

Improving the quality of geriatric nursing care: Enduring outcomes from the Geriatric Nursing Education Consortium

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Improving the Quality of Geriatric Nursing Care: Enduring Outcomes from the
Geriatric Nursing Education Consortium

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Abstract

The nations aging demographics, few nursing faculty with gero-expertise and insufficient geriatric content in nursing programs has created a national imperative to increase the supply of nurses qualified to provide care for older adults. GNEC, the Geriatric Nursing Education Consortium, a collaborative program of the John A. Hartford Foundation, the American Association of Colleges of Nursing, and the NYU Nursing Hartford Institute for Geriatric Nursing was initiated to provide faculty with the necessary skills, knowledge and competency to implement sustainable curricular innovations in care of older adults. This article describes the background, processes and the development of GNEC evidence-based curricular materials, and the dissemination of these materials through six, two and a half day national Faculty Development Institutes (FDIs). Eight hundred and eight faculty, representing 418 schools of nursing attended an FDI. A total of 479 individuals responded to an evaluation conducted by Baruch College that showed faculty feasibility to incorporate GNEC content into courses, confidence in teaching and incorporating content and overall high rating of the GNEC materials. The impact of GNEC is discussed along with effects on faculty participants over two years. Administrative and faculty level recommendations to sustain and expand GNEC are highlighted.

Index words: Geriatric nursing education, baccalaureate nursing, faculty development

Introduction

In 2011 the first of the Baby Boomers turned 65 years of age and every day 10,000 Americans celebrate their 65th birthday. By 2040, there will be over 79.7 million Americans over the age of 65 (Administration on Aging, 2012).

Our nation's three million registered nurses represent the largest health care provider group for older adults (U.S. Department of Health and Human Services, 2010) - just as older adults are the largest group of patients in hospitals, home care, and nursing homes. Nurses are vital to meeting the diverse health care needs of these patients and yet a serious gap exists between supply and demand of geriatric- prepared nurses.

Prior to the mid1990s, in nursing education, there were no national educational competencies on the care of older adults, very few nursing faculty were prepared to teach geriatric nursing, and there was little geriatric specific content in the baccalaureate curriculum. Only 23 percent of nursing schools had a required course in geriatrics, and 60 percent of baccalaureate nursing program had no gero-expert faculty (John A. Hartford Foundation, 2006). Similarly, in practice settings, there were no hospital-wide initiatives to improve overall care of older adults and scant resources to prepare staff or assess their knowledge in geriatrics. Fewer than 1 percent of the 2.2 million practicing registered nurses (RN) were certified in geriatrics (Institute of Medicine, 2008). Fewer than .002 percent of RNs were geriatric nurse practitioners or clinical nurse specialists.

Supported by a \$70 million investment from the John A. Hartford Foundation (JAHF), since 1996, major efforts have been mounted to build the geriatric capacity of the nurse workforce by enhancing the competence of individual nurses to care for older adults and by increasing the recruitment and retention of geriatric specialists (Bednash,

Mezey & Tagliareni, 2011). These initiatives, involving the American Association of Colleges of Nursing (AACN), American Academy of Nursing, National League for Nursing, Sigma Theta Tau, the Gerontological Society of America, the Hartford Institute for Geriatric Nursing (HIGN), New York University College of Nursing, and Hartford Centers of Gerontological Nursing Excellence, have increased and enhanced the nurse workforce capacity to care for older adults via faculty development and curricular efforts, and through clinical models such as NICHE (Nurses Improving Care to Healthsystem Elders, <http://www.nicheprogram.org>). They have transformed the field by growing a cadre of gero-expert nurse leaders in academia and by infusing aging into all levels of nursing curricula. In particular, this collaborative work of the HIGN and AACN, GNEC, has sought to prepare nurses during their formal education including development of the faculty and curriculum needed for that education. In doing so, the next generation of nurses will be prepared with the necessary skills and competence to provide quality care to our aging population.

The Geriatric Nursing Education Consortium (GNEC), a 3 year, national initiative, funded by the JAHF and implemented jointly by AACN and HIGN, used “train the trainer” Faculty Development Institutes (FDI) to infuse geriatric content in senior-level undergraduate nursing courses (Wilson, 2010). GNEC served as a major impetus to assure that baccalaureate- prepared nurses graduate with the necessary competencies to deliver quality care to older adults. This article summarizes the process used to develop and implement GNEC and presents outcome data from the GNEC national evaluation. Specifically, the article describes how GNEC was conceptualized, the implementation of FDIs, and the GNEC outcomes.

GNEC Conceptual Building Blocks

The GNEC model built on two prior AACN projects: a 2001 JAHF-funded initiative that supported efforts at 20 baccalaureate schools of nursing to redesign existing gerontology curriculum, develop innovative clinical experiences, and develop and disseminate BSN competencies in gerontological nursing and the End of Life Nursing Education Consortium (ELNEC), a national program administered by AACN for teaching end-of-life care to nurse faculty (<http://www.aacn.nche.edu/elneec/about/fact-sheet>). The success of the GNEC project from module development to creation of white papers and dissemination through the FDIs hinged on enlistment and support of faculty appointed to the GNEC advisory board and working committees. The GNEC modules were vetted, validated, and endorsed by the Advisory Board comprised of senior nurse leaders and curriculum experts. This multifaceted approach leveraged the broad geriatric nursing community expertise for development of learning resources and the six FDIs.

The vision of GNEC was to create a culture change about care of older adults in schools of nursing through development of an evidence-based educational program. Framed by *Older Adults: Recommended Baccalaureate Competencies and Curricular Guidelines for Geriatric Nursing Care* (American Association of Colleges of Nursing & The John A. Hartford Foundation Institute for Geriatric Nursing, 2000), the nine GNEC modules were envisioned as an upper division educational curricula on geriatric specific content to be used and disseminated by trained faculty. In addition, faculty would be given strategies to help colleagues “gerontologize” their senior-level curricula.

The geriatric specific content built on a core fundamental principles guiding nursing practice for care of older adults, e.g. patient autonomy; individualized,

comprehensive and coordinated care; promotion of independence in function; and, attainment of the highest level of wellness possible. A review of the literature and focus groups conducted with undergraduate nursing faculty revealed that while BSN programs had made strides in including geriatric content based on wellness, successful aging, normal age changes, and models of health promotion in foundational courses, a critical gap in the curricular content was lack of attention to inclusion of geriatric specific content for senior- level courses.

Focus group faculty underscored that, in order to be adopted, geriatric content should be structured so that it can be easily adapted to the typical curriculum in BSN upper division programs, which tends to focus on major health problems facing adults consistent with public health priorities. In 2006, when the GNEC modules were conceptualized, the National Center for Vital Statistics mortality data for persons 65 years and older living in the United States showed heart disease- ranking number one, followed by cancer, Alzheimer's Disease, and Diabetes Mellitus (Miniño, Heron, & Smith, 2006). Thus the country's public health mortality record and data became the conceptual framework for developing the GNEC modules; five of the 9 modules specifically pertain to assessment and management of these prevalent diseases. The remaining four GNEC modules focus on quintessential issues affecting the practice of caring for older adults with complex and specialized care needs, e.g. critical thinking, modification of assessment and atypical presentation of illness, assessment and management of older adults in critical care, mental health and illness, and interprofessional care.

Gagne's conditions of learning theory (1985) was selected to frame the educational blueprint of each module as it most closely aligns to existing educational frameworks used in instruction by nurse educators. In Gagne's conditions of learning theory there are 5 levels of measurable behavioral objectives: Level 1 objectives include measures of verbal information; Level 2 objectives include measures of intellectual skill; Level 3 objectives include measures of cognitive strategy; Level 4 objectives include measures of motor skill; and Level 5 objectives include measures of attitude. Within each of the 9 modules we identified various levels of objectives for faculty to use to measure if learning occurred. An example of a measureable learner level objective is presented in Table 1.

A blue print provided a consistent structure for module development (Table 1). Each module began with a Key Message stating the focus of the content. Faculty was reminded that the module was intended to build on lower-level knowledge of gerontology content. Module content followed a set formula, e.g. background, assessment, management, specific resources, setting specific issues, and special considerations. The content in all 9 modules were matched to *Recommended Baccalaureate Competencies and Curricular Guidelines for Geriatric Nursing Care of Older Adults* (American Association of Colleges of Nursing & Hartford Institute for Geriatric Nursing, 2010) to ensure content was included on critical thinking, communication, assessment, technical skills, health promotion, risk reduction, disease prevention, illness and disease management, ethics, role development and human diversity, among others.

A preliminary list of recommended modules and content were proposed and further validated by an advisory educational curriculum committee composed of 15 members selected by AACN to represent baccalaureate nursing programs across the country (Wilson, 2010). Members of this educational committee independently reviewed and rated the content proposed in each of the nine modules (Table 1). Item analysis and ratings for each module were computed and means scores of acceptable content and topical areas of the modules were determined before developing the final module.

Content experts comprised of national scholars and clinicians were selected to develop state of the science white papers on the 9 GNEC topics. An NYU Health Science Librarian was enlisted to search the literature for each topic and supply levels of evidence based on the AGREE appraisal process (AGREE Collaboration, 2001), which was provided to each author for review and reference. These evidence-based white papers, referenced by Stetler's level of evidence (Stetler, Morsi, Rucki et al., 1998) and the AGREE appraisal process (AGREE Collaboration, 2001) then served as the template of GNEC content. Geriatric content developed within each module conformed to the AGREE guidelines to include the latest level of evidence ranging from Level 1 to Level VI studies (Stetler et al., 1998). Content experts were also enlisted to develop complementary case studies accompanying each module.

The Faculty Development Institutes (FDIs)

GNEC content was disseminated through six FDIs each lasting 2½ days. Recruitment of faculty participants to the FDIs has been described elsewhere (Wilson, 2010). Each FDI participant received a training manual/binder and a CD-ROM with: (1)

Module overview, key message, assumptions and pre-requisites; the actual module content; learner objectives; and patient-level objectives; (2) the evidence-based white papers (3) a set of teaching content PowerPoint slides; (4) case studies; (5) additional printable materials and geriatric resources; (6) reference lists; (7) innovative teaching strategies; and (8) supplemental teaching materials. All GNEC materials can be accessed at www.gnecresources.com/.

Integral to the FDIs were strategies to foster faculty support and coaching in order to help faculty become champions for the content when they returned to their BSN program. By “anointing” faculty to champion content, resources and strategies, a sense of empowerment and confidence to teach the content emerged and was formally measured. From the outset of GNEC, overall progress in educating nurses to use the GNEC curriculum was gauged by faculty responsiveness to the training through surveys (see below) and by analyzing change in competency mapping for gerontology courses. Competency mapping was an exercise performed by all FDI participants to identify current use of the AACN/HIGN recommended gero-focused competencies in their existing curriculum, prior to attending GNEC. Additionally, faculty was asked to designate, using a Likert scale, how thoroughly they were currently addressing the content of the 9 GNEC modules.

Spanning two years, the FDI’s interactive, case-based and problem-based learning strategies were taught by experienced GNEC faculty. At the FDIs, faculty presented content in a formal lecture style, focusing primarily on teaching strategies for delivering the content, rather than an overview of the content itself. Subsequently, faculty served as group facilitators working with smaller groups to discuss issues related

to teaching the module content. FDI faculty used interactive, problem-based case studies to trigger dialogue among participants in small groups. Getting to the heart of, “How would you teach this concept?” and discussing, “What are the strengths and barriers to teaching the concept using this approach?” were shared. Key points of small group discussion centered on the use of innovative resources and strategies. Faculty was tasked with developing an initial plan for how to begin to infuse content as soon as they returned to their home institution, e.g. "A plan for Monday."

Project Outcomes & Analysis

The GNEC evaluation included development and administration of survey instruments as well as statistical analysis carried out by investigators at the School of Public Affairs, Baruch College¹. Surveys were sent to FDI participants one year and then two years after each Institute. The final integrative analysis was based on information primarily from Year Two surveys, but also included selected data from Year One. Both descriptive and inferential techniques to analyze data; reported here are descriptive analysis related to participant demographics, academic profile, and faculty responsiveness to integrating content from the 9 modules into courses, feasibility of

¹ The evaluation of GNEC was carried out by investigators at the School of Public Affairs, Baruch College; it was supported by the JAHF as part of an overall assessment of the Hartford Geriatric Nursing Initiative. The evaluation lead was Shoshanna Sofaer, Dr.P.H.; staff included Amy Shire, MPH and Jacqueline Fortin, MPA. More detail on the GNEC program evaluation can be found in the Baruch College evaluation brief accessed at <http://www.aacn.nche.edu/geriatric-nursing/GNEC-Evaluation-Brief.pdf>

using GNEC materials, confidence to teach and overall perception of modules. Data from the GNEC evaluation described below along with data in Tables 3 and 4 is found in more detail elsewhere (Sofaer, Shire, Fortin, & Kantor, 2012).

Evaluation Findings

Demographic Profile of Participants

Eight hundred and eight individuals representing 418 schools of nursing attended an FDI. Of these, 62 individuals subsequently changed institutions and were deemed ineligible for the Year Two survey, leaving an overall pool of 746 eligible participants. A total of 479 individuals completed Year Two Surveys, representing an overall response rate of 64 percent. Ninety six percent were female (n=459) and 4.0 percent were male (n=19; missing data for one person). Ninety percent were white (n=429); 5.3 percent were black (n=25); 2.9 percent were Asian (n=14), and 1.1 percent were Hispanic/Latino. Only a few participants considered themselves as ‘other’ (0.8 percent) or Native Hawaiian (0.2 percent).

The majority held a master’s degree, and 38.6% had a doctoral degree. The largest number of participants were assistant professors (47.3%) or associate professors (23.8%); an additional 18.8% were lecturers or instructors; 9.0% were professor. Nearly 95% of participants were full-time faculty members and averaged 11.48 years since receiving their highest nursing degree.

Overall outcomes

Overall the GNEC evaluation found that of the 344 reporting institutions, 281 (81.7 percent) revised and enhanced 676 existing senior-level nursing courses by infusing evidence-based aging content. In addition, 115 new stand-alone gerontology courses

were created as a result of GNEC (Sofaer, Shire & Fortin, 2012).

Feasibility of Incorporating FDI Curricular Responses into Courses

Nearly 70% of respondents rated the feasibility of incorporating the FDI curricular resources into senior-level nursing courses as very feasible (32%) or mostly feasible (38%) using a five-point Likert scale (Table 2). While only a little over a quarter (27%) thought it was “feasible,” less than 3% said incorporating the FDI resources was ‘hardly feasible’ or ‘not feasible at all.’ When asked about the feasibility for incorporating FDI materials into the clinical component of courses, slightly fewer respondents found it very (25.9%; n=123) or mostly feasible (38.3%; n=182), and under five percent found it ‘hardly feasible’ (4.8%; n=23) or ‘not feasible at all’ (.6%; n=3).

Confidence in Teaching and Incorporating FDI Materials, and in Being a Change Agent

The majority of respondents were either completely confident (33%) or confident (55%) that they could incorporate content and materials from the GNEC modules into their teaching (Sofaer, et al, 2012; Table 3). Nearly half of the respondents were at least confident they could convince other faculty to incorporate FDI resources into didactic courses (10% ‘completely confident;’ 42% ‘confident’); 38% were ‘somewhat confident.’ Approximately the same proportion of respondents was confident they could convince other faculty to incorporate FDI resources into clinical courses.

More than half the respondents had a high degree of confidence in their ability to be a change agent regarding geriatric emphasis beyond the curriculum (17% “completely confident;” 46% “confident”; 29% “somewhat confident”).

Overall Ratings of the GNEC Materials

Participants were asked to rate each of the 9 modules along a continuum of excellent to poor (Table 4). Overall, the percent of participants reporting modules as either fair or poor was very low. Ratings of excellent for any given module ranged from 57 percent for “Assessment and Management of Dementia and Delirium Related to Older Adults with Complex Care Needs” to 40 percent for “Models of Care and Interdisciplinary Care Related to Complex Care of Older Adults”. By examining, for each individual, the number of modules that they rated excellent and the number they rated either excellent or very good, on average faculty rated 4.03 modules as excellent and 7.51 of the nine modules as either excellent or very good.

Discussion

Findings from the development and dissemination of GNEC illustrate three important points: (1) carefully selecting and implementing a process and timing for mounting a national program on an under-developed but critical content area can yield major outcomes in terms of curricular change; (2) well thought out content addressing older adults with complex and specialized needs was exceptionally well accepted by both faculty and sponsoring institutions; and (3) curricular enhancements coupled with strong teaching strategies, can change the existing culture of education provided in senior-level nursing courses across the country.

In initiating GNEC, AACN and the HIGN had some concern regarding how a national program on care of older adults with complex care needs would be accepted by schools of nursing and by faculty. This concern primarily emanated from the fact that faculty repeatedly expressed that the curriculum is already full and that time and resources are scarce to add any additional courses, classes or clinical expectations. Several factors converged to contribute to GNEC’s success. AACN had successfully

developed and disseminated ELNEC, and content development of the GNEC modules and process decisions related to the FDIs drew heavily on the ELNEC train–the-trainer model.

Both ELNEC and GNEC benefited from the national context in which they were developed. ELNEC was developed at a time of national scrutiny of how palliative and end of life care was being delivered in US hospitals and nursing homes (Patrizi, Thompson & Spector, 2011). Similarly, GNEC emerged at the time of the publication of the IOM Report “*Retooling for an Aging America*” (Institute of Medicine, 2008). In addition, a national survey of BSN programs (Rosenfeld, Bottrell, Fulmer, & Mezey, 1999) had delineated deficiencies in geriatric content in BSN programs.

The publication by AACN of new core and geriatric competencies for BSN nursing education (American Association of Colleges of Nursing, 2008; American Association of Colleges of Nursing & Hartford Institute for Geriatric Nursing, 2010) served as a stimulus for BSN programs to re-examine their content on aging in the curriculum. Additionally, prior geriatric nursing initiatives of the JAHF helped create a demand for more geriatric resources for BSN programs. The clarity that emerged from the focus groups as to what geriatric content was missing from upper division BSN courses and how content could best be delivered, yielded geriatric modules that faculty could feasibly introduce into upper division BSN programs. Thus GNEC and ELNEC point the way to how similar strategies might be used to address other evolving content areas, such as genomics, that may need to be enhanced in nursing education.

The strong response to the GNEC FDIs, as evidenced by the large attendance, representing 418 BSN programs from all fifty states, is a testament to the success of 10 years of federal and foundation efforts to incorporate geriatric content into health professional education. GNEC represents tangible evidence of the collaborative impact of stimulus from federal agencies such as the Veterans Administration and HRSA and of the steadfast support in geriatrics of the JAHF and other private philanthropies. Nevertheless, the long-term outcomes of GNEC need to be monitored. It will be important to determine the extent to which curriculum revisions achieved by faculty who attended the GNEC FDIs are sustained over time.

GNEC appears to have made a substantial impact on BSN curricula. Over 80% of participating institutions have revised and enhanced their existing curriculum which represents widespread endorsement and need. While the findings suggest that schools and faculty are willing to embrace a curriculum with much greater focus toward care of older adults, there is limited evidence of how findings from GNEC compare to other nationwide programs aimed at curricular revisions in nursing. Clearly continued support for the role of faculty champions will be pivotal for future dissemination of GNEC within institutions, especially given projected attrition among nursing faculty.

It appears that GNEC had long standing effects on faculty participants. Even two years later, faculty retained both a strong sense of the feasibility and a high degree of confidence in their ability to use GNEC resources. These findings speak to the sustainability of GNEC. Empowering faculty to be champions of the material while providing them with expert faculty guidance along the way may be the underlying premise for this observation. Another factor influencing the championing behavior

demonstrated by participants may be related to the quality and relevance of the GNEC content itself. Much attention went into the development of the scientific rigor surrounding each module and the overall final GNEC material. In part, some of the success realized from GNEC may be related to the quality and relevance of the GNEC curricular materials. Not only did participants find GNEC materials useful, they found them relevant and usable even two years post-FDI. Few other faculty development programs have measured important behavioral outcomes of participants two years out, which again speaks to the longstanding commitment of the JAHF to create enduring change in geriatric health care education.

The highest rated GNEC modules were assessment and management of dementia and delirium (56.5%; n=269) and modification of assessment and atypical presentation and geriatric syndromes in older adults with complex illness (53.5%; n=254). This is not surprising given the high incidence of mental status changes, dementia, atypical presentations and geriatric syndromes including urinary incontinence and polypharmacy seen across all practice settings and managed by nurses. Even though the remaining 7 modules received slightly lower ratings the content and resources were identified as useful and easily integrated into the curriculum. In-depth analysis is needed to determine the reason(s) for variations in the responses to the different modules.

Limitations of the FDI's

Faculty participants in the FDIs were limited to mostly white participants. Greater efforts to recruit and enroll multi-cultural faculty to attend FDIs would create a more

representative audience. However it should be noted non-white faculty in schools of nursing compose only 16.8% of currently employed faculty (U.S. Department of Health and Human Services, 2008). Because of this limitation, we do not know if multi-cultural faculty would respond similarly to the GNEC and the FDIs.

Conclusion

GNEC has raised the bar of excellence in academic preparation of baccalaureate prepared nurses and faculty to care for older adults. The GNEC curriculum also has created a culture change among institutions that have adopted the latest evidence for care of older adults. This new curriculum sets the stage for future front- line nurse caregivers to provide quality care to older adults, especially those with complex and specialized care needs, many of whom are frail, vulnerable and at risk for additional co-morbidities, poorer health outcomes, and fatality.

Because of GNEC, 115 new stand-alone gerontology courses have been created bringing nurses one step closer toward meeting the healthcare demands of an aging population. It is time to consider other initiatives that can use nursing education as a vehicle to increase the geriatric competency of the nurse workforce. Setting a national benchmark to increase the number of RNs certified in geriatrics beyond the current one percentile is critical. To do so requires the consensus, buy in, energy, commitment, and resources of nursing administration, nursing educators, funders, and organizational partners.

In order to achieve this reality, several recommendations are offered. Existing GNEC faculty champions can train at least one new faculty member each year. As new

faculty are trained, geriatrics will gain a greater prominence within the curriculum. Furthermore, BSN curriculum committees should require on-going curriculum mapping to ensure placement of geriatric content in all courses and effective use of GNEC and other JAHF geriatric nursing resources.

Schools also should be encouraged to assure that a percentage of the faculty be certified in geriatrics. BSN program administrators can support geriatric faculty certification by ensuring that new faculty and faculty champions have release time in their teaching assignment, and time to prepare for certification. This includes sufficient clinical hours to meet certification requirements and reimbursement for the cost of the certification examination and for re-certification. Faculty accomplishments can be highlighted in newsletters and at faculty meetings.

It is clear that despite the success of GNEC in the classroom, work remains to maintain and expand the academic accomplishments and to export these learnings into the practice environment to ultimately improve the health care of our aging society. In order to reach the practice environment, schools of nursing could offer courses for clinicians from partner primary care practices, hospitals, nursing homes, and home care agencies in order to become certified in geriatrics. Schools could also encourage these health care institutions to employ more geriatric experts and to incorporate programs such as NICHE to create a more responsive geriatric culture within their institutions. It is not inconceivable that together, schools of nursing and affiliated hospitals, nursing homes and home care agencies could create a community standard whereby older people would receive their care from nurses with demonstrated competencies in geriatrics.

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Table 1. Sample Template for GNEC Content: Module 4 - Assessment and Management of Heart Disease Related to Complex Care of Older Adults

Module Number and Title	Module 4
Module Overview: Key Message	Module 4 prepares students to care for people ≥ 65 with hypertensive heart disease (HTN) & heart failure (HF). Students will be able to: assess subtle & overt presentation of HTN & HF, critically analyze the value & significance of treatment in various practice settings; assess & manage older adults with HTN, HF, co-morbidities and geriatric syndromes.
Assumptions	Assumes lower level knowledge of gerontology content as indicated in Appendix...
Actual Module Content:	<p>Background: Stages & progression of HTN & HF; Health promotion, risk reduction & impact of co-morbidities for older adults with HTN/HF.</p> <p>Assessment: Accommodations in Hx & PE due to HTN & HF</p> <p>Management Modifications: medications, exercise, nutrition, rehab, living considerations for older adults with HTN & HF</p> <p>Specific resources: Review/ evaluation of existing clinical practice guidelines for older</p>
Background	
Assessment	
Management	
Specific resources	
Setting specific issues	
Special considerations	

	<p>adults with HTN & HF.</p> <p>Setting Specific Issues: Outcomes related to living arrangements, QOL, ethical & end of life</p> <p>Special considerations: Strength of research evidence for care</p>
Learner Objectives	<p>Learner Objectives: Identify modifications in Hx taking and approach to PE of older adults with HTN and HF (Level 1*)</p> <p>Co-contribute as an interdisciplinary team member to ethical discussions in care of older adults with end stage HF (Level 3)</p> <p>Evaluate facility policy & procedures for outcome indicators of QOL for older adults with HTN & HF (Level 5)</p>
Patient Level Objectives	<p>People ≤ 65 with HTN & HF will be assessed for risk of developing geriatric syndromes, e.g. polypharmacy, falls, and urinary incontinence.</p>

*Reference: Gagne, R.M. (1985). *The conditions of learning and theory of instruction*. 4th edition. New York: Holt, Rinehart & Winston.

Table 2. Feasibility of Incorporating GNEC FDI Curricular Resources into Senior-Level Nursing Courses.

In your experience, how feasible is the overall strategy of incorporating FDI curricular resources...	Very Feasible (Number/ Valid Percent)	Mostly Feasible (Number/ Valid Percent)	Somewhat Feasible (Number/ Valid Percent)	Hardly Feasible (Number/ Valid Percent)	Not feasible at all (Number/ Valid Percent)
into the <i>didactic</i> component of senior-level nursing courses? (n=479; missing=0)	155 (32.4%)	181 (37.8%)	130 (27.1%)	8 (1.7%)	5 (1.0%)
into the <i>clinical</i> component of senior-level nursing courses? (n=475; missing =4)	123 (25.9%)	182 (38.3%)	144 (30.3%)	23 (4.8%)	3 (.6%)

Reference: Sofaer, S., Shire, A. P., Fortin, J., and Kantor, B. (2012). Summary of year two aggregate analysis of the Geriatric Nursing Education Consortium. Accessed 10 23 2013, <http://www.aacn.nche.edu/geriatric-nursing/GNEC-Evaluation-Brief.pdf>

Table 3. Confidence Levels in Teaching and Incorporating GNEC FDI Materials and Being a Change Agent.

How confident are you in your	Completely	Confident	Somewhat	Minimally	Not at all
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ability to...	Confident (Number/ Valid Percent)	(Number/ Valid Percent)	Confident (Number/ Valid Percent)	Confident (Number/ Valid Percent)	Confident (Number/ Valid Percent)
teach materials from the FDI modules? (n=475; missing=4)	155 (32.6%)	262 (55.2%)	54 (11.4%)	2 (.4%)	2 (.4%)
convince other faculty to incorporate FDI resources into senior-level <i>didactic</i> courses? (n=477; missing =2)	47 (9.9%)	199 (41.7%)	181 (37.9%)	44 (9.2%)	6 (1.3%)
convince other faculty to incorporate FDI resources into senior-level <i>clinical</i> courses? n=472; missing =7)	41 (8.7%)	190 (40.3%)	171 (36.2%)	63 (13.3%)	7 (1.5%)
be a change agent regarding geriatric emphasis within your school, beyond the curriculum? (n=476; missing =3)	80 (16.8%)	218 (45.8%)	136 (28.6%)	40 (8.4%)	2 (.4%)

Reference: Sofaer, S., Shire, A.P., Fortin, J., and Kantor, B. (2012). Summary of year two aggregate analysis of the Geriatric Nursing Education Consortium. Accessed 10 23 2013 From, <http://www.aacn.nche.edu/geriatric-nursing/GNEC-Evaluation-Brief.pdf>