One possible reason is that the majority of elders enter nursing homes dentate without the benefit of routine oral care such as plaque removal

- The worse oral health status of African-American elders in nursing homes may be the effect of accumulative dental health disparities over time

Acknowledgements

This study was supported by funding from the National Institute of Nursing Research, NIH, #P20 NR008988-01 (N. McCain, PI).



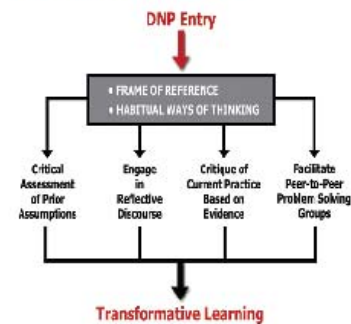
DNP SCHOLARSHIP: Transformative Learning in Distance Education

Marie Ann Marino EdD RN PNP ❖ Corrine Y. Jurgens PhD RN ANP-BC FAHA ❖ Keri Hollander MS
Stony Brook University, School of Nursing ❖ Stony Brook, New York

BACKGROUND

- ◆ DNP curriculum is delivered at Stony Brook University using a hybrid model of onsite and online education
- ◆ Building a community of scholars in distance education is challenging
- ◆ Transformative learning theory was used to guide program development

TRANSFORMATIVE LEARNING MODEL



PURPOSE

- ◆ To evaluate the effectiveness of transformational learning strategies in building a community of scholars in a DNP program

SPECIFIC AIM:
To promote DNP scholarship by preparing students as leaders to improve select clinical and healthcare system outcomes

METHOD

- ◆ Mixed method design used to conduct formative evaluation
- ◆ Thematic analysis of faculty focus group discussion of program and student issues
- ◆ 57 Item 5-point Likert scale student survey was designed based on focus group analysis
- ◆ DNP students completed survey electronically at 5 months and 18 months after enrollment

MEASUREMENT

- ◆ DNP Student Feedback Survey
- ◆ Developed based on data from a faculty focus group which discussed programmatic and student issues
- ◆ Administered at two timepoints: T1 (5 months) T2 (18 months)
- ◆ Likert-scale and open-ended response items
- ◆ Feedback solicited across six domains:
 - ~ Mentor-student relationship
 - ~ Satisfaction with curriculum
 - ~ DNP project development
 - ~ Usability of web-based student services
 - ~ Functionality of web-based program delivery
 - ~ Technical proficiency with computer applications
- ◆ 18-month survey included additional open-ended question about the effect of DNP education on role change and practice



RESULTS

- | | | |
|--|--|--|
| <h4>FORMATIVE</h4> <ul style="list-style-type: none"> ◆ N=30 responses ◆ T1 survey <ul style="list-style-type: none"> ~ 47% rated faculty feedback as timely and helpful ~ 89% rated assignments beneficial to scholarly development ~ 41% rated contact with mentor adequate ~ 50% believed groupwork essential to program ~ 20% rated their technical proficiency adequate ~ 22% reported mentor role clear | <h4>PROGRAM ENHANCEMENTS & MODIFICATIONS</h4> <ul style="list-style-type: none"> ◆ Modification of the faculty mentoring model <ul style="list-style-type: none"> ~ Cohort model of faculty mentors ~ Faculty increased direct mentorship time with mentees ◆ Development of on-site classroom intensives ◆ Development of on-line discussion database | <h4>SUMMATIVE</h4> <ul style="list-style-type: none"> ◆ N=13 responses ◆ T2 survey <ul style="list-style-type: none"> ~ 82% rated faculty feedback as timely and helpful ~ 89% rated assignments beneficial to scholarly development ~ 69% rated contact with mentor adequate ~ 39% believed groupwork essential to program ~ 77% rated their technical proficiency adequate ~ 62% reported mentor role clear |
|--|--|--|

THEMATIC ANALYSIS

- ◆ **Critical Assessment of Prior Assumptions**
 - ◆ "With every course, I had numerable 'I didn't know that' moments. These moments changed my perspective of the world and myself."
 - ◆ "The courses have opened a window of discovery and knowledge and for that I am grateful."
 - ◆ **Dialectical Critique of Current Practice**
 - ◆ "As a result of this collective knowledge, my approach to my clinical practice has changed. I have become more confident."
 - ◆ "I have adopted a much broader view of the patient as a whole."
 - ◆ "I can develop patient-centered care plans that are culturally-sensitive, ethical and promote self-care disease management."
 - ◆ **Role Validation and Transformation**
 - ◆ "My role and place in the practice in which I work has changed."
 - ◆ "The DNP has increased my credibility and my perceived value with my employer."
 - ◆ "I have developed new resources and relationships that will offer me new opportunities."
 - ◆ **Clinical Scholarship and Leadership**
 - ◆ "The DNP has increased my knowledge base and prepared me for doctoral level writing and inquiry."
 - ◆ "I will continue to participate in research activities to improve patient care."
 - ◆ "I feel I will be considered a leader in improving clinical practice."
- #### IMPLICATIONS
- ◆ Congruent with transformational learning theory, proactive program evaluation (vs. reactive) enabled timely enhancements to the program
 - ◆ Ongoing formative evaluation is critical to developing a community of clinical scholars



- **Poster formats vary between organizations**
- (Size & type: table top, mounted, electronic)
- **References take valuable space**
- Decide if references best provided on handouts
- **Consider color, white space, logos**
- Use larger font for title, avoid large spaces of white
- **Start the conversation with attendees**
- “The most interesting finding was ...”
- **Have Fun! Network! Keep conversation going after the meeting**



Examples of Abstracts from the
American Heart Association Scientific Sessions:

<http://circ.ahajournals.org/site/misc/supplindex.xhtml>

Abstracts from the 2013 Eastern Nursing Research Society are
available electronically in the March/April issue of the journal
Nursing Research

QUESTIONS?



Please take the time to submit questions in your chat window at anytime.

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Next Steps

Check out the Summit information on the Web Site:

<http://www.newcareersinnursing.org/current-programs/summit>

Call for poster abstracts:

http://ncin.forumone.com/sites/default/files/Call_For_Poster_Abstracts_%20May_2013.pdf

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