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Editor's Perspective

Transforming Nursing Education and Practice through QSEN

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One of Robert Wood Johnson Foundation initiatives is the Quality and Safety Education for Nurses (QSEN) which began approximately ten years ago. The overarching goal of QSEN is to prepare future nurses who will have the knowledge, skills and attitudes in providing quality and safe care to patients in all healthcare settings within which they work. QSEN encompasses six competencies that every nurse must demonstrate to ensure continued quality and safety in every work setting, be at the bedside, school nurse offices, at clinics and in patient's homes. To make certain that these competencies are achieved, it is important for nursing educators to integrate these competencies into the curriculum for both undergraduate and graduate education.

The six competencies espoused by QSEN are:

Patient-Centered Care. Every nurse must be mindful of the very reason why the nursing profession exists - it's because of patients. Therefore in providing care, nurses should always be considerate of the patient's comfort, preferences and values. The nurse must be respectful to the diversity of human experience. The patients or their designees should be the locus of decision making on how their care should be provided.

Teamwork and Collaboration. In working with other members of the healthcare team, nurses should have a keen awareness of their own strengths and limitations. At the same time, nurses must be aware of the strengths each health care team member brings. The key element of interprofessional collaboration is open and respectful communication.

Evidence-Based Practice. As the nurse provides individualized care plan to patients and families, it is important to consider the most current evidence, clinical expertise and the patient values and preferences. In doing so, the nurse must be resourceful in locating evidence reports and current practice guidelines.

Quality Improvement. One significant role of the nurse is to be able to collect data and monitor outcomes of the care provided. Through this role, nurses are able to recommend strategies to improve care based on what works and what doesn't. It is important for nurses to comprehend the use of quality measures and quality improvement processes.

Safety. It is the duty of the nurse to promote safety and minimize harm to all patients, to self and other providers. Nurses can lead the way in creating a culture of safety by promoting dialogue with all members of the health care team. Nurses promote safety by supporting a "just culture" where they can freely disclose their errors without fear of retaliation while maintaining their professional accountability.

Informatics. We live in an era where technology drives our culture. Nurses must embrace the use of technology that supports clinical decision making; prevents human errors; and promotes interprofessional collaboration. Nurses must be involved in designing and selecting these technologies that enhance the delivery of healthcare.

The six competencies are crucial in the delivery of safety and quality care. Adapting QSEN as an educational framework in the preparation of nurses and advanced practice nurses transforms nursing education and practice.

In reviewing the manuscripts published in this edition, I can see how a particular QSEN competency is embedded. The manuscript entitled "*Promoting Health Literacy through "Ask Me 3™"*" demonstrates QSEN competency 'Patient Centered Care.' In this study, health screening participants were surveyed on the National Patient Safety Foundation's initiative to improve literacy on their awareness of the "Ask Me 3™" program. The program uses a simple communication tool where patients are encouraged to ask their healthcare provider three simple questions: 1) *What is my main problem?*; 2) *What do I need to do?*; and 3) *Why is it important for me to do this?*

The manuscript on "*Albumin's Key Role in Improving the Quality of Care of Patients with ESRD: An Educational Program for Nephrology Team Members*" highlights the significance of QSEN competency 'Evidence-Based Practice.' The objective of this project was to provide an education module to increase the knowledge of care of patients with ESRD on dialysis regarding albumin as a quality indicator among team members in an outpatient, private hemodialysis clinic.

The “*Transition of Care of HIV-Infected Adolescent Patients to Primary Care in South Texas: A Pilot Study*” explores QSEN competency ‘Quality Improvement.’ The study explored the experience of HIV-infected adolescent patients as they transitioned to adult-centered care and described the factors that affect the transition process from the adolescent’s perspective.

The manuscript on “*Historical Analysis of Filipino Nurse Migration to the US*” exemplifies the QSEN competencies of ‘Patient-Centered Care’ and ‘Teamwork and Collaboration.’ Filipino-American nurses have been known to be very compassionate nurses. The patients that Filipino-American nurses have cared for rave about the attention and respectful care they have received. Filipino-American nurses are also known for their work ethic in working with other members of the healthcare team.

In conclusion, the QSEN competency initiative is a critical foundational educational framework that can be adopted in academia. It could also be used to develop an evaluation tool to assess competency of nurses in all practice settings.

Source: The QSEN Institute @ www.qsen.org

A handwritten signature in black ink that reads "Leo-Felix M. Jurado". The signature is written in a cursive style with a large, stylized 'L' and 'J'.

Leo-Felix M. Jurado, PhD, RN, NE-BC, APN, CNE
Editor-in-Chief, JNPARR

PNAA President's Corner

Lead, Empower, Transform: The Philippine Nurses Association of America and the Future of Nursing

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In 2011, a year after the enactment of Health Care Reform, the Institute of Medicine and Robert Wood Johnson Foundation issued recommendations for the Future of Nursing (IOM, 2010). They issued bold national recommendations, including transformation of the nursing workforce and nursing education system. They defined a clear agenda and blueprint for action, including changes in public and institutional policies at the national, state and local levels.

In July 2014, the Philippine Nurses Association of America (PNAA), established its strategic priority to focus on the IOM Recommendations for the Future of Nursing, by joining the Campaign for Action, in collaboration with other professional organizations across the country. PNAA's theme: **“Lead, Empower, Transform”**, creates a platform for Filipino-American nurses in transforming our health care system, with focus on leadership development, increasing diversity in the workforce and academic progression.

“Racial and ethnic minorities make up approximately 30 percent of the U.S. population, but just under 15 percent of registered nurses, and just seven percent of RNs are men. It is essential for the Future of Nursing that the nursing population evolves to reflect America's changing population” (Campaign for Action, n.d.).

PNAA launched its own campaign for action initiatives through the following program priorities:

- Formation of the “PNAA Action Coalition” to increase participation of state chapters in action coalitions across the United States;
- Leadership Institute for chapter leaders using innovative methodologies such as “liberating structures” to promote assertiveness and leadership engagement;
- Promotion of scholarship and recognition of nursing achievements;
- Academic progression through partnership with academic institutions;
- Active participation in leadership roles in national steering committees and professional organizations;
- Active participation in instituting ethical recruitment of foreign graduate nurses in collaboration with the Alliance for Ethical International Recruitment Practices and CGFNS; and
- Strong voice and advocacy in issues relevant to the protection of the integrity and image of Filipino-American nurses.

The future of nursing and PNAA is in our hands. We will remove roadblocks that have slowed our creativity and have reduced our productivity. Through strong leadership, we will achieve a balance between autonomy and responsibility. There is strength in numbers, but there is even more strength in joining our forces and talents in transforming our profession. We can and we will Lead, Empower and Transform Health Care, whenever and wherever we have the opportunity.

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Historical Analysis of Filipino Nurse Migration to the US

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Abstract

Background: Migration of Filipinos to the US began in 1889 after annexation of the Philippine by the US. Between 1889-1934 Filipino immigrants were classified legally as “nationals” because the Philippines was a colony of the US. Migration of Filipino nurses began after World War II when Filipino nurses educated in the Philippines have since become a favored solution to the cyclical nursing shortages in the US.

Objective: Describe the major influences that contributed to mass migration of Filipino nurses to the US.

Methodology: Historical research using archival research and telephonic interviews of key individuals who had first-hand experience of Filipino nursing migration. Several data bases were examined as primary and secondary sources.

Conclusion: Cyclical and worsening nursing shortages in the US prompted immigration policies and economic incentives for recruitment of Filipino nurse graduates who were educated in US-based curricula with English as the medium of instruction. Institutionalized exportation of labor by the Philippine government to help pay for its foreign debt has created massive emigration of Filipino nurses who seek better economic and educational opportunities and permanent residence in the US for themselves and their families. Because of their visibility as the largest foreign educated nurses in the US, Filipino nurses confronted backlash from American professional nurses and organizations as well as recognition of their significant contribution to ease nursing shortages and provide quality care in the US.

Keywords: Filipino nurses, Philippine nurses, foreign educated nurses, foreign nursing graduates, foreign trained nurses, foreign nurses in the US

Introduction

The Philippines has been the world leader in producing and exporting nurses for foreign employment for the past 60 years. In the 1950s, the training of Filipino nurses shifted from local employment to overseas employment, which catapulted the country as the world leader in supplying nurses to developed countries such as the United States, the Middle East, the United Kingdom, Australia, New Zealand, Singapore, Japan and Brunei (Brush & Sochalski, 2007; Choy, 2003; Pacquiao, 2004). The Philippines has earned the envy of developing nations like India, China & Korea where many of their nurses desire to emigrate.

This article aims to describe the major influences that contributed to mass emigration of Filipino nurses to the US. The article uses a historical approach to depict the evolution of trends in immigration, nursing and health care in the US as well as trends in the Philippines that supported nurse migration.

Emigration of Filipino Nurses

Push and Pull Factors for Emigration

Filipino nurses emigrate for economic, job related and sociopolitical reasons (Lorenzo, Galvez-Tan, Icamina & Javier, 2007). In 2007, a nurse's salary in the Philippines was approximately \$170.00/month (\$2,040.00 per year) as compared to \$3,000-\$4,000/month (\$36,000-\$48,000 annually) in the US (Brush & Sochalski, 2007). Nurses faced lack of overtime or hazard pay and inadequate health insurance. They were confronted with work overload, stressful work environment, lack of respect and collegiality from physicians and limited opportunities for promotion. The political and economic instability in the Philippines added motivation for nurses to leave the country (Lorenzo et al, 2007).

Conversely, the "pull factors" for emigration include better economic opportunity, job conditions, and stable sociopolitical environment in other countries. In addition to a higher income, nurses are offered better benefits and compensation packages. There are options for work schedule and specialties, opportunities to upgrade knowledge and skills, opportunity to travel and immigrate with their families (Lorenzo et al, 2007).

Role of Institutions

Institutions include material forms and mechanisms as well as ideological norms and protocols to organize systems of rules, conventions and practices that promote the creation, distribution and utilization of available information, resources, knowledge and belief systems (Leitch, 1992). Material forms include government institutions and private agencies who are motivated by their own political and economic gain to disseminate information to potential migrants (Goss & Lindquist, 1995), and establish systems of rules and resources that support migration opportunities. Mi-

grant institutions are exemplified by government agencies and their policies reinforcing labor migration which exist in both sending and receiving countries (Masselink, 2009) such as the Philippine Overseas Employment Administration (POEA) and the Commission on Graduates of Foreign Nursing Schools (CGFNS) in the US.

Americanization of Philippine Nursing

Choy (2003) argued that migration of Filipino nurses is a direct consequence of US imperialism in the Philippines starting from its occupation in 1898 and persisted even after the country regained its independence in 1946. Under Spain, Filipino women were largely excluded from formal education, especially at the university level. The Americans introduced nursing education as part of establishing a public health system. Americans viewed nursing mainly as a female profession, and saw its institutionalization for public health and as a pathway to civilization with division of labor by gender as a hallmark of a progressive society.

Initially, the Filipino elite saw nursing and its work as demeaning. Eventually nursing became an attractive profession and a passport for entry to the US (Choy, 2003). In 1911, the Rockefeller Foundation sponsored Filipino nurses to the US for training so they can employ American nursing practices and procedures they learned upon their return to the Philippines. Alice Fitzgerald, an American nurse travelled to the Philippines to introduce the League of Nursing Education in 1922 (Brush, 1995). These early beginnings paved the way for Filipino nurses to become the pipeline of nurses to mitigate nursing shortages in the US.

Colonial ties may help explain the migratory patterns from developing to developed countries (Portes & Borocz, 1989). Colonized countries may have been introduced to the colonizer's language and educational systems, which in turn facilitates migration (Masselink, 2009). Professionals particularly physicians and nurses are influenced by transnational professional networks between the colonial powers and their colonies as demonstrated by the movement of Pakistani physicians to the United Kingdom (Mullan, 2005) and the migration of Filipino nurses to the US.

Exchange Visa Program (EVP), 1948

After the Philippines gained its independence from the US on July 4, 1946, US military installations in the country continued until the 1990s. In 1948, the US Congress passed Public Law 402, known as the Information and Educational Exchange Act, which formed the basis for EVP. Thirteen years later, it became the Fulbright-Hays Act (Mutual Educational and Cultural Exchange Act, 1961) that facilitated entry of foreign educated nurses (FENs) to the US. EVP continues to exist today and was originally intended to enable the US government:

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to increase mutual understanding between the people of the United States and the people of other countries by means of educational and cultural exchange; to strengthen the ties which unite the US with other nations by demonstrating the educational and cultural interests, developments, and achievements of the people of the United States and other nations, and the contributions being made toward a peaceful and more fruitful life for people throughout the world; to promote international cooperation for educational and cultural advancement; and thus to assist in the development of friendly, sympathetic, and peaceful relations between the United States and the other countries of the world (International Student & Scholar Services, 2011, p.1)

EVP provides foreign nationals opportunities to participate in exchange programs in the US and go back after a maximum stay of two years to share their knowledge and experiences with their home countries. An exchange visitor is a foreign national selected by a sponsor who provides work, study/training and monthly stipend for the visitor. The US State Department designates sponsors to administer individual EVPs such as organizations, government agencies, educational and cultural organizations, and corporations. Sponsors provide exchange visitors with pre-arrival information and orientation as well as monitor their activities (International Student & Scholar Services, 2011).

Although the US Senate did not specifically refer to health care systems under EVP, several thousands of agencies and institutions including the American Nurses Association (ANA) sponsored exchange participants from Europe and Asia. The International Council of Nurses assisted ANA in foreign exchange placements. From 1957-1959, the first group of American nurses was exchanged with nurses from Great Britain, Denmark and Northern Europe including France, Germany, Switzerland, Holland, Norway, Finland and Scotland. In the late 1950s, the Philippine government became involved with EVP and a decade later, at least 80% of participants were from the Philippines, ushering the first wave of 11,000 Filipino FENs to the US (Choy, 2003).

Many EVP Filipino FENs were used for manpower because of the nursing shortage. Clarita Miraflor, founding president of the Philippine Nurses Association of America/PNAA indicated that upon her arrival in Chicago, the nursing administrator at Cook County Hospital assisted her and other Filipino FENs immediately to apply for reciprocity using their Philippine license. While Miraflor and her cohort understood that they came for training and education, Miraflor was asked by her supervisor to become the head nurse of one of the biggest divisions at the hospital after three months of orientation (Miraflor, personal communication, 3/20/2013). Some EVP nurses comprised the entire staff on some units as Licensed Practical Nurses or orderlies espe-

cially on evening and night shifts.

EVP FENs were supposed to go back to their countries after two years of advanced training but many of them found different avenues to stay in the US. Some converted to student visas while others married US citizens or permanent residents. Some nurses exited to nearby countries such as Canada and re-entered the US after a period of time. Others returned to the Philippines and came back to the US at a later time.

Immigration Nationality Act (INA), 1965

The 1965 Hart-Celler Immigration and Nationality Act/INA that amended the McCarran-Walter Act of 1952, abolished the restrictive national origins system began in 1924, which limited immigration from Asia and other countries. The prevailing political and cultural climate at the time favored entry of White Europeans to the US. INA 1965 used a quota and preference system as well as labor clearances for certain classes of immigrants. It introduced policy changes on two controversial issues affecting immigrants, their country of origin and type of occupation thus, allowing larger numbers of immigrants from Southern Europe, Asia and the Caribbean to enter the US (Keely, 1971). INA 1965 emphasized family reunification enabling US citizens and permanent residents to sponsor family members based on the categories of priority (Le, n.d.).

INA 1965 authorized a quota of 20,000 for each country in the Eastern hemisphere while countries in the Western hemisphere had no quotas. Children under 21 years of age, spouses, and parents of US citizens were exempted from this quota. At least 74% of the quota was assigned for family reunification, 20% for occupational preferences and the remaining 6% for refugees seeking political asylum. Occupational preferences (third and sixth) needed verification and approval by the Department of Labor. The Law also designated a non-preference category for immigrants who would invest at least \$40,000 in a business once they came to the US (Le, n.d.).

The Hart-Celler INA bill was signed into law at Liberty Island, New York, which was chosen for its symbolism of freedom and democracy. At the signing ceremony, President Johnson remarked:

This bill says simply that from this day forth those wishing to immigrate to America shall be admitted on the basis of their skills and their close relationship to those already here. This is a simple test, and it is a fair test. Those who can contribute most to this country--to its growth, to its strength, to its spirit--will be the first that are admitted to this land.” (Johnson, 1965 audio)

President Johnson downplayed the significance of INA

1965, “this bill that we will sign today is not a revolutionary bill. It does not affect the lives of millions. It will not reshape the structure of our daily lives or add importantly to either our wealth or our power” (Johnson, 1965 audio). Stephen Klineberg, a sociologist at Rice University, noted, “looking back, Johnson’s statement is remarkable because it proved so wrong,” as many in Congress thought that little would change because the measure gave preference to relatives of immigrants who were already residing in America. The other provision gave preference to skilled professionals needed in the US. Congress was really saying, “we needed some more British doctors and German engineers;” it never occurred to them that there were going to be African doctors, Indian engineers, Chinese computer programmers who would be able to migrate to America for the first time in the 20th century (Klineberg, 2006 audio). Obviously, the authors and supporters of INA 1965 underestimated the influx of non-Whites such as Asians who then comprised only 0.5% of the total population. They were under the impression that the vast majority of immigrants would continue to come from Europe (Le, n.d.). INA 1965 marked a radical break with previous policy and led to profound demographic change in contemporary America (Ludden, 2006 audio).

INA 1965 coincided with high unemployment in the Philippines so many health professionals migrated to the US through EVP and occupational preference of INA law. The latter was preferred because of the opportunity for permanent residence status for FENs and their families. Many nurses, who went home after their EVP visas were completed, reentered under INA law. The second wave of FEN migration to the US was paved by the increased demand for nursing services and more significantly by changes in immigration law abolishing the foreign residence requirement for nurses who entered under EVP (Choy, 2003).

Between 1965 and 1970, approximately 17,134 Filipino professionals representing almost one-third of all Filipino immigrants entered the US. The Immigration and Naturalization Services (INS) estimated that 3,222 nurses and 2,813 physicians from the Philippines immigrated during this five year period, not including those who entered through EVP. Filipinos comprised the largest group of nurses who received the US nursing license followed by Canadian and British nurses (Choy, 2003).

By 1967, the Philippines became the world’s top exporter of nurses to the US. In his address at the 1973 annual convention of the Philippine Nurses Association, President Ferdinand Marcos emphasized:

We intend to take care of [Filipino nurses] but as we encourage this migration. . . we will now encourage the training of all nurses because. . . this is a market that we should take advantage of. Instead of stopping the

nurses from going abroad, why don’t we produce more nurses? If they want one thousand nurses, we produce a thousand more (Tan, 2004).

The US Public Law 91-225 (J-1 Visa Waiver Program) passed in 1970, facilitated the adjustment of EVP visas to permanent resident visas. The two-year foreign residency requirement was waived as long as EVP nurses did not participate in a program financed by the US or the sending government, or the country of origin did not require services of the exchange visitor at the time of status adjustment. Some 7,495 exchange visitors adjusted their visas to permanent residency between 1966 and 1978 (Choy, 2003).

While EVP visa applications waned in the late 1960s, occupational visa applications became the major avenue of entry to the US by Filipino nurses and other professionals. The enormous increase in the number of applications resulted in a backlog of visa processing (Choy, 2003); by 1970, the waiting period for a third preference visa from the Eastern Hemisphere was approximately 13 months. Around the same year, an immigration amendment allowed H-1 visas (working visa) for temporary employment of foreign workers (Ong & Azores, 1994). Recruitment agencies in the US and the Philippines took advantage of H-1 visas which took only 30-90 days to process (Choy, 2003). From 1972 to 1978, 60% (9,158) of all nurses who entered the US with H-1 visas came from the Philippines, with Canada coming second with 3,034 nurses (Ishi, 1987).

There were different pathways for FENs to obtain RN licensure in the US. Before 1970, some states (Hawaii, Minnesota, Missouri, New Jersey, Ohio, Tennessee, Washington, and Washington, D.C.) gave licensure by endorsement of RN licenses from originating countries. In New York State, FENs had to petition the State Board of Regents for endorsement of their license which considered each application individually. Often, reciprocity was granted to Filipino FENs as long as they had current Philippine RN license (Buenafe, 1966). Other states implemented policies to ease the licensure applications of FENs because of increased demand for nursing services. In New York, temporary work permits were extended from six to eighteen months to allow FENs to complete additional educational requirements for endorsement (Schmidt, 1974).

In 1971, New York State changed its licensure process and required all FENs to pass the State Board Test Pool Examination (SBTPE) to test their knowledge of US nursing practice in medical, surgical, psychiatric, obstetric and pediatric nursing. The National Council of State Boards of Nursing (NCSBN) which was part of the American Nurses Association/ANA until 1978 developed the examination. Many states contracted with NCSBN to provide the examination for all RN applicants including FENs. In 1977, all states

discontinued licensure by endorsement and required all FENs to pass the SBTPE (Choy, 2003).

The SBTPE posed a huge hurdle for most FENs. The failure rate for FENs reported in 1976 was 77% (Ishi, 1987). The failure rate of FENs was more pronounced compared to US graduates. From 1972 to 1974, the failure rate for first-time FEN takers in New York ranged from 63.6 to 90.9%, with higher rates for repeaters (Schmidt, 1974). In California, 80-90% of FENs failed the SBTPE in the 1970s. Many Filipino FENs were demoralized and felt dehumanized; some even contemplated suicide because of repeated failures (McKinney, 1979). Rosario De-Gracia, professor of nursing at Seattle University and President of the local Filipino Nurses Association attributed this high failure rate to limited training in Psychiatric Nursing and high level of anxiety among those who have not been in school for a number of years. FENs found the multiple choice format of the exam confusing and different from how they were tested in their previous educational programs (Choy, 2003).

Failure to pass the licensing exam resulted to immediate revocation of working visas as RN practice was the condition for the visa. The deportation of many FENs on H-1 visas affected severely many hospitals in many states. Thirty-five Filipino nurses in Pontiac, Michigan were ordered to leave the country after failing the SBTPE (Tutay, 1975). Other states developed stop gap measures to prevent the mass exodus of FENs. In early 1970s, the Board of Examiners in Texas granted temporary work permits to FENs until they pass the SBTPE, which attracted many FENs to the state. In 1973, however, the Board of Examiners discontinued this practice because of the continuing high failure rate among FENs. The Texas Hospital Association protested this decision by using a previous exclusion clause that allowed nursing graduates to practice nursing in hospitals as long as they were under the direction of a physician. Hospital lawyers persuaded INS to reverse its previous decision, which was criticized by the executive director of the Texas Nurses Association as detrimental to the public since these nurses failed to demonstrate minimum competency through SBTPE (Felkner, 1974).

ANA's Commission on Nursing Services presented a resolution at its Biennial Convention in June 1974, to remove the preferential status of foreign nurses from US immigration policies and support the authority of state nurses associations to evaluate the practice of FENs. The resolution cited the following reasons: a) FENs were not prepared to work in roles expected of them; b) some employers placed FENs in roles for which they were not prepared; c) US schools of nursing cannot provide sufficient educational programs to FENs with academic deficiencies; d) FENs should not be given priority over US citizens to remedy their academic deficiencies; and e) presence of FENs was disadvantageous

to American nursing students because FENs accept salaries lower than the acceptable rate and were attracted to areas where US nurses cannot find employment (Asperilla, 1976).

ANA's resolution was not supported by all its constituents. Clarita Mirafior who was then president of the Philippine Nurses Association/PNA of Chicago led the protest against this resolution supported by Anne Zimmerman, executive director of the Illinois Nurses Association, Ann Zercher, ANA's treasurer and by many other nurses (Choy, 2003). According to Mirafior, "The implicit racism and know-nothing attitude that permeate this resolution has no place in our profession, which prides itself upon its dedication to the service of mankind" (Henry, 1975, p. 24). Mirafior, Zimmerman, Zercher and some ANA members formed an ad hoc committee to look at alternative solutions. The committee urged ANA to collaborate with the International Labor Organization and the World Health Organization to eliminate misleading recruitment practices. The committee recommended the creation of pre-screening examination for FENs believing that problems could be eliminated if nurses had the opportunity to be tested for communication skills and professional preparation in their country of origin prior to emigration. ANA's Hearing Committee and House of Delegates passed the alternative resolution with minimal opposition. In June 1975, a conference focused on foreign nurse graduates in Maryland was held where delegates recommended the creation of an independent organization in-charge of the pre-screening examination of FENs (Choy, 2003).

Commission on Graduates of Foreign Nursing Schools (CGFNS), 1977

As early as 1972, the Secretary of Labor and the Secretary of Health, Education and Welfare (HEW) discussed the issues particularly the high failure rate of FENs in the SBTPE and whether they should return to their home countries of origin or continue employment as non-professional nurses (technicians, medical assistants or nursing assistants). Some employers continued to employ them and expected them to perform RN functions with lower pay than regular RNs. The Secretary of HEW asked the Division of Nursing to look into these issues. ANA and Pace University in New York conducted studies on the feasibility of a screening examination that can predict the success of FENs in the licensure examination prior to receiving an occupational preferential visa and labor certificate. In 1975, findings from these studies were presented at a conference hosted by HEW which was attended by representatives from the American Hospital Association (AHA), nursing organizations, dental association, Department of Labor/DOL, Department of State, INS, New York State Education Department, Boards of Nursing and the International Council of Nurses. A recommendation was made to establish a private, not-for-profit organization responsible for the development and conduct

of a predictive testing and credentials evaluation of FENs (Nichols & Davis, 2009).

In 1977, the Commission on Graduates of Foreign Nursing Schools (CGFNS) was created through the joint sponsorship by ANA and the National League for Nursing (NLN). The CGFNS screening examination was developed in two parts: a nursing competency section that included the five nursing specialties covered by SBTPE and an English language competency section. CGFNS paid NLN \$120,640.00 to write the nursing competency section and \$53,942.00 to the Educational Testing Service to develop the English competency section. On October 4, 1978, the first CGFNS examination was administered in thirty-two cities around the world including Manila (Choy, 2003; Nichols & Davis, 2009).

The implementation of CGFNS screening examination evoked mixed responses from both US nurses and FENs. The October 1978 edition of the *American Journal of Nursing*, the official publication of ANA, included letters to the editor from two nurses who chastised ANA, INS and DOL for spending tax dollars for FENs who were characterized as dangerous import commodities that do nothing to further their professional cause and monies spent in developing the examination could have been used for scholarship and traineeship for young men and women in America who would like to become nurses (Vowell & Colon, 1978). Increasing dissatisfaction with Filipino nurses gave impetus to these events (Choy, 2003).

CGFNS examination was perceived by some Filipino nurses as anti-Filipino. In her first report, CGFNS Executive Director Adele Herwitz reported constant and ongoing harassment from various Filipino groups throughout the country. Some Filipino groups reached out to the state of Pennsylvania to rescind the not-for profit status of CGFNS located in Philadelphia, because they believed that it was a money-making scheme. Some groups linked CGFNS with discriminatory practices by ANA, NLN, HEW and DOL. Other groups approached the UN for WHO to bring CGFNS to the World Court on charges of discrimination. Attempts were also made to get a national television network to expose the “fraudulent activities” of CGFNS (Herwitz, 1980).

The implementation of CGFNS Certification Program in 1977 was viewed as an additional barrier for Filipino nurses who wanted to work in the US (Compas, de la Paz, & Solarte, 2009). Three Filipino nursing organizations (National Federation of PNAs in the US, which became the PNAA, the Foreign Nurse Defense Fund and the National Alliance for Fair Licensure of Foreign Nurse Graduates) called for an end to a culturally-biased nursing licensure exam. The Foreign Nurse Defense Fund used civil rights legislation to

oppose the racist nursing licensure examination. The National Alliance for Fair Licensure of Foreign Nurse Graduates and the Foreign Nurse Defense Fund ceased to exist in the early 1980s from lack of support.

In 1996, the Visa Screen Certificate was added as a requirement for Employee-based (EB-3) applicants in addition to CGFNS certification. This requirement was imposed by the Illegal Immigration Reform and Immigration Responsibility Act. The screening process consisted of three parts: educational analysis, licensure validation and English proficiency assessment. The International Commission on Healthcare Professions (ICHP) under CGFNS conducted this program. English language proficiency requirements can be met by passing the Test of English as a Foreign Language (TOEFL), Test of Written English (TWE) and Test of Spoken English (TSE), the Michigan English Language Assessment Battery (MELAB) or the International English Language Testing System (IELTS). The English proficiency requirement resulted from patients' complaints and negative patient outcomes related to FENs' difficulty with oral English communication that contributed to medication errors and failures in interdisciplinary communication (Nichols & Davis (2009). This assessment has remained a requirement for all FENs.

Since 2005, the National Council Licensure Exam for RN (NCLEX –RN) has been given outside the US for the convenience of candidates by reducing the time and cost of travelling to the US (NCSBN, 2013a). In 2005, Leo-Felix Jurado, who was then a member of the NJ State Board of Nursing, campaigned for the removal of CGFNS examination as a requirement for licensure in the state, asserting that NCLEX-RN had already been made available internationally. Jurado's successful initiative provided the impetus for the national movement to remove CGFNS requirements nationally. Through his leadership as PNAA President (2008-2010) in collaboration with state chapters of the organization, the national movement gained momentum. As a result, the Boards of Nursing in Michigan and Virginia abolished CGFNS as requirement for RN licensure. There are other states that are in the process of removing this requirement.

Philippine Nurses Association of America, Inc. (PNAA), 1979

PNAA was formed in response to the growing need for a concerted effort to address the issues and concerns of Filipino nurses in the US (PNAA, n.d.). While Filipino FENs had to deal with gender discrimination in the Philippines particularly in their relationship with physicians, they earned the reputation in the US as “coolies” because of working long hours and dealing with all kinds of discrimination during the early period post migration (Tan, 2004). In 1966, Richard Speck murdered eight student nurses in Chicago, including two Filipino FENs. Speck managed to get into the

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house rented by the nurses, bound and murdered them one by one. The lone survivor was a Filipina, Corazon Amurao. The tragedy was associated with misogyny and racism, as Speck had problems with previous marriages and claimed that he had contracted syphilis from “some kind of Oriental” (Choy, 2003).

Phoebe Andes, one of the founders of PNAA, observed differential treatment by some hospitals in New Jersey of Filipino and Irish FENs. Filipinos were accommodated in dilapidated housing in a blighted neighborhood while Irish nurses were placed in the hospital’s dormitory or apartments near the hospital. Filipinos were assigned on evening or night shifts and were not given a choice of work schedule. In contrast, Irish nurses worked on days and able to select what shift to work (Andes, personal communication, 3/20/2013).

In the 1970s, the problems confronting Filipino FENs included low pass rates in the licensure examination, exploitation by recruitment agencies, discriminatory hiring practices, unreasonable demotion of Filipino FENs at work, assignment to mostly evening and night shifts, etc. These problems were heightened by the arrest of two Filipino nurses, Filipinas Narciso and Leonora Perez on June 16, 1976 at the Veterans Administration Hospital in Ann Arbor, Michigan after they were charged with the deaths of ten patients in the Intensive Care Unit where they worked. Without notification, they were handcuffed, chained, and imprisoned without bail for two weeks. Both nurses were convicted in 1977 but acquitted by the appellate court after organized efforts by Filipino and American support groups. The nurses were made scapegoats for the patients’ deaths and the trial documented strong racist attitudes from other nurses (Choy, 2003). Remedios Solarte, who was one of the founders of PNAA and Past President of PNA Michigan, described her experiences when Perez and Narciso were arrested. She was angered by the fact that these nurses were not given due process. She joined the rallies and picket lines with the Filipino community and clergy to demand the release of these nurses. Leaders of PNA Michigan coordinated fund raising activities for the defense of these nurses who were labeled along with other Filipino FENs as ‘nurse killers’ (Solarte, personal communication, 3/20/ 2013).

Although there were few local PNA chapters in the US at that time, there was no national organization. Individual chapters had their own programs and activities like PNA Chicago which spearheaded a national and international effort to oppose CGFNS examination as a qualifying requirement for visa application. On September 3, 1978 at its annual convention, the House of Delegates passed a resolution to form an umbrella organization of Filipino nurses in the US. Clarita Miraflor, president of PNA Chicago contacted presidents of various PNA chapters in the US to rally be-

hind this resolution. On April 21, 1979, during the annual convention of PNA New Jersey, chapter president, Phoebe Andes, invited several PNA local organizations in the US to attend the convention to elect the officers of the national organization. Five PNA chapters were represented: Chicago, Michigan, New Jersey, New York, and Southern California. A caucus was held to elect the first slate of officers. The organization was named the National Federation of Philippine Nurses Associations in the US. Dr. Clarita Miraflor from Chicago was elected president. On June 30, 1981, the National Federation of Philippine Nurses Associations in the US was renamed the National Organization of Philippine Nurses Associations in the US and later changed to its current name, PNAA, Inc. on June 20, 1987. Through several name changes the organizations’ mission and goals have remained consistent.

Mission Statement:

As the official professional organization of Filipino-American nurses in the USA, PNAA will uphold the positive image and welfare of its constituent members, promote professional excellence, and contribute to significant outcomes to healthcare and society.

The Goals of the Association shall include, but not be limited to:

- a. Unify Filipino-American Nurses in the USA and its territories.
- b. Develop, implement, and evaluate programs in nursing leadership, practice, education, and research relevant to professional growth of its members and healthcare needs of the community.
- c. Facilitate professional and cultural adjustment of Filipino-American Nurses in the USA through collaboration with agencies and organizations in the USA and the Philippines.
- d. Participate actively in professional and cultural activities with professional organizations and agencies in the community and globally.
- e. Review and act on legislation and public policies which directly and indirectly affect healthcare and nursing practices (PNAA, n.d.)

For the past 36 years, PNAA has continued to protect the image of Filipino nurses in the US. It has facilitated the acculturation of many FENs through its local chapters, and provided professional development programs, scholarship, and research grants to its members. The organization has supported legislation, regulation, and public policies promoting FENs, nursing, and health care. It has initiated community development programs through medical missions and other projects locally and in the Philippines. Through international collaboration and programs, PNAA has promoted sharing of nursing education, research, and practice

with institutions and organizations in the Philippines.

PNAA is now one of the largest ethnic professional nursing organizations in the US and globally. It has grown to 45 chapters with 3,500 to 4,500 members throughout the USA including Hawaii and Alaska. It is affiliated with the National Coalition of Ethnic Minority Nursing Associations comprised of the National Black Nurses Association, National Hispanic Nurses Association, Asian-American Pacific Islander National Nurses Association, and the National Alaskan, Native American Indian Nurses Association.

Philippine Overseas Employment Administration (POEA), 1982

The POEA was created through Presidential Decree 797 by then President Ferdinand Marcos. It was formed by consolidating three existing organizations: the Overseas Employment Development Board (OEDB), the National Seamen Board (NSB), and the Bureau of Employment Services (BES). The decree placed POEA under the Department of Labor and Employment. Its objectives are to promote and develop the overseas employment program and protect the rights of migrant workers (POEA, n.d.). POEA serves to: (a) regulate private sector participation in labor export, (b) market labor internationally, (c) engage in government-to-government recruitment agreements, and (d) inform and protect overseas Filipino workers (Ball, 1997). In short, POEA was created to facilitate and regulate the deployment of workers for export abroad (Tyner, 1996).

The labor exportation program was never meant to be institutionalized rather, as a temporary solution to the Philippine foreign debt (Tyner, 2009). In the 1970s, Secretary of Labor, Blas Ople predicted that exporting labor would help the economy grow to the point that it was no longer necessary within 20 years. In actuality, it has become a permanent fixture of Philippine policy and practice (Ball, 1997; Lorenzo, 2007; Masselink, 2009).

The formation of POEA to manage overseas employment highlighted the government's role in promoting international labor (Tyner, 2009). It was a wise decision since the Philippine foreign debt was growing steadily and reached US \$26 billion in 1986 when Marcos was exiled from his 20 years of presidency. When President Corazon Aquino took office after the People's Power, her administration maintained a policy of state-facilitated labor migration in order to continue paying the country's huge foreign debt (Tyner, 2004; Masselink, 2009).

Overseas workers have been celebrated as heroes by the Philippine government, which declared official recognition days in their honor, proclaiming them as "ambassadors of goodwill" (Tyner, 1996) and legitimizing their self-sacrifice and hard work. Remittances from overseas workers have

increasingly boosted the Philippine economy from approximately US \$291 million in 1978 to US \$11 billion in 2005 (Tariela, 2006). In 2012, remittances from overseas workers amounted to US \$21.4 billion (Cuisia, 2013).

Immigration Nurse Relief Act (INRA), 1989

The Immigration Nurse Relief Act (INRA), Public Law 101-238 of 1989 amended INA allowing adjustment of status without regard to numerical limitations of registered nurses with H-1A (temporary work) visas. This Act granted permanent resident status to certain non-immigrant nurses on September 1, 1989 who had been employed in that capacity for at least three years, and whose continued nursing employment met certain labor certification requirements. It also established a five-year pilot program for new admission of FENs under H-1A visa, and required hospitals to comply with DOL procedures for attestation of manpower need (USCIS, 2012).

The nursing shortage in the 1980s was widespread and of significant magnitude, affecting all health care delivery settings and nursing practice areas. Many hospitals in urban and rural areas have temporarily closed patient admissions due to lack of nursing staff. Nursing homes had severe RN shortages. The RN vacancy rates had more than tripled between 1983 and 1987; at least 76% of all hospitals throughout the nation had some degree of nursing shortage. The shortage was not attributed to lack of supply but a result of increased demand. Although there was a 31% increase in the number of nurses from 1977 to 1989, increased demand for RNs was attributed to: a) cost containment leaving nursing vacancies unfilled, b) increased workload from additional responsibilities associated with work compression, and c) increased severity of illness and older population of patients in the hospital. The demand was exacerbated by changes in medical practice patterns, advances in biomedical technology, the HIV epidemic, and many other unforeseen changes in health care delivery systems. Consequently, there was a 14% increase in intensive care unit beds and increased demand for RNs in Medicare & Medicaid certified nursing homes (Gibbons, 1989).

Since 1980, between 20,000 to 25,000 FENs entered the US with 75% originating from the Philippines. In 1989, INS estimated that more than 50% of FENs who entered since 1980 had valid H-1 status, while others may have been out-of-status, returned to their countries of origin, or remained in the US without a valid visa. In September 1985, INS imposed a five-year limit on temporary visas in the US for all non-immigrants under the H-1 classification, with the possibility of extending to a sixth year for extraordinary circumstances, which took effect in March 1987 (Puleo, 1989).

It would have been catastrophic for the US health care sys-

tem if FENs with expired H-1 visas who numbered in several thousands were sent home after five years of work at the height of a severe nursing shortage. On May 21, 1989 at the hearing before the subcommittee on Immigration, Refugees, and International Law (Committee on the Judiciary, House of Representatives, 101st Congress), Congressman Charles Schumer of New York, the prime sponsor of HR 1507, INRA testified:

The shortage is nationwide. ... in New York City, health care is on the brink of disaster. The loss of 1,000 foreign trained nurses could push the city over the edge. .. Hospitals report vacancy rates of nurses ranging from 15% to 20%, or 5,400 unfilled positions, at the same time their occupancy rates exceed 95%. Nursing homes are experiencing a 25% vacancy rates in registered nurses. Faced with a growing number of patients requiring extensive and intensive care – AIDS victims, crack addicts, and the elderly – we cannot afford to lose beds and experienced nurses...

As a result of the shortage, many hospitals have recruited temporary, foreign-trained nurses. Regulations that went into effect in 1987 capped the length of service of these nurses at five years. For thousands of these nurses, their time is up. New Jersey hospitals, with 17% nurse vacancy rates, report that 10% of their registered nurses are in the US on H-1 visas. Without legislation, over 1,000 of these nurses will be out of status next year. California hospitals with a 9% nurse vacancy rate and a 19% turnover rate in nurses last year, report that a significant number of H-1 nurses will lose their status next year. H.R. 1507 would permit these nurses to remain in the US as permanent residents. .. it would build in protections for US workers and require facilities to recruit and retain US nurses. H.R. 1507 ..in the short term will stop the hemorrhaging. In the long term, it will require facilities to implement measures to make the profession more appealing and accessible to US labor.

Many individuals from different sectors of health care in various states testified at this hearing. They included chief nursing officers, immigration lawyers, politicians, and representatives from hospital associations, nursing organizations (Commission of Nursing, ANA, deans of schools of nursing), DOL, DHHS, and INS. Many others were not called to testify but submitted letters of support (US GPO Depository Documents, 1989). Filipinas Lowery, President of PNAA testified:

Our Association represents 15 constituent organizations across the United States, comprised of Philippine nurses who are US citizens, permanent residents or H-1 visa holders. ..With the increasing shortage of profes-

sional nurses, hospitals and nursing homes particularly in urban centers have been .. recruiting foreign educated nurses over the past ten years. ..The imposition of a five-year limit on H-1 visas posed a serious threat to the retention of thousands of qualified experienced nurses. Their departure would further aggravate the nursing shortage, paralyze hospital operations, and jeopardize the quality of health care. ..[and create a] staffing crisis across the nation, especially in urban areas such as New York and New Jersey .. the loss of almost 1,500 nurses after December 31, 1989, plus about 1,000 in 1990, will have a tremendous impact on the 15%-20% vacancy rate and result in significant hardship in maintaining effective health care delivery. ..Our Association requests that consideration be given to setting the cut-off to the date this bill is enacted instead of January 1, 1988, provided that nurses had passed the licensing examination. ..We request that licensed, out-of- status nurses hired prior to November 1986, who have not been granted extension of their H-1 visas, but are awaiting issuance of permanent immigrant status be included among those to be granted special immigrant status. There are a significant number of fully licensed and experienced nurses who have exceeded the allowed timeframe for H-1 visas including recent extensions, but have approved immigrant visa petitions and are just caught up in the backlog for sixth or third preference (Lowery, 1989).

Congressman Gary Ackerman of New York introduced H.R. 2111, Emergency Nurse Shortage Relief Act of 1989. This bill complemented H.R. 1507 in addressing the nursing shortage and included provisions for funding of programs to:

- a. retain practicing nurses through innovative restructuring of roles, working conditions, wages, and benefits; and by providing for career advancement;
- b. encourage entrants to the profession by increasing access to basic nursing education;
- c. provide for graduate nursing education;
- d. provide for scholarships for basic and advance nursing education.

INRA attempted to relieve the nursing shortage in the 1980s. DOL established Schedule A to alleviate the lengthy and labor intensive documentation required for labor certification by sponsoring employers. Schedule A allowed precertification of occupations such as nurses and physical therapists for which there were few qualified, willing, and available workers in the US. Wage determination requests for occupations under Schedule A were directly submitted to USCIS, streamlining the process for immigration of FENs. At least 10, 000 Filipino nurses entered the US between 1989 and 1991. In 1989, Filipino nurses comprised nearly 75% of the total FENs, and 85% in 2003 (Ong & Azores, 1994;

Advincula, 2004). The INRA ended in 1995, and those FENs without a special visa category were reverted back to the previous quota system (Nichols & Davis, 2009).

There are three federal agencies responsible for the entry of FENs in the US: USCIS under the Department of Homeland Security (responsible for processing immigrant visa applications and petitions for occupational visas), DOL (responsible for labor certification completed by employers attesting lack of US nurses to fill vacant nursing positions), and the Department of State (responsible for granting visas upon receipt of all required documents, fingerprints, and medical and background checks) (Richardson & Davis, 2009).

FENs can apply for different types of visa. Occupational visas require an employer sponsor and compliance with the labor certification process. The preferred category is the permanent visa or green card that allows FENs to work and stay in the US indefinitely. Others may enter the country with temporary limits as non-immigrants; however, some of these visas are no longer available. Temporary visas comprise H1-A, H1-B and H1-C. H1-A visa was created to ameliorate the nursing shortage by removing limits on the number of nurses who could enter the country and work for a period of five years. H1-A visa expired on September 1, 1995, and FENs with this visa had to convert to other visa categories available or go home. Through the efforts of many lobbying groups, H1-A visa was extended to September 30, 1997 for FENs with valid visas. Many thought that H1-A was ended because politicians mistakenly believed that there was no longer a significant shortage of nurses. Although lobbyists continued to advocate for its revival, the US Congress eliminated this visa category.

H-1B visa requires that FENs have a baccalaureate degree in nursing for entry level employment. Since most entry level staff nursing positions in the US do not require a BSN, FENs may be sponsored for supervisory or faculty positions. Only 65,000 H-1B visas are granted annually, and nurses must compete for this visa with other professionals such as engineers and computer specialists from all over the world.

H-1C visa was created under the Nursing Relief for Disadvantaged Areas Act (NRDAA) in 1999 but was limited to 500 nurses per year; only 25 nurses were allocated to each qualified state based on these criteria established by DHHS: critical shortage of nurses in the area, and hospitals serving a minimum of 35% of Medicare and 28% of Medicaid patients have at least 190 licensed acute care beds. Few hospitals met these criteria, and only 150 nurses were granted H1-C visas annually. H1-C visa expired on June 13, 2005, extended by Congress to December 2006 and finally ended on December 20, 2009 (Richardson & Davis, 2009).

Nursing Shortage

The nursing shortage at the beginning of the 21st century was very different from previous shortages since World War II, which was attributed to the imbalance between the demand and supply of nurses triggered by several events. Hospitalized patients were more acutely ill because of decreased length of stay and technological advances that allowed rapid diagnoses, treatment, and discharge. There was increased need for experienced nurses in specialty and other nursing settings. Enrollment in baccalaureate nursing entry-level programs continued to decrease for five years consecutively from 1995 to 2000. The birth of baby boomers between 1946 and 1964 was followed by the 11-year falling birth rates to a low of 146 births per 1,000. The 1990 census documented 77 million American boomers compared to 44 million Generation Xers, creating the smallest pool of entry-level workers since the 1930s. Another trend is the aging nursing workforce and faculty. In 2000, the average age of employed registered nurses was 43.3 years (AACN, 2000).

Long-term care facilities needed 100,000 registered nurses (Goodin, 2003), and more than 5,000 community hospitals needed 116,000 registered nurses to fill their vacancies (ANA, 2009). Shortage of nurses was correlated with longer hospitalization; increased incidence of urinary tract infections and upper gastrointestinal bleeding; and higher rates of pneumonia, shock, and cardiac arrest (Needleman, Buerhaus, Mattke, Stewart, & Zelevinsky, 2002).

Once again, the US health care system turned to developing countries (Philippines, India, Korea, and others) to meet their need for nurses. This time, there was no backlog of employment-based, third preference visas (EB 3 - green card) allowing thousands of Filipino FENs to enter the US as green card holders. It is difficult to ascertain the number of Filipino FENs who entered during this period because there was no single agency that kept track of nurses who migrated under many different categories of entry to the US. The Philippine Embassy (2005) in Manila reported about 7,994 nurses who emigrated under temporary H-1B and permanent EB-3 visas in 2004. Buerhaus, Staiger, & Auerbach (2009) estimated that FENs comprised one-third of the 476,000 full-time added RNs to the US workforce from 2001 through 2008.

In the Philippines, there was increased emigration of physicians and proliferation of MD-RN or nurse medics programs in 2000. Physicians who earned between \$2,000-\$10,000 annually wanted to become nurses in order to work in the US. Approximately 80% of physicians working in rural areas were re-educated as RNs (Conde, 2004). Many of them were females in their late 30s, married, and had between one-to-three children; the majority was trained in internal/general medicine, pediatrics, and family medicine, and a few were trained in surgery, pathology, and other spe-

cialties. The majority practiced medicine for more than 10 years (Pascual, Marcaida, & Salvador, 2003). Enrollment in medical schools dropped significantly in favor of nursing. Between 2000 and 2004, at least 3,500 Filipino physicians became RNs and emigrated as nurses, with 4,000 more enrolled in nursing programs (Galvez-Tan, Sanchez, & Balanon, 2004).

The mass exodus of health care workers particularly nurses and physician-RNs between 2000 to 2006 led to a massive “brain drain” in the Philippines. Dr. Jaime Galvez Tan, Executive Director of the National Institute of Health and Vice-Chancellor for Research at the University of the Philippines dubbed this phenomenon as “brain hemorrhage” (Cruz, 2004). The best and the brightest, and the most experienced professionals have emigrated to developed countries, leaving the less experienced to provide the health care manpower in the country. On the other hand, the Philippine economy had been unable to provide sufficient employment for its college graduates. The country had very few jobs for its population with an unemployment rate steadily increasing from 8.4% in 1990 to 12.7% in 2003 (Lorenzo et al, 2007). Twenty percent of the employed were underemployed, underpaid, or employed below his/her full potential. The Philippines underinvested in its own health care, leaving nurses underemployed. For every 10,000 new nurses, only 10% were employed in nursing (Pacquiao, 2004). Consequently, overseas employment continued to increase yearly from 1995 to 2000.

National Council of State Boards of Nursing (NCSBN), International Test Sites, 2005

NCSBN is an independent, not-for-profit organization founded in 1978. Its early beginnings can be traced to ANA’s Council on State Boards of Nursing. It was established because of the growing recognition that public safety and regulation of nursing practice should be separate from professional organizations representing nurses. Member boards of nursing that comprise NCSBN protect the public by ensuring that safe and competent nursing care is provided by its licensees. NCSBN is responsible for the development of a psychometrically sound and legally defensible nurse licensure examination consistent with current nursing practice. The examination is offered through a computerized adaptive testing in all US states and territories (NCSBN, 2013b).

In 2002, NCSBN approved designation of “international test centers” for administering NCLEX-RN outside the US and its jurisdictional territories. After an extensive study of the proposal NCSBN selected three pilot sites (Hong Kong, Seoul, Korea, and London, England) in June 2005. The Philippines was not included as an initial test site “without prejudice” due to the inability of the country to fully meet critical components of the selection criteria: (a) national se-

curity, including economic climate; (b) examination security; (c) similarity of local laws with US intellectual property and copyright laws; (d) availability of locations approved for high-stakes testing; (e) numbers and locations of internationally educated nurses; (f) regional accessibility; (g) number of US military personnel and dependents; (h) similarity of local nursing educational system with US nursing educational system (Lowery, 2005).

PNAAs NCLEX Task Force that included Leo-Felix Jurado and was led by Filipinas Lowery, continued to work with NCSBN to consider the Philippines as an international NCLEX test site for the following reasons: a) Filipino nurses have to fly to Guam or Saipan to take the exam and incur large expense or wait to take the exam after they secured their visa and entered the US; b) Filipino nurses comprise the largest cohort of internationally educated NCLEX test takers (35% in 2003 and 30.2% in 2004); and c) Filipino nurses comprise 83% of all FENs in the US who play a continuing vital role in alleviating the acute nursing shortage in the US for many years, while providing significant economic benefits to the Philippines (Lowery, 2005).

In 2006, NCSBN added twelve new sites including Australia, India, Japan, Mexico, Canada, Germany, and Taiwan but not the Philippines because of continuing national and examination security concerns. PNAAs task force sought support from the Philippine government and collaborated with the Commission on Filipinos Overseas (CFO), Philippine Nurses Association (PNA), and other Philippine government agencies. In June 2006, the publicized leak of the Philippine National Licensure Examination dampened all the efforts but PNAAs task force members along with representatives from CFO, PNA, and the Professional Regulation Commission (PRC), travelled to Chicago to dialogue with board members of NCSBN to address the issues surrounding the NLE leakage and the selection criteria of the NCSBN international testing site. On February 8, 2007, NCSBN announced the selection of the Philippines as an international test site.

Visa Retrogression

As early as October 2004, the Department of State entertained the probability of retrogression, restricting the entry of foreign workers. It is a way dealing with oversubscription of immigrant visa numbers allotted by law for a particular category and country. Since the Philippines has been the largest supplier of nurses to the US over the past several years, the increased demand for immigrant visas resulted in the oversubscription of employment-based third preference (EB-3) by countries like India, China and the Philippines. The Department of State imposes a cut-off date beyond which immigrant visa applications will not be processed until visa numbers become available. Retrogression has effectively created a major decrease in recruitment and

certification of FENs (Richardson & Davis, 2009). Despite the retrogression, the Philippines continues to lead the volume of first time NCLEX-RN applicants followed by India and South Korea.

Impact of Filipino FENs on Population Demographics

The American Community Survey indicates that there are 194,637 Filipino FENs which represent 52% of all FENs in the US (US Census Bureau, 2008). The enormous numbers of Filipino FENs entering the US prior to the retrogression changed the demographics of major cities particularly in the East Coast. New Jersey and New York are in the top ten favorite destinations for Filipino nurses. Others include California, Hawaii, Illinois, Texas, Washington, Virginia, Florida, Maryland and Michigan (US Census Bureau, 2000). In New York City, Filipinos are practically defined by a single occupation of nurses, and comprise the largest ethnic group of nurses in many hospitals. If you meet any Filipino, he/she is more likely to be a nurse or related to someone who is a nurse (Berger, 2003). In the 1980s New York hospitals actively recruited nurses in Manila and by early 1990s, 72 % of all female immigrants from the Philippines in New York City were RNs. By 1997, Filipinos comprised about 10 percent of the city's nurses, increasing to 18% in 2002. Filipinos had the highest labor force participation rate among women of over 85% (Foner, 2000).

There is no one neighborhood that Filipinos dominate nor is there a single Little Manila in US cities unlike "Chinatown" or "Little Italy." Filipinos have strong ties to their line of work, and form communities of networks instead of space (Foner, 2000). There are concentrations of Filipinos in neighborhoods with large hospitals, like Elmhurst in Queens, the Norwood section of the Bronx and Stuyvesant town in Manhattan.

In New Jersey, one in every nine RN is a Filipino, comprising a total of approximately 8,256 (Donohue & Gebeloff, 2003). The towns of Edison and Piscataway in Middlesex County and Toms River in Ocean County have high concentrations of Filipinos because local hospitals recruited Filipino FENs in the 1980s. Jersey City has 15,860 Filipinos with a Filipino enclave along Manila Avenue near the Holland Tunnel; it ranks second to Daly City, California. These areas have Filipino grocery stores, restaurants, bakeries and other business establishments (Berger, 2003).

In 2002, Filipino FENs earned more than any other group of native or foreign born. In NJ, there were only 85,245 Filipinos but had the highest household income average in comparison to any other group at \$80,946 compared to the state median household income of \$55,146 (Donohue & Gebeloff, 2003). After working for a few years, Filipino FENs were able to buy homes in the suburbs like Bergenfield where 3,133 Filipinos lived in a community of 26, 247 and

the only Filipino mayor in the state was elected (Bergen, 2004). Home ownership for Filipinos was 64% compared to the state average of 66% (Donohue & Gebeloff, 2003). Indians and Filipinos were the wealthiest of the recent arrivals, and lived in the newest and most expensive housing in NJ (Foner, 2000). In 1990, 40% of Filipino homeowners had homes valued at \$200,000 or higher. Because of their education and income Filipinos were able to move right into some of the best mainstream residential neighborhoods.

Conclusion

Shortages in nursing manpower in the US prompted changes in immigration policies that opened the gates for mass emigration of nurses from the Philippines. This trend began with EVP by giving opportunities for FENs to share knowledge and skills with American nurses. Today, Filipino nurses comprise the largest group of FENs in the US and have contributed to the demographic changes of nurses and Filipino immigrant population. Unemployment, underemployment, low wages, and low status of nurses in the Philippines have pushed nurses to emigrate. Nurses emigrated to seek employment in the US, improve their economic well-being, and obtain permanent residence for themselves and their families.

Emigration of Filipino nurses has been institutionalized by the Philippine government by being actively involved in the promotion of labor exportation, encouraging overproduction of nurses despite its inability to employ 80% of graduates, and celebrating FENs as ambassadors of good will to legitimize their contribution to ameliorate its foreign debt. Public policies have supported and legitimized the outward flow of nurses and physicians from the Philippines, which has created an alarming "brain drain" and decreased quality of health care services from loss of skilled health-care professionals.

However, the major influence in the unidirectional movement of Filipino nurses from the Philippines is the nursing shortage in the US that prompted policy changes in immigration to ease the entry of FENs, allowing healthcare agencies to massively recruit nurses from the Philippines. Worsening nursing shortage brought corresponding changes in policies, against the objections of American nurses and professional organizations, which saw FENs as taking away resources from US citizens and counterproductive to their fight for better wages and working conditions for nurses in the US. Highlighting the high failure rates of FENs in the RN licensure exams, American professional nursing organizations have successfully pushed for visa pre-screening examination (CGFNS) despite objections from Filipino nursing leaders and community, and some American nurses. The backlash from American nurses and organizations has prompted the establishment of PNA in certain states and the national organization, PNAA whose major mission is

to promote the positive image and well-being of Filipino nurses in the US.

More recent trends have combined to stop the mass emigration of Filipino nurses. The economic downturn created high unemployment in other sectors driving individuals to retrain and seek employment in nursing. Health care agencies are unable to fill vacancies because of budget issues. Professional nursing organizations have gained support from major stakeholders like Johnson and Johnson, and RWJF to attract students to nursing. The most significant deterrent is the visa retrogression, slowing down the visa processing and limiting the numbers of Filipinos who can enter the US legally to work. Thus, movement of Filipino nurses to the US is largely facilitated by macrosocial, economic, and manpower trends. While the Philippine government may have played a role to promote emigration of its nurses, international recruitment and supportive immigration policies have been the major pull factors for emigration of nurses from the Philippines.

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Albumin's Key Role in Improving the Quality of Care of Patients with ESRD: An Educational Program for Nephrology Team Members

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Abstract

Introduction: Serum plasma albumin, an important audit for end-stage renal disease (ESRD), is a predictor of patients' future health outcomes. To keep patients, especially those on dialysis, as healthy as possible, the nephrology team (nurses, patient care technicians, biomedical technicians, social workers, dietitians, advance practice registered nurses, nephrologists, and medical directors) must be vigilant in helping patients meet their albumin and nutritional goals. Therefore, team members' knowledge about albumin and the ill effects of hypoalbuminemia is essential to the provision of quality care.

Objective: The objective of this project was to provide an education module to increase the knowledge of care of patients with ESRD on dialysis regarding albumin as a quality indicator among team members in an outpatient, private hemodialysis clinic.

Methods: A convenience sample of team members (n=24) in an outpatient hemodialysis unit participated in an education program of four 25-minute sessions for four days. A 10-question pre-test initiated the program, followed by a PowerPoint presentation and a 10-question post-test.

Results: The test questions, which were analyzed using a paired sample t-test, showed a significant increase in nephrology team members' knowledge from pre-test to post-test (p= .000).

Conclusion: The education program was successful in improving team members' knowledge regarding albumin as a quality indicator, which can result in improved patient care.

Keywords: education, albumin, ESRD, quality care.

Introduction

The National Kidney Foundation Kidney Disease Outcomes Quality Initiative (NKF KDOQI, 2000) has established guidelines that have led to improvement in the process of kidney disease care, as evidenced by the development of clinical performance measures. Achievement of accepted clinical performance targets for clinical indicators, such as serum albumin and nutrition management, has led to fewer hospitalizations, decreased hospitalization costs, and better patients' survival (Plantinga et al., 2007).

To provide quality care, nephrology team members must have knowledge of albumin as a quality care indicator and be able to recognize that hypoalbuminemia, which can be caused by poor protein intake, inflammation, infection, fluid overload, external protein loss, and comorbid conditions (NKF KDOQI, 2000), is a major risk factor for morbidity and mortality in dialysis patients. This vital information for improved quality care is best disseminated through the provision of education to nephrology team members. This paper describes the creation, implementation, and evaluation of such an educational program for nephrology team members.

Background & Significance

Chronic kidney disease (CKD), a noncommunicable chronic condition in which the kidneys gradually decline in function, affects approximately 26 million adults in the US (Centers for Disease Control and Prevention [CDC], 2015). The decline in kidney function in CKD is initially asymptomatic, and if not managed, may progress through five stages to complete kidney failure called end stage renal disease (ESRD) in which patients require dialysis to replace the failing kidneys' filtering function and/or kidney transplantation in order to survive (NKF, 2015).

The care of patients with ESRD is complex due to the disruption in metabolic homeostasis that affects nearly every organ system in the body, making multiple complications possible as a result of diminished kidney function and the multifaceted relationship between uremia and dialysis management. Serum plasma albumin has been proposed as an important audit in hemodialysis patients because it is a predictor of future health outcomes. The predictive power of albumin is a reflection of the effect of many factors such as: reduced protein intake, inflammation, and the dialysis process (Plantinga et al., 2007). The National Kidney Foundation's Kidney Disease Outcomes Quality Initiative (NKF KDOQI) has recommended guidelines of an albumin concentration of >4g/dl or =4.0 g/dl, using the Bromocresol Green (BCG) laboratory method (NKF KDOQI, 2000). Improving albumin levels in clinical practice and establishing supporting practices by dialysis facilities will result in improved patient care (Grange, Hanoy, Le Roy, Guerrot, & Godin, 2013).

A low serum albumin level is related to protein energy wasting (PEW) in patients with ESRD on maintenance dialysis, and is associated with multiple adverse consequences (Himmelfarb & Ikizler, 2010). This hypoalbuminemia, which may result from reduced protein and/or caloric intake, uremia, metabolic acidosis, inflammation, or infection, is associated with hospital length of stay, a powerful risk factor for adverse outcomes (Himmelfarb & Ikizler, 2010). Hypoalbuminemia may also influence the possibility of detection and treatment of an underlying disorder, such as, cardiac disease, infection, and peripheral vascular disease (Friedman & Fadem, 2010). Establishing the causality of hypoalbuminemia requires the efforts and intervention of all health care providers involved in the care of patients on dialysis.

All members of the nephrology team have important roles in helping to keep the patient as healthy as possible: evaluating the dialysis treatment, participating in the ongoing process of helping patients' meet their albumin and nutritional goals (Pasticci et al., 2012). Their knowledge and use of the NKF KDOQI guidelines which determine these goals as well as target blood pressures and anemia, are key to treatment of patients on dialysis. Despite the availability of the guidelines, patient management remains highly variable and often suboptimal (McClellan et al., 2009). In a study by Lenz et al. (2005), of 198 patients with stage 4 and 5 CKD, only 10-17% had achieved target blood pressures, and 19% - 55% had optimal lipid levels based on recommended NKF-KDOQI guidelines. From 2002 to 2008, similar trends were observed in patients from Southern California Kaiser Permanente (Rutkowski et al., 2009).

Education is needed to bridge the gap between clinical practice and guideline targets (Estrella et al., 2013). In addition to increasing knowledge, education alters perception and changes work practice especially in vital areas such as hemodialysis (Hassona, Winkelman, El-Wahab, Ali, & Abdeen, 2012). Educational programs have been shown to increase the necessary knowledge. For example, nephrology nurses benefited from a computer-assisted learning module provided by the American Nephrology Nurses Association (ANNA) for members with three or less years of nephrology nursing experience. After completing the educational program, the non-experienced nephrology nurses showed > 20% in improvement in knowledge on dialysis complications (Dennison, 2011).

Rather than function as a singular dimension of intellectual activity, education programs should serve as contributions to learners' development and ultimately better quality of care and better patient outcomes. Knowledge of maintaining key guideline indicators such as serum albumin through educational programs can make a difference in the lives of patients on dialysis.

In order to provide quality patient care, nephrology team

members must be aware of the significance of albumin as a quality indicator of health and be able to recognize hypoalbuminemia as a major risk factor for morbidity and mortality in patients on dialysis (NKF K/DOQI, 2000). They must be aware of the guidelines established by NKF K/DOQI guidelines and strive for the achievement of accepted clinical performance targets for clinical indicators, such as serum albumin and nutrition management linked to fewer hospitalizations, decreased hospitalization costs, and better patients' survival, which have led to improvement in the process of kidney disease care (Plantinga et al., 2007). The educational module given to team members of an outpatient private hemodialysis unit was part of a quasi-experimental study that assessed the team members' knowledge of NKF KDOQI guidelines and topically related information taken from nursing journals especially relating to albumin with the aim of improving this knowledge which they will use in their care of patients with ESRD.

Clinical Question

Would an education program regarding albumin as a quality indicator result in a change in knowledge of nephrology team members?

Theoretical Framework

Patricia Benner's novice to expert theory of skills attainment (1984), based on Dreyfus' model of skills acquisition modified to nursing, was applied to this education program. This theory addresses various levels of team members' skill and experience and proposes that expert nurses develop skills and understanding of patient care over time through proper educational background and experiences. To create competent, expert nurses, nursing is focused on clinical skills as well as on the understanding of the science behind the skills (Allen et al., 2008). Thus, education enables nurses to progress through stages (as described by Benner). In the field of nephrology, the entry level of education often focuses on learning the mechanics of hemodialysis without the opportunity for learning the clinical implications. Nurses who care for renal patients rely on team expert members whose practice is described as intuitive (Ulrich, 2011). As suggested in Benner's theory, an individual's level of knowledge may be expert in one area and beginner level in another. Enhancing nursing professional development comes through nursing continuing education (Ulrich, 2006; Mensik, Scott, Martin, & Horton, 2011).

Design and Methodology

This study was a quasi-experimental, one group pre-test and post-test design research study, with an education program as the intervention. The pre- and post-tests created for the purpose of the study derived their educational content from: the *Clinical Journal American Society of Nephrology*, the *Journal of Renal Nutrition* and the *National Kidney Foundation Kidney Disease Outcomes Quality Initiative Guide-*

lines. Prior to the intervention, an informed consent for the educational module was obtained from each study participant, who consisted of a convenience sample of 24 team members working in a dialysis unit. Inclusion criteria were: ESRD/dialysis team membership; ages 18 and older; ability to read and write English and complete the program; and willingness to participate in the study. IRB approvals were obtained from Monmouth University, West Long Branch, NJ and the private dialysis company's research committee.

The format used to complete the program was: collection of demographic information; the pre-test; an educational PowerPoint that included topics such as: etiology of ESRD; NFK KDOQI serum albumin outcomes goals; risk factors for hypoalbuminemia; the cost of ESRD; the ways the body uses protein, NFK KDOQI dietary protein intake; and the post-test. The NFK KDOQI guidelines and topically related information from nursing journals were the basis of the pre- and post-tests, which were used to measure participants' knowledge.

Demographics

Of the 24 participants (75% female), the two highest age ranges (29.2%) were represented by those between the ages of 31-50 and 41-50. There was little diversity among participants. The most represented ethnic group was Caucasian (75%); the second Asian/Pacific Islander (25%). Participants with 16-20 years of dialysis experience were predominant (25%) with the second from 3-5 years of dialysis experience (20.8%). Participants with a four-year college degree were the most prevalent (25%). Although all employment titles were represented, the majority of participants were both nephrology technicians (33.3%) and registered nurses (33.3%).

Results

Data were collected as group data and analyzed using SPSS for Windows version 19.0. Descriptive statistics were used to analyze participants' demographics. The test questionnaires that included 10 pre- and post-education questions regarding albumin were analyzed using a paired sample t-test for significance of change in test scores, with values of $p < 0.05$ set to indicate statistical significance (See Table 1).

Table 1 Pre- and Post-Test Questions Results (Sample of Questions)

Question : What is the recommended serum albumin value (NKF KDOQI)?

	Pre-test Frequency	Pre-test Percent	Post-test Frequency	Post-test Percent
Incorrect	7	29.2%	0	0%
Correct	17	70.8%	24	100%
Total	24	100%	24	100%

Question: What is the recommended daily dietary protein intake?

	Pre-test Frequency	Pre-test Percent	Post-test Frequency	Post-test Percent
Incorrect	12	50%	0	0%
Correct	12	50%	24	100%
Total	24	100%	24	100%

A paired sample t-test was calculated to compare the mean pre-test mean score (7.08 (sd = 2.02)); with the post-test mean score (9.83 (SD = 0.38)). A significant increase from pre-test to post-test was found (t (23) = -6.382, p= 0.000). The analysis discovered that there were significant differences between pre-test and post-test (p = .000). The mean shows that the intervention was successful (see Table 2).

Table 2 Paired Samples Test

	t	df	Sig. (2-tailed)
Pair 1 Pre-test and post-test Questions	-6.382	23	.000

Table 3 Pre-test and Post-test Results

	Pre-test	Post-test
Scored 100%	3	20
Scored <100%	21	4
Total	24	24

On the pre-test, the majority of participants answered one or more questions incorrectly; however, on the post-test, the majority answered all questions correctly (See Table 3).

Limitations

Because the project data were gathered only in one dialysis unit from a small number of participants, the results may be limited to units of a similar size with similar employee characteristics. The small number of non-participants (<10%) in this study was considered to have little influence on the results. In the future, additional studies should be conducted to improve and update staff's current knowledge on other topics such as infection and bone remodeling if these are not part of annual competencies.

Conclusions

The rapid changes in health care and the emphasis on the delivery of quality care have driven the learning needs of health care professionals to new dimensions. For example, quality of care indicators, valued by organizations and regulators, are increasingly being used to highlight care parameters that need improvement and to provide optimal, evidenced-based treatment to patients with ESRD on dialysis. Members of the nephrology team must be knowledgeable about ESRD-specific indicators such as albumin that predict patient outcomes, which can be significantly influenced by the successful partnership between the educated nephrology team member and the patient. Through educational programs, team members may become more confident in their level of knowledge related to albumin and the underlining mechanism of complications that result from hypoalbuminemia, thereby enabling them to deliver better quality of care. The success of this program encourages future programs; however, their effect on the potential to improve patient outcomes, for example, bloodstream infection, clinical depression screening, metabolism and anemia management in the dialysis clinic should be considered.

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Poster Abstracts

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Abstracts are listed according to the following categories:

Clinical/Evidence-Based Practice (CEBP)

Chapter Best Practices (CH)

The presenting author is listed as the first author for all the abstracts accepted for presentation.

Education (ED)

Research (R)

CEBP-01

CATHETER ASSOCIATED URINARY TRACT INFECTIONS (CAUTI)... OR IS IT?

Jisebelle Tizon, MSN, RN, ACNS-BC, CCRN, CWON, Philippine Nurses Association of Colorado

Objective: To prevent Catheter Associated Urinary Tract Infections (CAUTIs) in the Intensive Care Unit at Saint Joseph Hospital, Denver, Colorado.

Significance and Background: CAUTI accounts for 36% of hospital acquired infections. About 3% of these patients develop bacteremia, which carries a 2.8% mortality rate (Critical Care Nurse, 2013). CAUTI has also been identified as one of the preventable hospital acquired conditions that is not reimbursable as part of the value based purchasing from Centers for Medicare & Medicaid Services (CMS).

Purpose: Despite our organization's initiatives in CAUTI prevention, our rates in our 26-bed medical/surgical ICU remained high in 2012. The purpose of this initiative was to prevent future CAUTIs, and prevent false positive results from improper urine specimen collection that could subsequently expose patients to unnecessary antibiotics.

Interventions: In 2012, our CAUTI rate was 1.924. Root Cause Analysis (RCA) found opportunities in: (1) catheter insertion, (2) maintenance, (3) timely removal, and (4) correct process of obtaining urine culture. The kits were changed, and education to address maintenance, removal and specimen collection were provided to the nurses through quality outcomes presentations. The process of obtaining urine culture was the biggest opportunity as many of the urine culture specimens were obtained from old catheters (≥ 3 days old). The CAUTI team, which consists of the Infectious Disease physician, ICU Clinical Nurse Specialist, ICU Clinical Manager, and Infectious Disease pharmacist, believed that this process could potentially have been providing false positive culture results. With our venture towards ZERO CAUTIs and antibiotic stewardship, it was imperative that this process changed. Through collaboration with the CAUTI team, clear and specific instructions were developed and given to the nurses through series of inservices and via tipcards. It states, "If the catheter has been in for more than 72 hours, remove the old catheter, allow for patient to void once, and obtain specimen per protocol on the second void; if the patient still needs the catheter, obtain

urine culture specimen on the new catheter after allowing a few hours of urine flow to wash out the biofilm."

Evaluation and Discussion: Our CAUTI incidence decreased by 40% from 2012-2013 and 60% from 2013 to 2014. Resistance was met, as the old practice had been the standard of practice for years, and the new practice was felt to be impractical and of no value. Periodic presentations of our improved outcomes during our staff meetings with nurses and physicians gained their buy-in. This process change required the support of several stakeholders such as the attending physicians, intensivists, unit nursing leaders and the nursing staff to have been successful and achieved our outcomes. This process has now been implemented outside our ICU to the rest of the hospital and also to other hospitals in the system.

CEBP-02

ANIMAL ASSISTED THERAPY: BRINGING JOY TO THE ICU.

Maria Lourdes G Bayog, PhD(c), CNS, RN, Steven Koster, RN, Sharlene Peeke, RN, Charlotte Garwood, RN, MS, CNS, Hildy Schell-Chaple, PhD(c), RN, CCNS, University of California, San Francisco

Objective: Describe the Animal Assisted Therapy (AAT) program and its effect on patients, family, and staff in an Adult Medical Surgical Intensive Care Unit (ICU).

Significance and Background: AAT has been associated with decreases in pain, anxiety, and anger as well as improved mood in medical, surgical and burn ICU patients. Despite the benefit of AAT in patient outcomes, little is known about its impacts on family members and staff.

Purpose: Establish an AAT program with regularly scheduled dog visits to patients in the 32-bed adult medical-surgical ICU at University of California, San Francisco (UCSF) Medical Center and to examine the effect of AAT on the patients, family, and ICU staff mood.

Interventions. In collaboration with the San Francisco Society for the Prevention of Cruelty to Animals, we coordinated volunteers and dogs for two-hour AAT visits, twice per month. Patient screening included interest, inclusion/exclusion criteria, and physician approval of AAT. Visits

ranged from five to 15 minutes, either in the ICU bed or at the door.

Evaluation. A survey was developed using a Likert scale to evaluate patients' response to the AAT visit and the impact of AAT on family and ICU staff mood.

Results and Discussion. There were 108 patient visits, averaging eight patients per day. 27 surveys were collected. There were anecdotal reports of patient improvement in attention, cognition and decreased anxiety. All patients reported the highest level of interaction score and highest score of a positive change in their mood. All family members reported their own positive mood change related to the AAT visit. The majority of clinicians reported their own positive mood change with AAT visit. In summary, an AAT program in the ICU is feasible, sustainable, and can improve the mood of patients, families, and staff.

CEBP-03

BRINGING MEANINGFUL DATA AT THE BEDSIDE TO ACHIEVE PATIENT SAFETY AND COMPLIANCE. Jonathan Guardo Gecomo, MSN, RN, Catholic Health Initiatives (CHI) Baylor St. Luke's Medical Center

Achieving 97% Barcoded Medication Administration (BCMA) compliance on a weekly basis is a tall order from Catholic Health Initiatives Quality Department. Baylor St. Luke's Medical Center has transitioned to Epic last June 2012 and BCMA compliance ranges from 90% to 95% every week since implementation. The current rate of BCMA compliance impacts patient safety because of a break on the closed-loop medication administration system. This gap may also increase medication errors because of the workarounds utilized by clinicians using BCMA technology. The Patient Care Informatics Group had collaborated with Pharmacy, Nursing and Information Technology (IT) to come up with the following solutions; BCMA report that provides information on the usage and compliance of all units on BCMA. Nursing to validate the report and provide feedback on technology and medication scanning issues encountered at the bedside. Information Technology have re-calibrated existing scanners and replaced old and non-working scanners. A weekly overall BCMA report was generated and sent to all managers and hospital leaders that delivers current department standing on BCMA compliance. A separate unit/department specific report is generated that offers each staff compliance and specific medication overridden during the process of BCMA. The report revealed several medications that will not scan at the bedside caused by an old linear scanner and non-calibrated scanners; several ancillary departments don't have enough scanners to comply with BCMA and inpatient medications ordered at Community Emergency Centers but not available on automated dispensing cabinets. IT department was tasked to replace all old linear scanners and recalibrate existing scanners. Ancillary departments ordered scanners to increase BCMA compliance and Pharmacy Department work with Epic analysts to update medications at the Community Emergency Centers.

Clinical Managers have utilized the report to the fullest and have come up with workflow changes in their respective units. These changes were completed second week of March and the current BCMA compliance of BSLMC for the past two weeks of March, 2015 were 97.9% and 98.02%.

CEBP-04

QUALITY IMPROVEMENT: BACK TO BASIC: PROMOTING CONSISTENT POSITIVE PATIENT AND SPECIMEN IDENTIFICATION FOR PATIENT SAFETY.

Jonathan Guardo Gecomo, MSN, RN, Pamela Windle, MSN, RN, CPAN, FAAN, Catholic Health Initiatives (CHI) Baylor St. Luke's Medical Center

Baylor St. Luke's Medical Center completed a "Big Bang" Epic implementation in June 2013 that includes switching from Care Fusion specimen collection to Epic specimen collection process. After one year of implementation, a huge spike in the number of barcode overrides were observed from scanning the patient armband down to scanning the specimen label to complete the collection process. These breakdown greatly impacts patient safety due to a gap in positive patient and specimen identification. Several concerns were raised from equipment problems (barcode scanner, printer not working, training), several specimen collection process by service (Emergency Department (ED), In-Patient Units to Perioperative Services), network issues, system issues and workarounds developed after one year post-Epic implementation. Positive Patient and Specimen Identification Committee were convened to address the problem. The committee looks into change management components; People, Process and System to come up with solutions and address the issue. System: equipment, network and Epic system were reassessed and concerns were immediately resolved; Process: specimen collection workflow were revisited, a report was created in Epic to drill down to the user level who overrides barcode scanning; People: a module specific training were developed for each service: ED, In-Patient and Perioperative Services. Monitoring of barcode overrides through the use of Epic workbench reports started July 28, 2014. Constant reporting to clinical managers and other stakeholders were sent 2 to 3 times per week to find patterns and zero-in on repeat offenders. The drill down reports were used to concentrate the clinical managers efforts to repeat offenders and system problems. Label printers, barcode scanner and network issues were addressed and mandatory module specific education were completed August 15, 2014. Despite the different challenges encountered, the total number of overrides went down from 140 every 2 days to 32 after 40 days of project implementation.

CH-01**MEDICAL MISSION: A JOURNEY OF INTERPROFESSIONAL COLLABORATION AND PRACTICE.**

Alice Namata Andam, BSN, RN, Emilie Gaborne Dearing, MSN, RN, PMHCNS- BC, Philippine Nurses Association, Metro Washington DC

This poster describes the processes of conducting a comprehensive Medical Mission to the underserved population of the Philippines by the Philippine Nurses Association of Metropolitan DC (PNAMDC). The diverse team, composed of health and allied professionals volunteering for the last thirteen years, works together towards interprofessional collaboration and practice in the delivery of a comprehensive multi-disciplinary medical, surgical, ophthalmological, pharmacological and dental services to the indigent patients of Luzon, Visayas and Mindanao. The PNAMDC Medical Mission supports the mission of the Philippine Department of Health by providing health care services to local communities that have limited access to care. The different phases of the Medical Mission activities illustrate the knowledge, skills, experiences, challenges and opportunities of the local and US multi-disciplinary team. Administrative support, physical infrastructure, policies and procedures, required documentations, clearances and basic requirements are discussed. Empowerment, cooperation, collaboration and partnership- key elements in conducting an effective and successful medical mission that yield quality health care are explained. Likewise, the poster addresses the many facets of communication, joint ownership and partnership with the multidisciplinary team from the US, local volunteers, hospital staff and community leaders.

ED-01**MEASLES OUTBREAKS IN THE U.S. AND THE CORRELATION TO DECREASED VACCINE RATES.**

Augustina Manuzak, MD, MPH, PhD, Joseph M. Foss, RN, BSN, CCRN, CFRN, NREMT, Hawai'i Pacific University

Measles is a highly contagious virus spread through airborne and direct person-to-person contact. It remains a significant cause of morbidity and mortality in the developing world, but is no longer endemic in the United States or much of the western hemisphere. In the U.S. measles was declared eliminated about 15 years ago, however nearly 20 million cases of measles occur every year around the globe, and importations of the disease to the U.S. continue to pose a threat to unvaccinated persons. Despite being declared eradicated from the U.S. in the year 2000, inadequate levels of vaccination are threatening the herd immunity in the U.S. population. The importation of measles from overseas has threatened pockets of unimmunized and under-immunized communities in this country. The purpose of this study is to examine the relationship between measles outbreaks and unvaccinated and under-vaccinated populations in the U.S.

ED-02**SCHISTOSOMIASIS: NEGLECTED TROPICAL DISEASE.**

Augustina Manuzak, MD, MPH, PhD, Courtney Henegar, RN, BSN, Hawai'i Pacific University

Schistosomiasis or bilharziasis is an infection caused by a parasitic blood fluke that affects around 440 million people worldwide. Africa has the highest prevalence of the disease and the fewest available resources. Schistosomiasis infection is acquired by contact with fresh water infested by blood fluke larvae called schistosomes. The adult worms lay eggs, which are deposited in the blood vessels causing massive damage of urogenital and intestines tracts of affected people. Schistosomiasis is considered a disease of poverty and a neglected tropical disease (NTD). Primary prevention is limited, and interventions are focused on reduction of disease morbidity and mortality. The preferred treatment of schistosomiasis is the chemotherapeutic agent Praziquantel. The resources for treatment are inadequate. This includes the availability of Praziquantel and the funding for control programs. Disease control and treatment programs should utilize secondary environmental control interventions to reduce transmission and reinfection rates. In May 2013, the World Health Organization adopted resolution World Health Assembly 66.12 which calls for intensified, integrated measures, and planned investments to improve the health and social well-being of populations affected with NTD. The purpose of this paper is to assess the epidemiological standpoint of schistosomiasis in the populations of endemic regions through literature reviews and discuss the role of the advanced practice nurse in disease prevention, management, and intervention of this devastating disease.

ED-03**CERVICAL CANCER PREVENTION IN PRIMARY CARE: NURSE PRACTITIONER'S ROLES.**

Augustina Manuzak, MD, MPH, PhD, Hidemi Dela Cruz, RN, BSN, Hawai'i Pacific University

Cervical cancer is the second most common cancer in women worldwide. More than 85 % of women who are in low-and middle-income countries are affected. In 2012, approximately 270,000 women died from cervical cancer, and 530,000 new cases of cervical cancer were diagnosed worldwide. The United States has been using the Papanicolaou smear test (Pap smear) to identify early stage of cervical cancer since the 1940s. Annually, about 33,369 women in the United States were diagnosed with cervical cancer related to Human Papilloma Virus (HPV). Consequently, health care providers need to provide more health education and preventive care for their patients to further reduce the incidence and mortality rates caused by cervical cancer. This paper will address the basic knowledge of how HPV is associated with cervical cancer. In addition, this study will provide updated information on the incidence and mortality rates of cervical cancer worldwide, in the nation, and state-wide. This paper will discuss the importance of the nurse practitioner's role in advocating education and preventative

care for their patients in primary care in reducing the burden of cervical cancer caused by HPV, and ultimately to decrease the incidence and mortality rates of cervical cancer.

ED-04

EVIDENCE-BASED PUBLIC HEALTH STRATEGY FOR PREVENTION AND CONTROL OF ADULT OBESITY.

Erica Stoll, RN, BSN, Augustina Manuzak, MD, MPH, PhD, Hawai'i Pacific University

Obesity rates have steadily increased since the 1960s. Over a third of the American population is obese in today's society. Multiple factors make treating obesity in patients difficult on a societal level. Research of obesity is of the upmost importance because there is a positive correlation between obesity and risk of mortality. Obesity alone is not a single cause of death, but is a risk factor and a contributor to other chronic diseases, such as, diabetes and cardiovascular diseases. The overall mortality risk of obesity is 33%, with 31.1% in male and 34.8% in female. Chronic diseases account for 88% of total deaths of non-communicable disease in the United States. Cardiovascular diseases are contributed to 31% of deaths and diabetes contributed to 3% of chronic diseases deaths. This current upward trend needs to be stopped and ultimately reversed. The purpose of this study is to generate a new perspective on obesity, analyze current available data, and identify gaps in the literature for potentially developing prevention and control strategies for obesity. In addition, evidence-based public health intervention strategies for adult obesity will be reviewed and recommendations for further epidemiological study will be presented.

ED-05

SHIGELLOSIS: REVIEW OF PREVENTION AND CONTROL METHODS IN DEVELOPING WORLD.

Augustina Manuzak, MD, MPH, PhD, Kristiana Lazarova, RN, BSN, Hawai'i Pacific University

Objective: Improving prevention and control measures for persistent endemic of shigellosis in developing world. As the rate of resistance to the most commonly used antibiotics is rising, the choices of antimicrobials are becoming more limited in treating shigellosis. This is especially concerning since epidemic dysentery in developing countries is often caused by *Shigella dysenteriae* serotype 1, a virulent enteric pathogen that causes large scale outbreak with high mortality rate.

Significance and Background: Shigellosis or bacillus dysentery is an enteric bacterial infection cause by a group of bacteria called *Shigella*. According to the World Health Organization, shigellosis is the cause of approximately 1 million deaths per year mainly in children younger than 10 years of age in developing countries. Infections with *Shigella* bacteriae are often associated with poor infection prevention practices.

Purpose: The purpose of this paper is to identify areas of improvement needed in detection method, public health education and access, and social and cultural approach, in order to reduce the global burden of shigellosis that has been estimated at 165 million cases per year, of which 163 million are in developing countries.

Evaluation: As effective vaccines is the ultimate goal for prevention, such a vaccine is not readily available and would need to have all the key elements of being cost-effective, multivalent, easy to manufacture, easy to administer, and well tolerated. Education is currently the prime method of prevention.

Discussion: *Shigella* bacteriae are transmitted from person to person with a low amount of inocula. Given its relatively low infectious dose for transmission that cause a high fatality rate, it is a health threat to the developing world. Therefore, target interventions in endemic areas that have limited access to resources, prevention need to be made by the simplest and cost-effective way.

ED-06

TYPE II DIABETES IN THE U. S. PEDIATRIC POPULATION: PREVALENCE AND PRIMARY PREVENTION TOOLS.

Jennifer Hamamoto, RN, BSN, Augustina Manuzak MD, MPH, PhD, Hawai'i Pacific University

In the United States, the prevalence of type II diabetes has increased 167%. 50% of all new cases of diabetes are diagnosed Type II diabetes. We can easily attribute obesity, sedentary lifestyles, inadequate diet and nutrition, and insulin resistance as common contributors to causing Type II diabetes. Both federal and state governments have implemented programs within the public school systems to educate children about diabetes, nutrition, and exercise. While tools have been put in place for years now, the prevalence of the pediatric Type II diabetic population is still widely noticed and continuously increasing. Implementation of education needs to have stricter guidelines for health care professionals as well as the U.S public school system. Collaboration within the communities is essential to initiate the awareness and create the change needed with the educational tools currently available. Support within the community is a key factor to create change to decrease the prevalence and incidence rate of type II diabetes in our pediatric population. The purpose of this paper is to define the prevalence, causes, and preventative methods of type II diabetes in our pediatric population within the United States.

ED-07**THE PREVALENCE AND PREVENTION OF GONORRHEA IN THE UNITED STATES AND HAWAII.**

Lauren M. Dumpit RN, BSN, Augustina Manuzak, MD, MPH, PhD, Hawai'i Pacific University

Gonorrhea was the most common STD worldwide for the majority of the 20th century. With an estimated 88 million new cases per year across the globe, gonorrhea continues to be a significant public health concern. Gonorrhea is a sexually transmitted disease that is particularly rampant among teens and young adults aged 15-24. Data collected in 2013 reveals the prevalence of this disease among various ages, races, and ethnicities in the United States and specifically Hawai'i. In the United States alone, there are approximately 700,000 new cases of gonococcal infections occurring each year. In 2013, the gonorrhea rate among Native Hawai'ians/Other Pacific Islanders was 94.0 cases per 100,000 people, which was 2.7 times the rate among Caucasians. Disease prevention is suggested by increasing awareness, providing patients and the public with education of the disease, and by performing routine screening on patients during office visits. The role of the nurse practitioner as an educator remains vital in controlling the incidence of gonorrhea. Primary prevention aims to prevent disease occurrence and can be done in the clinic by spending time with patients to offer them information regarding sexually transmitted diseases and how to protect themselves.

ED-08

PNEUMONIC AND BUBONIC PLAGUE: CLINICAL AND EPIDEMIOLOGICAL MANIFESTATIONS IN NATURALLY OCCURRING DISEASE AND BIOTERROR ATTACKS. Augustina Manuzak, MD, MPH, PhD, Rene Gilberto Steinhauer RN, EMT-P, Hawai'i Pacific University

Plague is a systemic invasive infectious disease caused by bacterium *Yersinia pestis*, a zoonotic bacterium found in rodents and their fleas. Depending on the route of infection, there are three forms of plague: bubonic, septicemic, and pneumonic plague. Plague can be transmitted between animals and human by the bite of infected fleas, direct contact, inhalation, and ingestion of infected materials. Plague epidemics have been reported in Africa, Asia, and South America. The World Health Organization reported 783 plague cases worldwide in 2013, including 126 deaths. Current literature suggests that naturally occurring outbreaks of plague exhibit pneumonic presentations that are much smaller than bubonic presentations. As the technology of warfare advances in all nations, the potential for a biologic attack against military and civilian targets grows. A biologic attack with plague will create an event that will present with predominantly pneumonic etiology, in numbers significantly higher than naturally occurring outbreaks. Therefore, it is important for medical providers to be familiar with the clinical manifestations and medical management of plague. The purpose of this research study is to provide guidance based on the Advanced Practice Registered Nurse (APRN)

recommendations for the management of plague outbreaks. Furthermore, assessments of plague epidemiology and public health response in the event of plague bioterror attack will be discussed.

ED-09**PREVENTION AND CONTROL OF TUBERCULOSIS IN HAWAII.**

Augustina Manuzak, MD, MPH, PhD, Nicholas J. Munoz, RN, Hawai'i Pacific University

Hawai'i has double the incidence and a third more mortality from tuberculosis (TB) in comparison to the rest of the United States. Multi-drug Resistance TB (MDR TB) and Extensively Drug Resistance TB (XDR TB) cases are increasing in Hawai'i and the surrounding Pacific Island communities, which pose an increased public health threat. TB was the 8th most deadly disease in the world; in 2013, the estimated number of tuberculosis associated deaths is 1.5 million worldwide. The incidence rate of TB nationally was 1.3% among U.S. born in comparison to 2.6% in Hawai'i populations. This study will outline the current state of prevention and control of TB in Hawai'i in comparison with national and international epidemiological best practice standards. The purpose of this research study is to provide guidance based on Advance Practice Registered Nurse (APRN) recommendations in the prevention and control of TB. This can be accomplished through increasing inter-agency collaboration and collaboration/assistance to other countries in the Pacific. In addition, healthcare provider education campaign on the screening of TB, and state regulations on reporting of latent tuberculosis infection (LTBI) will be discussed.

ED-10**PREVALENCE OF DIABETES IN NATIVE HAWAIIANS AND PACIFIC ISLANDERS.**

Sunny Hwang-Oras, RN, Augustina Manuzak, MD, MPH, PhD, Hawai'i Pacific University

Diabetes has become a worldwide epidemic. Due to the health disparities certain ethnic groups have been affected more than others. In the State of Hawai'i, diabetes was the 5th leading cause of death in 2009. It was estimated that more than 100,000 adults in Hawai'i had diabetes and over 900 people died annually from diabetes related complications. Native Hawai'ians and other Pacific Islanders are known to suffer from chronic diseases and diabetes is most prevalent in this population. Diabetes is often preventable and controllable. The debilitating complications can be delayed by addressing several modifiable risk factors. However, the prevalence and incidence rates of diabetes increases each year. To battle this epidemic, primary, secondary, and tertiary prevention is crucial. Cultural values, beliefs, and practices of Native Hawai'ians and other Pacific Islanders should be considered to improve patient outcomes, with a goal of decreasing morbidity and mortality. The purpose of this paper is to evaluate through literature reviews the epidemiological

aspect of the disease, the risk factors of the population, and the public health prevention and intervention measures from the Advance Practice Registered Nurse perspective.

**R-01
TUBERCULOSIS AMONG PERSONS BORN IN THE PHILIPPINES AND LIVING IN THE UNITED STATES.**

Lilia Ponce Manangan, RN, MPH, Robert Pratt, BS, Catheryn Jumao-as Salibay, MPH, Steve Kammerer, MBA, Centers for Disease Control and Prevention (CDC), Atlanta, Georgia 30333

Objectives: We examined demographic, clinical, and treatment outcome characteristics of Filipinos with tuberculosis (TB) in the United States (U.S.).

Significance and Background: The U.S. TB case rate has been consistently higher among foreign-born than among U.S.-born residents. The most reported country of origin after Mexico is the Philippines.

Purpose: To determine the extent to which country of birth is a risk factor for TB.

Methods and Analysis: We performed an epidemiological analysis of U.S.-residing Filipinos with TB disease reported to the National Tuberculosis Surveillance System (NTSS). We calculated TB case rates from U.S. Census Bureau population data for U.S.-born non-Hispanic Whites and U.S. residents born in the Philippines, India, China, Cambodia, Vietnam, Pakistan, and Korea—countries that are major contributors to the TB burden in the United States. We compared Filipinos with the other groups through univariate and multivariate analyses of 2000–2007 NTSS data. We calculated 2008–2013 TB case rates and analyzed NTSS Filipino healthcare worker data.

Findings and Implications: During 2000–2007, of 45,504 TB patients, 7,083 were Filipinos; 19,959 were other Asian/Pacific Islander (API) groups; and 18,901 were Whites. Per 100,000 persons in 2007, the TB rate was 73.5 among Cambodians, 54.0 among Vietnamese, 52.1 among Filipinos, and 0.9 among Whites. Filipinos were more likely than other groups to be female, employed as health care workers, aged >44 years at time of diagnosis, and U.S. residents >2 years. Filipinos were more likely to have used private health care providers but less likely to be HIV positive and to be offered HIV testing. During 2008–2013, the average Filipino TB rate was 44.4 per 100,000 persons compared to 3.5 overall U.S. TB rate; of 4,753 Filipino patients, 586 (12%) were healthcare workers. The persistently high TB rate among Filipinos indicates that innovative TB control strategies should be accelerated for this population. Healthcare providers should be vigilant in prompt diagnosis, initiation, and completion of appropriate TB treatment. Demonstration projects designed to evaluate the effectiveness of targeted prevention in local Filipino communities, especially among healthcare workers, should also be implemented.

**R-02
THE EXPERIENCES OF FILIPINO-AMERICAN MEN IN NURSING EDUCATION.**

Julie Kientz Elting, EdD, MSN, APRN, CNE, Hawai'i Pacific University

There is a call for professional nursing to increase diversity in gender, race, and ethnicity. Nursing education has responded and 30% of undergraduate students identify as a racial or ethnic minority and 11% are men (AACN, 2014). A small, but growing, body of research communicates the experience of men in nursing education but the voices of minority men are not well represented. The purpose of this qualitative, phenomenological study was to explore the educational experiences of Filipino-American men in undergraduate nursing. Four male Filipino-American senior nursing students in an urban undergraduate nursing program volunteered to participate in a semi-structured group interview. Questions elicited responses regarding the men's career motivations, perceptions of gender in nursing, and experiences related to gender in their educations. This study found the men's nursing career choice was influenced by family members, particularly strong female role models in the nursing profession, thus rejecting feminine stereotypes of nurses. They believed the high value placed on family and community fosters a caring ethic in both genders in the Filipino culture, making nursing a common career choice for men and women. They generally enjoyed and embraced their minority status as men in the program, viewing their physical strength, youth, and perspective as an asset. They saw themselves as less studious than female students, but not less capable. They highly valued their sense of camaraderie and would have appreciated more male faculty in the nursing program. As men, they believed that criticism by female faculty in front of others, especially patients, was a blow to their pride and interfered with learning. Although this was a small, nonrandom sample this study provided insight into the perceptions of these nursing students. These data can assist faculty in creating a positive, culturally informed educational experience for Filipino-American men and other diverse student populations.

**R-03
CASE STUDY: IMPLEMENTATION OF ELECTRONIC HEALTH RECORD USING ROGER'S DIFFUSION OF INNOVATION.**

Rosario P. Estrada, DNP, RN-BC, CPN, Rutgers University, School of Nursing

Objective. The objective of this project is to construct a case study research to gain insight on how implementation of an electronic health record (EHR) is diffused and adopted across nursing units.

Significance and Background. In 1999, the Institute of Medicine reports that “at least 44,000 people “and perhaps as many as “98,000” die in the hospital each year as a result of medical errors that could have been prevented. The IOM has identified six goals to adopt electronic health records:

safety, effectiveness, patient-centeredness, timeliness, efficiency and equity.

Purpose. The purpose of this case study is to examine the effect of the use of an EHRs on nurses attitudes and users satisfaction before and after system implementation, thus, promoting EHR adoption that supports patient safety, improves quality care, and patient outcome. Rogers's Innovation-Diffusion Theory was used to guide the implementation of this technological innovation.

Methods and Analysis. Multiple methods were used to promote rigor and methodological triangulation of the case study. Survey questionnaires, interview, time and motion study, and documentary data were collected and analyzed, thematically, and/or statistically. Data were reduced to conceptual groups so that conclusions could be derived and a case description was developed.

Findings and Implications. There were no statistically significant findings on the paired samples T-test comparing pre and post mean scores on the attitude scale, $t=1.938$, $p=.094$ (sig. 2-tailed). Results of the 2-tailed Pearson correlation set up at the level of significance of $p=.01$ to $.05$ revealed (2) statistically significant findings: Years of work as a nurse and years worked at this hospital were moderately correlated with mean scores on the attitude scale pre and post-implementation ($r=.739$ and $r=.786$ respectively, at $p=.05$). Results of this case study will be valuable to streamline EHR, improve nursing workflow, and develop/plan effective implementation strategies in the diffusion of the EHR hospital wide. Staff involvement, training and management support are essential in the planning and implementation process. Overall, nurses' experiences were positive. Successful implementation of EHR may allow for substantial improvement in the use of nurses time, patient safety, quality of patient care/outcome and cost savings for the organization.

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Promoting Health Literacy through “Ask Me 3™”

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Conflict of Interest

The authors declare that there is
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Abstract

Introduction: Low health literacy is a significant community health problem associated with poor health outcomes. Approximately 80 million American adults have limited health literacy, with rates higher among vulnerable populations.

Objective: To improve health literacy, the National Patient Safety Foundation (NPSF) developed the “Ask Me 3™” program. The program uses a simple communication tool where patients are encouraged to ask their healthcare provider three simple questions: 1) What is my main problem?; 2) What do I need to do?; and 3) Why is it important for me to do this?

Method: This study assessed the knowledge of the Ask Me 3™ program and likelihood to use the three questions among individuals attending health screenings.

Results: Health screening participants (N= 280) were surveyed on their knowledge of the program and level of comfort in using the questions. They were also provided a copy of the Ask Me 3™ tool. Majority of the participants (95%) were unaware of the Ask Me 3™ program. However, more than 97% reported comfort on using the questions. Follow-up revealed that those who used the tool found it a helpful reminder and a facilitator of communication between the patient and the healthcare provider.

Conclusion: The results suggest that the Ask Me 3™ program is not known in the community. Where used, the Ask Me 3™ questions promoted communication between patient and healthcare provider. The Ask Me 3™ program should be disseminated in avenues where healthcare interactions take place especially among vulnerable populations.

Keywords: Health literacy promotion, Ask Me 3™, patient-provider communication, community health screening

Introduction

Health literacy refers to the “degree to which individuals can obtain, process, and understand the basic health information and services they need to make appropriate health decisions” (US Department of Health and Human Services, USDHHS, 2000). It includes skills necessary for people to function effectively in the health care environment and act appropriately on health care information (Berkman et al., 2011). These skills include the ability to interpret documents, read and write prose (print literacy), use quantitative information (numeracy), and speak and listen effectively (oral literacy). Health literacy requires knowledge of health topics. People with limited health literacy often lack knowledge or have misinformation about the body as well as the nature and causes of diseases. Without this knowledge, they may not understand the relationship between lifestyle factors such as diet and exercise and various health outcomes. Limited health literacy also affects people’s ability to navigate the healthcare system (including filling out complex forms and locating providers and services), share personal information with providers (such as health history), engage in self-care and chronic-disease management, and understand mathematical concepts such as probability and risks (Berkman et al., 2011).

Low health literacy is a significant problem in the United States (US). The 2003 National Assessment of Adult Literacy reported that 36% of the adult population of the US (approximately 80 million adults) had limited health literacy (Johnston et al., 2006). The rates of limited health literacy vary across populations. The rates were higher among vulnerable populations such as the elderly, minorities, individuals who have not completed high school, adults who spoke a language other than English before starting school, and people living in poverty (Johnston et al., 2006). Several studies have also shown the relationship between low health literacy and poor health outcomes. Differences in health literacy level have been consistently associated with increased hospitalizations, greater emergency care use, lower use of mammography or receipt of influenza vaccine, poorer ability to interpret labels and health messages, and, among seniors, poorer overall health status and higher mortality (Berkman et al., 2011). Given the burden of low health literacy and the potential to reduce poor outcomes, several national organizations have called for action including the US Department of Health and Human Services (DHHS), the Institute of Medicine (IOM), American Medical Association (AMA) and National Institutes of Health (NIH). The US DHHS created the Healthy People initiative to set nationwide objectives every 10 years to outline health improvement priorities, to increase public awareness of important issues and to provide measurable objectives for researching these issues. One of the goals of Healthy People 2020 is to improve communication between patients with low health literacy and healthcare providers through

the use of easy-to-understand patient instructions (Healthy People, n.d.). The NIH (2014) has promoted health literacy as a research priority. The Joint Commission has reported that effective communication is the cornerstone of patient safety (2014; 2007). Many of the National Patient Safety Goals are created to protect patients with low health literacy (The Joint Commission, 2014).

Individual and systemic factors influence health literacy. Individual factors may include, communication skills and knowledge of health topics of lay persons and professionals. Systemic factors may include culture, healthcare and public health systems demands, and demands of the situation or context (US DHHS, 2000). One approach to improve communication between patients and their clinicians is the “Ask Me 3™” campaign promoted by the National Patient Safety Foundation or NPSF (2013). The Ask Me 3™ is a patient education program designed to improve patient and health care provider communication, encourage patients to become active members of the health care team, and promote improved health outcomes (NPSF, 2013). The program encourages patients to ask their healthcare providers three simple questions: 1) *What is my main problem?;* 2) *What do I need to do?;* and 3) *Why is it important for me to do this?.* According to NPSF (2013), patients who understand health instructions make fewer mistakes when taking their medicine or in the preparation for a medical procedure thereby getting well sooner or are more able to manage a chronic health condition. Communication between the patient and practitioner can also reduce potential errors and promote patient safety. Singh and colleagues (2013) reported that most of the errors in the primary care setting are related to communication process breakdown in the patient-practitioner clinical encounter.

Although the Ask Me 3™ is supported by numerous professional organizations, there is limited research on the extent of its nationwide dissemination. Further, there is limited evidence on whether the Ask Me 3™ can facilitate communication between the patient and/or family and their healthcare providers. Mika and colleagues (2007) reported that a passive implementation of the Ask Me 3™ program in a pediatric practice predominantly serving low-income Hispanic clientele helped the parents remember to ask questions and know what questions to ask. The Wisconsin Collaborative for Healthcare Quality and the Department of Health Services of the State of Wisconsin (2010) conducted a collaborative Ask Me 3™ pilot project among health centers. The pilot program encouraged patients to ask questions, improved communication of the patients with the health care professional, and increased patient satisfaction with the visit. A study among African American patients in Michigan concluded that the Ask Me 3™ pamphlet is an easily implemented low-cost method to help patients increase participation in the physician-patient interaction (Michalopoulos

lou et al., 2010). The patients reported higher satisfaction and found the questions helpful in learning more about their medical condition or illness in their visit to the doctor.

The Ask Me 3™ program also improved health communication of patients with other health care professionals. Miller and colleagues (2008) assessed the effects of the Ask Me 3™ program in terms of the health communication of community-dwelling elders with their pharmacists. Following the Ask Me 3™ program, a significantly higher proportion of participants reported planning to or actively bringing a list of current medications when visiting the pharmacist. These studies provide evidence to support for the use of Ask Me 3™ program. Therefore, the program should be adapted in all settings where patient and healthcare provider interactions take place.

This study assessed the awareness of community members attending health screening activities at festivals organized by and for minority populations in South Texas of the Ask Me 3™. It also assessed whether the surveyed health screening participants would be comfortable in asking Ask Me 3™ questions at their next healthcare visit.

Methods

Setting

Data from this study were collected from attendees of the Asian Festival and Texas Folklife Festival, sponsored and organized by the Institute of Texan Cultures (ITC) of The University of Texas Health at San Antonio. The Asian Festival coincides with the celebration of the Chinese New Year, which includes showcasing the culture and traditions of Asian communities in South Texas (ITC, 2014). The Texas Folklife Festival, inaugurated in 1972 and modeled after the Smithsonian's Folklife Festival in 1968, celebrates the rich and colorful heritage of more than forty cultural community groups in Texas (ITC, 2014).

Procedures

The International Nursing Students Association (INSA) of the School of Nursing, University of Texas Health Science Center at San Antonio organized the health screenings. Faculty and student volunteers conducted the health screenings, which were available to any festival attendee. Each free screening was advertised as part the festival program. Community participants interested in being screened were informed of the services provided and consents were obtained. Demographics and relevant health history were collected followed by determination of body mass index (BMI) and measurements of blood pressure, blood glucose and total cholesterol. Following the screening, the patient data gathered determined the appropriate health education provided along with information about the Ask Me 3™ program. The health screening participants were asked whether they had heard about the Ask Me 3™ program. They then received

a description of the program and its components including the 3 simple questions: 1) *What is my main problem?*; 2) *What do I need to do?*; and 3) *Why is it important for me to do this?*. They were encouraged to use these questions at future health provider (i.e., doctors, nurses, and pharmacists) interactions. Subsequently, the participants were asked whether they would be comfortable in asking these questions at their next healthcare visit. If they answered no, the reasons were explored and further education was provided. At the completion of the screening and health education, each participant was provided a small wallet sized copy of the Ask Me 3™. They were encouraged to keep the copy in their wallet and use it as a reminder for what questions to ask at their next healthcare provider visit. The participants were also given a choice to provide their phone number if they wanted a follow-up call three months after the health screening. The follow-up call asked the patient if: 1) there were changes to their health; and 2) they have used the Ask Me 3™ questions at their health provider visit.

The application for approval for the publication of the data from this health screening was assessed by the Institutional Review Board of the University of Texas Health Science Center at San Antonio as health surveillance.

Data Analysis

Data from the Texas Folklife Festival and the Asian Festival health screenings in 2013 and 2014 were initially analyzed separately for descriptive statistics. The results were comparable. All data from both health screenings were then merged for summative descriptive statistics.

Results

Participants

Two hundred and eighty (N = 280) community members participated in the health screening. Table 1 shows the summary of the demographics of participants. The participants were mostly female and married, with a mean age of 45 years old. Most of the participants were Hispanic (37%) followed by Caucasians (24%), Asians (20%), African American (8%) and Native Americans (2%). Majority of the participants have their own health insurance (67.85%) and primary care provider (66.07%). Fifteen percent (15%) reported to smoke, while 10.36% reported drinking alcohol on average of 1.49 glasses per day. The mean of the participants' health screening values were: BMI = 26.98; systolic blood pressure = 125.54 mmHg; diastolic blood pressure = 78.18 mmHg; blood glucose = 114.04 mg/dl; and blood cholesterol = 171.75 mg/dl. Table 2 shows the summary of the health screening data.

Table 1. Demographics and health profile data of health screening participants who received the Ask Me 3™ health education and completed the survey.

Demographics	Number	Percent
Gender		
Male	127	45.36
Female	153	54.64
Race		
African American	23	8.21
Asian	57	20.36
Caucasian	67	23.93
Hispanic	103	36.79
Native American	5	1.79
Not known	25	8.92
Marital Status		
Single	102	36.43
Married	124	44.29
Divorced	19	6.79
Not known	35	12.5
Age (years)		
19 and below	21	7.47
20-29	36	12.81
30-39	40	14.23
40-49	36	12.81
50-59	55	19.57
60-69	30	10.58
70-79	15	5.34
80 and above	9	3.20
Smoking		
Yes	29	10.36
No	271	96.79
Alcohol Consumption		
Yes	98	35
No	182	65

Table 2. Health screening data (mean and range) of health screening participants.

Health Screening	Mean	Range
Body Mass Index	26.98	18-48
Systolic Blood Pressure (mmHg)	125.54	72-220
Diastolic Blood Pressure (mmHg)	78.18	59-121
Blood Glucose (mg/dL)	113.98	35-367
Blood Cholesterol (mg/dL)	171.75	100-310

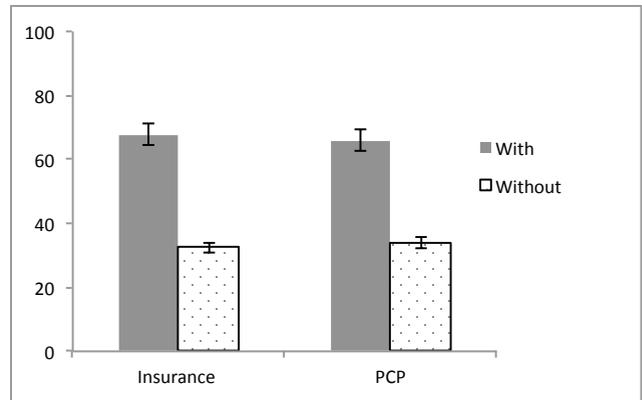


Figure 1. Percentage of participants with or without health insurance and primary care provider as per self-report. While majority of the participants have health insurance and a primary care provider, 32.14% did not have health insurance and 33.92% had no primary care provider.

Ask Me 3™ Campaign

Majority (95%) of participants reported that they are unaware of the Ask Me 3™ Program. When asked if they feel comfortable about asking the three simple questions at their healthcare visits, the majority said that they felt comfortable, with asking the following: 1) *What is my main problem* (97.86%); 2) *What do I need to do?* (97.14%); and 3) *Why is it important for me to do this?* (97.14%). Hence, less than 3% felt that they would be uncomfortable using the Ask Me 3™ questions. Health education was provided to these participants to highlight the importance of understanding their condition and what they could do about it. Three participants (1%) refused to participate in the Ask Me 3™ survey due to the lack of time.

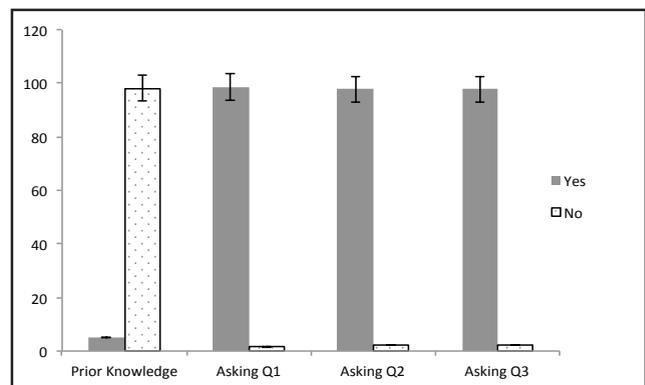


Figure 2. Percentage of participants' prior knowledge of the Ask Me 3™ campaign and expressed comfort to use the Ask Me 3™ questions (Q): Q1) What is my main problem?; Q2) What do I need to do?; and Q3) Why is it important for me to do this? Majority (98.18%) of the participants have no prior knowledge of the Ask Me 3™ campaign and the questions. Following health education, more than 97% of the participants expressed comfort in using the questions during interactions with healthcare providers.

Follow-up

Eighty-three community participants (29.64%) voluntarily provided their telephone number for a follow-up call three months after the health screening. Twenty-three (27.71%) were successfully reached. Of those reached, 39.13% had seen their healthcare provider. One hundred percent (100%) reported having used the Ask Me 3™ questions and found it helpful by “reminding them of what questions to ask”, “made asking questions easier” and “giving them some structure of the communication with their healthcare provider”.

Discussion

Despite the support and promotion of the national entities, only 5% of the attendees of South Texas festivals organized by and for minority populations know about the Ask Me 3™ program. However, following description of the Ask Me 3™, more than 96% of the surveyed participants expressed that they would be comfortable in using the Ask Me 3™ questions. The participants who used the Ask Me 3™ questions at their healthcare visits appreciated how the tool reminded them of aspects to ask. They also reported that the questions facilitated communication between themselves and their respective healthcare provider. This study shows that the Ask Me 3™ program can be promoted and disseminated through community-based activities especially those that involve minority populations.

Poor health literacy is a significant community health issue that is associated with poor health outcomes (Johnston et al., 2006). Poor health literacy is also higher among vulnerable populations such as the elderly, minorities, individuals who have not completed high school, adults who spoke a language other than English before starting school, and people living in poverty (Johnston et al., 2006). Participants of this study were mainly Hispanic (37%), although there were also Caucasians (20%) and Asians (24%). While majority (65%) had health insurance, 32% indicated that they did not have any form of health insurance. About 34% of the participants indicated that they had no primary care provider. Their profile (Table 1) and health scores (Table 2) indicate that these individuals are vulnerable. Interestingly, only 5% knew about the Ask Me 3™ program. Thus, the health education on the Ask Me 3™ is a much needed intervention to help improve health literacy in this population.

The Ask Me 3™ program has already been shown to be an effective, simple, and easy to remember tool in increasing health literacy among minority populations (Mika et al., 2007; Michalopoulou et al., 2010). The questions are basic enough that patients can be comfortable asking their clinician, yet they are clear enough to provide patient understanding of their diagnosis, prescription, and instructions

for taking medication. Data from this study support previous studies which showed that the Ask Me 3™ program is a simple approach to facilitate communication between patients and physicians (Mika et al., 2007). Patients were generally willing to share their concerns during medical visits and wanted to know about proposed treatments and procedures (WCHQ and State of Wisconsin DHS, 2010). Similar to the results of this study, the Ask Me 3™ program was found to be a good tool for helping patients remember what questions to ask, as reported by staff at Wisconsin health centers. Interestingly, the staff also reported that they have used the three Ask Me 3™ questions in their own medical visits. They also reported that the implementation of the Ask Me 3™ program increased awareness of issues associated low literacy.

The Ask Me 3™ program was successfully implemented in a pediatric practice that serves predominantly low-income, minority clientele (Mika et al., 2007). A nonaggressive implementation strategy (i.e., posters and brochures) resulted in nearly half of the parents being aware of the Ask Me 3™ program. More importantly, half of those parents used the questions during interactions with their child’s physicians. Mika and colleagues (2007) suggested that more aggressive implementation of the program would result in more parents being aware of the program and using the questions. The dissemination of the Ask Me 3™ program should be more aggressive and widespread. The statewide implementation of the Ask Me 3™ program in several health centers of Wisconsin is an approach that should be emulated. This study shows that the dissemination of the Ask Me 3™ program to the general community, especially minority populations, resulted not only on increase in knowledge but also the use of the Ask Me 3™ questions. More importantly, it facilitated communication between patient and healthcare provider. Partnership with local programs and activities was an essential component of this approach towards improving health literacy among minority populations.

Low income and minority-group members often lack a sense of self-empowerment in healthcare settings and cultural norms argue against questioning of authority (Michalopoulou et al., 2010). However, research shows that improving empowerment through a variety of approaches can improve health care and health outcomes (Findley et al., 2004; May et al., 1995; Mika et al., 2007; Sakisian et al., 2005; Valdez et al., 2002). The Ask Me 3™ is a low cost method to help improve patient-provider communication and also a platform for self-empowerment on healthcare issues as it provides the questions to ask.

Effective communication is a critical component of the patient-provider relationship (Gutierrez et al., 2014). Shared decision making between providers and patients can improve patient outcomes, particularly among patients with

chronic diseases (Judson et al., 2013; Schillinger et al., 2003; Stewart, 1995). This process requires more than just the provider verbally giving a patient a diagnosis and treatment plan. It includes an interactive exchange between the provider and patient to empower patients to ask questions and make shared decisions about their health (Judson et al., 2013; Ong et al., 1995). The Ask Me 3™ questions can be a useful tool in this process as it can provide patients with the questions to ask relevant to the information given by the provider.

Strengths and Limitations

Conducting a health literacy promotion initiated in conjunction with health screening in cultural minority festivities allowed access to a number of individuals in one given activity. This health surveillance provided the participants information about their health scores while at the same time providing tools to improve health in a more relaxed atmosphere. The health screening was conducted free of cost, and thus relieved participants of the financial burden related to participation. As sometimes expressed during the health screening, the health screening provided has become an important resource to those who do not have access to healthcare.

This study has some limitations. The sample population was limited to festival attendees who chose to participate in the free health screening, which was a small fraction of all festival attendees. Inherent in a convenience sampling is the possibility of bias. Our sample population may be biased to individuals who have healthcare access issues or individuals who are interested in knowing their health numbers. Nevertheless, it was insightful on how these individuals were unaware of the Ask Me 3™, and how they seemed to be receptive to using the tool.

Only a fraction of those screened agreed for the follow-up phone call, which limited us in fully determining the impact of the health literacy promotion. While most participants expressed interest and comfort in using the Ask Me 3™ questions, it is not known if this really translated into a behavioral change to promote their knowledge of their condition, what they have to do and why is it relevant for them to adhere to the recommendations. At yet another level, it is not known whether this improved knowledge translated into health activities that are relevant to their condition and adherence to medical recommendations, where appropriate. Longitudinal studies that examine the impact of the use of Ask Me 3™ on healthcare knowledge and behavior change as well as long-term outcomes would test the relevance of this program to the health of the community.

Conclusion

In conclusion, Ask Me 3™ program provides three simple easy to remember questions that patients can ask their

healthcare providers to improve health literacy and communication. Nationwide dissemination of this program must be supported at all levels of healthcare where patient and provider interaction occurs. The healthcare community can avail of the resources from the National Patient Safety Foundation aimed at improving patient-provider communication through the Ask Me 3™ program (see <http://www.npsf.org/for-healthcare-professionals/programs/ask-me-3/>).

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Transition of Care of HIV-infected Adolescent Patients to Primary Care in South Texas: A Pilot Study

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Conflict of Interest

The author declares that there is no conflict of interest.

Abstract

Introduction: Transition from child to adult-centered health care is an inevitable process that all pediatric patients must navigate to continue care. Little is known about transition services of youth who are HIV-infected. Adolescents living with HIV/AIDS need flexibility in their care. There is a lack of programs geared toward adolescents who are HIV-infected or living with HIV/AIDS. There is a need to explore the experience of adolescents during the transition period.

Objective: The purpose of this pilot study was to explore the experience of HIV-infected adolescent patients as they transition to adult-centered care and describe the factors that affect the transition process from the adolescent's perspective.

Methods: This study used a qualitative descriptive approach to recruit and collect data from nine adolescents who were HIV-infected. Semi-structured interviews were done using open-ended questions. Conventional content analysis was used to code the interviews.

Results: Two themes emerged from the data to describe the experiences of HIV-infected adolescents' transition from pediatric to adult care and to describe factors that might influence the transition processes. The major themes that emerged from the conventional data analysis were, *It changed my life* and *I have to start all over*. Several subcategories emerged within the two broad themes. Conclusions: Transition planning should be a standard practice in providing health care to HIV-infected adolescents. Nurses can play a role in the transition process by developing adolescents' friendly communication strategies.

Key words: Transition, care, HIV-infection, adolescents, qualitative

Background and Significance

Adolescents and young adults are at increased risk for HIV infection. Since the Acquired Immunodeficiency Syndrome [AIDS] epidemic in 1981, there are nearly 39,035 adolescents who have been diagnosed and living with Human Immunodeficiency Virus [HIV]/AIDS by the end of 2010 in the United States. Minority adolescents are disproportionately affected. The majority of adolescents acquire HIV infection through sexual contact (Centers for Disease Control and Prevention [CDC], 2012). Adolescence is a transition period regardless of the health status of the individual. Young people face many developmental challenges such as personal identity, sexuality, education, and vocational choices. The choices they make maybe influenced by physical or mental abilities, forced independence, and perceived prognosis. Transition from child to adult-centered health care is an inevitable process that all pediatric patients must navigate to continue care. The challenge is to have the adolescent and young adult transition to adult care in a seamless manner without dropping out and returning to seek medical care when the disease has progressed or a major medical crisis is encountered.

Adolescence is defined as the period between childhood and adulthood (Maturro, Powell, Major-Wilson, Sanchez, De Santis, & Friedman, 2011). Due to the changing views of this developmental period, the CDC has extended this developmental adolescent or youth period to 24 years (CDC, 2008). Transition is defined as the purposeful, planned movement of adolescents and young adults with chronic medical conditions from a child-centered to an adult-centered health care system (Blum et al., 1993). Many youth have problems transitioning to adult medical care, while adjusting to adult responsibilities and life. Transition services can help smooth some of the processes to avoid gaps in health care (Lotstein et al., 2009).

Little is known about transition services of youth who are HIV-infected. Limited research has been done to look at HIV-infected adolescents' transition from pediatric to adult care. The literature suggests that transition should begin as early as possible after diagnosis, depending on the developmental readiness of the adolescent (Alpay, 2009). Many barriers to transition have been identified, such as lack of coordination between the pediatric and adult units, problems related to parents, resistance of families or the patient, and lack of planning or institutional support (Committee on Pediatric AIDS, 2013; Vijayan, Benin, Wagner, Romano, & Andiman, 2009; Wiener, Kohrt, Battles, & Pao, 2009). The purpose of this pilot study was to explore the experience of HIV-infected adolescent patients as they transition to adult-centered care. This was a qualitative descriptive study. Nine HIV-infected adolescents were recruited to share their transition experiences.

Literature review

Adolescents living with HIV/AIDS need flexibility in their care. Adolescents are very vulnerable because they are dealing with multiple issues such as safer sex choices, disclosure of HIV status to partners, early experiences of loss in the family, constant struggle with possibility of severe illness, and/or death, and exposure to discrimination and prejudice (Machado, Succi & Turato, 2010).

In the review of literature on transitions of adolescents living with HIV/AIDS to adult-oriented care, Machado and colleagues (2010) provided many examples of transitions from pediatric subspecialties that manage chronic conditions such as cystic fibrosis, asthma, sickle anemia, various endocrine, heart conditions, cancer and post-transplant care, as well with pediatric patients with special needs. However, few have focused on the transition of HIV-infected adolescents.

Weiner, Zobel, Battles, and Ryder (2007) described an intervention study with a sample of HIV-infected adolescents who were enrolled in a National Institutes of Health (NIH) Clinical Research Program planned for closure within a year. Thirty-nine parent-caregiver dyads and 12 adolescents/young adults ages eighteen and older participated in the transition readiness program. They each completed two sets of identical interviews within an average of 6.8 months apart; the first was when they were informed of the clinic closure (T1) and the second was on the last clinic visit prior to the program closing (T2). The participants completed the Transition Readiness Scale and the State portion of the State/Trait Anxiety Inventory for Adults (Spielberger, 1983). Paired sample t-tests were completed to compare readiness and state anxiety scores between T1 and T2. The mean transition readiness scores increased significantly between T1 and T2 ($t=7.5$, $df=50$, $p<.001$) and state anxiety scores decreased significantly ($t=2.5$, $df=49$, $p<.05$). Readiness was negatively correlated to state anxiety ($r= -.35$, $p<.05$) and the relationship was no longer significant at T2. Before the participants enrolled in the transition readiness program, the readiness scores were negatively correlated with the number of years they had been receiving treatment at the NIH ($r= -.32$, $p<.01$). After participation in the transition readiness program, there was no significant relationship between the readiness scores and number of years enrolled at NIH clinical research program. In patients who were transitioning, there were no significant differences in the levels of readiness or the state anxiety. However, participants who had no confidence in their home provider had significantly lower readiness scores at both T1 ($t=4.1$, $df=49$, $p<.001$) and T2 ($t=3.4$, $df=49$, $p=.001$). The researchers found that poor transition readiness was associated with higher levels of anxiety, greater number of years enrolled in the NIH treatment program, and lack of confidence in the home provider but not with the degree of severity of the disease.

Vijayan and colleagues (2009), in a qualitative study, interviewed 18 adolescents, 15 parents, and 9 pediatric health care providers in which they identified challenges in caring for young people and barriers when they transitioned to adult health services. The challenges included treatment adherence, sexuality, and disorganized social environments. Potential barriers to inadequate transition identified in the study included lack of autonomy, negative perceptions or experiences of HIV/AIDS, and difficulty letting go of the relationship between pediatric providers and families. These issues created barriers for many adolescents who were transitioning to adult-oriented health care systems. Many adolescents were found reluctant to talk about HIV. Mauro et al., (2011) described the development of a protocol for transitioning adolescents with HIV infection to adult care. The protocol was developed at a university-based clinic in Miami by a multidisciplinary team of adolescent HIV-care providers at the Specialty Adolescent Clinic (SAC). The authors described the “Movin’ Out” transition protocol, which addressed two issues: (a) the number of HIV-infected adolescents currently in the care of pediatric or adolescent providers at the SAC who required inpatient services were often hospitalized on adult units, and (b) there was a need to address the high attrition rates for adolescents after they were transferred to adult services. The iterative process led to the development of a five phase transition model, including (a) discussing transition with clients pre-identified by age 23, (b) introducing the client at age 24 to adult infectious disease provider at SAC, (c) making the client’s next 3-month routine appointment with adult infectious disease physician but held at SAC, (d) first visit with adult infectious disease physician accompanied by a peer educator or a social worker, and (e) follow up session at 1 year conducted between the client and the psychosocial team. Follow up revealed that barriers to transition still existed.

Gilliam, Ellen, Leonard, Kinsman, Jevitt, and Straub (2010) discussed the characteristics and current practices surrounding the transition of adolescents from the clinics of Adolescent Trials Network [ATN] for HIV/AIDS interventions to adult care medical care. The authors interviewed 19 key site informants from 14 ATN clinic sites. Findings revealed that the concept of transition was not well defined across all the participating centers, and transition was viewed as a process. There was also a lack of strategies to follow up with clients after they had transitioned to adult care.

Though some progress has been made in developing transition protocols for HIV-infected adolescents, there is a need to identify the transition experience of the adolescents involved. This can help in the development of delivery care systems that meet the needs of this vulnerable group. Transition in general is difficult. For HIV-infected adolescents, transition is a challenging process that has not been fully explored from the perspective of the adolescent. There

is a lack of programs geared toward adolescents who are HIV-infected or living with HIV/AIDS. There is a need to explore the experience of adolescents during the transition period. Programs that meet the health care of adolescents and young adults must be pilot tested, evaluated and more broadly implemented.

Methods

This pilot study used a qualitative descriptive approach, which allowed the researcher to obtain answers to questions that were relevant to adolescents’ transition from primary pediatric to adult care. Semi-structured interviews were done with each participant using open-ended questions. Probes were used to clarify participant’s comments and responses to questions. Conventional content analysis approach was used to code the interviews (Hsieh and Shannon, 2005). This approach helped the researcher to gain information from the study participants. It allowed for categories to develop from the data. The investigator used an interview guide with probe questions that were revised several times to collect data from participants. The interviews were tape-recorded and transcribed verbatim by a trained transcriptionist. The interviews took place in the participants’ home or in a private office at the clinic site. The investigator played the transcriptions back while reading the transcription notes to check for accuracy of the transcriptions. The participants completed a demographic tool after the completion of the interviews. The data collected from the demographic tool included name, age, ethnicity, relationship status, level education, employment status, income per month, and time since diagnosis. The investigator also kept field notes that were transcribed immediately after each interview. The Institutional Review Board (IRB) at the University of Texas Health Science Center at San Antonio approved the study. Pseudonyms were used to maintain the confidentiality of the study participants.

Participant Population

The target population for the study was HIV-infected adolescents age 13- 24 who used the Family Focused AIDS Clinical Treatment Services (FFACTS) clinic affiliated with a University Hospital. Recruitment of participants began when the adolescents called the toll-free phone number provided on the study flyers, which were posted on bulletin boards at the clinic site or when they contacted the investigator by email. The staff members and the investigator shared the flyers and word of mouth about the study with all adolescents’ and their parents who used the FFACTS clinic. The investigator returned all phone calls and used pre-screening questions to establish eligibility. For those less than 18 years of age, they were informed that the parent/guardian had to give consent for them to participate in the study. The investigator then scheduled for a one-to-one interview in a private location either at the participant’s home or in a private room at the HIV clinic site. Upon initial con-

tact with the HIV-infected adolescent and/or adolescent and the parent/guardian, the investigator continued to establish the eligibility by explaining purpose of the study.

The investigator had established some trust and respect with the participants and their parents/guardians through her work at the clinic site. On the day of the interview, the purpose of the study was reviewed with each participant and/or the participant and their parent/guardian. The investigator obtained informed consent from the participant and/or both the participant and parent/guardian for participants less than eighteen years of age before proceeding with the interview. Two copies of the informed consent forms were signed with the participant and/or participant and parent/guardian. The participant or participant dyad received the second copy of the consent form. The investigator recruited a convenient sample of nine adolescents who were HIV-infected to participate in the study. The IRB had approved the recruitment of ten participants for the pilot study but data saturation was reached with the nine study participants. The participants received a \$20 gift card for their time.

Inclusion Criteria and Exclusion Criteria

All HIV-infected adolescents between the ages of 13 and 24 were included. The participants spoke English because the investigator only spoke English. The interviews were done in English. All HIV-infected adults, non-English speaking adolescents were excluded from the study. The investigator sought to answer questions related to the transition experience of adolescents to adult-oriented care.

Data Collection

Semi-structured interviews were used to collect data. Two tape recorders were used concurrently to collect the data and a third tape recorder was available for backup in case of any equipment failure or malfunction. The investigator used an interview guide to collect the data from the participants. Probe questions were used and were revised frequently to generate data and fill in the gaps of the various developing categories. The interviews were all tape-recorded and transcribed verbatim by trained transcriptionist. The investigator played all the transcriptions back while reading the transcription notes to check for accuracy. The investigator also kept field notes that were transcribed immediately after each interview and these were included in the data analysis.

The interviews lasted 20-90 minutes but the exact time depended on the individual participant. The participants who were less than 18 years of age had the option to have their parent/guardian present in the room during the interview but none of the participants' parents stayed. Participants were informed that everything they shared was confidential and that they could stop the interview at any time without fear of repercussion from the investigator, staff or losing services at the clinic site.

Results

Nine adolescents who were HIV-infected participated in the study. Their ages ranged from 17-23 years, a mean of 19.55 years and a median of 19. Five of the participants (55.6%) were male and four (44.4%) were female. All of the male participants were Hispanic, three females were African American and one white. The largest number of adolescents in the study (n=5) reported making less than \$999 per month, two teens made between \$1000-\$2999, and two had no income. A variety of education levels were found among the participants in the study ranging from those who did not complete high school, three who were in high school and one was in a technical college. The number of years the adolescents were living with HIV infection ranged from less than 12 months to greater than 48 months. Two of the adolescents had HIV since birth.

Two themes emerged from the data to describe the experiences of HIV-infected adolescents' transition from pediatric to adult care and to describe factors that might influence the transition process. The major themes that emerged from the conventional data analysis were *It changed my life and I have to start all over*. Several subcategories or subthemes emerged within the two broad themes. *It changed my life* had three subcategories; *It is hard*, *Taking care of myself* and *Having support*. The second theme of *I have to start all over* had two subcategories; *Don't know the difference* and *It is personal*. The participants in the study described the HIV-experience as a life-changing process. HIV infection placed them on a journey of dealing and coping with depression immediately following the diagnosis to living with HIV and looking forward to the future. All the participants in the study had to make a transition to having inner strength and seeking support to live with HIV infection.

It Changed my Life

The diagnosis of HIV-infection changed the way the adolescents lived their lives. All the participants in the study described how the experience of the diagnosis of HIV had changed them. Abby said "*It changed my life from the person that I used to be to the person I am today.*" Devon further added:

"Life changing as in I had to grow up quick because it's a situation that is serious and you just have to be responsible about it. So I guess life changing in a way is that I had to grow up real quick and you know be responsible."

Some participants in the study feared being isolated and

treated differently but later realized this was not the case as Devon explained:

“Um...I used to be scared at first but once getting treated it’s completely different. And it’s not as scary as what it seems. It’s just another you know...disease. And thank God that there’s...there’s meds. So it can be life changing but at the same time it’s doesn’t have to be difficult...so that’s one thing.”

One participant identified that HIV infection had made a permanent change in his life but he was still committed to living his life. Glen stated: *“It’s going to change my life because I’m going to have to take medication until the day I die. But that’s it. Everything else is going to be the same.”* Another aspect of the change was that participants in the study verbalized they had to grow up fast. HIV infection had significantly impacted their life. Hanzila felt that

“It’s put a big impact on my life. It’s a big heavy set on my shoulders. I mean some people can say...oh I fine with living with HIV. It’s been...it’s been four years going on five years. It changed me in my self-esteem...changed. I don’t know I...I have to grow up fast. So I didn’t really...I guess it was a big step for responsibility cause you know keeping up with my medicines.”

Three of the female participants in this study described how the HIV infection changed their lives, way of thinking, and relationships with others especially men. Hanzila explained: *“I don’t know how to say...it changed me. Like I guess it just...it just changed the way I think about things. It changed the way...how I think about men or how I think about you know other females that have it or...”*

Within the theme *It changed my life*, there were three sub-categories as to how the experience of HIV-infection had changed the participants’ view of living with a chronic illness. These categories were *It is hard*, *Taking care of myself* and *Having support*. Living with HIV was very hard for all the participants in the study but many sought health care and support from their family, friends, and health care providers to take care of themselves. Though it was life changing in some ways, HIV empowered the participants to take care of themselves and view life differently. Glen summed it up this way:

“A different perspective on life is because I used to apparently think people with this disease...I used to think different about it. I would probably...I wasn’t as knowledgeable as I am now. And I didn’t really understand what it was and now I do.”

Glen further added:

“I have a different perspective on life because a lot of things have to change now. Cause I was planning on going on to the military but because I’m HIV positive I won’t be able to. So then now I just pick a different career and keep on going.”

It is Hard

Devon felt at first his life was over *“and it is hard thinking that it’s over”* yet even at such low moments of the adolescents life, they felt they can make it in life as Hanzila stated:

“I don’t want this to...like how you say it...take over my life. I don’t want it...you know take over my life... I don’t...I really don’t know how to explain it. It’s just hard...it’s hard for me. I was 15 when I found out and...on my birthday...15th birthday. I was in juvenile. And that was the worst place to find out...you know what I’m saying. So it was...it was hard...it’s hard for me. It’s hard.”

Abby further added: *“It’s...it gets hard when you feel like you can’t tell your family because you get scared of how they would act.”* The teens wondered whether living with HIV-infection would get easier. Inali stated: *“I hope this gets easier. I don’t want it to get any harder cause it’s hard enough...life is hard enough period.”*

Flash shared this on how hard living with HIV-infection was:

“Um...at first it was hard. I had...I don’t know like that was the main thing in my head. All the time...I mean I was going to school then. I mean I was going SAC and I couldn’t focus on anything. Like why am I taking this class? Like you’re going to die...you’re going to die. Why waste your time...like you’re going to die. But like a month later...a month and a half later like I got over it...like well you’re going to live. Like...like stop...stop what you’re doing or stop thinking the way you’re thinking and you know like do something with yourself.”

Taking Care of Myself

The participants’ experience of living with HIV was marked by various changes. The transition was marked by how hard living with HIV was. The participants focused on taking care of themselves; Abby said:

“If I’m not taking care of myself...and making sure that I’m ok then that’s just going to bring me down. So therefore I stay on top of my game with everything...my appointments...to school...to what I’m doing at home.”

The participants also wanted to live their lives and made ef-

forts to stay healthy. This desire motivated the participants to seek treatment and stay in care. Cody stated: *“I’m living my life. I’m mean like getting a job and wanting to better myself. And just staying positive as in keeping a good mindset.”* Flash thought of HIV infection as a blessing: *“God blessed me with something to like keep me moving or to like not worry about stuff like that. Just keep myself healthy and work at it. Like keep moving.”*

He further added:

“No cause I know I want to survive so I’m going to be looking for treatment. And I’m going to keep up my treatment. Because I’ve been doing so well so far compared to other people who have you know high viral levels. Right now I’m undetectable so I want to keep it at that. You know I want to keep living like stronger and healthier and longer.”

The participants identified part of the change in their lives was to get support to take care of themselves. All the participants in the study expressed a desire to live well despite the HIV infection. Devon stated: *“Taking care of myself. I guess myself as in you know...working out. Making sure that I’m physically healthy, eating...being consistent on my meds and also with seeing the doctor.”* They wanted to maintain a normal life and set some goals for themselves as Flash shared:

“What keeps me going is...like I want to graduate from college. And I want to see my nieces and nephews grow up and have them graduate. And I want to be successful so I’m taking a pill like to keep me alive basically. Those pills are keeping me alive...No cause I know I want to survive so I’m going to be looking for treatment. And I’m going to keep up my treatment. Because I’ve been doing so well so far compared to other people who have you know high viral levels. Right now I’m undetectable so I want to keep it at that. You know I want to keep living like stronger and healthier and longer.”

Some of the goals and perspectives on what their lives ought to be changed, but they shared they still could have a good life.

Having Support

The participants in the study were successful in making the transitions of life changes because of the support they received from three support systems: a) health care providers, b) their family, and c) friends. The pediatric providers and their team took time in assuring that the participants received what they needed to take care of themselves from the initial contact with them. Cody explained: *“I do remember finding out and having great people around and support*

from the people at the clinic. And then them referring me here and then from here...it’s a lot...it was a lot going on.” Devon confirmed this support by further adding: *“So I just remember seeing a lot of people filling out a lot of paperwork.”* The pediatric team had various resources to ensure the participants received the assistance they needed. This is what Devon had to say about the resources and support from the pediatric clinic:

“Coming to the clinic and you know them offering their services. In many ways to make sure that I am ok. So you know they offered me counselors. They offered me...I guess I was a...they gave me a case manager. So she made sure that I was well...you know...well rounded in all the situations...that if I needed anything that they were there. So just great support...they just made sure everything was going to plan and how everything is going to work. So then now that’s it’s easy I don’t really have to worry that much so...”

Flash added: *“So I just did some research and I found this place downstairs and I...or upstairs and they gave me all the support that I needed and told me where to go and what I needed to do...and stuff like that. So here I am like a year later or almost a year later...so...”*

Majority of the participants in the study had family support; only one participant had not disclosed his diagnosis to his family because of fear of rejection. The participants received and valued the support their families and friends offered as Devon put it: *“Well since the very beginning...since day one when I found out I told my families. So I had great support there. That in itself has helped me.”* Hanzila shared the same views: *“My support system. Really...it’s really my immediate family that’s my support system. All my other family we really don’t converse with about this.”* Family members got involved in the care of the adolescent and made sure they took their medication. Flash described his support system this way: *“But I think my family got me through it cause like they make sure I take my medicine. And they do like HIV jokes with me and I joke back. So I’m really open with them now than I was before. So that’s a really strong.”*

Some of the participants had friends and families have their support system. Abby’s support comprised of family, friends and others:

“My best friends...my girls. They’re there for me through thick or thin...my fiancé now...his mom and my sister. They are all my support system and they make sure I’m doing okay...check up on me...takes me out all the time. I have a lot of support from even...from one of the Dean’s...well actually 2 of the Deans’ at the school...they also support me. They make sure that my

health comes first before my school. I just make sure I have my notes. But they're very understanding. And they're not judgmental. And that's very helpful. And I tell them every day too...along with everybody else how thankful I am for them."

Two participants in the study had no consistent support system and they felt they had to depend on themselves. This is what Cody had to share about his support:

"Um...I lose people in and out. So I mean basically it's just myself. It's just myself. Like I can count on my aunts...I can count on my friends. But like they all let me down at one point or another...so like it's just myself. I just look for another person to like help me support for a moment..."

I Have to Start All Over

The second theme that emerged from the adolescent's description of the transition period was I have to start all over. This stage was marked by anxiety and uncertainty about the transition to the adult primary care. Flash provided the following observation about the transition process:

"Major concerns um...I would just like to keep the one on one you know that I have with my doctor. Like my doctor recently retired so you know as...I have to start all over ... So it's kind of like personal so I hope that like the doctor I do get is like you know good focus on me and you know call me by my first name all the time and joke around and stuff like that."

The participants' felt they had to discuss their illness from the beginning and they believed the care would not be the same. Evert wondered if the care was going to be the same as she simply stated: *"If they're...they're not going to be the same. So I have to explain. It will probably be harder. Well just telling them."* Within this theme there were two subcategories, *Don't know the difference* and *It is personal*.

Don't Know the Difference

The adolescents in this study did not know the difference between the pediatric and adult care and did not know when they will transition to adult care as Inali explained: *"Honestly I can't tell you. I don't know yet."* Adolescents described factors that would affect their transition to the adult primary care. These adolescents had to first transition to accepting the fact that they were HIV-infected, Devon put it well: *"I've been HIV positive since I was 18; so transitioning from high school to the real world I really don't know no other thing... I had to grow up quick..."* Though the participants were aware that the transition to adult-centered care would happen eventually and thought about it frequently, it was still difficult for the participants to accept the change. Devon said: *"think about it all the time. It's scary because*

it's something new."

The pediatric providers treated the adolescents as family. For some participants the providers were there when they needed them. Devon stated: *"I'm used you know... my doctor. And he's been there since the beginning so it almost feels like in a weird way like family."* He further added:

"Transition to a real...or not a real cause I have a real doctor but... To the big people. So you just think well what so...difference or what is it? Or what are they not providing that they're not providing here or...so I don't know...you know I really don't know."

The participants were concerned they will not receive the same care in the adult primary setting as Devon commented: *"there I feel I'm just going to be any other number..... so I guess it's just... it won't be... like a boutique feel. I think."* However some adolescents realized the transition was inevitable and to continue living healthy with HIV, they will have to seek care. Flash stated:

"No cause I know I want to survive so I'm going to be looking for treatment. And I'm going to keep up my treatment. Because I've been doing so well so far compared to other people who have you know high viral levels. Right now I'm undetectable so I want to keep it at that. You know I want to keep living like stronger and healthier and longer."

It is Personal

The participants perceived the adult doctors would not be as caring. Devon shared:

"I feel that I don't think it'll be as warm or inviting as...as the real doctors. So you know...and then I'm so used to you know...my doctor. And he's been there since the beginning so it almost feels like in a weird way like family. And now it's just like coming to...it's just like being another number because you're just among the many."

Glen also said: *"Well I have a...my only concern is if it's going to be the same type of care...if it's going to be the same. The same method I guess...the same feel...you know the same...I guess the same."*

The pediatric provider took time to offer support and information to the adolescent participants and they were not sure if this will be carried through to the adult primary care as Abby explained:

"She was like...my doctor was very open. She was very helpful with everything. She's done...build with a lot of patience like me so therefore she knows how to handle it. And

me...I'm easily...to get along with people so it don't take that long for that little scared to be out of the way."

Two participants had the same pediatric provider since they were born; Evert said: *"It's been ok. I've been knowing him since I was born so."* The adolescents had come to depend on their providers' concern, for both personal and illness related needs. The participants in this study felt the pediatric provider and team members were more personal and cared about them as individuals and not just clients with HIV. Abby explained: *"Of course my doctor was telling me well you can still do this and do that. And that's more helpful."* Flash added: *"Yeah...but not to like get attached. Like I don't want you to be my mom or have the doctor be my dad. I just want it to be like what's up Dr. Thomas...like I'm feeling fine today. I'm feeling great."*

All participants shared that the caring by the pediatric provider and team members motivated them to stay in care and there was mutual respect between the provider and the participant. The participants felt free to discuss their concerns with the pediatric provider. Hanzila shared this about her level of comfort with the provider:

"Everything cause I went there for everything. I'm talking for every little thing. And he was like...he was like dad to me. He has his daughter like 20 something years old. I respect them and...but Dr. Thomas was my favorite. He was my favorite cause I would...I guess cause I never had a male figure in my life."

The pediatric provider was a constant presence in the participants' lives because he was the only one who had provided the HIV care to majority of the participants since the time of their diagnosis. Participants had come to trust him and they believed he was fully vested in their lives. Hanzila explained:

"And for him to get after me like that...it...it was comfortable for me cause all of the other past relationships my mother been in...I never allowed them to tell me what to do. I never allowed them to you know...get in my business...never allowed...you know what I'm saying."

Discussion

The purpose of the study was to describe and explore the experience of HIV-infected adolescents' patients as they transitioned from pediatric care to adult-centered care and to describe the factors that affected the transition process from the adolescent's perspective. The nine participants in the study were under a pediatric care team in South Texas. Data analysis was done using conventional content analysis (Hsieh & Shannon, 2005) in which two major themes emerged: *It changed my life* and *I have to start over*. *It changed my life* had three subcategories or subthemes; *It*

is hard, *Taking care of myself* and *Having support* while *I have to start over* had two; *I don't know the difference* and *It is personal*.

The sample demographics mirrored the national trend in that minority adolescents aged 13 to 24 years are disproportionately affected by HIV-infection (Dowshen & D'Angelo, 2011). The majority of the participants in the study were Hispanic males 55.6% (5) which was representative of the population in South Texas. Nationally, the rate of HIV infection among Hispanic/Latino males was 3.1 times the rate for whites (CDC, 2012). Most of the new infections in Hispanic/Latino males were due to men who had sex with men, but this was not determined in this study (CDC, 2012).

The diagnosis of HIV-infection changed the way the adolescents in the current study lived their lives. It facilitated their maturation as one participant stated: *"I had to grow up quick because it is a situation that is serious and you have to be responsible."* These findings are similar to Doukkali, Winterling, Eriksson, Lampic, Hagstrom, and Weltergren (2013) who found that adolescents and young adults with cancer described their experience with cancer as having had a positive effect on their life; it had changed their values and priorities in their life and made them more mature. As with the current study, the participants became more responsible for their lives; keeping up with taking their medications, which is similar to the above study, in which the experience of having cancer motivated them to do well in school and to carry on with their lives.

In the current study, the participants described the experience of being HIV-infected as being hard. The hardest obstacle to overcome was disclosing to their loved ones about the HIV status. Disclosure was hard because of the stigma associated with HIV infection as reported in the literature (Boudreau & Fisher, 2012; Cervia, 2013; Hosek, Harper, Lemos & Martinez, 2008; Vijayan et al., 2009). Peer disclosure was hard for the HIV-infected adolescent and a source of stress (Hosek et al., 2008). In the current study, participants feared being rejected by their peers. Though living with HIV-infection was hard, the participants focused on taking care of themselves. One participant described having HIV-infection as a blessing so that he could keep moving on with his life and work at staying healthy.

The participants in the study received support from pediatric care team, family and friends. Weiner and colleagues (2009) also reported that the pediatric providers were intimate and personalized. Participants received assistance to complete the paperwork. The participants in the study believed they were successful in making the transitions in their lives because of the support they received. Unfortunately, one participant in the study had not disclosed to his family because of fear of rejection and therefore had not

received support from his family.

The pediatric team was considered as family for the participants in this study, which has strong evidence with the literature (Dowshen & D'Angelo, 2011; Gilliam, et al., 2011; Valenzuela et al., 2011; Vijayan et al., 2009). Two participants in the current study, who had been perinatally infected, had known their pediatric provider all their lives so transition to adult primary care was compared to loss of family. Similar findings were reported in the literature (Dowshen & D'Angelo, 2011; Gilliam, et al., 2011; Valenzuela et al., 2011; Weiner et al., 2009). Similar to Valenzuela and colleagues (2011), the current study also showed that adolescents had a strong connection with the pediatric care team. Vijayan and colleagues (2009), reported that adolescents described positive attributes of their pediatric providers, however, the adolescents felt the providers offered a non-pressured environment, which they felt the adult service would not provide the same type of care. Participants in the current study reported that the adult setting would not provide the "boutique" feel to their care.

The participants in this study were anxious and uncertain about starting over in the adult primary clinic because they had to build new relationships with the adult providers; other studies also reported the same concerns (Fair, Sullivan, Dizney, & Stackpole, 2012; Sharma, Willen, Garcia, & Sharma, 2014). The participants perceived differences in the care provisions between the pediatric and adult care systems and described it as not being personal relationship as reported in prior research work (Fair et al., 2012; Huang et al., 2011; Sharma et al., 2014). Participants in the current study reported that retelling of their life story, and medical history to new providers was going to be hard as they start over, which was similar to other findings (Fair, et al, 2012; Sharma et al., 2014; Valenzuela et al., 2011;). The participants in the current study reported that the emotional bonds with pediatric health providers' care were not possible to be replicated in the adult care settings and that would make the starting over more difficult.

The adolescents in the current study did not know the difference between pediatric and adult health care settings. Fair and colleagues (2012) reported that the adolescents were unable to articulate expectations of being transitioned to the adult care setting. Interestingly, Fair, Sullivan and Gatto (2011) reported that providers routinely introduced the topic of transition during adolescence. The difference in the findings could be the fact that there was no transition program at the clinic site where the participants for this study were recruited. Participants identified that adult care would be boring. They wanted to be informed of the differences between the pediatric and adult clinic as part of the recommendation for a smoother transition (Fair et al., 2012).

The loss of relationships with the pediatric clinic staff

that had taken care of them since time of their diagnosis or their entire lives is consistent with findings from previous work (Lotstein, McPherson, Strickland, & Newacheck, 2005; Lotstein et al., 2009). Participants referred to the pediatric team as family, similar to what has been reported in the literature (Dowshen & D'Angelo, 2011; Lotstein et al., 2005; Gilliam et al., 2010; Fair et al., 2012; Valenzuela et al., 2009). Vijayan and colleagues (2009) found that adolescents had positive attributes of their pediatric providers which could be assumed that the providers in the adult setting and adult care were thought of as not welcoming. The other challenge of the transition to adult care was that the adolescent participants perceived the adult care doctors would not be warm or inviting as the pediatric providers. Participants had strong emotional attachments with their pediatric providers, which were consistent with earlier research (Weiner et al. 2007; Valenzuela, et al., 2011).

Concerns for the continuity of care are similar to the findings in the literature (Dowshen & D'Angelo, 2011). Assistance to maintain continuity was one of the leading recommendations for transition improvement (Weiner, et al., 2009). HIV-infected adolescents face many similar challenges in transitioning to adult care as do youth with chronic health conditions (Ross, Camacho-Gonzalez, Henderson, Abanyie, & Chakraborty, 2010). The bond with pediatric providers is also common among adolescents with other chronic illness (Huang, et al., 2011). As with HIV-infected youth, youth with other chronic illnesses perceive differences in practice between pediatric and adult care settings (Reiss, Gibson & Walker, 2005).

The findings from this study build and add on the current knowledge of HIV-infected adolescents' experiences and the transition from pediatric to adult-centered care. This is important because practitioners have identified lack of a systematic transition protocol as a barrier to transition process from pediatric to adult-centered care (Huang, et al, 2011). These barriers can lead to HIV-infected adolescents to fall out of care; which can increase rates of infection among this vulnerable population. This is important to nursing research and practice because HIV- infected adolescents are living longer as a result of improved antiretroviral therapy (The Antiretroviral Therapy Cohort Collaboration, 2008). Due to the increased survival time more than 25,000 adolescents aged 13 to 24 years living with HIV will need to be transitioned to adult-centered care in the next 10 years (CDC, 2011).

Implications

Findings from this pilot study provided the impetus for the need for further research with a larger population sample and the development of tools to measure outcomes from existing transition programs. Research studies that seek to understand the HIV-infected adolescents' experiences and

the transition processes could help develop polices to guide clinical practice and advance the care of this growing vulnerable population.

Implications for Research

There is a need to do further research studies with larger samples from different clinical sites serving HIV-infected adolescents in South Texas. This would be valuable in building more understanding on the current findings and allow for generalizability of the findings. This would also be important to build the body of scientific evidence that could lead to development of transition programs to care for this vulnerable and stigmatized population. The findings from this pilot work were shared with the clinic director and staff to recommend the implementation of a transition program between the pediatric and adult HIV/AIDS clinics.

Timing of transition of HIV-infected adolescents to adult-centered care should be explored. This understanding may minimize the pediatric patients' perceptions about differences in the care provided between pediatric and adult-centered health care systems. Though work has been done with transition of adolescents with chronic health care needs, evaluation of these programs is lacking (Betz, Lobo, Nehring, & Bui, 2013). Guidelines have been developed for transition of HIV-infected adolescents from pediatric to adult venues. However, the programs have not been universally implemented and rigorous evaluation is deficient (Andiman, 2011). Therefore, research should be developed and refined to be culturally appropriate for this population and to provide more evidence about the benefits of transitioning patients from pediatric to adult-centered care (Freed & Hudson, 2006). Patients have reported emotional bonds with the pediatric health care teams that would not be possible to replicate in the adult care settings. Therefore, research should be conducted and evaluated to examine the clinical outcomes from pediatric to adult-centered transition models and programs to assess the effectiveness of these programs.

Implications for Practice

Participants in the study described not knowing the difference between pediatric and adult-centered care. Health care providers working with HIV-infected adolescents can bridge the gap by introducing the discussion about transition from pediatric to adult-centered care as soon as it is developmentally appropriate for the HIV-infected adolescents and their parents/or guardians. Nurses can play a role in the transition process by developing adolescents' friendly communication strategies (Boudreau & Fisher, 2012). Nurses and other health care providers can bridge the gap by connecting the adolescents to the adult providers using their chosen methods of communication.

The participants had a strong bond with the pediatric health care providers and had strong emotional attachments to

their providers. The nurses and providers of HIV-infected adolescents can minimize concerns of the transition processes by working with the adult-centered care providers to create a seamless transition. This can be possible if transition planning is a standard practice of providing health care to HIV-infected adolescents. The transition process will also require a collaborative approach of the health care providers, youth, and family to create an individualized plan for each youth to ensure success (Committee on Pediatric AIDS, 2013).

Limitations

The convenience sample of the participants from one clinic site was a limitation of this study. Recruitment of the participants for the study was very difficult and this could have impeded sampling of a diverse population for the study even though the sample was representative of the population in South Texas. The recruitment process was difficult because the study dealt with a vulnerable population and participants might have been fearful of being stigmatized; though confidentiality was assured and adhered to by the investigator throughout the research process.

Conclusions

Though the evidence of the transition model and programs is growing, more work needs to be done to explore outcomes of the transition process (Fair et al., 2012). Two themes, *It changed my life* and *I have to start over* were the major findings with five subcategories or subthemes to describe the experience HIV-infected adolescents' as they transitioned from pediatric to adult-centered care in the current study. This area of research is important in order to prevent fall out to care of adolescents with HIV infection or living with HIV/AIDS, increase retention and adherence to medication regimen to increase and maintain quality of life. This is possible if transition planning is a standard practice in providing health care to HIV-infected adolescents. The transition process will require a collaborative approach of the health care providers, youth, and family to create an individualized plan for each youth to ensure success (Committee on Pediatric AIDS, 2013). Nurses can play a role in the transition process by developing adolescents' friendly communication strategies and introducing the discussion about transition process to adolescents and their families (Boudreau & Fisher, 2012).

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