President’s Message

Celebrate GAPNA’s 30th Anniversary

Where will you be in mid September? Hopefully you will be with the greatest, most fun-loving group of advanced practice nurses anywhere! I’m referring, of course, to the members of GAPNA. Don’t miss out as we meet, learn, and play together September 14-17, 2011, in Washington, DC, during our 30th Annual Conference. There is a lot to be excited about: The setting (the historic Marriott Wardman Park Hotel), the keynote speaker (Mary Wakefield, PhD, RN, Administrator, Health Resources and Services Administration), the opportunity to hear about the latest evidence and recommendations for the care of older adult patients (with the opportunity to earn up to 19 contact hours), and taking a walk back through time as we celebrate GAPNA’s 30th Anniversary.

When humans turn 30 their systems decline at the rate of 1% a year. That’s not what we see in store for GAPNA. Hand in hand with looking back at our past, the Board of Directors will be meeting with a consultant in June to help us develop a strategic plan to guide GAPNA into the future. All of you will be asked to complete a survey and share your vision for GAPNA. We want to take advantage of your wisdom and experience so we know that we are reflecting our membership as we create this vision and plan for the future.

Call for Volunteers: Get Involved Now!

Get involved by joining a GAPNA committee or special interest group (SIG). You don’t need a long list of publications or prior experience, just your interest, knowledge, and commitment to participate.

Committee and SIG work are primarily accomplished through conference calls and emails. There is also a non-mandatory meeting held every year during the GAPNA Annual Conference. Most committees and SIGs hold hourly teleconferences every 6-8 weeks. In between conference calls, members may be asked to review materials, comment on ideas, and/or develop plans and programs.

By devoting a little of your time and expertise to serving on a GAPNA committee or SIG, you can make a tremendous impact on association programs, activities, and publications that enhance patient care, expand educational opportunities for GNPs, and influence regulatory and legislative issues.

Committee Opportunities

Conference Planning Committee. This committee reviews abstracts via fax, mail, and email for the GAPNA Conference. They meet via teleconference to establish the outline for the program and identify key speakers. The committee will continue to meet, via regularly scheduled conference calls, throughout the year to plan the Annual Conference.

Call for Awards Nominations

It’s that time again to recognize the outstanding contributions of GAPNA members with the GAPNA Awards nominations. Six awards will be presented at the GAPNA Awards Dinner during the 30th Annual Conference, September 14-17, 2011, in Washington, DC.

❖ Chapter Excellence
❖ Excellence in Clinical Practice
❖ Excellence in Community Service
❖ Excellence in Education
❖ Excellence in Leadership
❖ Excellence in Research

Nominations are due by June 1, 2011. For a more detailed description of each award and a nomination form, visit www.gapna.org

Call for Poster Abstracts: 2011 Conference

GAPNA is currently accepting clinical and research poster abstracts for the 2011 Conference, to be held in Washington, DC, from September 14-17, 2011. The due date for poster abstracts is July 15, 2011.

Please visit the GAPNA website at www.gapna.org for abstract submission guidelines or contact the National Headquarters via GAPNA@ajj.com for more information.

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Improving Lives of Older Adults: Practice and Policy

Make plans now to attend GAPNA’s 30th Annual Conference, September 14-17, 2011, at the beautiful and historic Marriott Wardman Park Hotel in Washington, DC. Earn up to 19 contact hours and experience an educational event that will enlighten and enliven you!

Examining emerging trends in practice, health policy, and health delivery systems relevant to advanced practice gerontological nurses. Choose from 24 specialized concurrent sessions and on-target general sessions including “Health Care Reform: Issues and Opportunities” by Mary Wakefield, PhD, RN, administrator, Health Resources and Services Administration.

Two dynamic preconference workshops – “Research Project Preparation” and “Tricks of the Trade in Geropharm” – will be featured. Peer-conducted research presented as interactive poster sessions and oral presentations will provide evidence-based knowledge critical to the management of acute and chronic illness in older adults. Educational interactions with leading industry representatives in GAPNA’s exhibit hall will ensure a fun and relaxing learning atmosphere. Excellent networking opportunities will be available throughout the conference especially during coffee breaks, luncheons, and the annual awards reception and dinner.

To top it off, this excellent educational event will be experienced in the attractive accommodations and amidst the history and excitement of our Nation’s Capital. Look for your conference registration brochure soon or visit GAPNA’s web site for more details. Join your colleagues in Washington, DC, to exchange ideas and clinical experience with expert faculty and colleagues specializing in the care of older adults. Through care, continuity, and connection, we will improve the lives of older adults.

GAPNA Foundation Events Planned For Conference

For the 6th year running, the GAPNA Foundation has three fabulous and fun events planned for the 2011 Conference in Washington, DC!

The first is the 6th Annual Foundation Best Ball Golf Tournament, Wednesday, September 14 at the lovely East Potomac Blue course on the Potomac River. Tee off time is 12:45 p.m. Remember, this event does not require you to be a good golfer, just willing to go out and have a lot of fun raising money for the foundation. Family members are welcome, so if your significant other or another guest wants to play, the more the merrier.

The second event is the Annual Fun Run/Walk at 6:00 a.m., Friday, September 16. Join your colleagues for an energizing morning run/walk around the beautiful neighborhood surrounding Wardman Park. It’s a great way to start the day!

The final event is the Moonlight Trolley Tour of the Washington Monuments, Saturday, September 17, from 7:00 p.m. to 10:00 p.m. This exciting tour includes stops at the Iwo Jima Memorial, Lincoln Memorial, and Vietnam Veteran’s Memorial. Along the way, professional tour guides will share historical tales and anecdotes about the city’s fascinating history. Space is limited so sign up early!

If none of these options appeal to you, or if you are in a generous mood, you can also select a cash donation. Remember, your donations are tax deductible and allow the foundation to provide scholarships to budding researchers and student scholars.

See the registration brochure or GAPNA web site to register!

New for 2011 – An Online Library and a Paperless Conference!

Receive added educational value for your conference investment. Here are some of our exciting changes:

Free Access to GAPNA’s New Online Library!
www.prolibraries.com/gapna

What does this mean?
• As an attendee, you’ll have indefinite free online access to all approved sessions.
• You can “virtually” attend sessions you may have missed on site or revisit courses you found particularly interesting.
• You’ll never have to choose between concurrent sessions again!
• You can even share the meeting content with two colleagues at no charge.

Content will be available approximately 3 weeks after the conference, so be sure to take advantage of this additional learning experience at your convenience. Access all the content of the sessions you missed in the GAPNA Online Library (CNE contact hours may be obtained for a separate fee).

Handouts Available Online: This is a great option: You no longer have to carry a bulky program book! Approximately 2 weeks before the conference, redeem conference code GAPNA11 in the Online Library (www.prolibraries.com/gapna) to access the handouts.

Paperless Online Evaluations and CNE Certificates: No need to worry about filling out paper forms and submitting them on-site. Simply complete the evaluation and print your CNE certificate at your convenience from home or work! Now, you can focus on networking and enjoy the conference!
Have You Submitted Your Idea to the Center Yet?

An exciting new web tool was launched recently at www.innovations.cms.gov that allows you to shape the future of Medicare and Medicaid.

The Center for Medicare & Medicaid is seeking new ideas, both to help build the Innovation Center and to help identify innovative ideas about how care can be delivered and paid for in ways that will be cost effective while improving health and health care.

This is an opportunity for those of us in advanced practice to submit ideas and share experiences. The submitted ideas will be reviewed by the Innovation Center staff and the most promising ideas will be incorporated into payment and care delivery models tested by the Innovation Center. They need to hear about your work and have an interest in developing relationships with people across the country.

You can share ideas, receive email updates on their activities, and apply for funds to launch or support a demonstration project. Who better than advanced practice nurses to provide the models that demonstrate health care delivery that improves the patient experience, results in better health, and lowers the total costs of care?

Areas of focus include patient care models, coordinated care models, and community or population health models. You have the opportunity to become part of the innovation community, listen and learn, or simply share your ideas.

Pat Kappas-Larson, MPH, APN-C, FAAN
Immediate Past President
pkappaslarson@preshomes.org

Pat Kappas-Larson

New Member-Get-A-Member Campaign Launched

GAPNA is excited to announce the launch of a new Member-Get-A-Member campaign. Recruit three colleagues to join GAPNA and you’ll receive a free 1-year membership.

It’s as easy as 1, 2, 3!
1. Fill in your name next to “Who asked you to join GAPNA?” on the membership application.
2. Make copies of the application and give them to colleagues who may want to join GAPNA or have them join online at www.gapna.org. Just make sure your name is listed as a referral.
3. Ask them to let you know when they have joined. You’ll be notified by GAPNA of your free 1-year membership and your account will automatically be credited.

Offer good until December 31, 2011. Questions? Contact GAPNA’s National Office at gapna@ajj.com or 866-355-1392; or visit GAPNA’s web site at www.gapna.org

Get three and you’re free!

Exciting Research Sessions Planned For 2011 Conference

Several exciting programs supported by the GAPNA Research Committee will be presented at the GAPNA Annual Conference, September 14-17, 2011, in Washington, DC.

Pre-Conference Workshop: The purpose of the pre-conference workshop “Research Project Preparation,” is to assist novice researchers, DNP students and graduates, and advanced practice nurses to begin the development of a research study or clinical outcome project proposal. Participants will discuss the steps involved in developing an answerable and clearly stated evidence-based question related to older adults using PICO format, and also the steps involved in moving their PICO question into a realistic and doable study/project. Participants are asked to bring an idea or two they would like to develop to the session, which will be held Wednesday, September 14, from 12:00 p.m.-5:00 p.m. The session, which will be 4.5 contact hours, includes instructional lectures and small group work with an experienced researcher or evaluator facilitating discussion and individual study/project development.

Concurrent Sessions: The concurrent session, “Moving Your Project Into Reality: Confer with the Experts,” is a new format that allows for individual attention and access to experts on various topics related to project development and implementation. A roundtable or “confer with the experts” format will be used to facilitate participant project development needs, strategies, and resources using experts in various topics. Experts will be available to discuss funding, IRB, qualitative analysis, quantitative analysis, survey development, finding appropriate instruments, or for general questions on project development and implementation. Participants should have a project idea and plan already in development and come with questions to the session, which will be held Saturday, September 17, from 1:30 p.m.-2:30 p.m.

The concurrent session, “Successful Writing for Publication: Guidance from the Editors,” will provide information on getting your ideas, research, and projects published. It will be held Friday, September 16, from 10:45 a.m.-11:45 a.m.

The Research Committee wants to acknowledge and thank the contributors to the research section in the spring newsletter: Francisco Diaz, Patrick Luib, Melodee Harris, and Maureen Smith.

Joanne Miller, PhD, APN/GNP-BC
Co-Chair, Research Committee

Celebrate!
National Nurses Week 2011
May 6-12
Nurses Trusted to Care
Chapter News

FL-GAPNA

On February 5, 2011, FL-GAPNA had its first quarterly meeting of 2011. The meeting was held at the Hilton University of Florida Conference Center, in Gainesville. Go Gators! It was attended by 11 members and two guests. Elections were finalized, and our new president elect is Karen Jones, North Palm Beach, FL, and our new secretary is Marva Edwards-Marshall of Palm Bay, FL.

JoAnn and Karen had just come from the Florida Medical Directors Association (FMDA) Board Meeting and were excited to report that the board approved a Position Statement for Prescriptive Authority for Advanced Registered Nurse Practitioners and Physician Assistants in the state of Florida. This is the first time a medical organization has supported this scope of practice issue in Florida and we are very grateful for their support!

Susan Lynch and Cindy Drew from the Council of Advanced Practice Nurses Political Action Committee (CAP PAC; www.cap-pac.org) were welcome guests and gave all in attendance an update on the status of legislative initiatives. Since the legislative sessions were about to begin, there will not be a bill brought forward related to prescribing authority; however, with FMDA’s support we may have a better chance in 2012. Rallies were planned for February 26 in five areas around the state and all were encouraged to attend. JoAnn Fisher was a speaker and presented FMDA’s Position Statement.

The chapter is planning a CE day for April 2, 2012. Bea Matthews, president of the Florida Gulf Coast Chapter, was also present and felt her group would participate. Charlene Demers, treasurer, agreed to chair the planning committee. The first planning meeting was held on February 26 following the rally in Orlando.

Our next meeting will be in early May in Melbourne. Keep an eye on our web site (www.flgapna.org) for updates! For now, FL-GAPNA is committed to traveling to the different regions of the state to promote new membership and offer an opportunity for all chapter members to attend at least one meeting a year.

All of those present were reminded of the 30th Annual GAPNA Conference in Washington, DC, and were encouraged to attend and spread the word!

JoAnn Fisher
jmfisher@cfl.rr.com

Georgia

On February 3, the Georgia Chapter kicked off 2011 with its quarterly business meeting at Davios. The presentation on “Management of Neuropathic Pain” was delivered by a local rheumatologist and staff physician for the Atlanta Falcons. The meeting had record turnout for our young chapter with 35 in attendance!

The chapter also recently held its second annual CE day on February 26, 2011, at Emory University School of Nursing. The keynote speaker, Lisa Gwyther, MSW, of Duke’s Alzheimer’s Disease Research Center and former president of the Gerontological Society of America, launched the day by sharing practical advice for clinicians as they educate and engage family caregivers. The event attracted 55 registrants, many of whom were first-time attendees and included NPs, MDs, and students. The day was well-supported by exhibitors from pharmaceutical and informatics industries and service providers for the aged. The planning committee has already met to discuss the third annual event, in which we anticipate an exciting new partnership.

Carolyn Clevenger
carolyn.k.clevenger@gmail.com

Chicagoland

Spring has finally arrived in Chicago. CGAPN had a quarterly meeting on February 9. The educational program, presented by two members, was a case study entitled “Cholesterol Management: Can We Be Too Aggressive?” We also broke into discussion groups and reviewed our chapter’s strategic plan draft. The board has finalized the plan and it will be presented at our annual dinner at Francesca’s on May 11. Ballots were sent to all members at the end of March for the open executive board positions and the new graduate/student leadership intern. The new board will take over in June and our quarterly meeting will be in August.

Anne Maynard
maynard78@yahoo.com
Ohio

The Ohio Chapter of GAPNA will host its Third Annual Continuing Education Day, “Building Skills and Advancing Excellence in Geriatric Care,” Saturday, May 21, 2011, at the Quest Conference Center in Columbus. We have been working hard to organize this special day, emphasizing the care of older adults, provided by advanced practice nurses in Ohio.

This day will offer seven accredited continuing education contact hours, including 3 hours of pharmacology. Some topics that will be addressed are medico-legal issues when prescribing, transitional care, geriatric oncology, and APN legislative updates. And, back by popular demand, Stephanie Odom-Darling will speak on vascular ulcers and treatments.

Registration will begin at 7:30 a.m., and the program will run from 8:00 a.m. to 5:30 p.m. Breakfast, lunch, and a snack will be provided. Tuition is inexpensive, so please join us for this exciting day to learn and network with others who care for older adults in Ohio. Visit https://www.gapna.org/chapters/ohio.html for more information. We hope to see you there!

Alicia Wolf, GNP
AliciaWolfGNP@yahoo.com

Looking for a CHAPTER NEAR YOU?

GAPNA
Interested in Starting a Chapter?

ARIZONA (SONORAN)
Ellen Cavanaugh
ecavanaugh1@cox.net

NORTHERN CALIFORNIA
Liz Macera
Lizmacora@gmail.com

DELAWARE/PENNSYLVANIA
Marie Ash
mash0129@aol.com

FLORIDA GAPNA
Jo Ann Fisher
jmfisher@cfl.rr.com
joannfisher@oslermedical.com

FLORIDA GULF COAST
Beatrice Matthews
Beatrice_m_matthews@oslermedical.com

GEORGIA (ATLANTA)
Katherine Abraham
Katherine_a_abraham@uhc.com

ILLINOIS
(CHICAGOLAND GAPNA)
Anne Maynard
Maynard78@yahoo.com

LOUISIANA/MISSISSIPPI
(MAGNOLIA)
Dr. Lisa Byrd
lbyrd3@comcast.net

MARYLAND
Margaret Hammersla
hammersla@son.umaryland.edu

NEW ENGLAND
Timothy P McGrath
tmcnurse@gmail.com

MICHIGAN (GREAT LAKES)
Mary Jane Favot
mjfavot@comcast.net

NORTH CAROLINA (TRIAD)
Marigold (Margo) Packheiser
marigold_a_packheiro@uhc.com
marigoldtnp@aol.com

OHIO
Marygold (Margo) Packheiro
marigold_a_packheiro@uhc.com

NEW ENGLAND
Timothy P McGrath
tmcnurse@gmail.com

MICHICAN (GREAT LAKES)
Mary Jane Favot
mjfavot@comcast.net

TENNESSEE (MIDSOUTH)
Amber Velasquez
ambervelasquez@gmail.com

TEXAS (GULF COAST) - HOUSTON
Rhonda Hunsucker
rhunsucker@consolidated.net

WISCONSIN (SOUTHEAST)
Christine Pasinski
cpasinski@wwrr.com

Contact the GAPNA National Office
GAPNA@ajj.com • (866) 355-1392 • Fax (856) 589-7463

President’s Message
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The future of the care of older adults is a hot topic right now in Washington, DC, with frequent conversations about cutting the funding for “entitlements,” Medicare and Medicaid being two of the largest. Funding is also on the table for programs that support education and research. Now more than ever APRNs who care for older adults need to be engaged in the political process. We are grateful to Charlotte Kelley, former board secretary and current Health Affairs co-chair, for her dedication as our representative on the Nurse Practitioner Roundtable. She spends hours each week on phone calls and travels occasionally to DC to ensure GAPNA’s interests are well represented.

Our special interest groups are very active, as are our committees and chapters. We are represented at state meetings and we will be present at the American Academy of Home Care Physicians Annual Meeting and the American Geriatric Society Meeting. If any of you are planning to attend, please stop by the GAPNA exhibit booth and introduce yourself.

Lots of wonderful plans are on the horizon and we want you to be part of them. Complete the survey for the strategic plan, and put September 14-17, 2011, on your calendar so you will be there with us as we celebrate 30 years of GAPNA.

Evelyn Duffy, DNP, GNP/ANP-BC, FAANP
President
The Affordable Care Act (ACA) signed on March 23, 2010, put in place health insurance reforms intended to unfold over 4 years and beyond, with most changes taking place by 2014. ACA-mandated changes effective April 1, 2011, will affect the way physicians refer patients receiving either home health or hospice services. To implement the changes mandated by the ACA, CMS has created a Final Rule requiring face-to-face encounters with patients prior to Home Health Certification and for hospice recertifications beyond 180 days. The major points of this new legislation are summarized.

The Rule for Home Health
A physician must have seen a patient being referred to a home health agency (HHA) within 90 days prior to the referral for the condition that he or she is being referred. Additionally, the physician must certify the patient is homebound. When it is not possible for the encounter to occur prior to the home health referral, it must occur within 30 days after the patient is admitted to a HHA. This requirement means to ensure a referral is based on the physician’s current knowledge of the patient’s condition.

Who May Perform a Face-to-Face Visit for Home Health?
A nurse practitioner (NP) or physician assistant (PA) may perform the face-to-face visit if she (or he) is working in collaboration with the physician signing the POT (485), and may not be employed by the HHA for such a purpose. If a patient needs a HH referral in conjunction with a hospital discharge, a hospitalist may sign the attestation that the face-to-face encounter occurred and hand-off the patient to the community physician. In rural areas, specified certified telehealth sites may also provide the face-to-face encounter.

What Is Required?
An attestation of the face-to-face visit must accompany each Home Health Start of Care (SOC) when billed to Medicare as a condition of payment. Most HHAs have recently developed attestation forms to accompany patient referrals. Required information for a face-to-face encounter includes the date when the physician, NP, or PA saw the patient, along with a brief narrative that describes the clinical condition supporting the patient’s homebound status and the need for specific skilled services. This must be in writing, signed by the provider performing the visit, and the physician. This document will accompany the 485 that the physician must sign.

The Rule for Hospice
Hospice face-to-face provisions are somewhat different than HH requirements. No face-to-face encounter is required on admission, but it does require that a hospice physician or NP have a face-to-face encounter with a Medicare beneficiary enrolled in hospice prior to their 180-day recertification (3rd lifetime benefit period) and for each 60-day recertification period after that. If a patient is being admitted into his/her third or greater benefit period, a face-to-face visit must be made prior to admission.

Who May Perform a Face-to-Face Visit for Hospice?
Given the differences between home health face-to-face and hospice face-to-face requirements, it is important to understand who is eligible to make a hospice face-to-face visit. This information is found on page 10 of the document.

Documentation of Face-to-Face Encounter

Patient Name and Identification: __________________________

I certify that this patient is under my care and that I, or a nurse practitioner or physician’s assistant working with me, had a face-to-face encounter that meets the physician face-to-face encounter requirements with this patient on: (Insert date that visit occurred):

________________________________________

Month    Day    Year

The encounter with the patient was in whole, or in part, for the following medical condition, which is the primary reason for home health care (List medical condition):

________________________________________________________________________

I certify that, based on my findings, the following services are medically necessary home health services (Check all that apply):

Nursing
Physical therapy
Speech language pathology

To provide the following care/treatments: (Required only when the physician completing the face-to-face encounter documentation is different than the physician completing the plan of care):

________________________________________________________________________

My clinical findings support the need for the above services because:

________________________________________________________________________

Further, I certify that my clinical findings support that this patient is homebound (i.e., absences from home require considerable and taxing effort and are for medical reasons or religious services or infrequently or of short duration when for other reasons) because:

________________________________________________________________________

________________________________________

Physician Signature

________________________________________

Date of Signature

________________________________________

Physician Name (Printed)
When I received the GAPNA Scholarship to attend the American College of Nurse Practitioners (ACNP) Leadership and Healthcare Summit in Washington, DC, I was charged with ambition, and attending the summit lived up to my expectations. I gained a renewed perspective and confirmed my commitment to promoting nurse practitioners as primary care health care providers. One of the important take-away messages was to promote recognition as a provider and part of the health care team. Compensation should be based not on the type of provider but for the service provided. After 2 days of enlightening conferences, I was pumped for action. The messages “the stars are aligned,” “this is a perfect storm,” and “be visible” were with me as I headed to Capitol Hill on Monday morning. I was more inspired than ever to deliver a message to my legislators.

I felt prepared to visit my legislators. I know who I am, I know what a good job I do, and I know how important it is to my elderly patients to have access to care. Prepared with the information ACNP provided about key issues, I was ready to deliver the packets provided for me at the summit with very specific information to convey to my legislators. Accompanying me was another summit participant, Patricia Noser, NP, a DNP candidate from Spruce Pine, NC.

I was unable to secure an appointment with Sen. Richard Burr’s (R-NC) office, but that didn’t daunt me. The ACNP lobbyist assured me most offices are happy to receive “drop in” constituents. My legislators work for me, right? I presented a packet of information to the staffer, left my card, and followed up with an email to introduce myself and offer myself as a resource.

Venturing on to Sen. Kay Hagan’s (D-NC) office, I met with her staffer. He is a young man from Sampson County, NC, where there is a rural clinic staffed by a nurse practitioner, and he had questions regarding the training and education of NPs. What could the Senator do for us? We elaborated on personal stories as NPs, explained Senate Bills 52 and 227 and the current concern of NPs in North Carolina, touching on the (not yet approved) federal budget with our hope that nursing education would have continued funding. He took notes, was responsive, and I have hopes he will convey our conversation to Sen. Hagan.

My third meeting of the morning was with Rep. Howard Coble (R-NC) who personally met with me. He asked me “Are you an RN?” This gave me the opportunity to explain the educational preparation of NPs as advanced practice RNs and suggested he could think of us as APRNs with more education and a primary care focus. Then he asked what he could do for me. Great! I was prepared with the Senate Bills, as well as companion House Bills that are soon to be introduced in the House. He wanted to know who was going to introduce those bills and thankfully I was prepared with the names (thank you David Mason, ACNP Director of Government Relations!).

Will I continue to volunteer my time, my energy? Yes, I remain committed to my profession to be a leader in health care. All NPs are leaders in health care, some know it, and some don’t. I believe the promotion of nurses and nurse practitioners is best for access and the promotion of health in my state and country. I know the legislative/political process can improve or harm health care and I want to be on the improvement side.

My first time attendance at the ACNP Summit was consistent with me always being politically active and just not knowing it. At times I’ve taken breaks from professional or political action, particularly when my family relocated to North Carolina, but I have remained interested my entire nursing career.

At home, I am active in the North Carolina Nurses Association and Nurse Practitioner Council. I have been a Regional Liaison Person for the Greensboro Region for several years. Due to my specialty and interest in working with older adults, I am also an active member in the Gerontological Advance Practice Nurses Association (GAPNA). Last year the NC GAPNA Chapter lost momentum and needed new leadership. So, as a chapter, we rallied with a new board and I became president with a resolution to revitalize the chapter. In November we held our fall conference which was an overwhelming success. The NC Triad Chapter is more active than ever!

Margo Packheiser
2011 GAPNA ACNP Summit Scholarship Recipient
marigold_a_packheiser@uhc.com
Valproic acid is an effective therapy for many disorders, including many types of seizures, bipolar mania/hypomania, migraine prophylaxis, neuropathic pain, restless leg syndrome and social anxiety (Wadzinski, Franks, Roane, & Baynard, 2007). Valproic acid is also often prescribed for dementia-related agitation and frequently combined with antipsychotic medicines for dementia-related agitated psychoses. Psychotic symptoms (e.g., hallucinations, delusions, etc.) can occur at different times and with differing levels of intensity throughout the course of dementia and often predispose to more pronounced agitation. Psychotic agitation is often a more prominent feature in late-stage deteriorating illness. Non-psychotic behaviors for which valproic acid is used include pacing, wandering, impulsivity, and (non-homicidal) aggression (Rayner, O’Brien, & Schoenbachler, 2006). Approximately 70% of elders with dementia experience some form of agitation. Valproic acid has been prescribed for over 10 years with varying levels of success in an effort to control agitation and agitated psychosis in dementia (Lonergan & Luxenberg, 2009).

Adverse Reactions
Valproic acid may place the patient at risk for numerous drug interactions and severe toxicities such as hepatic damage, pancreatitis, teratogenicity, thrombocytopenia, and hyperammonemia (Wadzinski et al., 2007). Ammonia is a toxic end-product of protein and amino acid metabolism (Cuturic & Abramson, 2005). Even in the presence of standard dosing and normal serum valproic acid levels, hyperammonemnic encephalopathy can develop (Wadzinski et al., 2007). Asymptomatic hyperammonemia can occur in normal liver function and no direct association with the quantity of valproic acid prescribed has been found. Asymptomatic hyperammonemia and symptoms of encephalopathy have developed in patients who have taken valproic acid for extended periods of time without adverse reactions (Carr & Shrewsbury, 2007). It is thought protein consumption and carnitine levels may influence ammonia levels (Cuturic & Abramson, 2005).

Symptoms of Hyperammonemia and Encephalopathy
Symptoms of encephalopathy include altered mentation and lethargy, focal neurologic changes, and increased seizure frequency. Other symptoms include asterixis, vomiting, perseveration, aggression, ataxia, and eventual coma and death (Carr & Shrewsbury, 2007). Hyperammonemia should also be considered in patients with hypothermia (temperature <35° C; 95° F) (Drugs.com, 2010).

In a double blind, multicenter trial of valproic acid in the elderly with dementia (mean age 83), a significant proportion of patients experienced somnolence and a large proportion developed dehydration. In those patients with somnolence, there was also reduced nutritional intake and weight loss. These effects tended to occur more in patients with lower baseline albumin levels, higher BUN, and lower valproate clearance (Drugs.com, 2010).

Risk Factors
Risk factors include urea cycle disorders, infancy, and carnitine deficiency due to either hereditary dysfunction or dietary restrictions. A family history of mental retardation of unknown etiology and/or a high number of stillbirths, miscarriages, and infant deaths, especially male deaths, could suggest genetic metabolic disorders (Cuturic & Abramson, 2005). A low calorie diet, high nitrogen load, and possibly increased carbohydrate intake may also be contributing factors (Carr & Shrewsbury, 2007).

Combining valproic acid with other anti-epileptic medications, especially phenobarbital, phenytoin, or topiramate, increases the risk of hyperammonemia. Elevated ammonia levels have also occurred with the combination of valproic acid and risperidone (Carr & Shrewsbury, 2007).

Mechanism of Action
The removal of ammonia from the body is regulated in the hepatic and renal systems through enzyme action in the urea cycle. Ammonia levels can build and cause toxicity if there is a lack of one or more of these enzymes. Previously undetected abnormalities in the urea cycle may become evident with the use of valproic acid (Cuturic & Abramson, 2005).

Encephalopathy occurs as ammonia increases within the central nervous system, raising glutamine levels within the astrocytes. This increase results in cerebral edema and astrocyte dysfunction. In chronic hyperammonemia, it is thought the brain compensates for astrocyte swelling through decreased osmolarity by down-regulation of myo-inositol and increased brain tissue compliance. Mild-to-moderate brain atrophy can result (Cuturic & Abramson, 2005).

Treatment
Treatment often utilizes lactulose or neomycin just as hepatic encephalopathy would be treated. Long-term use of valproic acid is thought to decrease hepatic carnitine. Carnitine supplementation has been utilized by some clinicians. However, carnitine is mainly stored in muscles. Therefore serum levels cannot adequately diagnose deficiency (Carr & Shrewsbury, 2007). Asymptomatic hyperammonemia is the most prevalent and, when present, requires close monitoring of plasma ammonia levels. The primary treatment is the discontinuance of valproic acid (Wadzinski et al., 2007).

Conclusions
The management of psychotic and non-psychotic behaviors in dementia is a complex issue and requires a multidisciplinary approach using non-pharmacological measures along with medications as needed. A meta-analysis of clinical studies determined the results were limited and failed to establish valproic acid as an effective treatment for agitation in patients with dementia when compared to control groups and higher rates of adverse reactions were prevalent (Lonergan & Luxenberg, 2009). When utilizing valproic acid therapy, serum ammonia levels should be monitored routinely as clear cut behavioral symptoms of hyperammonemia may emerge. If an ammonia elevation persists, discontinuation of valproate therapy should be considered.

Beatrice M. Matthews, GNP-BC
Beatrice_m_matthews@uhc.com

Paul R Clements, PhD, ARNP-BC

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Opportunity seems to knock when you least expect it. For Alice Bonner, PhD, RN, GNP, FAANP, a once-in-a-lifetime opportunity has opened the door for her to use her skills and her passion to effect change on a national level.

Dr. Bonner, a GAPNA member, was tapped to direct the Division of Nursing Homes at the Centers for Medicare and Medicaid Services (CMS), joining the Survey & Certification Group that is responsible for ensuring the country’s 16,000 nursing homes and skilled nursing facilities comply with CMS standards. She described the appointment as a chance to influence national policies and regulations and make a positive difference in nursing home quality for the entire country.

“Health policy is created through careful analysis, literature review, review of evidence and comparative effectiveness research, and the application of sound principles,” she said, noting those are the very skills she honed through her doctoral work and precisely what she’ll be doing in her new position.

“There is more we can do, to not only meet the current standards for nursing home care but to develop and apply optimal standards and best practices for our nation’s elderly.”

Dr. Bonner was recruited by CMS, where officials were aware of her work as the bureau director of health care safety standards and best practices for our nation’s elderly.

“A geriatric nurse practitioner for 20 years, Dr. Bonner had the clinical director of long term care and geriatrics at the Fallon Clinic, Worcester, MA. She joined the faculty at the University of Massachusetts Graduate School of Nursing (GSN) in 2002 as a clinical instructor and coordinator for the GSN geriatric track and was named assistant professor of nursing in 2008. Her research and policy interests include falls prevention, medication safety, and improving quality and safety in nursing homes. She received her PhD in nursing from GSN in 2008.

Though she set out on a path for a different career altogether (she was a French major in college, determined to become an interpreter for the United Nations), Dr. Bonner took a job in a nursing home during college and fell in love with it. “I loved what the nurses did. They had both a leadership role and a hands-on role, and they had an ability to make a real difference in their residents’ lives and create meaningful relationships with residents and families.”

“Geriatrics is the ultimate team sport,” she continued, noting the close collaboration of nurses, patient care attendants, primary care providers and specialists — and patients. “Patients are teaching us every day.”

Facing a surge in the elderly population as the baby boomer generation ages, Dr. Bonner is excited by the prospect of working with colleagues who have expertise in home care and community care to provide elders with choices. “Nursing homes are one of many ways of caring for our frail elderly,” she said. “Some people prefer to be in their own homes, but for others, a residential facility offers important social connections as well as nursing care. I think we’ll see a shift in the balance as our population ages.”

Barbara Resnick, PhD, CRNP, FAAN, FAANP
Professor of Nursing
University of Maryland School of Nursing
barbresnick@mail.com

Should Nurses Be Social Networking?

Yes, by all means nurses need to be social networking! This is a way of participating and learning about new and different therapies, new legislation, and issues and experiences in different parts of the country and various practice settings. Do we need to be aware of HIPAA laws and breaches of confidentiality? Of course we need to be aware of the laws concerning patient privacy. But that should not prevent us from blogging about nursing issues, community and public concerns, and offer education to all who want to read. The House Calls special interest group is currently working on setting up a blog on Facebook to talk about issues in the House Calls setting. It is an exciting time in the nurse practitioner field and we want to stimulate interest in this avenue of nursing. Watch for our announcement concerning the blog in the near future.

Peggy Brewer, MSN
Co-Chair, House Calls SIG
pbgnp@embarqmail.com

Find GAPNA on Facebook

Take advantage of the benefits (and fun!) of social networking on the GAPNA page on Facebook (www.facebook.com/GAPNA). Facebook connects friends, coworkers, and others who share similar interests. On GAPNA’s page, you can start a conversation, share photos, discuss gerontological nursing, and much more. The page gives you one more way to interact with nurses and others interested in GAPNA and our specialty. To become a fan, visit GAPNA’s page (www.facebook.com/GAPNA) and click the “Like” button.
The Final Rule clearly states the physician must be either employed by or contracted with the hospice agency. An NP must either volunteer or receive a W-2 form from the agency as an employee. NPs may not be contracted with the agency for this purpose, although they may be hired per diem. A patient's attending physician may not make the face-to-face visit.

What Is Required?

During the hospice face-to-face visit, meaningful metrics must be applied to demonstrate a patient remains eligible for the benefit based on a continued decline in function and a terminal diagnosis. Per the requirements, this visit must be made and a written narrative submitted up to 30 days prior to the recertification date by the hospice physician. These visits may be performed in a convenient place for the patient such as a home visit or can be performed in an office setting if it is safe for the patient to travel.

The Advantages of this New Legislation

The CMS-mandated changes may add an additional step to the HH referral process, but ultimately these required face-to-face encounters have the potential to improve patient care by ensuring those who receive services are homebound, have skilled needs, and have been referred appropriately. Other potential benefits may include improved coordination between the physician and HH agencies resulting in improved patient outcomes and an overall cost savings to Medicare. The same is true for hospice. While the hospice agency will not see additional Medicare reimbursement for the face-to-face visit, unless other medically necessary care is rendered at the same time, the potential for enhanced coordination of care as well as patient and family satisfaction may ultimately pay for itself.

Challenges and Opportunities

Given these referral rules with the narrow conditions under which patients may receive services in their home setting, more patients with chronic illness and multiple co-morbid conditions will be considered inappropriate for either home health or hospice care for the long term. Their complex needs will continue to grow and, unless programs of chronic disease management are put into place, will remain under-served.

Deborah I. Wolff-Baker, MSN, CHPN, FNP-BC
ElderCare Specialist and Home-Based Primary Care Provider
Deborah.baker@ncmahealth.com

References


Hyperammonemia

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References


Perceptions of Quality of Care for the Elderly Is Associated with Better Hospital Quality of Care

Affects Their Physical Functioning

Caregivers Leads to Improved

Anemia Is Common among Nursing Home Residents and Affects Their Physical Functioning

More than half of 451 nursing home residents who participated in a study of a restorative-care intervention to improve their functioning were anemic. These anemic residents tended to have lower scores for function, balance, gait, and overall mobility than residents without anemia, found the researchers. Two-thirds of anemic residents were treated with at least one medicine to treat this condition — iron replacement in more than half of cases and an erythropoietin in less than 10% of cases.


Better Hospital Quality of Care for the Elderly Is Associated with Lower Mortality after Discharge

Higher quality of care during hospitalization resulted in a lower likelihood of death 1 year after discharge, reveals a new study. This is important, as nearly one-quarter of all hospitalized older adults die within 1 year after being released from the hospital.

The researchers used a set of 16 Assessing Care of Vulnerable Elders quality care measures to evaluate the quality of care at one medical center. One year after discharge, 495 participants (26.7%) had died. After controlling for several variables, a higher quality of care was associated with a lower risk of dying after 1 year post-discharge. According to the researchers, every 10% increase in quality score meant that patients had a 7% less likely chance of dying. They also found that patients who received a nutritional assessment had a 39% less chance of dying 1 year after discharge.

For more info, see Arora, V.M. et al. (2010). Relationship between quality of care of hospitalized vulnerable elders and postdischarge mortality. Journal of the American Geriatrics Society, 58(9), 1642-1648.

More Nursing Home Residents Are Receiving Hospice Care

A growing number of nursing homes are collaborating with Medicare-certified hospice providers to provide palliative care to their dying residents, and resident referrals to Medicare hospices have increased. In fact, a new study finds that delivery of hospice care in nursing homes has increased significantly over time. However, current efforts aimed at reducing Medicare hospice costs may have a negative impact on the availability of hospice care in nursing homes, caution researchers.

In 1999, the number of Medicare hospice beneficiaries in nursing homes was 101,843. By 2006, this number had doubled to 233,844 beneficiaries. This growth resulted in part from the growth in the number of hospices providing care in nursing homes, which jumped from 1,850 in 1999 to 2,768 in 2006, a growth rate of 49.6%. Rates of nursing home hospice use more than doubled from 14% in 1999 to 33% in 2006. Mean lengths of stay also increased, from just 46 days in 1999 to 93 days by 2006. In 1999, 69% of patients in nursing home hospices died from a non-cancer diagnosis. This increased to 83% in 2006.


Colony-Stimulating Factor Is Effective in Reducing Infection for Elderly Patients with Non-Hodgkin's Lymphoma on Chemotherapy

Elderly patients with non-Hodgkin's lymphoma (NHL), who are undergoing chemotherapy, benefit from prophylactic colony-stimulating factor (CSF), concludes a new study. Most cases of NHL are diagnosed in individuals aged 65 and older. The decision to treat elderly patients with chemotherapy is not always straightforward, because the risk of febrile neutropenia after myelosuppressive chemotherapy is greater in older adults. Myelosuppression increases with age. Febrile neutropenia is associated with life-threatening infections. To combat this, CSF, which can reduce the incidence and duration of febrile neutropenia, is administered.


Review Looks at Approaches to Improve Drug Prescribing in Nursing Homes

Over the years, various interventions have been tried to improve prescribing practices in nursing homes. Recently, researchers conducted a review of randomized, controlled trials to see what interventions have been tried and their success rates. They found a variety of interventions with mixed results.

Published an Article Recently?

We are looking for GAPNA members who have recently published clinical or research articles. Let us know the title, publication, volume, and issue number of your article, along with a brief abstract/summary, and we'll share it with your fellow members in the GAPNA Newsletter. Keep us updated at GAPNA@ajn.com
Understanding Urinary Incontinence

Urinary incontinence (UI) is classified as either acute or persistent. Acute UI has an abrupt onset and is usually related to a reversible condition. When the condition is corrected, the incontinence usually resolves. Persistent UI continues after reversible conditions have been addressed.

It is important to differentiate between acute and persistent UI because acute UI may be a sign or manifestation of a serious but reversible condition. Evaluation of UI should begin with the correction of reversible factors. Reversible factors include delirium, infection, bladder irritants, atrophic urethritis or vaginitis, pharmaceuticals, psychological conditions, polyuria, restricted mobility or dexterity, urinary retention, stool impaction, or constipation.

Acute Urinary Incontinence

1. Delirium results in an inability to perceive or act on the urge to void. Determine and correct cause of delirium (illness or medication).
2. Infection. New onset of UI or increased volume or frequency of UI may be the only presentation of a urinary tract infection in the elderly. Urinary tract infection should be considered in any elderly patient with new onset of decline in clinical or functional status.
3. Bladder irritants promote lower urinary tract symptoms such as increased awareness of bladder filling, increased urgency and/or frequency, and urinary incontinence. Documented irritants include alcohol, caffeine, and nicotine. Anecdotal reported irritants are artificial sweeteners, concentrated urine, glucosuria, and perfumed bath or hygiene products.
4. Atrophic urethritis or vaginitis results in increased bladder irritability and decreased urethral resistance caused by estrogen deficiency. It may present as dyspareunia, dysuria, increased frequency and/or urgency, stress incontinence, urge incontinence, vaginal dryness, irritation, or pain. Clinical presentations may include smooth, pale, dry vaginal mucosa; red inflamed, bleeding mucosa; or prominent cherry red urethra. The condition may be corrected with vaginal estrogen therapy or vaginal lubricant or moisturizer.
5. Pharmaceuticals
   a. Certain drugs result in a reduced ability to recognize and respond to bladder filling. These include alcohol, hypnotics, narcotics, sedatives, and tranquilizers.
   b. Other drugs result in a decreased contractility of the bladder muscle resulting in incomplete emptying, increased urgency and/or frequency, and urine leakage. These drugs include antiarhythmic, antidepressants, antidiarrheals, antihistamines, antihypertensives, anti-Parkinson’s, antispasmodics, antipsychotics, and narcotics.
   c. Nonprescription oral or nasal cold medications may result in increased urethral resistance resulting in incomplete emptying of the bladder, increased urgency and/or frequency, and leakage.
   d. Rapid production of large amounts of urine resulting in increased urgency and frequency and leakage may be caused by alcohol, caffeine, and diuretics.
   e. Determine if the onset or exacerbation of UI correlates with initiation of a new medication or change in medication.
6. Psychological factors. Certain conditions may result in an inability to recognize or act on the urge to void due to cognitive impairment. Such conditions may include depression, dementia, confusion, learning disabilities, change in emotional or mental status, delirium, and anxiety.
7. Polyuria is excessive urine output resulting in increased urgency and frequency or leakage which may be due to CHF, diabetes insipidus, diuretics, excessive liquid intake, and hyperglycemia.
8. Restricted mobility or dexterity. Urinary incontinence may be due to factors resulting in an inability to reach a toilet in a timely manner. Contributing factors include environmental barriers, physical limitations, and assistive equipment.
9. Urinary retention may present as a sensation of incomplete emptying, dribbling of urine without the urge to void, hesitant urinary flow, interrupted urinary flow, postvoid dribbling, strain to void, urgency, and weak urinary stream. Causes of urinary retention are BPH, DM, fecal impaction or constipation, medications, MS, cystocele, pelvic surgery, SCI, CVA, tumors, urethral stricture, and hemorrhoid surgery.
10. Stool impaction or constipation. Pressure of a fecal mass on the bladder may stimulate bladder contractions resulting in increased urgency and frequency or urge incontinence. Pressure of a fecal mass on the bladder, urethra, and local nerves may cause physical obstruction of urine flow resulting in overflow incontinence or urinary retention.

Persistent Urinary Incontinence

1. Stress incontinence. Involuntary loss of urine caused by a sudden increase in intra-abdominal pressure with a corresponding increased pressure in the bladder with coughing, sneezing, or lifting due to poor pelvic muscle tone and/or urethral sphincter weakness. Stress incontinence may be managed with pelvic muscle exercises, biofeedback, vaginal weight cone therapy, electrical stimulation, or magnetic therapy. Pharmacologic therapy should be used with caution in elderly patients. Vaginal estrogen can be used for treating urogenital atrophy and stress incontinence.
2. Postprostatectomy incontinence may be related to sphincter deficiency, detrusor instability, or reduced bladder compliance. Therefore, postprostatectomy incontinence should be assessed carefully to determine the causative factor.
3. Urge incontinence involves involuntary loss of urine that occurs when a person is aware of the need to void but is unable to inhibit the urge long enough to reach a toilet. Urge incontinence may be managed with bladder training or urge inhibition, biofeedback, or electrical stimulation. Pharmacologic therapy should be used with caution in the elderly.
4. Functional incontinence is caused by problems outside of the urinary tract such as cognitive impairment, poor dexterity, or impaired mobility. Management options include scheduled toileting, prompted voiding, or containment.

Charlene Demers
Clinical Practice Committee
cdemersm@cfl.rr.com

References continued on page 13

**Clinical Research Corner**  
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Of the 18 studies, seven focused on various educational approaches to improve suboptimal prescribing practices. Another two studies measured the impact of computerized decision-support systems on adverse drug events and appropriate drug orders. Five studies looked at the role of the pharmacist and medication review activities. Two studies incorporated more than one intervention, and two studies used a multidisciplinary approach. Fifteen of the 18 studies (83.3%) resulted in a significant improvement for at least one or more dimensions of suboptimal prescribing. Three of the more recent studies were able to examine medication-related adverse patient events. Three of the four studies that focused on central nervous system medications showed a significant decrease in residents taking these medications after an educational intervention. Three trials on anti-infectives showed significant improvements in appropriate antibiotic prescribing after an educational or multifaceted intervention was implemented.


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**Call for Volunteers**  
*continued from page 1*

_Education Committee._ This committee participates in developing educational programs and information for the GAPNA web site and other resources; committee members may participate in a faculty special interest group in conjunction with the National Organization of Nurse Practitioner Faculties.

_Health Affairs Committee._ This committee monitors legislative events and activities and keeps the Board of Directors and membership apprised of events of potential interest and impact to GAPNA and advanced practice nurses who work with the older adults.

_Historical Committee._ This committee gathers and preserves GAPNA documents and pictorial memorabilia from inception in 1981 to present and is charged with creating a display of said material during the Annual Conference.

_Member Services Committee._ This committee serves to promote and retain GAPNA membership and oversee the formation of new state chapters.

_Practice Committee._ This committee is responsible for monitoring practice-related issues and keeping the membership informed of issues impacting advanced practice nurses in long-term care.

_Research Committee._ This committee solicits manuscripts for the GAPNA Newsletter and promotes and reviews research and practice posters, as well as oral presentations for use at the Annual Conference.

**Special Interest Group (SIG) Opportunities**

_Assisted Living SIG._ This SIG was formed to determine where GAPNA and the nurse practitioner can best impact this practice. Some goals include: evaluate state laws for consistency/inconsistency; research and identify various standards, polices; define the role; provide tools and resources to enhance the role; and reduce hospital/ER visits through early identification of changes in resident condition and early PCP notification.

_Hospice/Palliative Care SIG._ This SIG meets regularly to network and explore the partnership opportunities with key palliative care organizations to leverage each other’s strengths around practice, research, policy, education, and advocacy.

_House Calls SIG._ This SIG is interested in the area of primary care of geriatric patients that receive their health care in the home. Goals include: develop interest in the House Calls (HC) arena; provide information on starting a HC business or working in field; promote and support legislation that improves HC; and educate other nurses and general public about services of HC NPs.

_LTC/Nursing Home SIG._ This SIG discusses issues specific to nursing homes (NH) and brings issues of interest/importance to GAPNA related to nursing homes. Goals include: develop/accumulate resources useful to APNs in the NH field; promote APN leadership in the NH; and recognize policy issues and make recommendations to the Health Affairs Committee.

_Transitional Care SIG._ This SIG is interested in positioning GAPNA as an expert resource for transitional care (TC) issues of older adults. Goals include: increase awareness of TC within the context of older adult care delivery; identify best practices that incorporate TC; identify members currently involved in TC; and encourage other SIGs to have a goal related to TC.

We encourage you to support GAPNA by choosing a committee and/or SIG that matches your interests and experience. Please visit our web site (www.GAPNA.org) to download and complete the Volunteer Opportunities Form. All response forms are reviewed and evaluated based on current needs. If you have any questions or require additional information, please contact GAPNA at 866-355-1392.
**Presidents**

Evelyn Duffy, DNP, GNP/ANP-BC, FAANP  
CWRU-FPB/School of Nursing  
Cleveland, OH  
exd4@case.edu

Beth Galik, PhD, CRNP  
University of Maryland  
School of Nursing  
Baltimore, MD  
galik@son.maryland.edu

Pat Kappas-Larson, MPH, APN-C, FAAN  
Transformative Solutions  
Hastings, MN  
Patterson1@comcast.net

Barbara (Nikki) Davis, MSN, RN, FNP-C  
Evercare - Georgia  
Braselton, GA  
Barbara_N_Davis@uhc.com  
nikki779@hotmail.com

Barbara (Nikki) Davis, MSN, RN, FNP-C  
Evercare - Georgia  
Braselton, GA  
Barbara_N_Davis@uhc.com  
nikki779@hotmail.com

**Secretary**

Barbara (Nikki) Davis, MSN, RN, FNP-C  
Evercare - Georgia  
Braselton, GA  
Barbara_N_Davis@uhc.com  
nikki779@hotmail.com

**Treasurer**

Marianne Shaughnessy, PhD, CRNP  
University of Maryland, Baltimore  
School of Nursing  
Baltimore, MD  
shaughne@son.umaryland.com

**Director-At-Large**

Alice Early, MSN, ANP-BC  
Beaumont Hospital  
Division of Geriatrics  
Royal Oak, MI  
amie626@aol.com

James Lawrence, PhD, GNP-BC  
James Sexson, MD and  
Kaplan University School of Nursing  
Atlanta, GA  
jilapm@bellsouth.net

**National Office**

Michael Brennan, CMP  
Executive Director  
BrennanM@ajj.com

Sherry Dzurko  
Association Services Manager  
DzurkoS@ajj.com

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Please send mail and email address changes to GAPNA@ajj.com

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