National Black Nurses Association, Inc.

NBNA NEWS

NBNA SPECIAL ISSUE ON THE FUTURE OF NURSING

This newsletter is a tribute to two great leaders in the profession of nursing and the Institute of Medicine's Report on the Future of Nursing.

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Dr. Deidre Walton, President
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President's Message

IT IS TIME TO REFLECT on where we are as a nursing profession since the October 2010 release of the Institute of Medicine's (IOM) report on the Future of Nursing: Leading Change, Advancing Health. The National Black Nurses Association (NBNA) has joined forces to implement the recommendations outlined in the report in this transformation of the nursing profession. It is critical that registered nurses assume leadership roles to meet the increased demand for access to quality health care. As we move forward with the implementation of the Affordable Care Act and its intersection with the Transformation of Nursing as outlined with the Future of Nursing, NBNA stands firm with other professional nursing organizations to lead the change, playing a vital role in implementing strategies that will transform health care leading us to a healthier nation. The nursing profession is at a pivotal point to impact our health care system. A health care system whereby all Americans have access to high-quality, patient-centered care and nurses contribute to the delivery of care functioning to the full extent of their skills, training and education. NBNA continue to be recognized as a leader in transforming health care by demonstrating that we are well informed of relevant and pertinent legislation and critical issues in the United States but also issues that encompass a global perspective. We are sought after for our invaluable source of knowledge in education, research, and evidence-based clinical practice.

Two of the eight recommendations in the IOM report on the future of nursing call for increased leadership by nurses. The recommendations call for expanded leadership preparation for nurses. Specifically, nurses are needed to lead innovation at the bedside, to work collaboratively with physicians and other members of the interdisciplinary health care team to redesign care that is affordable and effective, and to service on public and private boards related to health care. (Scott, 2011).

Diversity in leadership roles is equally important to meet the changing needs of consumers of health care. NBNA holds membership on various national and federal advisory committees including the National Advisory Committee, Office on Women's Research, NIH; National Advisory Committee for the Office of Minority Health; National Advisory Council on Nursing Education and Practice; FDA Nominating Group; Joint Commission of Healthcare Organizations Nursing Advisory Committee; National African American Drug Policy Coalition, Inc.; National Council of Negro Women; Balm in Gilead Cervical Cancer Advisory Board; Healthy Mothers; Healthy Babies Coalition; Partnership to Fight Chronic Disease; CMS Medicare Partners; Coalition to End Cervical Cancer; Nursing Spectrum Magazine; and others.

NBNA host the NBNA Founders Leadership Institute at the organization's Annual Institute and Conference. The goal of the Institute is to establish and maintain learning opportunities directed at increasing NBNA member's leadership foundation and skills. NBNA Founders Leadership Institute is designed to develop nursing leaders among all association members.

In 2008, the Robert Wood Johnson Foundation and the IOM launched a two-year initiative to respond to the need to assess and transform the nursing profession. The IOM appointed a committee on the RWJF Initiative on the Future of Nursing. The committee's purpose was to produce a report that would make recommendations for an action-oriented blueprint for the future of nursing. (Academies, 2011). The committee determined that nurses should achieve higher levels of education and training through an improved education system that promotes seamless academic progression. The IOM committee suggests that nurses be educated in new ways that better prepare nurses to meet the needs of the population (Academies). NBNA's Ad Hoc Committee on the Future of Nursing is continuing its focus on Recommendation 4: Increase the proportion of nurses with a baccalaureate degree to 80% by 2020. NBNA has also established relationships with universities to offer opportunities for NBNA members to achieve seamless academic progression.

NBNA will continue its strategic direction for leadership and education as the nursing profession continues to implement strategies for the eight recommendations made by the IOM. NBNA, as an advocate for change and improving the quality of health care in our communities, continues to stand firm behind the IOM report. We will continue to take leadership roles in this call for action to transform the nursing profession.

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Our Future is in Our Hands

Ronnie Ursin, DNP, MBA, RN, NEA-BC, NBNA News, Editor-in-Chief, NBNA Parliamentarian

THE INSTITUTE OF MEDICINE (IOM) (2010) Report on the Future of Nursing supplied future nurses and current nursing professionals with clear expectations and direction for our future. The report stated, "Nurses should achieve higher levels of education and training through an improved education system that promotes seamless academic progression." The report also stated that we should, "Increase the proportion of U.S. nurses with a baccalaureate degree from 50 to 80 percent; and to double the number of nurses with a doctorate by 2020."

While we encourage and promote nursing as a profession, it is equally important to understand some barriers for student's entering and matriculating through nursing programs. In a study conducted to improve the awareness of barriers to successful completion of a nursing program, several factors were identified that are important for nurse leaders and academicians to understand (Loftin, Newman, Dumas, Gilden, and Bond, 2012).

- **Financial Support:** Student must work while matriculating through nursing programs; to cover education expenses and to care for the family.
- **Emotional and Moral Support:** Insufficient numbers of African American students in nursing programs decreased the opportunities for students to connect and develop relationships with other African American students leading to feelings of social isolation and loneliness
- **Advising and Academic Support:** Students are not provided with a full scope and perspective of the demand of a nursing program.
- **Mentoring:** Lack of minority faculty to serve as mentors and role models.

Understanding these and other factors will assist our efforts in developing stronger and sustainable strategies to ensure black nurses are positioned for success (80 percent by 2020).

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THE NATIONAL BLACK NURSES Association is pleased to present a Special Newsletter on the Future of Nursing. The transformational IOM Report on the Future of Nursing prompted NBNA to focus on two major platforms from the report, Nursing Leadership and Nursing Education. Since the release of the Report in 2010, NBNA has published articles on a quarterly basis on the two platforms. This issue chronicles past publications and offers novel programs around nursing leadership and nursing education. This Special Newsletter is filled with articles from NBNA leaders, other thought leaders, clinicians, academicians, researchers and policymakers about innovations in nursing leadership and nursing education.

NBNA continues its work through various advisory committees and councils to help make decisions about changing nursing practice. NBNA appreciates its members who serve on the State Action Councils to help reform nursing practice at the state levels. NBNA is grateful to its membership and stakeholders who contribute to the NBNA scholarship program so that nurses and nursing students will have the financial support to continue their nursing education (80 by 20). NBNA is thankful for the supporters of its leadership programs, the Presidents' Leadership Institute, the Founders Leadership Institute, the Summer Youth Institute, the Forty and Under Forum and the Student Nurse Forum…all designed to inspire and encourage nurses and student nurses to become excellent nurse leaders.

NBNA is most appreciative to Dr. Linda Burnes Bolton, NBNA Past President and Vice President and Chief Nursing Officer, Cedars Sinai Medical Center, Los Angeles, CA and Dr. Donna Shalala, President, University of Florida, Miami, FL, for their astute leadership to produce the Future of Nursing Report. This Special NBNA Newsletter on the Future of Nursing is published to bring to you the best in nursing leadership and nursing education.

Millicent Gorham, HD, MBA, FAAN
Executive Director
National Black Nurses Association

The NBNA on the Future of Nursing Campaign for Action

Rita Wray, MBA, RNC, FAAN

THE ROBERT WOOD JOHNSON Foundation (RWJF), in collaboration with AARP, has embarked on a national Campaign for Action that builds upon the findings in the landmark Institute of Medicine (IOM) report *The Future of Nursing: Leading Change, Advancing Health.* This campaign seeks to advance comprehensive healthcare change by fully using the expertise and experience of all nurses.

RWJF and AARP are working with Action Coalitions that are coming together in states across the country, comprised of diverse groups of stakeholders including providers, policymakers, consumers, and businesses that can affect long-term sustainable change. Action Coalitions, led by a least two entities—representing a nursing and a non-nursing organization—are active in thirty six states. The goal is to have Action Coalitions in most states by early 2012. Action Coalitions are identifying key changes they will strive to achieve, and are also capturing and sharing best practices, determining research needs, tracking lessons learned, and identifying replicable models. Action Coalitions are charged to track their progress, in fulfilling their objectives and share progress, challenges, and lessons learned across states as a community of change agents.

Each Action Coalition has developed a strategic plan to further the Campaign's goals and objectives that takes into account local and regional concerns.

The recommendations issued by RWJF/IOM of the Initiative on the Future of Nursing's (IFN):

- Nurses should practice to the full extent of their education and training.
- Nurses should achieve higher levels of education and training through an improved education system that promotes seamless academic progression.
- Nurses should be full partners, with physician and other healthcare professionals, in redesigning healthcare in the United States.
- Effective workforce planning and policymaking require better data collection and an improved information infrastructure.

These recommendations were addressed by the NBNA Board of Directors and members in CY 2011 by incorporating the following proposals into NBNA's strategic plan:

- Maintain a leadership track for members—assuring nurses have an opportunity to lead and diffuse collaborative improvement efforts.
- Implement an entrepreneurial professional development subtrack that will enable nurses to initiate programs/businesses that will contribute to improved health and healthcare.
- Incorporate into our health policy agenda measures which support all nurses practicing to the full extent of their education and training.
- Collaborate with other healthcare associations and organizations in the promotion of seamless academic progression and an increase in the proportion of nurses with a baccalaureate degree from 50 to 80 percent by 2020.
- Continue NBNA's Annual Institute and Conference assuring nurses have an access to programs providing continuing competency requirements and lifelong learning experiences.

It is now time to further define our goals and objectives. NBNA is currently seeking input 1.) to further determine our direction in advancing the recommendations and our organizational impact in leading change and advancing health as it relates to our mission and members, and 2.) to formulate steps to make an impact in the areas of *promoting seamless academic progression and leadership*. We need your help. Several NBNA members have undertaken instrumental roles in leading this endeavor—from serving as Vice Chairperson of the IOM report to serving as Co-Leads of Action Coalitions to independently helping to advance the Campaign's goals through worksite and various organizations.

The overarching goal remains—to improve patient care. Let us hear from you on best practices of organizationally incorporating NBNA's nurses in leading change and advancing health.

Rita Wray, MBA, RNC, FAAN, Ad Hoc Committee Chairperson on the Future of Nursing; Co-Lead Mississippi Action Coalition.

Campaign for Action Names 10 State Groups as Regional Action Coalitions to Ensure a Prepared and Effective Health Care Workforce

Goal is Long-Term Change in Health and Health Care

THE FUTURE OF NURSING: Campaign for Action, a Robert Wood Johnson Foundation initiative to ensure that the health care workforce can deliver high quality, patient-centered care to every American, today announced the selection of 10 Regional Action Coalitions (RACs). These long-term partnerships have been convened to move key health care workforce-related issues forward at the local, state and national levels.

The Campaign for Action (CFA) is focused on preparing health professionals to lead the change that will improve the health care system. It aims to maximize their contributions to collaborative, interdisciplinary teams across the spectrum. In collaboration with AARP, CFA is enlisting support across the health care spectrum and engaging prominent leaders and organizations from government, business, academia and philanthropy.

"The Campaign for Action must work at every level if we are to initiate and sustain the changes necessary to improve health care for all Americans," said Susan B. Hassmiller, Ph.D., R.N., F.A.A.N., senior advisor for nursing at the Robert Wood Johnson Foundation. "Our new RACs will help shoulder this effort. They are essential to fulfilling the campaign's mission."

The following states join the New Jersey, New York, Michigan, Mississippi and California RACs, which initiated their activities last fall.

- Washington
- Utah
- New Mexico
- Indiana
- Virginia
- Idaho
- Colorado
- Illinois
- Louisiana
- Florida

RACs function as a component of the campaign's field operations. Comprised of diverse groups of stakeholders from a variety of sectors, their mission is focused on fostering interprofessional collaboration, the ability of all health care professionals to practice to the full extent of their education and training, strengthened nurse education and training and the increased participation of nurses as leaders. RACs will further CFA by capturing best practices, determining research needs, tracking lessons learned and identifying replicable models.

"The uniqueness of each applicant's coalition and their proven capacity were key factors in our selection of these 10 geographically diverse groups from across the country," said Susan Reinhard, Ph.D., R.N., F.A.A.N, senior vice president of the AARP Public Policy Institute and chief strategist, Center to Champion Nursing in America. "They have already made great strides in their states, and their RAC applications reflected capable coalition leadership and clear goals and objectives coupled with strong action plans."

Twenty applications were received in February for this round of RAC selections. CFA aims to ultimately engage groups in all 50 states. To help build and sustain momentum across the country, states that have not yet become RACs have access to campaign materials and communications for use in the change efforts they have initiated in their states.

According to Hassmiller, "we are glad to see such enthusiastic interest from the states in becoming RACs, and look forward to reviewing additional applications and again expanding the RAC community this summer."

The Robert Wood Johnson Foundation focuses on the pressing health and health care issues facing our country. As the nation's largest philanthropy devoted exclusively to improving the health and health care of all Americans, the Foundation works with a diverse group of organizations and individuals to identify solutions and achieve comprehensive, meaningful and timely change. For more than 35 years the Foundation has brought experience, commitment, and a rigorous, balanced approach to the problems that affect the health and health care of those it serves. When it comes to helping Americans lead healthier lives and get the care they need, the Foundation expects to make a difference in your lifetime. For more information, visit www.rwjf.org.

Reforming Health Care: We've Got the Power

Beverly Malone, PhD, RN, FAAN, CEO, National League for Nursing

YOU'VE ALL HEARD IT A MILLION TIMES: What happens in Vegas stays in Vegas. Well, ever since the National League for Nursing's annual Education Summit this past fall, nurse faculty have been turning that ubiquitous saying on its head. Returning to homes and classrooms across the country and around the world, you have been telling students and colleagues about how the power of nursing education and nurse educators—our vision, our knowledge, our influence, our strength—has shaped history and continues to shape the world we live in. (By the way I saw many of you at the Summit, strongly present, representative of the best that NBNA brings to our health care system.)

We often talk about the power of nursing education, but in 2010 especially, that power has been made manifest by our impact on current events. We focused that power, keeping our eyes on the prize: health care reform.

Fundamental to the nursing profession and integral to NLN core values is the principle that all individuals must have equitable access to comprehensive health care services. In 2008, even before the rapidly increasing unemployment rate, a staggering 46 million-plus people in our communities lacked health insurance, and millions more had inadequate coverage. The NLN is committed to the principle that everyone in the nation must have access to health care including a health home for health promotion, basic care, and non-urgent medical needs.

Nurse educators believe that it is our responsibility to remember that, at the end of the day, we're serving patients and advancing the health of our nation. That as we teach the future nurses of America, we touch all Americans; as our colleagues around the world teach their students, they touch people to the four corners of the earth. And this imperative was recently advanced with the most significant historical shift in nursing of this century, the October release of the Institute of Medicine (IOM) Report. Funded by the Robert Wood Johnson Foundation (RWJF) Initiative on the Future of Nursing, it will have a profound impact on how we educate nurses for a transformed health care system.

Along with our fellow organizations in the Tri-Council for Nursing—the American Association of Colleges of Nursing, the American Nurses Association, and the American Organization of Nurse Executives—the League wholeheartedly endorsed its recommendations. We are united in our view that it provides a practical blueprint for elevating nursing's role in transforming the health care delivery system and meeting the challenges of health care reform for the betterment of patient care.

The report's timing was perfect, as well, capping a wave of significant initiatives in 2010. This was the year that Congress finally passed health care reform legislation in the form of the "Patient Protection and Affordable Care Act." This was the year that the NLN and fellow Tri-Council organizations released a statement warning that any policy that diminishes the pipeline of future nurses puts the health of Americans at risk. Disseminated widely and receiving a lot of attention, the statement advised against slowing the production of RNs given projected demand. And 2010 was the year that the NLN tackled a host of other important issues, creating a platform to understand divergent thinking and allow the community of nursing to come together, based on the NLN's core values: caring, integrity, diversity, and excellence. Divergent approaches provide organizational room and support for our sisters and brothers who are LPNs or LVNs. They are the most visible providers of nursing care to our older adults in the community.

The National League for Nursing wholeheartedly supports the principal recommendations outlined in the IOM report, which were developed around these four key messages:

- Nurses should practice to the full extent of our education and training.
- Nurses should achieve higher levels of education and training through an improved education system that promotes seamless academic progression.
- Nurses should be full partners, with physicians and other health care professionals, in redesigning health care in the United States.
- Effective workforce planning and policy-making require better data collection and information infrastructure.

We urge our colleagues in the National Black Nurses Association and the entire nursing community to recognize that with these recommendations come opportunity and responsibility. Resources will be available to implement, manage, and evaluate them in states and regions across America. The conversation has already started as we seek to maximize this opportunity to make a difference to the future, to transform nursing education and nursing with daring ingenuity in the pursuit of excellence.

Dr. Beverly Malone has been the chief executive officer of the National League for Nursing, the voice for nursing education, since 2007. She had previously served as general secretary of the Royal College of Nursing, the United Kingdom's largest professional union of nurses and as deputy assistant secretary for health within the US Department of Health and Human Services, the highest position so far held by any nurse in the federal government. Her dynamic career has encompassed public policy, education, administration, and clinical practice.

Removing Barriers to Nursing Practice

Catherine L. Gilliss, DNSc, RN, FAAN, President, the American Academy of Nursing

IN OCTOBER 2010, THE INSTITUTE of Medicine released *The Future Of Nursing: Leading Change, Advancing Health*, a report funded by the Robert Wood Johnson Foundation and written by a distinguished panel of leaders in health care. The report identified four key messages about the future of nursing and eight, specific recommendations. The Board of the American Academy of Nursing (AAN) was gratified to note the report's focus on an issue called out by the AAN in its recently developed strategic plan: Removal of the Barriers that limit nurses from practicing to the full scope of their preparation.

As its first "key message," Leading Change declares: Nurses should practice to the full extent of their education and training. The first of the report's eight recommendations reinforces the key message, calling to "Remove scope-of-practice barriers." The call is well supported by the evidence and long overdue.

Dating back to 1995, the evidence for equivalent outcomes between nurse practitioners (NPs) and certified nurse midwives (CNMs) and physicians (MDs) was presented in a rigorous meta-analysis (Brown and Grimes, 1995). More recently, two studies conducted by the Research Triangle Institute (2010) and the Lewin Group (2010) reported comparable outcomes for certified registered nurse anesthetists (CRNAs) and anesthesiologists (MDAs)and favorable cost data for CRNAs, when compared to MDAs, respectively. Even the editorial pages of the New York Times (NYT, September 7, 2010) took a stand in support of the CRNAs, suggesting that the additional cost of preparing an MDA provider and the additional charges for their services should be considered when planning future approaches to health care delivery design and work force planning.

Despite the evidence, the politics of advanced practice nursing overlapping with physician practice continues to dominate state-based policy on scope of practice for nurses. The need for physicians is not under dispute. The question is how to create a rational approach to workforce planning and delivery design. The evidence is clear that nurses can substitute for physicians when dealing with stable problems and common procedures, which comprise the bulk of those addressed in today's health care system. Given their advanced training, physicians should similarly practice at the top of their licenses, addressing the most complex of cases.

The evidence further supports that NPs, CNMs and PAs are in adequate supply in states with favorable practice environments (Sekscenski, et alia, 1994). In othere words, these providers migrate to environments where the barriers to practice to not limit the scope of practice.

Given this evidence and the need to expand health care services for the millions of Americans who will be able to access health insurance under the Affordable Care Act, there is an imperative to act quickly to remove the barriers to the public being able to access affordable, high quality, equitable, safe health care services by advanced practice nurses.

Recommendation 1: Support immediate changes in existing Medicare and Medicaid regulatory barriers, such as the requirement that physicians sign off on APRN referrals to home health and hospice or to order DME.

Recommendation 2: Support rational approaches to health workforce planning and related educational supports that assume that each provider will practice "at the top" of the license.

Catherine L. Gilliss is the Helene Fuld Health Trust Professor of Nursing and Dean at the Duke University School of Nursing, where she serves as Vice Chancellor for Nursing Affairs

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A Reflective Look at Practical Nursing

Ottamissiah Moore, President, National Federation of LPN; NBNA Life Time Member

OVER 26 YEARS AGO, I stood with a group of my peers in a crisp white uniform, holding a nightingale lamp. It was my graduation from License Practical Nursing (LPN) school and my entrance into the nursing profession. Armed with my new license, a new nursing venture and a great mentor, I was preparing myself for best career of my life.

The past

When I look at the history of practical nurses, some contend it began in 1897, with the programs at Massachusetts General Hospital in Boston, and New Haven Hospital in Connecticut which opened around 1873. Others believe LPN practice started with the programs established in New York. These "trained" nursing schools were Bellevue Hospital in New York City, the Ballard School in New York (1893) (Anderson, 2001, p. 17); and a training program for practical/vocational nurses developed by the American Red Cross (1892) at the Young Women's Christian Association in New York City. After the turn of the century, LPN education and licensure became more formalized with the opening of the Thompson Practical Nursing School in Vermont in 1907 and the Household Nursing School in Boston in 1918 (White & Duncan, 2001).

World War II brought the need for additional nurses, which focused attention on the contributions of the LPN/LVN. The "Practicals" were licensed through waivers and different States had different ways. Some required a letter of recommendation from a physician, a supervisor, etc., and the nurse had to have worked as a practical nurse for at least five years immediately prior to application. State-by-State, they were waived into nursing. Their licenses had a "W" on it and for many of them it was a stigma until they actually took the licensure exam. By 1945, 19 states and one territory had licensure laws. One state was permissive licensing.

The National Federation of License Practical Nurses (NFLPN) was organized in 1949 to provide a structure at the national level through which LPNs and LVNs (Licensed Vocational Nurses) could promote better patient care and to speak and act on behalf of the occupational group. It is the only organization in the United States governed entirely by LP/VNs for LP/VNs. NFLPN is recognized by the other national nursing organizations as the official voice of LP/VNs.

The Present

The discussion about the "phasing out" practical nurses has been going on for more than 26 years. Although the conversation is quietly spoken, practical nurses are slowly leaving areas they have practiced in for many years. Licensed Practical/ vocational Nurses across the county are voicing their concern over several issues as discussed below.

The underutilization of practical nurses, in some states and workplaces, prohibits practical nurses to perform tasks that they have been taught, and show knowledge, skill and competency to perform. LP/VNs are being replaced by unlicensed assistive personnel. During periods of nursing shortage, LP/VNs are often recruited for positions which were originally RN jobs and assistive personnel are often recruited for jobs traditionally held by LP/VNs. While they can assist with tasks associated with the maintenance and support of the aged, they do not and cannot replace the LP/VN at the bedside. While we may not be able to conduct comprehensive assessments of the patient, we do understand patient response, we have been taught how to conduct general assessments and able to accurately convey patient status, care concerns and needs in a manner unknown to unlicensed assistive personnel.

LP/VN students are not receiving the education and career opportunities previously afforded the profession. Clinical experience has always been an integral part of nursing education. It prepares student nurses to be able to perform as well as have knowledge about the clinical principles in practice. Clinical practice stimulates students to use their critical thinking skills for problem solving. There is a strong demand for high-quality, cost-effective clinical education experiences that facilitate student learning in the clinical setting. The clinical learning environment (CLE) is the interactive network of forces within the clinical setting that influence the students' clinical learning outcomes. We believe clinical experiences would improve the knowledge, skills and abilities of LP/VNs. We have heard about problems existing with students obtaining clinical experiences, preceptorships, and job placement. No studies have been conducted on this issue. Concerns about lack of clinical experiences for LP/VN students may be one of the barriers to the NCLEX pass rate and employment opportunities.

The Future of practical nursing

It appears there are more questions than answers. The practice, the market and the education of LP/VNs is changing every single day. The questions are…

How will LP/LVN become educated?

Who will offer clinical sites to LP/LVN students?

What will the skill set of an LP/VN look like over the next 10 years?

How will practical nurses transition to another position if the market does not utilize them?

Who will precept LP/VNs new to practice?

These questions and others about the issues are endless. Leadership in nursing must take a look at what part LP/VNs have in nursing history, bedside nursing, patient outcomes and work together to carve out a role and practice specifically for LP/VNs now and for the future. Leadership must be creative in our

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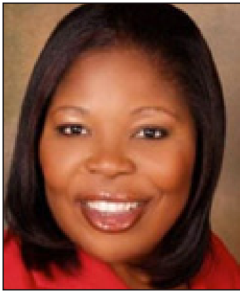

The Voice of Tallahassee

Daphne Campbell, RN, Florida State Representative

AS A PRACTICING REGISTERED NURSE for 30 years, stepping into the political arena in 2010 was an eye-opening experience which allowed me to view the medical field in a different light. I had now been granted the voice needed to bring change to areas that myself, as a registered nurse, as well as many of my coworkers felt were necessary. As I experience my second Florida Legislative Session, I pride myself in being able to make informed decisions about bills regarding the medical field.

One of my main priorities in the Florida Legislature is to expand the scope of practice for advanced registered nurse practitioners (ARNP). ARNPs in Florida and Alabama are the only ARNP's in the United States who are not able to prescribe controlled substances. In November 2011, Florida Taxwatch, a not-for-profit, private, nonpartisan research institute published an article that estimated that Florida taxpayers would save $339 million annually if the Legislature enabled nurse practitioners to function at their "full scope" of practice. Legislation to expand the scope of practice for ARNPs is scarce. The lack of legislation is due to powerful lobbying groups in Florida that serve the needs and financials of other self-serving medical professionals.

I filed House Bill 4103, during the 2011 Legislation, to delete provisions that require for a physician to supervise certain ARNPs and physician assistants at medical offices other than the physician's primary practice location. However, due to heavy lobbying against this bill by powerful medical lobbyist groups, this bill was not heard on any committee. For this reason, I filed House Bill 1195 and Senator Gary Siplin (D-Orlando) has filed Senate Bill 1750 to allow ARNP's sign a Certificate of Involuntary Examination under the Baker Act. A Certificate of Involuntary Examination is used when a patient is suicidal or homicidal. It allows the healthcare provider the ability to protect the public from a homicidal patient. Professionals who currently have this ability include: social workers, marriage and family therapists, psychiatric nurses, and physician's assistants. HB 1195 and SB 1720 put ARNPS as an addition to the list. ARNPs education and training fully qualifies them to execute an involuntary examination certificate.

ARNPs provide primary and acute care in many Florida clinics, emergency rooms, and hospitals. ARNPs are often the only health care providers in free and low-cost clinics; especially in rural areas. When ARNPs are the only health care providers on duty, they must call a Law Enforcement Officer to evaluate a patient and to sign the certificate. Susan Lynch, an ARNP who spoke on behalf of the bill in the Health and Human Services Access Subcommittee in the Florida House of Representatives, testified that she had once waited over 2 hours for a law enforcement officer to arrive at her clinic where a patient had threatened to commit suicide. This process ties up valuable police time and can often take a deputy of the street for several hours. Using law enforcement for this purpose is a poor use of resources.

Authorizing ARNPs to initiate Baker Act exam prevents delays in treatment and transfer of patients to the inpatient psychiatric care setting and avoid using law enforcement in an unnecessary manner.

Daphne Campbell is a first-term Florida State House Representative elected in 2010. She has just completed her first year in office. Representative Campbell is originally from Haiti and has been a Registered Nurse for over 30 years. Due to the many problems voiced by members of her community, Daphne ran for office in 2010 and won the seat for District 108. She has helped pass several bills like "Medical Malpractice" and "Affordable Housing." During this upcoming 2012 Session, Representative Campbell has several bills such as "Student Involvement in Educational Governance" which will establish a student advisory council in the Department of Education and "Employment of the Homeless" which will give a tax credit to employers willing to hire the homeless.

A Reflective Look (continued)

thinking to assist LP/VNs to transition to the role of an RN. The nightingale light of LP/VNs is still shining. Given the opportunity, LP/VNs will prove the value of practical nursing in the primary, preventive and long-term care settings. We only need to have our light shine brighter.

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Growing Nurse Leaders at UnitedHealth Group: Nurse Leader Executive Program

Dawn Bazarko, DNP, MPH, RN; Senior Vice President, Center for Nursing Advancement, UnitedHealth Group

UNITEDHEALTH GROUP is one of the largest employers of nurses in the nation and its Center Nursing Advancement has created a number of programs to harness the capacity of nurses to drive transformative change in health care in our country. One key area of focus is on nursing leadership and the creation of enhanced executive mindset in our nurses.

Through a number of efforts to assess unmet needs in our more than 10,000 nurses, we identified several gaps that we believed prevented nurses from moving to greater leadership roles in our company. These gaps primarily centered on executive presence and business acumen.

A major leadership development opportunity emerged for UnitedHealth Group nurses based upon these findings: The Nurse Leader Development Program. In this program, six to ten company nurses are provided the opportunity to attend a retreat-based educational experience at a local university in Minneapolis, Minnesota. Eligible nurses come from across the continental U.S. and are selected based upon their level in the organization, their proven track-record as a leader, and their commitment to actively engage in all aspects of the program.

The curriculum focuses on enhancing executive mindset and developing business acumen through mini-courses in change management, finance, executive communication, process improvement, ethics, strategy, human resource management, and other important topics. Program development is guided through a nursing lens. A senior nurse leader serves as the Industry Faculty Lead, teaches in the program, and attends all aspects of the program to ensure strong linkages back to the challenges and opportunities that nurse's face as leaders.

In addition to the classroom experience and the rich networking opportunity, nurse participants from UnitedHealth Group also receive peer and leader 360 degree feedback at the start of the program and again at program end, this feedback is utilized to create ongoing development plans. Each nurse also works on a Leader Development Project over the course of one-year. The Leader Development Project is the translation of knowledge into action and is an important aspect for measuring the return on our investment. We further support our nurses' development by offering additional enrichment opportunities as our participants identify; examples include enhanced presentation skills and additional training in finance in healthcare. Nurse participants present their projects to key UnitedHealth Group executives at the mid-term and completion of the one-year experience.

Program participants benefit from a company executive serving as their project sponsor. Additionally, each is assigned a "career sponsor" who is responsible for ensuring that the nurse leader benefits from ongoing coaching, mentoring, and development throughout this experience and beyond. The career sponsor champions for the advancement of the nurse leader within our organization and seeks out other high-profile assignments and opportunities to enhance the leader's visibility.

As we enter our third year of the program, UnitedHealth Group is realizing 100% retention of the nurse leaders who have participated in this offering. Several of our nurse participants have appreciated significant role expansion that they attribute to this experience. There are several other outcome measures that we are monitoring beyond retention rates, role expansion and the project return on investment. These include promotion rates, employee engagement scores and an assessment of the leader shadow. The leader shadow evaluates the impact that this nurse leader has on living our company values and positively growing and influencing their "followers", whether their direct team members or others they touch.

The Institute of Medicine's Future of Nursing Report has served as a beacon to organize us around a common goal and a set of action-oriented recommendations. UnitedHealth Group's Center for Nursing Advancement is proud to report that our work has been well-aligned with the report recommendations and that we continue to innovate and find ways to invest in our nursing workforce in a bold and courageous fashion. These investments, like the Nurse Leader Executive Program, are making a real difference in our workforce, and more importantly, in the lives of those we serve.

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AORN Offers Solutions and Tools to Support Needlestick Safety in the O.R.

Linda Groa, MSN, RN, CNOR, NEA-BC, FAAN, Executive Director/CEO, Association of Peri-Operative Registered Nurses

ACCORDING TO A REPORT published in the April, 2009 issue of the *Journal of the American College of Surgeons* (JACS), the rate of accidental sticks in non-surgical settings in hospitals has dropped 31.6% since the Needlestick Safety and Prevention Act was signed in 2000. During that same period, however, the rate of accidental sticks in OR settings has increased by 6.5 percent. What needs to take place in the operating room to keep our colleagues and patients safe?

To find out, the Association of periOperative Registered Nurses invited several leading experts in OR management and safety to join AORN's Nursing Practice Committee to offer their perspectives on the issue of sharps safety in the OR. This multidisciplinary team of experts outlined some specific actions that OR teams can take to reduce the risk of accidental sticks, including many options that can be introduced immediately, such as the use of double gloving, establishing a neutral zone to pass instruments, the use of products designed to reduce stick risk such as safety suture needles, and simpler reporting of needlestick injuries to make sure that OR teams are aware of the scope of the problem.

We know from the JACS report that while these issues affect the entire OR team, about 80% of accidental sticks in surgical procedures affect nurses or surgical technologists and 75% of sticks occur when instruments are passed from one member of the OR team directly to another. With these troubling statistics, the clear conclusion is that improved sharps safety practices must be adopted and maintained by ORs across the U.S.

According to Deborah G. Spratt, RN at Canandaigua Veterans Medical Center, concern about accidental needlestick is common among nurses. She calls for hands-free passing zones, blade-protected scalpels and blunt suture needles to create a "culture of safety" to protect both patients and nurses and other members of the OR team.

Dr. Ramon Berguer, MD, FACS, at Contra Costa Regional Medical Center finds that accidental sticks among surgeons are often not reported, perhaps because of onerous reporting requirements. He also confirms that some surgeons may be slow to adopt new and safer technologies to reduce the risk of accidental stick.

Sherri Alexander, CST, President of the Association of Surgical Technologists, calls for expanded resources to educate perioperative teams about the risk of accidental stick, indicating that many surgical technologists support efforts to position sharps injury prevention as a key component in a "gold standard" of patient care.

Sue Barnes, RN, National Leader Infection Prevention and Control, believes that surgical suites should consider a "zero incidence" goal for infections associated with accidental needle sticks, indicating that this goal is achievable with improved safety standards and products.

In an effort to address this issue, AORN is working in collaboration with other health care organizations to identify new strategies and resources for OR teams. In March we plan to introduce a Sharps Safety Tool Kit specifically designed to provide OR teams with the tools they need to take proactive steps to reduce the risk of accidental sticks. The kit will include educational tools to help any OR team use safer devices and procedures. It will also include a universal sharps safety policy with clear guidance on acceptable standards. The kit reinforces the need for all members of the OR team to take an active role in meeting or exceeding acceptable safety standards.

The kit includes a letter to surgeons, a Sharps Safety Policy & Procedure, Neutral/Safe Zone Policy and Procedure, Sharps Safety Education Power Point, Recommendations on how to create a Sharps Safety Board for the OR, a Hands-Free Passing Zone video, a selection of Sharps Injury Prevention Devices and Guidelines for Clinical Educators, an Implementation Plan for Trialing Blunt Suture Needles, Sharps Injuries Literature Review, Sharps Safety Bibliography, and a Sharps Safety Online Resource List.

The kit is just one example of resources and strategies that OR teams can consider and access to improve safety. OR teams can and should be challenged now to set target goals for improved safety and reduced risk of infection and to develop a plan of action that will achieve those goals as quickly as possible. Without taking action, many nurses and other OR team members will remain at risk unnecessarily.

A Call to Nurses for More Leadership

Thelma R. Roach-Serry, BSN, RN, NE

WHAT DOES LEADERSHIP as a nurse mean to you? As nurse leaders we should all be actively involved as leaders not only at the bedside, but also in the board room. We should expand our calling to help others at the highest level and farthest reach that we can have. Since my days at Howard University in Washington, D.C. and perhaps as growing up as one of four children amongst three male siblings, I learned a lot in in regards to leadership. I quickly learned to speak up in order to survive teasing and taunts from my brothers.

According to Robert K. Greenleaf, leadership "begins with the natural feeling that one wants to serve, to serve first. Then conscious choice brings one to aspire to lead." As a self-professed leader, I have felt a tremendous calling to be actively engaged in my church, community and profession. I have a long history of being engaged with professional organizations from the Student Nurses Association at Howard, to involvement at the local and state level of the Virginia Nurses Association, to my involvement with Nurses Organization of Veterans Affairs (NOVA) at the chapter level and serving on national board, to being connected to a number of service organizations and groups including Alpha Kappa Alpha Sorority, Inc. and Chi Eta Phi Nursing Sorority, Inc.

As nurse leaders, we are challenged and compelled to do more, be better leaders showing others through our service and leadership that we voices that need to be heard. As we reflected in our current state with health reform and the Roberts Woods Johnson Foundation Institute of Medicine report on the Future of Nursing (IOM/FON), we have to accept the call to represent the nursing profession at every opportunity more than ever before because people want to hear what we have to say. When we are asked to provide input or to participate, we are demonstrating leadership.

Recently, I had the opportunity to attend FDA Office of Women Health Nurse Stakeholders Meeting which was held in the US Capitol on Wednesday, October 26th. I was there officially representing NOVA, but I also was there because as Nurse Manager of Specialty Clinics at McGuire Veterans Affairs Medical Center in Richmond, Virginia I also saw the opportunity to gain new contacts and additional resources of information for the staff in involved with our women's health programs. The meeting pertained to Women's Health issues from the perspective of nurses who are stakeholders in providing this care. The meeting was held at the Association of Women's Health, Obstetrics, and Neonatal Nursing (AWHONN). The meeting was attended by various individuals representing more than twenty organizations. The meeting was lead Beverly Gallauresi, MPH, RN, Senior Nurse Advisor (Beverly.Gallauresi@fda.hhs.gov) and of FDA HHS and Marsha Henderson, MCRP Associate Commissioner for Women's Health, FDA OWH. The Meeting Objectives were three fold—networking dialogue with nursing professionals who share similar goals and objectives in support of women's health, opportunities for collaboration with OWH Outreach and Research and Development teams, and introduction to FDA OWH Hispanic outreach efforts on Safe Medication Use.

Participants elaborated on their organization priorities and there was excellent dialogue about their priorities for 2012 for women's health. I had the opportunity to share information about the VA. The outcome of the meeting was directed at enabling the participant organizations to collectively plan a strategy to enhance and expand efforts related to women's health care throughout the nation. It was also a time to network and make new connections with other who are actively engaged in nursing organizations. It was an opportunity for nurses to engage with other nurses to strategize and plan on how we can be more engaged with each other and more importantly with the healthcare community.

I also had the opportunity to speak about the IOM/FON and to challenge nursing leadership at the October meeting of BNA, Central Virginia Chapter. The meeting was held at John Randolph Medical Center in Hopewell, Virginia and was attended by Virginia State University Nursing Students, BNA members, and the executive nursing team of the medical center. What an awesome opportunity for me to be involved as a nurse leader serving as a role model for rising nurse leaders and inspiring fellow colleagues to continue to represent the nursing professional proudly and unashamedly. Other presenters at the meeting included Florence Jones-Clarke, RN, MSN of the Virginia State Board of Nursing and National Board Member of the American Nurses Association and Pat Lane, RN, MBA, the Neuroscience Coordinator—St. Francis Medical Center in Chesterfield, Virginia and former member of the NBNA Board of Directors. These two ladies are examples of nursing leadership. The meeting was a strategic planning meeting for leaders to mentor others and a call to service for all in attendance. I walked away feeling empowered and challenged to do more as a nurse leaders.

So what does leadership as a nurse mean to you? I compliment every nurse for what you are doing to serve others, but I also challenge you to continue to excel as leaders and to always push the envelope and always be willing to be a voice as nurse leaders.

Thelma R. Roach-Serry, BSN, RN, NE, currently works as the Nurse Manager, Specialty Clinic at Hunter Holmes McGuire Veterans Affairs Medical Center. She is the Vice-President of the Virginia Nurses Association. Thelma also functions as a National Board Member of Nurse Organization of Veterans Affairs.

NBNA Empowering a Nurse Leader to Serve the American Red Cross

Marie O. Etienne, DNP, ARNP, PLNC

ON JULY 15, 2011, The National Black Nurses Association (NBNA) entered into a partnership agreement with the American Red Cross to provide services and assistance to communities prior to and after disaster events in the United States. In this Memorandum of Understanding, Dr. Debra A. Toney, NBNA Immediate Past President, appointed me as the NBNA representative to serve on the American Red Cross National Nursing Committee (NNC).

This opportunity enabled me to work collaboratively with nurse leaders in the Red Cross to address nursing challenges facing the healthcare system in the United States and issues within Red Cross. One of the topics addressed in NNC was the 2010 Institute of Medicine (IOM) Report in partnership with the Robert Wood Johnson Foundation on the Future of Nursing: Leading Change, Advancing Health. The NNC focused on how nurses in the Red Cross could help advance these objectives and make recommendations in order to better serve the local communities. Through NNC, I was able to participate in the discussion and review of the IOM report to develop a blueprint for the future of American Red Cross nursing. Burnes Bolton (2010) indicated nurses and nursing organizations must assume professional and leadership responsibilities when adopting the IOM recommendations on improving professional nurses' capacity to engage in healthcare system transformation.

Consequently, NNC identified three of the eight IOM recommendations that were relevant to the American Red Cross Nursing.

- Nurses should practice to the full extent of their education and training.
- Prepare and enable nurses to lead change and advance health.
- Build an infrastructure for the collection and analysis of interprofessional healthcare workforce data.

This unique opportunity afforded me the sense of a renewed commitment not only to nursing, but in NBNA, especially to my chapter—the Black Nurses Association, Miami Chapter, and the other organizations that I belong to and participate in. One of the goals of NBNA is to promote its members through various leadership roles, and being a member of NNC is a vivid example of how members within the organization can enhance their leadership skills and serve the country effectively. This partnership between NBNA and the American Red Cross is a true exemplar of how organizations can come together to devise a concrete plan of actions of how nurses can play a significant role in the delivery of healthcare utilizing their education, skills and expertise effectively to promote quality care and community services. As members of NNC, we strongly believe that the American Red Cross and its nursing workforce should capitalize on these outlined recommendations to provide high quality in nursing care, whether or not they are responding to disasters, providing direct service, educational program in the communities, or any other activities within the scope of the American Red Cross such as disaster preparedness exercises, promoting blood donations, or supporting military personnel and their families. NNC is very proud of the fact that Red Cross nurses are already established as leaders within the Red Cross. They are pleased to have partnered with organizations such as NBNA to provide the expertise based on prior disaster experiences for disaster services.

One specific recommendation from the IOM Report that "hit home" and is relevant to me as a nurse educator was to increase the proportion of nurses with a baccalaureate degree to 80 percent by 2020. This recommendation is essential for nurses who do not have a BSN at this time especially for minority nurses who tend to have challenging family and work responsibilities. Embracing a practice culture encompassing inquiry, evidence-based practice and advancing education and certification is critical to the success of achieving high standards (Messmer & Gonzalez, 2006; Strichler, 2010). NBNA leaders support nurses pursuing advanced nursing degrees, therefore, as recommended by the American Nurses Association, academic institutions and nurse leaders in all nursing schools should work together to increase the proportion of nurses with a baccalaureate degree in nursing (www.nursingworld.org).

We realize that this may be difficult; however, my educational preparation and experiential learning (Associate Degree, Baccalaureate, Masters, Advanced Registered Nurse Practitioner in Pediatrics, Post Masters in Family and Gerontology, and Doctor of Nursing Practice) prepared me for this unique opportunity to accept this honor to serve my country through NBNA.

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Leading Change, Advancing Health and Getting Closer to the Health Needs of the Public

Catherine L. Gilliss, DNSc, RN, FAAN

AS A TRANSPLANTED RESIDENT of the state of North Carolina, I have been impressed by the progressive nature of this state, particularly in matters of health. The work on behalf of the state's residents has historically been enhanced by structures that convene key constituencies, a culture of cordial relationships that encourage direct discussion of difficult issues, and an abiding focus on the needs of the public. So it should come as no surprise that North Carolina has formed a regional action coalition to advance the implementation of recommendations published in the *Institute of Medicine's Future of Nursing Report: Leading Change, Advancing Health* (IOM, 2010).

North Carolina's progress was reported in a recent issue of the *North Carolina Medical Journal* (Wilmoth, 2011). In April 2011, a statewide summit of a broad set of stakeholders convened to discuss the report and its relevance to North Carolina and polled those in attendance on the priorities, from the eight published in the *IOM Report*, to be addressed in our state. Four priorities were identified: 1) improve access to healthcare (formerly removing barrier to practice); 2) preparing nurses for of leadership roles and responsibilities; 3) increasing the proportion of nurses prepared at the baccalaureate level; and 4) advancing workforce planning across the health professions. Convened by the North Carolina AARP and the Foundation for Nursing Excellence, the North Carolina coalition has moved forward to publicize the report and raise the needed support for advancing the work. In early November, the first meeting of the Future of Nursing Advisory Committee was held, a group of which I am a member.

Through the frank discourse of that meeting, we learned that a number of our Advisory Committee members believed that the report, itself, was viewed as celebratory of nursing. Others reminded us that the implementation phase of this report should not be about *nursing*, but about the *health of the public*. These words have been spoken at national discussions of the report, but they took on new significance for me in the gathering of state-based partners. To enlist the support of colleagues in our communities, we must make the work of this report about the public's health and in each state we must ask, "How can nursing assist in advancing solutions to the key health problems in my own state or community?" Where to begin?

The State Department of Health and Human Services published update on the health of North Carolinians (NC State Center for Health Statistics, 2011) offers clear direction to those of us in North Carolina. More than 60% of all the deaths in the state are the result of cancer, heart disease, stroke and chronic lung disease. Obesity and diabetes are on the rise; fully 65% of the population was overweight or obese. Infant mortality, though decreased over the last 15 years, is still among the ten worst in the nation and the data reveal significant racial disparities. The statewide relevance of the *Future of Nursing Report* in North Carolina lies in identifying the role of nurses in addressing these problems. How can nurses at the local, regional and state-wide levels help persons with chronic conditions to manage these diseases? How can school nurses help to care for the nearly 20% of school-age children who are living with chronic conditions? How can nurses mobilize the resources to support people to make the behavioral life-style changes that will lead to weight loss? How can nurses lead the community of healthcare providers to better prepare the public for decisions they will need to make regarding treatment decisions and decisions regarding care at the end of life?

In each of our states, we need to understand how addressing the IOM Report recommendations can concurrently advance the health of the public. Without a clear relationship to improved health, the report is, indeed, celebratory. More important, without an explicit relationship between the recommendations and the improvement of the health of the public, nursing will have lost an important opportunity to make a difference.

Dr. Catherine Gilliss serves as the Dean and Helene Fuld Health Trust Professor of Nursing at the Duke University School of Nursing, where she also holds the title of Vice-Chancellor of Nursing Affairs for Duke University. Gilliss has devoted her career to nursing education, particularly the preparation of nurse scientists and advanced practice nurses for roles in primary care. She is the immediate past-president of the American Academy of Nursing and a Lifetime Member of the National Black Nurses Association.

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NBNA Empowering (continued)

Dr. Marie O. Etienne is a Professor at Miami Dade College (MDC), Medical Campus, School of Nursing and the 2007 recipient of the MDC Stanley G. Tate and Family Endowed Teaching Chair for Excellence in Academia. Dr. Etienne is a member of the Black Nurses Association, Miami Chapter, past president of the Haitian American Nurses Association of Florida (HANA) and a 2011 Marie Claire Heureuse Leadership Award recipient.

Diversity for the Nursing Profession

Edward J. Halloran, PhD, MPH, RN

THE NORTH AMERICAN NATIVE AMERICAN Indians have a phrase in their language used to describe people—translated the phrase means "human beings." It occurs to me that the phrase "human beings" is entirely interpretable, without the bias often associated with other terms we use to describe ourselves. Man, woman, children, boys, girls, blacks, whites, Germans, Irish, Indians, tall, blond, old, young. Each descriptor of persons comes with an incredible amount of baggage related to our tendency to dichotomize or polarize these descriptions. It is as if everyone fits on a continuum: big-small, smart-dumb, fat-thin, good-bad. Not so! There are just too many ways to characterize human beings that no single one is sufficient to draw a conclusion with any lasting meaning. Gould (1981), in his classic work *The Mismeasure of Man*, argues forcefully against the dichotomy that attributes human behavior to either inherited traits or learned activity (environment). The search for such simplistic explanations of behavior has led to man's great inhumanity to man. Blacks, women, and Jews are not inferior by any genetic measure. Only cultural bias, sometimes in the form of stereotype threat places human beings on this so-called continuum from good to bad.

Claude Steele, the I. James Quillen Dean for the School of Education at Stanford University, has authored an important book, *Whistling Vivaldi*, that identifies the pernicious effects on performance of stereotype threats. These threats hamper improvements in social problems like persistent intergroup tensions that impair a range of human functioning. He says performance gaps among minority groups are related to self-doubts and fears of confirming negative stereotypes. The resultant anxiety becomes upsetting enough to interfere with performance. Stereotyping is a major obstacle African Americans, Hispanics and men find when considering the nursing profession. Steele and his colleagues have also shown that specific yet small interventions can largely eliminate performance gaps between stereotyped groups and non-stereotyped groups.

Steele's research reports show that using high standards when giving feedback and letting persons know that you expect them to eventually succeed improves performance; so does having a critical mass of minority students, say thirteen percent. Clearly expressing the value of diversity improves performance as does allowing stereotyped individuals to express self-affirmation. Using inter-group conversations framed as learning experiences eliminates performance gaps as does helping stereotyped individuals to develop narratives about the setting that explain their frustrations while at the same time projecting positive engagement and success.

It may be time to prepare a tool kit for hospitals and nursing schools to give guidance on how Steele's concrete, research based recommendations can be achieved. Perhaps such an exercise can begin with counting, an activity all minorities perform in any setting where being minority is obvious. While African Americans make up 13% of the population only 5.4% of nurses are Black. Hispanics comprise 16% of the US population and 3.6% of nurses, and men are a small proportion of nurses, 6.6%. The nursing profession is alone among professions in not having made changes in membership that better reflect the population. Human beings need the best from the nursing profession and excellence in service can be realized by greater diversity among nurses.

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Dr. Halloran has been an administrator and educator in the nursing profession for more than four decades. He was chief nursing officer at University Hospitals, Case Medical Center in Cleveland. He also taught at the Frances Payne Bolton School of Nursing, Case Western Reserve University before coming to the University of North Carolina at Chapel Hill where he now teaches nursing and is an activist with the American Assembly for Men in Nursing

American Red Cross Nursing Charts Its Future With a Blueprint for Action

Sharon A. R. Stanley, PhD, RN, RS, COL (ret) USAR, Chief Nurse, American Red Cross

THE COMMITTEE ON the Robert Wood Johnson Foundation Initiative on the Future of Nursing created a mechanism for making the report comes to life through The Campaign for Action. This campaign has mobilized diverse stakeholders nationally and in 49 states to "address the nation's most pressing health care challenges—access, quality and increasing cost—by utilizing nurses more effectively and preparing nursing for the future." Dr. Susan Hassmiller, Senior Advisor for Nursing at the Robert Wood Johnson Foundation is also a member of the National Nursing Committee (NNC) of the American Red Cross. In her position at RWJF, Sue not only facilitated the Future of Nursing publication, but remains a vital part of the effort to propel it into action through the Campaign for Action.

In 2010, shortly after the Future of Nursing publication, a workgroup in National Nursing Committee of the American Red Cross (NNC) reviewed how nurses had been, are, and could be used to help advance the strategic and business objectives of the Red Cross to best serve our local communities. The NNC studied the IOM Report and its potential impacts on nursing in the Red Cross and published its own the Blueprint for the Future of American Red Cross Nursing, identifying three of the eight IOM Report recommendations as being especially relevant to Red Cross nursing:

- Remove scope-of-practice barriers (i.e., nurses should practice to the full extent of their education and training) – IOM Report Recommendation;
- Prepare and enable nurses to lead change to advance health (i.e., ensure that leadership positions are available to and filled by nurses) – IOM Report Recommendation; and
- Build an infrastructure for the collection and analysis of interprofessional health care workforce data (i.e., a collaborative effort to improve research and the collection and analysis of data on workforce requirements) – IOM Report Recommendation.

The Red Cross Blueprint for Action aligned these recommendations with Red Cross strategic and business priorities and outlines how nurses can and should be actively engaged as full contributors in achieving such priorities. It has served for a strategic plan of direction in Red Cross nursing for two years, informing operations and infrastructure build of the Red Cross nursing network.

We have been able to, thanks to the Blueprint, address measurable changes in our Red Cross health services, that better touch and more competently provide care in our communities. One of the major changes is the change to a full scope of nursing practice, provided in accordance with a nurse's education and training, within the Red Cross. We've also been able to revitalize health professional volunteer practice in our Department of Defense (DOD) and Veteran's Administration (VA) health care systems and have plans to reintroduce volunteer nurses back into our blood donor sites after a two-decade hiatus.

Currently, we are working on the 2013 revision to our Blueprint thanks to Sue and a senior nurse leader workgroup led by NNC Vice Chair Donna Dorsey, MS, RN, FAAN . The anticipated completion will be mid-summer with a new release in the fall of 2013 to coincide with the 3-year anniversary of The Future of Nursing publication.

The IOM Report on The Future of Nursing: Leading Change, Advancing Health, identifies challenges and opportunities for the nursing profession, generally, and for nursing in the American Red Cross, specifically. We know that using nurses to build programs, services, and leadership capacity at the local and national levels will increase revenue, donations, and ultimate financial sustainability. We will continue to enhance teamwork as volunteer nurses partner with chapter leaders to serve their communities' preparedness, health and safety needs, serve military personnel and their families, as well as educate the public about the critical need for blood and blood products. By using the Blueprint, the Red Cross will be better able to achieve its strategic and business objectives; be able to work with other national organizations like the NBNA in leading change in the nursing profession and in the health care arena; be faithful to the principles of the Red Cross movement; further its status as a national leader in nursing; and modernize and revitalize the Red Cross nursing practice. In short, a strong nursing workforce within the Red Cross will yield a stronger Red Cross overall.

Sharon A. R. Stanley

As the American Red Cross Chief Nurse, Dr. Stanley works in partnership with the National Chair of Nursing, the National Nursing Committee, and Regional Nurse (RN) Network to lead a network of 20,000 nurse volunteers nationwide. Stanley was instrumental in restoring nurses' ability to provide care consistent with their education and training after more than a 25 year limitation in practice scope.

Stanley has worked in the public health field for 30 years, to include Chief of Disaster Planning at the Ohio Department of Health and local health commissioner. Just before joining the Red Cross, she was the program director for the Ohio Center for Public Health Preparedness, College of Public Health at The Ohio State University. COL (ret) Stanley served 34 years as an Army Nurse, ending her career as a Brigade commander for multiple states and with 12 years on active duty.

Raise the Voice!

Joanne Disch, PhD, RN, FAAN

"HEALTH CARE IN AMERICA today is inaccessible to many, expensive for most and fragmented for all."[1] In January 2012, the Institute of Medicine published *Living Well with Chronic Illness: A Call for Public Health Action*[2], outlining the 'epidemic' of chronic disease which represents 75% of the $2 trillion spent annually on health care. The report emphasized the numerous determinants affecting health, such as genes, biology, behavior, coping responses, the role of peers and family, the social-cultural context, and the physical environment. None of this is new to us as nurses: We have always worked with the patient in the context of the family, environment, community and socioeconomic considerations. In fact, while health care systems have created monumental structures that perpetuate the physician-dominant, acuity-oriented, hospital-based care model evident today, nursing innovators have quietly gone about developing new models of care that are cost-effective, personalized, convenient and successful in helping individuals and families deal with chronic illness. Perhaps too quietly.

This is why the American Academy of Nursing, under the leadership of then-president Linda Burnes Bolton, launched the Raise the Voice! campaign to educate the public and policymakers about the creative approaches that nurses are taking to assure that people, often the under- and un-insured, receive the care that they need and minimize the complications of chronic disease. Over the past six years, 49 nurses have been identified as Edge Runners, or practical innovators who have developed new care models that achieve significant clinical and financial outcomes. Here are profiles of a few Edge Runners and their work:

- **11th Street Family Health Services** is a community-based center that provides access to not only clinical services but to a wide range of health promotion and disease prevention services to inner-city Philadelphia residents. Employing a broad trans-disciplinary team of health professionals, it also has a strong educational and research component, serving as a clinical site for many health professions' students. In addition to more than 25,000 clinical visits, it has made 1650+ home visits to pregnant or new mothers, and thousands of wellness and health encounter sessions. In 2011, the center reduced pre-term births to 2.5% in African American for their women, compared to 15.6% in the city. (Patty Gerrity, PhD, RN, FAAN)
- **The St. Francis Health Center** improves access to quality primary health care services for the poor and uninsured, integrating both physical and mental health assessment, treatment and follow-up services, regardless of employment status or income. Founded and managed by a team of nurse practitioners and clinical nurse specialists in Joliet Il, they use weekly team meetings to discuss case management and approaches to care. Their patient base includes place-bound elderly and disabled, victims of domestic violence, the working poor and uninsured. Since their opening, they have provided services to more than 6,500 patients. They offer services daily, with some evening hours and weekend coverage by NPs. (Carol Jo Wilson, PhD, RN, CNP)
- **INSIGHTS** help parents and teachers recognize children's temperaments so that they can deal effectively with minor behavioral problems, help them learn self-regulation strategies and enhance their interpersonal relationships with families, teachers and friends. This 10-week intervention, developed in partnership with African American and Hispanic community members, has helped children with ADHD without using medication, reduced the behavior problems of children with serious disruptive behaviors, enhanced parents' ability to handle their children's behavior; and reduced aggressive behavioral episodes in the classroom. (Sandee McClowry, PhD, RN, FAAN)

The Academy website (http://www.aannet.org/raisethevoice) offers details on these innovators and other Edge Runners. Also on the website are the criteria for becoming an Edge Runner. Consider applying for this designation or nominating colleagues if you or they have developed an innovative care model that has made a measurable difference in health care outcomes. Nominees need not be Fellows in the American Academy of Nursing. Here are the criteria:

- Nominations support the innovative work of nurses and demonstrate the holistic and integrated philosophy underlying nursing care.
- The nomination demonstrates how an innovative solution (intervention or model of care) remedied a problem in the delivery of health care or an unmet health need of a population.
- Although single demonstrations are acceptable, data that substantiate the success and impact of the project must be included with the nomination.
- There is evidence that the original work has been replicated or has the promise of leading to replications in other settings.

In conclusion, nurses have historically understood what the public wants from health care, and have generated creative solutions for delivering it. It's time to showcase the important work that nurses are doing, and Raise the Voice! on the significant contributions that nurses are making to achieve a reformed health care system.

Dr. Joanne Disch is a Clinical Professor and Director of the Katharine J. Densford International Center for Nursing Leadership, and the Katherine R and C Walton Lillehei Chair in Nursing Leadership at the University of Minnesota School of Nursing. She is currently the President of the American Academy of Nursing.

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Dr. Gloria Smith, NBNA Co-Founder and International Nursing Icon Remembered

GLORIA R. SMITH, PhD, RN, FAAN, NBNA Co-Founder lived a notable life. Dr. Smith was recognized as a pillar in the international health community as she served as the vice president for programs at the W.K. Kellogg Foundation in Battle Creek, Michigan. "It is with profound sadness that NBNA has learned of the passing of one of this world's most ardent supporters of the profession of nursing and supporter of the elimination of health care disparities", said Reverend Dr. Deidre Walton, President, National Black Nurses Association. "NBNA Co-Founder Dr. Gloria Smith was an institution within the NBNA community who provided unwavering support to nurses, nursing students and nursing faculty. She loved the Black nurses."

During her tenure at the W.K. Kellogg Foundation from 1991 - 2002, Dr. Smith was responsible for program development and administration as well as program/project evaluation and dissemination. "Dr. Smith was a visionary. She believed in finding ways to negotiate solutions and strategies and fix the problems that were 'right' for specific communities", stated Dr. Walton.

Before joining the Foundation, Dr. Smith served as the dean of the College of Nursing at Wayne State University, Detroit, Michigan and the dean of the College of Nursing at the University of Oklahoma, Oklahoma City. She served as the director of the Michigan Department of Public Health, Lansing, Michigan. She served on the faculties of Tuskegee University, Tuskegee, Alabama and Albany State College, Albany, Georgia.

Dr. Smith received numerous awards for her service to the profession of nursing and health care in general. Dr. Smith was elected to the membership in the Institute of Medicine of the National Academy of Sciences in 1997. In 2000, the National Black Nurses Association honored Dr. Smith with its Trailblazer Award in recognition of her professional achievements and commitment to improving health. Dr. Smith received the 2003 Commission on Graduates of Foreign Nursing School's International Distinguished Leadership Award. The American Academy of Nursing honored her as a Living Legend in 2007. She was the 2008 recipient of the Mary Starke Harper Distinguished Leadership Award by the National Hartford Centers of Gerontological Nursing Excellence.

Dr. Gloria Smith was a phenomenal supporter of the National Black Nurses Association. She spoke at several NBNA conferences including the plenary sessions in Washington, DC in 1995 and New York City in 1997. In 2004, through the W.K. Kellogg Foundation, the National Black Nurses Foundation was awarded a grant to address the nursing shortage and the effect on African American communities. In 2009, through the Foundation, the National Black Nurses Association was awarded a grant to conduct sessions for the NBNA leadership on leadership, governance and fund development. Dr. Smith was a member of the American Nurses Association, Sigma Gamma Rho Sorority and The Links, Incorporated. Dr. Walton stated, "Dr. Smith leaves an indelible mark on the National Black Nurses Association, the profession of nursing worldwide and is an invaluable treasure for future nurse leaders."

The Patient Protection and the Affordable Care Act: Transforming the Nursing Curriculum

Eric J. Williams, DNP, RN, CNE

FLORENCE NIGHTINGALE, founder of modern day nursing, was committed to health promotion and disease prevention with emphasis on nursing in the public's domain. However, over the years, nursing has lost focus on health promotion and disease prevention due to a focal point on acute care. On March 23, 2010, President Barack Obama signed into law a federal statue, The Patient Protection and Affordable Care Act (PPACA or ACA) legislation. President Obama demonstrated his commitment to health care along with many nurses who have advocated for health promotion and disease prevention in their individual practice for decades.

Currently, an additional 32 million Americans will have access to health care services in the United States with the passage of the PPACA. The PPACA is a timely dream that has come true for those uninsured, underinsured, and underrepresented. The legislation ensures access to a wide array of health care services which will facilitate optimal health care for consumers. Nurses' work with consumers daily and are often first line responders who witness a lack of health care resources in our communities, hospitals and families. Also, nurse educators have a significant role in meeting the needs of a global society by transforming nursing curriculums.

PPACA and transforming the nursing curriculum. As nurse educators prepare graduates to meet the needs of a global society through transforming curriculums, these changes are viewed as contemporary and reflect the needs of an ever changing environment. The implications for nursing education is to transform nursing curriculums across the nation which will require collaboration, partnership linkages, advocacy, and research to ensure a better educated health care consumer. Curriculum transformation will focus attention on critical information produced by the Institute of Medicine, and professional nursing organization's statements which will assist in redesigning nursing education based upon competencies. The impetus for quality care decisions will involve redesigning nursing education based upon competencies, clinical training, use of technology, and evidenced based data (Hassmiller, 2010).

The Institute of Medicine/Robert Wood Johnson Foundation Report on "The Future of Nursing" encourages schools of nursing to transform the nursing profession by assessing current needs of patients across the life span. This concept should result in a "Call to Action". A "Call to Action" for discussions by nursing faculty, state boards of nursing, accrediting and professional organizations and many other stakeholders to actively engage in increasing our efforts to promote health and wellness by maximizing the utilization of the PPACA. Aspects of the PPACA can be integrated throughout the nursing curriculum based upon recommendations from stakeholders. Being actively engaged as stakeholders regarding the PPACA will enable nurses to promote better access to care, reduce errors, and promote favorable health outcomes (Hassmiller, 2010).

From licensed practical/vocational to doctoral nursing programs, nursing faculty will be compelled to strengthen their efforts to facilitate health promotion and disease prevention with outcome data that reveals a decrease in morbidity and mortality. As a result of the PPACA, millions Americans will be insured and have access to health and wellness coverage. Nursing schools must have curriculums that focus on outpatient education, health promotion and disease prevention. Such outpatient programs will include vaccinations, cancer screening, annual physicals, public health education, rehabilitation services (physical and mental) and preventive medicine. The health promotion and disease prevention curriculum content can be interwoven in all nursing courses by:

- Discussion of public policy issues which address concerns such as income, food, employment, and work conditions.
- Utilizing community partners which can expand clinical experiences and service learning with a focus on health promotion and disease prevention models (health fairs, workshops and seminars).
- Identifying best practices to incorporate into nursing students patient families' plans of care that emphasizes health promotion and disease prevention with self-reflection.
- Course and program objectives that measures deliverables on health promotion and disease prevention.

An evaluation of the effectiveness of the integration of health promotion and disease prevention into the nursing curriculum can be examined by several methods. Some are:

- Student and faculty feedback through surveys can serve as a mechanism to gather data and facilitate future directions for transforming nursing curriculums.
- Obtain feedback from practice industry leaders (nursing administrators in all settings) that employ new graduates (hospitals, clinics, etc), and governmental organizations to measure outcome deliverables.

The faculty, student, and practice industry leader entities can all be brought together by using an advisory committee. The advisory committee will begin to strengthen the concept of health promotion and disease prevention as an integral concept in nursing curriculums. These entities could review PPACA programs and recommend curriculum changes to incorporate health promotion and disease prevention elements to better ensure the delivery of quality health care services. Nursing schools need to maximize our collective efforts to promote health and prevent diseases through transforming nursing curriculums across the nation. The nursing profession is experiencing exciting times with the implementation of the PPACA.

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Obesity... Who's To Blame?

Beulah Nash-Teachey, PhD, RN

OBESITY IS A COMPLEX medical condition with no single cause or cure that can scientifically be eradicate. However, research has identified factors that clearly impact obesity in an individual. Millions of American adults are morbidly obese (Body Mass Index (BMI) 40+), which is almost twice as high as 1980 while another several millions having a BMI of 35-40. The percentage of overweight children ages 6-11 has nearly doubled since the early 1980's as documented by US Census 2004.

Obesity occurs when the caloric food intake is greater than what is burned off over a period of time. Other influences related to obesity are family history, lack of physical activity, race and environment. Current research suggests genetic causes are not all inclusive. While a predisposition to obesity can be inherited, obesity has increased drastically during the last few decades and appears to discount genetics as a major cause. Each succeeding generation is heavier than the last, indicating that changes in our environment maybe playing a key role. Families share common dietary patterns, physical exercise, attitude and lifestyle routine that may also contribute to obesity. Separating these phenomenons from purely genetic factors is not an easy statistical or diagnostic task.

Today, many cultures facilitate overeating. Portions in fast-food restaurants and other eateries are large or super-sized to the point that one meal can provide an entire day's worth of calories. Food is a central part of many social activities. Gatherings of families, friends, work events, and holidays are usually centered on food.

During the group exercise and meetings sponsored by Concerned National Black Nurses Association of Central Savannah River Area, Inc. several discussing identified factors that influenced obesity from their perspectives.

Perspectives as discussed by the group:

Poor self-esteem. Overweight may lower self-esteem and lead to eating as a way to escape with certain issues. Repeated failure at dieting impacted self-esteem and make it harder to lose weight.

Emotional issues. Emotional stressors and chronic illnesses contributed to overeating.

Medical conditions. Some medical conditions and medicines cause weight gain, such as hypothyroidism, certain antidepressants, pain meds and corticosteroids medications.

Sedentary lifestyles influence obesity. Globally, there has been a large shift towards less physically demanding work and currently at least 60% of the world's population gets insufficient exercise. In children, there appear to be declines in levels of physical activity due to less walking and physical education. According to The World Health Organization, people worldwide are taking up less active recreational pursuits, while a study from Finland found an increase, and a study from the United States found leisure-time physical activity has not changed significantly. In both children and adults, there is an association between television viewing time and the risk of obesity. A 2008 meta-analysis found 63 of 73 studies (86%) showed an increased rate of childhood obesity with increased media exposure, with rates increasing proportionally to time spent watching television. Studies that have focused upon inheritance patterns rather than upon specific genes have found that 80% of the offspring of two obese parents were obese, in contrast to less than 10% of the offspring of two parents who were of normal weight.

Parental behavioral patterns concerning shopping, cooking, eating and exercise have an important influence on a child's energy level and ultimately their weight. Family dieting and lifestyle are important contributory causes to modern child obesity, especially at a time of rising affluence. Research suggests obese children frequently grow up to become obese adults; however, it's not clear that family influence extends to adult obesity. While genetic influences are important to understanding obesity, they cannot explain the current dramatic increase seen within specific countries or globally. There are a number of theories as to the cause but most believe it is a combination of various factors.

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Patient Protection (continued)

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"Follow the Money"

Dr. Irene Daniels Lewis, NBNA Treasurer

THIS STATEMENT COMES from the movie, "The Godfather." It's a great line and it is an excellent strategy to examine the mission and goals of an organization. In this first article about money by your current National Black Nurses Association (NBNA) Treasurer, Dr. Irene Daniels Lewis, we are going to do just that.

All income (revenue) and expenses (debits) processed by each local chapter's treasurer should be used for the mission and goals of that chapter. Generally speaking, our mission/goal is to decrease healthcare disparities for Blacks and other minority consumers in our communities. We also try to help nursing schools recruit African American students, retain them in nursing schools, graduate them, and help them successfully pass the NCLEX-RN and/or NCLEX-LPN/LVN. Likewise, each local chapter's strategic plan has to be aligned with NBNA's. For now, we are going to focus on the former (revenue/debits) and not the latter. In a future article, we shall discuss the relationship between the budget and the local chapter's strategic plan.

So, in what ways do members and others bring revenue (income) into the local chapter? Well, members pay annual dues according to different membership categories. Members participate in "fund-raisers"; members may make donations to the chapter; others, besides members, may make donations to fund-raisers or to scholarships; the chapter may partner with others to obtain grants and/or contracts; members and others may leave money for the chapter in their trusts or wills. These sources of revenue (income) may be restricted or limited to specific programs or activities, e.g., student scholarships. They may also be donated without any restrictions. e.g., for day-to-day operations (business matters of the chapter), or for chapter programs.

Local chapter treasurers, your revenue and debits are the nuts and bolts of a plan to accomplish your local chapter's mission/goals (Penner, 2004). To be in the "black" and not the "red", your budget needs to balance or better yet, your budget needs to have more revenue than debits. It's not unlike your personal check book. You need to keep it balanced or in the "black". If your check book has more debits than revenue, you will have an "over draft" fee to pay. You will be in the "red". Your local chapter president and Board of Directors are counting on you to "follow the money" and keep the budget balanced.

At times during the year, your debits may be more than your revenue, however you should be able to explain the difference (variance) and predict new revenues that will again balance your budget or put you in the "black". When the chapter is spending more than its revenue, the chapter is headed for trouble. Being a "good private-eye" is essential to being a good treasurer. You should always "follow the money" from the source of revenue to the expenditure (debit). Likewise, local chapter treasurers, there has to be a fit between the revenue, debit and your chapter's mission and goals.

I believe this is a wonderful start of the NBNA Treasurer's Corner. If any Local Chapter Treasurer would like me to look at a draft of your 2012 local chapter's budget and your mission/goals or if you have any questions, send me an email: irene.lewis@sjsu.edu. Give me 10 business days to reply.

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Know Your Cancer Risk: A Daughter's Story

Veronica Clarke-Tasker, PhD, MBA, MPH, RN

Lelena Gebremariam, SN

WHEN A WOMAN FINDS a lump in her breast, it can be a very frightening experience. Usually the first thought or question that comes to mind as they wish the lump away is, "is this breast cancer?" I know because I've been there four times since my 31st birthday in 1979. The shock and disbelief can be unbearable. As nurses, we are expected to remain calm, supportive and empathic as we encourage ourselves, our patients and our loved ones to seek medical attention. We are also expected to educate women along with their family about their cancer risks and be their advocate. As many of you know from your own personal experience with breast cancer, sometime knowledge about a disease can keep us from acting positive. What happens when the person you are to be supportive of is your Mom? I had to be there for Mommy who knew I was an oncology clinical specialist, yet didn't want me to know about her rapidly growing breast mass. I also had to be there for one of my dearest friends who called me late one evening and said I want the truth, what are my chances of surviving breast cancer? You see, her sister had undergone a mastectomy for breast cancer just five years earlier. Yes, my colleagues, it is a big responsibility but it must be done.

Breast Cancer Risk factors

The Washington Post has provided testimony and much needed information about breast cancer particularly in the African American community (*The Washington Post*, March 21, 2012 and April 10, 2012). One of the most valuable tools we can equip our family and public with is accurate information about breast cancer and their breast cancer risks. Yes, it is true we still do not know the exact cause of breast cancer. However, we do know what factors may increase an individual's risk for developing this disease. A more complete list of breast cancer risk factors can be found in Table 1 below. (ACS, 2011)

Race and ethnicity: In 2011, the American Cancer Society estimated 26,840 African American women would be diagnosed with breast cancer making it the most commonly diagnosed cancer in African American women. In addition, their prognosis of dying from the disease, an estimated 6,040 of those diagnosed, is greater than any other racial group. Factors contributing to poor prognosis include distal stage of disease, higher tumor grade, and having a negative hormone receptor status.

Age: Although African American women have a lower risk of developing breast cancer they have a higher risk for developing the disease before the age of 45. It is believed that 1 out of 8 invasive breast can found in younger women.

Genetic risk factors: Inherited mutation BRACA1 and BRCA2 are the most common cause of hereditary breast cancer. It is highly recommended that women speak to a genetic counselor before seeking genetic screening. Talking with a trained professional that can interpret results along with what the test can and cannot tell you may reduce the stress and answer questions that many people have about genetic testing. Table 1 is the US Preventive Services Task Force's recommendations for genetic testing for BRCA mutations.

Family history of breast cancer: A women's risk for developing breast cancer doubles if the relative was their mother, sister, or daughter. The risk increases 3 fold if breast cancer is diagnosed in a 2nd degree relative. Having a father or brother diagnosed with breast cancer may also increase her risk.

Table 1: US Preventive Services Task Force recommendations for genetic testing for BRCA mutations:

- Two first-degree relatives (mother, sisters, daughters) with breast cancer, one of whom was diagnosed when they were younger than 50
- Three or more first- or second-degree relatives (includes grandmothers, aunts) diagnosed with breast cancer
- Both breast and ovarian cancer among first- and second-degree relatives
- A first-degree relative diagnosed with cancer in both breasts
- Two or more first- or second-degree relatives diagnosed with ovarian cancer
- A male relative with breast cancer
- A first-degree relative with breast or ovarian cancer
- Two second-degree relatives on the same side of the family with breast or ovarian cancer

Source: Adapted from *Breast Cancer Facts & Figures 2011-2012*, p 13

Table 2: Factors That Increase the Risk for Breast Cancer in Women; Relative Risk Factor

- Age (65+ vs. <65 years, although risk increases across all ages until age 80)
- Biopsy-confirmed atypical hyperplasia
- Certain inherited genetic mutations for breast cancer (BRCA1 and/or BRCA2)
- Mammographically dense breasts
- Personal history of breast cancer
- High endogenous estrogen or testosterone levels
- High bone density (postmenopausal)
- High-dose radiation to chest
- Two first-degree relatives with breast cancer
- Alcohol consumption
- Ashkenazi Jewish heritage
- Early menarche (<12 years)
- Height (tall)
- High socioeconomic status
- Late age at first full-term pregnancy (>30 years)
- Late menopause (>55 years)
- Never breastfed a child
- No full-term pregnancies

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Know Your Risk (continued)

- Obesity (postmenopausal)/adult weight gain
- One first-degree relative with breast cancer
- Personal history of endometrium, ovary, or colon cancer
- Recent and long-term use of menopausal hormone therapy containing estrogen and progestin
- Recent oral contraceptive use

Source: *Breast Cancer Facts & Figures 2011-2012*, p. 12

My Story

It was May 1985 and I just returned from an oncology nursing workshop when I received a call from my younger sister. Quietly she told me, "Mommy found a lump in her breast but said not to tell you." Needless to say, I couldn't believe what I was hearing. I remember that day like it was yesterday down to the color top she wore and the room we were standing in when she arrived home. When she saw me she looked at me as she put her bags down and said, "I see your sisters can't keep their mouths shut." She knew they were going to tell me and maybe that's why she told them. As she removed her blouse, I just stood still. I saw the lump before she pointed it out to me. Mommy had large hanging breast and the lump was the size of a small lemon. I just couldn't believe what I was seeing. Can you imagine how hard it was to remain calm when the women who birth you, stands before you with a large breast lump and didn't tell you when she first found it? I felt like a failure and trust me my three sisters made sure they reinforced those feelings.

Mommy agreed to see the surgical oncologist I worked with the next day. I cried all night feeling guilty, and hating the strong possibly that Mommy had breast cancer. On top of that, how were my grandmother and the rest of the girls going to handle the possibility of Mommy having cancer? Dr. R and I had worked together for over 6 years. He was a very supportive and caring physician who had asked me to join his team. I loved what I did as an oncology nurse, but that day in June 1985 was different. I had to be the supportive daughter with too much knowledge about cancer. After her clinical breast examination and mammography Mommy agreed to a one step surgical procedure. She consented to have a right modified radical mastectomy. I tried to encourage her to have a two-step procedure where she would get the diagnosis from the biopsy and then make her decision. But Mommy being Mommy opted to have her breast removed if the tissue biopsy during surgery was positive. In addition, she wanted to have reconstructive breast surgery.

My grandmother and I accompanied Mommy to the hospital on June 13, 1985. If any of you know me, I could not sit still. I prayed and tried to not appear frightened as I held my grandmothers hand. When Dr. R came into the waiting room his face said it all. Not only was the diagnoses positive but she had a very aggressive rare cancer known as cystosarcoma phyllodes. I knew that the next couple of months would be hard but I had to be strong. Within a year Mommy had successfully undergone radiation and chemotherapy as prescribed along with reconstructive breast surgery. When the cancer returned one year later it was even more aggressive and she was encouraged to undergo additional treatment. Mommy was in the hospital receiving chemotherapy Memorial Day weekend, 1987 when she asked me to call the family together for our usual celebration. I got permission to bring her home for the day. I knew as she tried to stand on her own that this may be the last time she would see all her family together. I tried to get the family to come the week before to the Tumor Board as Dr. R had asked Mommy's permission to present her case. I, along with my colleagues at the hospital, knew the severity of her cancer and how important it was for others to learn from this case. As my aunt and uncle stood by my side during the tumor board, I knew her time here on earth was very short. None of my sisters would come because they didn't believe Mommy was dying of breast cancer.

On June 13, 1987, exactly two years after being diagnosed, and in her own bed at home, Mommy quietly went home to be with the Lord. My daughter walked into her bedroom at 6 a.m. and thought her grandmother was sleeping, as she had a smile on her face. However, when she touched her she knew Mommy had passed. Although the pain was great, and I did not agree with all the decisions Mommy made about discontinuing her treatments, I was at peace. My colleagues helped me to be the supportive daughter and not the caregiver. For two years my sisters did not speak with me because they felt I should have made Mommy continue therapy. No, I said, the best thing you can do is join me in the clinical trial that I had enter which may prevent us from getting breast cancer. For you see all of us have fibrocystic disease of the breast just like Mommy and are at high risk for developing breast cancer.

I successfully completed five years in the Star Clinical trial in November, 2011. During this double-blind clinical trial, I later learned I was taking Tamoxifen. Although I gained weight, I was thankful. I was at high risk for developing breast cancer and I did something about it.

In closing, if you or anyone in your family has not followed the recommendation for breast cancer screening, start now. If you don't know your breast cancer risks talk with your nurse practitioner or physician. My sisters and cousins are now having yearly mammograms. Lastly, talk to your family about breast cancer and teach them the correct way to examine their breast.

In Loving Memory of Doris Mae McLeod and Sadie Brown-Hicks

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On the Front Lines: Nurses Key to Fighting Influenza and Pneumococcal Disease

Debra A. Toney, PhD, RN, FAAN and Susan Rehm, MD

YOU PROBABLY HEARD a lot about the influenza H1N1 pandemic last year and perhaps you think the danger has passed. It has not.

H1N1 and other strains of influenza continue to cause sickness and death in our patients, family, friends, and members of our communities. Add to that another very dangerous condition, and one that is a lot less understood by the public—pneumococcal disease—and you have a one-two punch that nurses need to be equipped to fight. The key to winning the fight in both cases is vaccination. Vaccination is the most effective way to be protected against influenza and pneumococcal disease, yet tens of millions of adults who should be immunized are not.

The Centers for Disease Control and Prevention (CDC), the National Foundation for Infectious Diseases (NFID), the National Black Nurses Association, and other organizations have issued calls for increased immunization efforts aimed at adults. Nurses are on the front lines and can lead in this important effort by using proven strategies to boost vaccination rates, which can have a measurable impact on reducing unnecessary illness, disability, and death among patients and others.

The impact of flu and pneumococcal disease

Influenza can affect people of all ages. Though there are some exceptions (e.g., the 2009 H1N1 influenza pandemic), the influenza season typically runs from about October through May.[1] It causes more than 200,000 hospitalizations and up to 49,000 deaths in the U.S. yearly, depending on the types of flu viruses circulating and the level of immunity among people exposed to the viruses.[1] Flu can result in complications such as pneumonia (pneumococcal pneumonia is one type), bronchitis, sinus and ear infections, and it can worsen chronic conditions like diabetes, lung and heart disease. Recent evidence suggests that influenza can trigger heart attacks in those with cardiovascular disease.[2]

Pneumococcal diseases, which are various manifestations of infection with a bacterium called Streptococcus pneumoniae (the pneumococcus), are common complications of influenza, but they can occur throughout the year. The pneumococcus is a major cause of the more than 900,000 annual cases of community-acquired pneumonia in Americans 65-years of age and older. [3] Streptococcus pneumoniae also causes bacteremia and meningitis (so-called "invasive" pneumococcal infections), which are less common than pneumonia, but much deadlier. Fatality rates are 30% for pneumococcal meningitis, 20% for pneumococcal bacteremia, and 5% to 7% for pneumococcal pneumonia; rates are even higher among the elderly. [4, 5]

Boosting Vaccination Rates

The influenza and pneumococcal vaccines are safe and effective, and immunization rates in adults are far too low. The elderly and those who suffer from chronic disease are especially vulnerable, and there is a pressing need to raise vaccination rates among these ever-growing populations. We also need to pay special attention to African American and Hispanic individuals, who are immunized far less frequently against flu and pneumococcal disease than whites. Compared to whites, African Americans are 28% less likely to be vaccinated against influenza and 37% less likely to be vaccinated against pneumococcal disease. [6] The reasons for these disparities are numerous and complex, and include differences in access to care, lack of information, and barriers created by provider and patient beliefs and behaviors.

Nurses are uniquely poised to promote disease awareness and boost vaccination rates. Whether you work in hospitals, academic medical centers, community clinics, or private practices, you can take advantage of time spent with patients to educate them about the serious consequences of these respiratory diseases, as well as the benefits of vaccination. You should also leverage all available tools and methods to ensure that vaccinations are a routine part of adult medical care.

Nurses can take the lead in reminding patients of current recommendations, and identifying patients who are at high risk for severe illness or death. Annual flu vaccination is now recommended for everyone 6 months and older, and is 70% to 90% effective in preventing infection in healthy young adults. [7] The pneumococcal vaccine for adults (PPSV23) is recommended for everyone 65 and older and for those 19 to 64 who smoke or have asthma, chronic heart, liver, kidney or lung disease, diabetes, or immunocompromising conditions. [8] For most adults, one dose of PPSV23 is 60% to 70% effective against the pneumococcal strains responsible for more than 90% of invasive disease. [9]

Nurses should also try to anticipate and address patient concerns or other barriers to vaccination. For example, many patients incorrectly fear they will get the flu from influenza vaccine. Patients' action in response to concerns varies. For example, African Americans who share this fear are still likely to be responsive to recommendations for vaccination from African American nurses due to their perceived shared personal beliefs and values. [10, 11] Patients should also be advised that Medicare plans provide first-dollar coverage for both vaccines [12], and that most private insurance companies provide at least partial coverage for CDC-recommended vaccinations. NFID has an array of educational materials and tools available (www.adultvaccination.org) to help you educate patients about adult immunization.

Nurses can help to ensure that timely vaccination is a part of routine care. This requires identifying, advising, and immunizing patients who have not received their seasonal influenza vaccine, as well as those who would need pneumococcal immunization, which can be given at any time throughout the year. Tools that can help nurses accomplish this include vaccine trackers

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On the Front Lines (continued)

and electronic medical record (EMR) systems. During influenza season, these tools can be used to generate patient reminders for vaccine appointments and to prompt doctors to give the vaccine. Similarly, EMR systems can be programmed to flag patients with specific conditions (e.g., diabetes, heart disease, asthma) that make them candidates for pneumococcal vaccination.

Standing orders have been shown to be one of the most effective methods to improve vaccination coverage. [13, 14] Standing orders programs permit nurses, where allowed by state law, to administer vaccines by following an established protocol. Standing orders directed to nurses lead to patients receiving a pneumococcal vaccine significantly more often (51%) than when reminders are sent to physicians (32%). [14] Standing orders materials are available at http://www.immunize.org/standing%2Dorders/ and at http://www.immunizationed.org/standingorders/.

Infectious diseases are not just a problem for patients. Nurses are also at risk for infection, and you must make sure that you get vaccinated as needed to best protect yourself, your family, and your patients from serious illness.

Without a doubt, influenza and pneumococcal disease have proven to be dangerous adversaries. However, there is an array of evidence-based strategies available that gives nurses the means to combat these diseases and prevent unnecessary suffering and death.

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NBNA's National Obesity Initiative Yields Wonderful Pilot Results!!

Audwin Fletcher, PhD, APRN, FNP-BC, FAAN, NBNA Board Member

ON NOVEMBER 15, 2010, ten NBNA chapters were selected to participate in the obesity-centered seed grant initiative. Originating from a $20,000 gift from The Coca-Cola Company, each chapter received $1,000 to carry out innovative approaches in curtailing obesity within their chapter, city, or state. The focus of the submitted proposals centered on strategies in curtailing the obesity epidemic as well as the 40,000 pound weight loss challenge for chapter members.

During the 40th Annual Institute and Conference, held in Indianapolis, Indiana, July 13-17, 2011, these ten NBNA chapters displayed their efforts in curtailing the fight against obesity via poster presentations, podium presentations.

Chapters, chapter project titles and project overviews were:

BNA Greater Washington, DC Area, Inc

"Healthy Life Styles Challenge (HLSC)" — was a multifaceted, personalized approach to encourage adherence to lifelong management of excessive weight and maintenance of weight loss by following a healthy diet and regular physical activity. Recognizing that life style change is a daunting task, HLSC helped individuals to make significant changes in small incremental steps with the goal of health improvement over time.

Birmingham BNA, Inc.

"Ten pounds, ten weeks, and ten ways" — Alabama ranks 2nd in the nation for obesity. The BBNA proposed to change the behavior of the membership by embracing the challenge of curtailing obesity and becoming role models for the clients of whom they treat. Chapter members walked at least three times per week; they attended yoga classes; and adapted to the use unique healthy recipes.

Central Carolina BN Council, Inc.

"Project MOVE: A Call for Action" — was an initiative directed at the members of the CCBNC. The project was designed to assist members to improve quality of life by focusing on a healthier lifestyle and to decrease the incidence of obesity. The key components of this project were exercise, nutrition, and increased self-awareness.

Cleveland Council BN of Ohio

"CCBN Healthy Lifestyle Resource Manual and Website" — embarked on a mission to reduce obesity among chapter members and the communities of which they serve. Members enhanced their community's health promotion role by modeling healthy behaviors and by documenting their collective experiences with weight loss. CCBN compiled proven weight-reduction options that were grounded by journal reports of physical activity and well-balanced nutritional plans used by chapter members are available in the form of a manual.

Concerned NBN of Central Savannah River Area

"Embracing a Healthier Lifestyle through Maintaining a Healthier Weight" — sought to collaborate with other organizations, schools and churches to present awareness information on a healthier lifestyle, which included the control and prevention of obesity, diabetes, and hypertension. The projects approach was family centered and selected obese families were encouraged to collectively lose 100 pounds each.

Eastern Oklahoma BNA, Inc.

"Diamonds in the Rough" — Oklahoma ranks 8th in the nation for obesity. The EOBNA proposed to collaborate with community advocates to conduct this after school wellness program at the Briar Glen Elementary School. The focus of the program centered on weight management, healthy eating, physical activity, and education on chronic illnesses.

Fort Bend County BNA

"BMI Beware, A Nursing Association's Strategy for Changing BMI" — focused on each member of the FBCBNA losing ten pounds in recognition of FBCBNA 10 year anniversary. Changing individual behaviors by self-assessment journaling, health promotion strategies, lifestyle changes/alterations, monthly meal planning, and chapter empowerment were the basis for the change in BMI endeavor.

Little Rock BNA of Arkansas

"Get Fit, Get Moving" — was a program designed to provide members of LRBNAA with fun, cardiovascular activities. Line dancing afforded participants the opportunity to burn calories, move large muscle groups, and improve overall physical fitness. The program served as a catalyst and motivator for members, their families, and friends to move and lose pounds.

Northern Connecticut BNA, Inc.

"Hartford HEALS (Healthy Eating and Living Strategies)" — was an innovative and strategic approach that focused on education and physical activity. The plan was four-fold: 1) members toured the local Big Y grocery to better understand the NuVal system; 2) registered dietician/chef conducted healthy eating sessions to church and NCBNA members; 3) chapter

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NBNA's Obesity Initiative (continued)

launched the Walk to National Convention campaign; and 4) chapter worked with the high school nursing academy to bridge the intergenerational gap.

Southern Nevada BNA, Inc.

"Getting Fit and Eating Healthy" — sought to deliver an innovated approach to goal accomplishment. The key objective was to be victorious and contribute to the NBNA supported initiative to fight obesity. SNBNA developed, guided, and demonstrated a series of options that allowed and encouraged participants to maintain their enthusiasm, which ultimately permitted them to accomplish improved fitness and healthier eating habits needed for proper weight loss and effective health promotion.

Chapters had until June 1, 2011 to accomplish proposed objectives. Winners were notified on June 15 and chapter presentations convened in the following formats:

- The chapter documenting the "BEST" results and who presented at the Presidents' Leadership Institute was Birmingham BNA.
- The next four chapters with good documentation results who presented podium presentations during the Obesity Institute were: Northern Connecticut BNA; Fort Bend County BNA; Little Rock BNA of Arkansas; and BNA Greater Washington, DC Area.
- The final five chapters presented poster presentations during the Obesity Institute.

Through the combined efforts of conducting Tia Chi, Zumba, and line dancing sessions, walking, convening healthy eating sessions, devising chapter websites, tweeting, face booking, conducting health fairs and the establishment of partnerships with other civic/professional/church based organizations, the NBNA's Obesity Initiative chairperson, Dr. Audwin Fletcher states, "While the challenge for NBNA chapters was to collectively lose 40,000 pounds in recognition of the 40th Annual Institute and Conference, the ultimate goal was to become a HEALTHIER organization". The results for the 2010 - 2011 seed grant, Cycle I are reported. Collectively, NBNA chapters participating in the initiative achieved the following:

- A total weight loss of 965 pounds
- A total reduction of 268 inches
- A mean BMI change of 40.1 to 35.5
  NOTE: An overall status change of morbid obese to obese
- A total of 9,600 miles walked
- Two chapters were featured in journals
- Four chapters were featured in newspapers

Susan Sanders, Vice President, Scientific and Regulatory Affairs of The Coca-Cola Company states, "Congratulations to all of you for the excellent active, healthy living programs that included both nutrition and physical activity interventions. Keep up the great work! You have accomplished so much in this first year, showing that small, gradual changes help people to incorporate the new behaviors into their lifestyles, so that they build new and healthier habits over time. The Coca-Cola Company is very proud to be a sponsor of these effective programs".

The 2011-2012 seed grant, Cycle II began September 1, 2011. Each of the competing chapters will receive an additional $1,000 to continue the wonderful work that was initiated last fall.

In conclusion, NBNA's immediate past president, Dr. Debra A. Toney states, "Obesity is a major health problem that has reached epidemic levels in Black communities. I am pleased that the NBNA Obesity Initiative provided and will continue to provide members with the opportunities to offer innovative programs that combat this devastating disease".

Dr. Audwin Fletcher is Professor and Director of Multicultural Affairs at the University of Mississippi Medical Center School of Nursing. He is a member of the NBNA Board of Directors. He may be reached at 601.984.6210 or afletcher@umc.edu.

Engaging the Faith Community to Address Mental Health Disparities

Keneshia Bryant, PhD, RN, FNP-BC, NBNA Board Member

HOLISTIC CARE IS NOT a new concept to nursing or other healthcare fields, but the attention to the mind, body, and spirit when caring for those with major depressive disorder (MDD) has had minimal attention to date. Among African Americans health disparities exist with the treatment and outcomes of MDD. New strategies must be developed to address and eliminate these disparities. One avenue is to partner with the faith community with an effort to prevent, recognize, and treat those with MDD. According to the National Institute of Mental Health (2010), approximately 14.8 million American adults in a given year experience MDD. African Americans are less likely to be diagnosed with MDD than non-Hispanic Whites; however some question if their presentation of depression may differ leading to under diagnosis (Baker, 2001; Das, Olfson, McCurtis, & Weissman, 2006; Rusch, Kanter, Manos, & Weeks, 2008). Recently, there have been efforts to better understand the roles that culture and social differences play with regard to diagnosis of MDD. Potential reasons for misdiagnosis and under recognition of depression among African Americans have been identified, including cultural barriers, language, and values in the relationship between the doctor and the patient. In addition, other reasons may include the masking of depressive symptoms by other medical conditions, somatic complaints, and substance abuse, and reliance on the support of the religious community (National Mental Health Association (NMHA), 2004; Das, et al., 2006).

Studies have shown that one's belief system can impact ones coping strategies, beliefs about the causes of depression, and the prevention of suicide (Jang & Johnson, 2004; Holt & McClure, 2006; Bryant-Bedell & Waite, 2010). African Americans have shown to give more importance of spirituality than whites in relation to depression care (Cooper, Brown, Vu, Ford and Powe, 2001; NMHA, 2004). This included the use of prayer and faith to treat depression. Among the African Americans who are diagnosed with MDD, the treatment outcomes are worse in comparison to Whites. According to the National Healthcare Disparities Report (2009), the percentage of adults with a MDD episode in the last 12 months who received treatment was significantly lower for Blacks than Whites (52.6% compared with 66.8%). The engagement of the faith community and the integration of spirituality in the care of African Americans with MDD should be used to eliminate these disparities.

Other studies (Stansbury, Brown-Huges & Harley, 2009; Stansbury & Schumacher, 2008) have explored how African American ministers may affect the belief systems of their parishioners and their understanding of mental health. But additional research is needed to understand the beliefs of the faith community including ministers and parishioners about depression and how to cope or manage MDD. These findings can then be used to develop evidence-based interventions. Additionally, through the engagement and collaborative process between researchers and the faith community the understanding of depression could be improved. This could include the relation of stressors to MDD, faith beliefs, and help-seeking behaviors. This approach may also aid in decreasing stigma, increasing the recognition of MDD, supporting referrals to mental health services and developing supportive environments.

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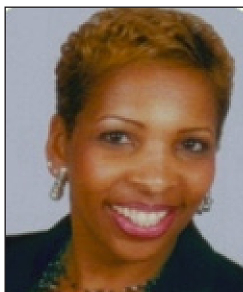
Dr. Keneshia Bryant is an Assistant Professor and Translational Research Institute (TRI) KL2 Scholar with a research interest in eliminating mental health services disparities. She has a particular interest in collaborating with the faith community to address the needs of rural African Americans with depression.



NBNA MEMBERSHIP THEME 2012: "Every 1 Counts, Make 1 Phone Call, Send 1 Email, Have 1 Conversation, Recruit 1 Member"

Marcia Lowe, MSN, RN-BC, NBNA Membership Chair

EVERYONE WHO RECRUITS a new member is a winner. The theme this year is, "Every1Counts." The membership committee of the National Black Nurses Association, Inc. (NBNA) has taken on the challenge to develop strategies that will enable chapters and individuals to recruit members.

NBNA celebrated forty years of nursing excellence this year. What can we do as members of NBNA to continue the legacy? Where are the younger members and why are they not members of NBNA? What incentives would be attractive to potential members when selecting a professional organization to join? These are all valid questions that need more investigation. NBNA currently offers many incentives during the membership drives.

What can your chapter do or you as a member to recruit? Many chapters have developed innovative strategies to meet the goal of increasing membership. Several chapters hold annual membership drives to introduce potential members to NBNA. Others have incorporated educational offerings for continuing nursing education to entice potential members. Many chapters have websites that showcase the benefits of membership and ongoing chapter activities. The NBNA website lists the many benefits of this great organization.

Another area that needs addressing is what can NBNA do to attract the new graduates or younger nurses to the organization? These nurses are vital to the continued existence of NBNA well into the future. Today's younger nurses routinely use computers, facebook, texting, webinars and conference calling. In other words they do not want to sit in a meeting. Current chapter activities must incorporate communication on the same level in order to attract these nurses.

Each local chapter of NBNA and each individual member must work to promote the growth of this great organization. We have to speak positively about our organization to our colleagues, friends, family members, and church members, whomever we meet. We have to be involved in our communities and publicize the goals of the organization so that members of the public will know that the National Black Nurses Association exists and that there are many chapters. We have to visit schools of nursing and invite students to join us. We must offer incentives to ensure that student members will remain active after graduation. We have to offer scholarships and encourage their involvement with activities.

Remember that every nurse, student nurse or retired nurse is a potential member. NBNA is inclusive, not exclusive. The burning question remains, what are some successful strategies that can be utilized to recruit and retain members?

Here are some tips for recruiting and retaining new members:

- ***Assemble a creative membership outreach team.*** Each chapter needs a membership coordinator and a visionary committee.
- ***Hold a membership recruitment effort*** at the beginning of the year to recruit new members. Make it innovative.
- ***Develop a network.*** Think about your community. Interact with nurses, student nurses and retired nurses.
- ***Seek opportunities to be visible in the community.*** Participate in health fairs, doctor days, school of nursing events, church events or career days at schools.
- ***Promote NBNA.*** Create a flyer that will tell potential members of the benefits of membership. Refer potential members to the NBNA website.
- ***Work with the media.*** Let the media know of events that your chapter is participating in. Notify NBNA so that your chapter activities can be shared with other chapters.
- ***Use personal contacts.*** Look around at your friends, neighbors and co-workers. Everybody knows a nurse. Contact former members with a personal invitation.
- ***Increase activities, not meetings.*** Meetings are important to discuss business, but keep them short and to the point. Make sure that members have information prior to the meetings so that when decisions need to be made, it won't take up so much time.
- ***Offer CEUs*** as a part of your recruitment strategy. This will require some effort and planning. And don't forget to provide refreshments.
- ***Just ask!*** People often say that they did not know that there *is* a National Black Nurses Association. "Make 1Phone Call, Send 1 Email, Have 1 Conversation, Recruit 1 new member."

We must invest our time and talents to ensure that NBNA remains a vital professional organization. The NBNA membership committee would like for you to share any innovative strategies that have been successful for your chapter in the area of membership recruitment. What successful strategies have been initiated by your chapter? Please submit your article to the NBNA newsletter.

Marcia A. Lowe, MSN, RN-BC, is past president of the Birmingham Black Nurses Association, Inc. and currently serves as the Communications Chairperson. She serves on the National Black Nurses Association's Board of Directors, is the Membership Chair, on the Scholarship and Awards, Adhoc for Chapter Development and Program Committees.

Which Nursing Path Will You Choose?

Patty Palmer, LPN, NBNA Board Member

"Education is what remains after one has forgotten what one has learned in school."
— Albert Einstein

AS A NONTRADITIONAL STUDENT, I chose the pathway of enrolling in a Licensed Practical Nurse (LPN) Program to get a solid skill set. I consider myself a nontraditional student because of my age, having been in a male dominated work force, and an entrepreneur. I joined the Atlanta Black Nurses Association (ABNA) and the National Black Nurses Association (NBNA) immediately upon entering nursing school. At that time, I was introduced to a multitude of Black nurses who were highly educated. Their education levels ranged from Associates in Arts (AA) in nursing to a Doctorate in Nursing. I approached a Master-level prepared RN about mentoring me; she agreed. Acquiring a mentor played a key role in opening my mind to continuing my career path to RN and beyond.

Membership in the National Black Nurses Association (NBNA) and then, being elected to the NBNA Board of Directors (BOD) as a student representative helped me enormously. This access and insight into the fascinating field of nursing has been great. The accessibility to networking opportunities on a diverse level proved invaluable. The NBNA BOD is in agreement with the recommendations of the Institute of Medicine (IOM) Future of Nursing document. Specifically, Recommendation 4: "Increase the proportion of nurses with a baccalaureate degree to 80 percent by 2020" (p.3). Recommendation 7: "Prepare and enable nurses to lead change to advance health" (p.5). The advancement of AA and diploma nurses to a minimum of a Bachelor of Science (BSN) education will have a positive impact on the nursing profession by giving it more credibility. Better educated nurses typically lead to improved patient care outcomes. Therefore, my next choice was to enroll in South Georgia College (SGC) LPN-RN Bridge Program. I will graduate in 2012 with an AA in Nursing.

The Georgia Board of Regents approved a mission and sector change for South Georgia College. This decision resulted in SGC becoming a state college. SGC will confer a BSN pending Georgia Board of nursing approval November 2011 (SGC Press release, 2011). I will be in that first BSN class. Having my AA degree and my RN license will let me work part-time while getting a BSN. My goal is to earn an advance practice nursing degree specializing in Wound Care and Hospice. Later, I would like to become a nursing manager. This is my chosen path. What career path will you choose?

"The concept of a career ladder places value on continuing your education and the acquisition of additional knowledge, abilities, and skill sets to provide appropriate and acceptable client-centered care" (Nunnery, 2010).

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Patty Palmer is a RN student and currently serving as the Student Representative for the National Black Nurses Association. Patty is a member of the Atlanta Black Nurses Association.

Giving Up is Not an Option

Patty Palmer, LPN, NBNA Student Representative

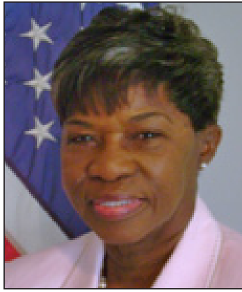
BEING A NON-TRADITIONAL student can be very challenging with the added and vigorous coursework of the nursing program. I found myself with virtually no time for outside activities. This journey was/ is a stark contrast to my previous profession as an over the road truck driving. After ten years of driving an eighteen- wheeled truck and seeing this wonderful country of ours, I decided to pursue my first love, nursing. I completed the prerequisites required in one year and got into the RN program at South Georgia College (SGC) immediately. I was elated.

During this time, I found the National Black Nurses Association (NBNA). While reviewing the Johnson & Johnson scholarship pages, I noted that NBNA had scholarships for non-traditional students. Becoming a member of this organization was not an option for me it was a must. The mission of NBNA was right in line with my personal mission and vision. Immediately after joining the Atlanta Chapter, the nurturing began and has not stopped. The encouragement that was afforded me by the wonderful mentors at NBNA has been very instrumental in my perseverance. The members of the Board of Directors (BOD) have been very inspiring, not only because of their numerous educational accomplishments in the nursing field, but many of them are entrepreneurs as well.

The first rounds of nursing classes were a weeding out period, but I survived. Sadly, I did not survive the Med-Surg class. The testing language for Med-Surg and Psych was unlike anything that I had ever experienced. The amount of information to be digested was tremendous. The degree of compassion and concern that I have for those who are facing health challenges compels me to persevere in the health care arena, despite my personal obstacles. Down but not out, I enrolled in the LPN program at the local technical college. I am proud to say that I graduated and am now a LPN. I have been accepted into the LPN-RN Bridge at SGC and feel more than ready for the challenge. My foundation skills have been solidified and I am more than prepared for the challenge of the nursing courses.

My goal is to attain the education and experience required to provide expert nursing care to those who stand in need. I am specifically interested in the area of wound care as a team leader. Wound care is especially relevant to the African American community, with the plague of diabetes effecting our population so disproportionately. I am motivated to be a part of the solution to this problem. I intend to gain sufficient expertise to pioneer innovative treatment for diabetic wounds. Wound care education and management is the key areas on which I will focus. Working together towards a common goal in a team oriented environment will help me to effectively provide quality care for the people I will serve.

If you want to be become a nurse and be successful, arm yourself with mentors in a professional organization such as the National Black Nurses Association. Study hard, stay encouraged, stay focused and network with positive people. Giving up is not an option!



Leadership... Are You a Leader?

Beulah Nash-Teachey, PhD, LTC (Ret), RN

IS LEADERSHIP LEARNED or are you born with the gift? It can be both. My first response to the question is, it a gift from God. I truly believe God has given individuals very different attributes that can only be explained as a gift. Thus, in this short article, I will discuss some general applications to leadership, my growth and development in the military and list Bass Theory (the leadership guide I use when helping young military officers).

In life's journey we choose to lead and in other circumstances we are forced into a leadership position. In either situation, you must lead with passion and determination. How you lead will determine how successful you will be and how those who follow you will remember you.

Leadership literature and research has repeatedly confirmed that most of the time we lead by example. If you expound on procedures or techniques that you do not follow or demonstrate, those who follow you will probably fail. Then the question is what happened, why is this situation failing? The answer most likely will reflect badly on you as the leader. Being able to stand the test of leadership requires an individual to live by what you teach.

My mentor echoes. "Leaders must accept each opportunity to lead and always do your best." Brian Tracey (leadership guru) suggest that a leader should read at least one hour every day, be committed to learning for life, embrace every opportunity to lead, and learn to listen.

Being a leader, weather a gift from God or if you are thrust into the position, serving in the military will soon put most individuals on the right path. As an Army Nurse Corps Officer for over 27 years, it has given me a wide view of leading, mentorship, and how to govern. I have pondered the question, "Am I a leader?" Leadership is defined in many different terminologies. I view leadership as the ability to influence others to complete the mission, no matter how hard the task may be. Striving to be a great leader has been my center of growth and development as a nurse and Staff Officer.

Commanding troops and being responsible for their safety requires knowledge, will power, understanding your surrounding and having a no none sense attitude. However, of all the traits that have been identified in leadership, the ability to first follow is very important. Being able to motivate individuals to move forward to complete the mission, although in a threat, is always challenging.

Good leaders are developed through a process of self-study, education, training, and experiences (Jago, 1982). Bass theory has helped me to develop and guide other military officers.

Bass' Theory of Leadership

Bass' theory of leadership states that there are three basic ways to explain how people become leaders (Bass, 1990). The first two explain the leadership development for a small number of people. These theories are:

- Some personality traits may lead people naturally into leadership roles. This is the Trait Theory.
- A crisis or important event may cause a person to rise to the occasion, which brings out extraordinary leadership qualities in an ordinary person. This is the Great Events Theory.
- People can choose to become leaders. People can learn leadership skills. This is the Transformational or Process Leadership Theory. It is the most widely accepted theory today and the premise on which this guide is based.

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NBNA Strategic Plan at a Glance

Keneshia Bryant, PhD, RN, FNP-BC
Little Rock Black Nurses Association of Arkansas
NBNA Board Member/Lifetime Member

IN ORDER FOR ANY organization to be successful, each member should know and understand the organization's strategic plan and work towards obtaining its goals. A strategic plan is the process of determining an association's long-term goals and then identifying the best approach for achieving those goals. The mission of NBNA is to "represent and provide a forum for black nurses to advocate for and implement strategies to ensure access to the highest quality of health care for persons of color." Based on this mission the NBNA 2011-16 Strategic Plan contains seven goals. Below is an overview of each goal.

Goal 1: Membership – Enhance and maintain a viable membership that can fulfill and sustain the mission and goals of NBNA.

There is power in numbers and in order to fulfill the mission of NBNA, a growing active membership is vital. Membership recruitment and retention are the key elements of the membership goal. The membership recruitment objectives are to: 1) develop a comprehensive recruitment campaign; 2) identify and eliminate barriers to recruitment; and 3) increase visibility at Historically Black Colleges and Universities and key nursing organizations. For membership retention the objectives are to: 1) develop and implement effective retention plan and strategies; 2) increase and enhance member services; and 3) maximize chapter benefits.

Goal 2: Leadership – Promote NBNA as a global health care leader.

The growth and advancement of the NBNA membership to become global nurse leaders is the basis for this goal. The strategic plan includes the development of a leadership track for members which includes leadership programs and institutes. Additionally the plan is to establish and maintain collaborations and networks with other professional organizations for leadership development.

Goal 3: Health Policy – Maintain and strengthen the organization's capacity to influence health policy.

The purpose of this goal is to: 1) promote NBNA's position on health policy issues. This will be done by the development of an annual national health policy agenda and increasing the number of skilled health policy nurse leaders; 2) seek and support membership appointments to policy, regulatory, and governmental committees; 3) strengthen the ability of chapter members to shape national health policy that is based on local issues; and 4) to provide support to international health policy students. The expected outcomes for this goal are to strengthen the ability of NBNA chapters, board members, and chapter members to shape national health policy that is based on local issues.

Goal 4: Program Development – Establish and maintain a comprehensive NBNA program agenda.

Programs are often the key to establishing community partners, promoting health and wellness, and diversifying the workforce. Therefore, NBNA is dedicated to health promotion, health protection, and disease prevention programs. Examples of these programs include: The obesity initiative; the identification of annual health goals; participation in international health conferences; and providing annual educational scholarships.

Goal 5: Research – Establish and maintain, in collaboration with the National Black Nurses Foundation, a NBNA research agenda that promotes the community's ability to promote health.

Through this goal, NBNA will prioritize research activities, which leads to the increased body of knowledge about health care needs of African Americans/Blacks and other minorities, effective health care delivery systems for minorities and the utilization of nursing services. Additionally, identify funding sources to promote and support nursing research.

Goal 6: Sustainability – Improve and sustain the organization's financial stability.

The strategic direction for this goal is to develop a secure a financial base for operating expenses and budgeting for marketing campaigns, in addition to increasing the organization's overall revenue.

Goal 7: International Health – To establish NBNA as a partner in global health care.

The desired outcome for this goal is to promote a dialogue around nursing education practice as it relates to global health. In addition, distinguish global health issues as they relate to local policies. These goals will be achieved by collaborating with NBNA members in the Caribbean, conducting forums focused on nursing education issues, and highlighting global health issues.

Each member has a responsibility to be active in the fulfillment of the NBNA strategic plan. Without the support of the membership the goals cannot be obtained. Therefore, a member's charge is to identify the areas they would like to support and strengthen to move the organization towards its desired outcomes.

Dr. Keneshia Bryant is an Assistant Professor and Translational Research Institute KL2 Scholar at the University of Arkansas for Medical Sciences in Little Rock, Arkansas.

Mentors as Nurse Leaders

Wendy Williams, RN, MS, MPH, President, Eastern Oklahoma BNA; Director of Clinical Quality and Community Education, Morton CHC -Tulsa, Oklahoma

I MUST ADMIT THAT ALL my years of practicing as a registered nurse, teaching Licensed Practical Nurses and volunteering to promote health in my community, I never saw myself as a nurse leader. However, I did believe I was a mentor to my peers, patients, or adolescents I encountered. It was not until attending my first NBNA Conference and Institute that I learned that mentorship is indeed leadership. The IOM Report "Future of Nursing: Leading Change, Advancing Health" recommends that the nursing workforce prepare nurses to assume leadership positions. In the career paths of many African American nurses we are not always privy to these leadership opportunities. We have to advance in education and be creative "helmsmen".

"The helm is the function of steering the ship, thereby controlling her direction. Ashore, a helmsman is a person who is at the helm that is in position of control." (Conyers and Ewy, 2004) The courage to command the helm is what I needed to move forward as a nurse leader; thus starting a NBNA chapter in my State. In the State of Oklahoma the nursing workforce, taken from a survey of Registered Nurses in 2004, is comprised of 89.2 % White, Non-Hispanic and 6.5% Black, Non-Hispanic. These statistics are very much evident today and require the attention of nurse leaders to change. The inspiration to start the Eastern Oklahoma Black Nurses Association, Inc. (EOBNA) stemmed from the lack of mentoring of African American nurses and potential nurses.

As I mentioned, I always saw myself as a mentor and was enthusiastic about getting other nurses involved in my passion. I quickly learned that some are not always willing to support what it takes to get where we going and they are not reserved about expressing their views. "Why do we need a Black Nurses Association?" is an often asked question. I was baffled for a long time, but then realized it was up to me to dispel the myths.

Mastrangelo et al, 2004 state, leadership delivers organizational benefits if it secures the willing contribution of people. The study further states, that this is achieved by combining professional and personal leadership. In developing the EOBNA chapter in Oklahoma, I sought out to recruit nurses with personal attributes that aligned with my own; expertise, integrity, empathy, sharing of authority and a love for people. If our chapter was going to be successful, I as the mentor, knew that if I could create a spirit of willingess to serve, the chapter would sustain the course ahead. My aim was to make a difference in the professional and educational lives of nurses, while impacting the communities in which we worked and studied.

As a result of stepping out on faith and channeling my mentorship into leadership, Eastern Oklahoma Black Nurses Association, Inc. was charted in August of 2010 at the 38th NBNA Conference and Institute. We have 28 paid members on the national and local level, comprised of nurses of all educational levels, students and retired nurses. We have started many partnerships in the community to address the health issues that disproportionately affect African Americans. We were 1 of 10 national chapters to be awarded the Obesity Initiative Grant sponsored by the Coca-Cola Corporation. Finally, we have partnered with Saint John Medical Center (SJMC), a magnet hospital in Tulsa, to increase diversity in the workplace. Through this Minority Mentoring Project, SJMC and EOBNA will provide mentoring support to minority nursing students.

I can without hesitation express my gratitude to the mission and vision of the National Black Nurses Association, Inc. My short tenure with this professional organization has provided the mentoring to me to proclaim the title of nurse leader. I am no longer reserved in stating that I am a mentor to many and a nurse leader to the profession of nursing.

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HHS Secretary of Health, Chief of Staff, Ms. Sally Howard Discusses Primary Care Workforce and Health Disparities in Atlanta, Georgia

Laurie C. Reid, MS, RN

IN RESPONSE TO A REQUEST for community engagement from the Department of Health and Human Services (DHHS), Region IV, the Atlanta Black Nurses Association (ABNA), truly answered the call! In partnership with the Byrdine F. Lewis School of Nursing and Health Professions, Georgia State University (GSU), ABNA hosted the U.S. Secretary of Health and Human Services, Chief of Staff, Sally Howard who led a roundtable discussion with nurse leaders, educators and other key stakeholders this past January. The discussion focused on the importance of the relationship between nurses and patients in closing the coverage gap, especially when delivering care to the underserved. Additionally, the tremendous HHS financial investments of awarding nearly $900 million in scholarships and loan repayments to health care professionals, including nurses, to help expand the country's primary care workforce and meet the health care needs of vulnerable populations across the country, was highlighted.

Howard was joined by panelists Dr. Jackie Williams, ABNA member and assistant chair and professor of nursing, Georgia Perimeter College; Dr. Joan Cranford, Assistant Dean of Nursing at GSU; and two GSU nursing students. Discussions focused on the Affordable Care Act and the impact it has on HHS's efforts to increase the number of health care professionals working in the National Health Services Corps (NHSC). The NHSC provides primary care to people in underserved communities throughout the nation; tools used to increase these numbers include the NHSC Loan Repayment Program and the NHSC Scholarship Program for primary care providers, such as nurse practitioners, who give two to four years of service in high need communities. Howard also stated that the ultimate goal of the Affordable Care Act was to be sure the uninsured had access to health care, but she noted that as the variety of health care avenues for the uninsured were created, more health care providers must also be trained to care for the additional patients.

Anton Gunn, Regional Director, Region IV, HHS, moderated the event and led the follow-up discussion and Q&A. Student questions focused on finding jobs after graduation and they encouraged HHS to consider a similar program for undergraduate nursing students to increase the number of RNs serving rural communities. Nursing educators weighed in on the issues of producing the nursing work force to include competition for clinical placement and it was noted that faculty retention is also a challenge as faculty can often earn more as practicing nurse than as an educator. Many educators echoed the sentiment and agreed that, "thinking outside of the box," was important. Dr. Jackie Williams added that another problem facing the development of the health care workforce was barriers to the scope of practice. She voiced that with the Affordable Care Act, there was a growing need to put more advanced practice nurses in rural areas to serve patients and in order to keep these nurses in the communities and serving as primary care professionals, there must be an expansion of duties and pay for the nurses. Other participants in the audience, including Pat Johnson-Gunter of the ABNA, also cited the need to remove practice barriers to advanced practice nurses. The Secretary's roundtable provided the Atlanta Black Nurses Association with a forum to advocate for the health care needs of vulnerable populations and promote strategies that ensure access to health care, equal to, or health care standards of the larger society as stated in the NBNA mission.

Laurie C. Reid is President of the Atlanta Black Nurses Association and serves as a public health advisor and program consultant at the Centers for Disease Control and Prevention.

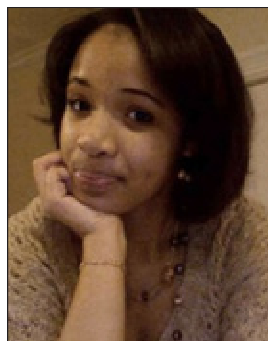
Youth Gun Violence Impact on Chicago

Daisy Harmon-Allen, PhD, RN

HADIYA PENDLETON is the face of Gun Violence; she was shot to death while waiting for shelter from the rain at a park. First Lady Michelle Obama attended the funeral. Also, President Barak Obama brought the Hadiya parent's to the State of the Union Address. Their presence helped highlight needed polices on gun violence. This high media case received an extensive attention. However, there are five hundred children who have been killed over the period five of time years, but they have been forgotten; only their families and communities are left to answer "why"? The entire nation is searching for reasons for youth violence.

The Chicago Chapter National Black Nurses Association (CCNBNA) is searching for answers too. There are a host of possibilities why youth gun violence is so high in Chicago. Are the youth replicating mass murders like Columbine, Virginia tech, Tucson, and Sandy Hook? The headlines were vivid and most of the perpetrators got their five minutes of fame. The leadership in Chicago is placing an emphasis on increasing law enforcement. This is not an upstream approach; it does not address primary prevention. CCNBNA members see the aftermath of gun violence: we see it in emergency units, surgical suites, rehabilitations units, and the mental health facilities.

Hadiya Pendleton, age 15



According to, Dr. Carl C. Bell's Seven Principles for Changing At-Risk Behavior and Cultivating Resiliency among Youth, in his book is called *Sanity of Survival,* he encourages all practitioners to:

- Rebuild the village; reweave the social fabric; recreate a sense of community; and reestablish the community by bringing together churches, schools, and families to create networks, organize resources and establish programs that provide support, safety and security for our youth. A sense of community also reinforces cultural identity.
- Provide access to ancient and modern technology to provide practical systems for the application of knowledge Providing models, tools, skills and techniques to facilitate implementation of the concept or program (for example, mentoring, multi-family groups, how to cultivate resiliency, wellness and manualized family interventions).
- Provide a sense of connectedness Creating situations, programs and relationships that foster a sense of connection, attachment, and belonging to a larger group or a common goal. This counters feelings of alienation, helps provide feelings of security, and increases self-esteem. Again, reestablishing the village reinforces cultural identity and can be a platform for the delivery of cultural education. Well thought out rites of passage (e.g. the belt system of progression in Japanese martial arts) programs have been very effective in actualizing this principle.
- Provide opportunity to learn social & emotional skills providing social and emotional skills that people need to interact and communicate with each other. This not only increases self-esteem but effectiveness in relationships as well. These include parenting skills, refusal skills, negotiating skills, the capacity to remain calm in a crisis, and more.
- Provide opportunities to increasing self-esteem giving our children a sense of power (self-efficacy) by showing them they can do things for themselves and positively influence their own lives.
- Provide an adult protective shield providing an adult protective shield and monitoring speaks to providing supervision, discipline, and a caring adult presence. These foster a sense of safety and security. The concept of the village with multiple adult figures taking responsibility for the nurture and well-being of the village children is a concept that connects us to our culture and our spirituality. Wellness is also important in this respect. A child can be severely stressed by the illness of a caretaking adult, so it is in the best interest of the adult to adopt behaviors that promotes wellness, both personally, and as a model for children to emulate.
- Minimize trauma – Develop and individual's spirituality, a person's sense of self-efficacy, helping create a sense of safety, and providing stress management skills as well as psychological first aid. (carlcbell@pol.net)

"Let the children come"

"Our children are being murder by gun violence every day, Let the children live, let the children live.

For of such the Kingdom of Heaven shall come one day, Let the little children live.

Jesus has gathered them and folded them in His arms; Let the children come, let the children come.

Safe from every danger and from all harm, Let the children come."

Dr. Daisy Harmon-Allen is the President of the Chicago Chapter National Black Nurses Association & Vice President of School Board District 88, Bellwood, IL

The Future of Nursing and the Role of Nevada Nurses

Debra A. Toney, PhD, RN, FAAN, Chair, Nevada Action Coalition

2013 IS THE YEAR of transformation. Two years have passed since The Institute of Medicine first released The Future of Nursing: Leading Change, Advancing Health. The implementation of this landmark report is intended to transform the U.S. health care system by strengthening nursing care and better preparing nurses to meet the health demands of our country for years to come.

Health care today is more complex. Our population is aging and becoming more diverse. The demand for nursing care has increased and we do not have enough nurses in the pipeline to fill the void. Technology has contributed to the way we provide care to our patients. In a study by Dr. Peter Buerhaus and others it is estimated that 500,000 new nurses will be needed by the year 2025.

As members of the largest group of healthcare professionals in the health care workforce and the most trusted, nurses are integral to overcoming our health care challenges. Our delivery system is fragmented and overcome with health care disparities. Nurses are on the front lines of health care delivery and will play a major role in overhauling our health care system.

However, nurses continue to face barriers that prevent them from performing to the best of their abilities. In some states nurses are not able to work to the fullest extent of their education and training nor are they at the table when important decisions are made.

The mission of this initiative is to ensure that all Americans have access to high quality, patient-centered care in a health care system where nurses contribute as essential partners in achieving success. Central to this report are four key messages which serve as the building blocks for implementing health care change.

1. Nurses should practice to the full extent of their education and training.

2. Nurses should achieve higher levels of education and training through an improved education system that promotes seamless academic progression.

3. Nurses should be full partners, with physicians and other health care professionals, in redesigning health care in the United States.

4. Effective workforce planning and policy making requires better data collection and information infrastructure.

I first became involved in this initiative while serving as president of the National Black Nurses Association. Having the opportunity to provide testimony at one of the many forums was quite rewarding. This began my journey to learn as much about the campaign as possible and to ensure that nursing colleagues understood what it meant to their future.

I now have an opportunity to share this information with nurses in my state…. Nevada. The Health Care Sector Council and the Nevada Alliance for Nursing Excellence have joined together to form the Nevada Action Coalition within the State. They are bringing their experience and intellect together in an extraordinary collaboration to improve the health of Nevada. The goal of the Nevada Action Coalition is to bring all stakeholders under the umbrella of the Action Coalition, uniting to achieve common strategic goals as outlined by the Future of Nursing: Campaign for Action.

As chair of the Nevada Action Coalition I have the opportunity to work with some amazing nurses throughout the state to bring awareness regarding the campaign. I was invited to be a member of the National Program Design Team to shape the agenda for the work nurses are doing in their home states. At the time of this publishing I will have attended the National Summit in Washington, DC and am looking forward to a very productive meeting and networking opportunities.

Nevada currently has several activities occurring that are in line with the IOM report including, the development of nurse residency programs, leadership training for nurses and legislative efforts to remove scope of practice barriers. Senate Bill 69 will remove the requirement to have physician approved protocols for advanced practice nurses (APN) in Nevada. Instead the Nevada State Board of Nursing will determine the authorized scope of practice for APNs.

This is critical legislation that will be addressed in this legislative session. Passage of this act will be a huge accomplishment for nursing. It will assist in closing the primary care gap in Nevada and improve access to quality care that will be provided by advanced practice nurses.

Nevada nurses are prepared to lead. The future of health care depends on all of us and Nevada nurses are involved in transforming health care in our State and the country.

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Future of Nursing Campaign for Action: District of Columbia Action Coalition

Pier A. Broadnax, Ph.D. RN, Nurse Co-Leader, DC Action Coalition

IN OCTOBER 2010, the Institute of Medicine (IOM) released the report, Future of Nursing: Leading Change, Advancing Health. The purpose of the report was to provide a blueprint for "nurses to act as partners with other health care professionals and to lead the improvement of and re-design of health care systems and its many practice environments". (IOM, 2010) The report contained four (4) key messages which will undergird the transformation of nursing needed to deliver the right care at the right time. The key messages are:

1. Nurses should practice to the full extent of their education and training.
2. Nurses should achieve higher levels of education and training through an
   improved education system that promotes seamless academic progression
3. Nurses should be full partners, with physicians and other health
   professionals, in re-designing health care in the United States.
4. Effective workforce planning and policy making require better data collection and an improved information infrastructure.

It was determined that Action Coalitions would be the work units developed to implement various components of the messages. In January 2013, the District of Columbia's proposal for an Action Coalition (DCAC) was accepted. The initial focus of the DCAC is to:

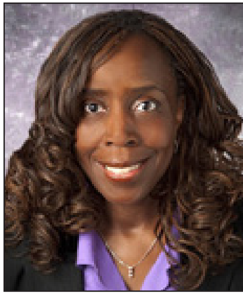
- facilitate the education progression of the unlicensed assistive provider to the advanced practice nurse;
- improve collection of data to support workforce planning and policy making.

Additionally, a highlight of the DCAC proposal recognized by the Robert Wood Johnson Foundation/AARP proposal reviewers was the diversity within the DCAC Executive Committee. Executive committee members include representatives from the National Black Nurses Association, National Hispanic Nurses Association, a local clergy, a Chief Nurse, Board of Nursing and an academic Nursing Program Director. All of the Executive committee members are ethnic minorities which is in unusual.

It is our overall intention to encourage and support nursing care providers progressing through a seamless system of nursing education. It has been validated that patients have better outcomes when the care is provided by baccalaureate prepared nurses. (Atkins, 2003). A Joint Statement of Agreement was issued by the major nursing organizations in support of preparing a well educated and diverse nursing workforce to meet the needs of an aging population, complex care needs and to fulfill the need for primary care providers. (Joint Statement, 2012)

As the DC Action Coalition continues to grow, we will seek support from a variety of experts in the healthcare delivery system, legislators, business and others. This is an opportunity for nurse leaders that we must not let slip by.

Dr. Broadnax has been employed by the University of the District of Columbia as the Director of the RN/BSN Program since 2010. She is active in the nursing community and health policy development.



Putting the IOM Future of Nursing Report in Action Within Pennsylvania

Dawndra Jones, MSN, RN, NEA-BC

IT IS AN HONOR for me to share with you the exciting efforts happening in Pennsylvania (PA) in order to apply the recommendations made by the IOM Future of Nursing Report. Similar to the response of other states, PA has created an Action Coalition charged with developing sustainable strategies within the state to meet the IOM recommendations. The PA Coalition is supported through the Pennsylvania State Nurses Association (PSNA). The State Steering Committee for the Action Coalition consists of diverse stakeholders representing major organizations throughout the state that are interested in improving the health of Pennsylvanians. In 2013, the Robert Wood Johnson Foundation (RWJF) awarded the Pennsylvania Action Coalition (PA-AC) funds to achieve three specific goals:

- To strengthen the sustainable statewide structure of the PA-AC for advancing selected goals of the IOM Future of Nursing report;
- To strengthen BSN education in Pennsylvania, including assessment of articulation models and the capacity of the nursing faculty pipeline; and
- To enhance the diversity of the Pennsylvania nursing workforce.

Pennsylvania is a state rich with nursing knowledge and expertise having approximately 83 different RN programs offering three options points of entry to the nursing profession. To become a registered nurse in PA, you need to obtain either an associate or bachelor degree or diploma in nursing. Having these three options brings with it unique opportunities for PA's implementation IOM report within the state. To maximize effectiveness, the Pennsylvania Action Coalition has established Regional Action Coalitions in nine areas of the state. Any nurse and non-nurse interested in engaging in local efforts to initiate change in their region are welcome to participate in the Regional Action Coalition.

In order to address the third requirement of the grant, enhancing the diversity of the Pennsylvania nursing workforce, the PA Action Coalition has just started to create a statewide Nursing Diversity Council. As this council is just beginning to be developed, some of the anticipated goals for this council include to complete a gap analysis between state demographics and nursing database in regard to diversity; evaluate "Best Practices" for seamless articulation to identify any specific action or strategy to enhance diversity; partner with minority nursing organizations throughout the state and within the Regional Action Coalitions to determine "Best Practices" for seamless articulation likely to be successful in each region; Partner with academic programs to increase enrollment of underrepresented groups in BSN programs; Identify source(s) of scholarship funding to support underrepresented groups in BSN programs; and identify source(s) of scholarship funding for underrepresented groups in PhD nursing programs. We are looking for individuals with a passion for diversity and inclusion in healthcare to be part of this council. If you are interested in participating on the Pennsylvania Nursing Council and/or one of the PA Regional Action Coalition please contact Dawndra Jones, MSN, RN, NEA-BC at jonesd1@upmc.edu or Frances Ward PhD, RN, CRNP at fward@paactioncoalition.org.

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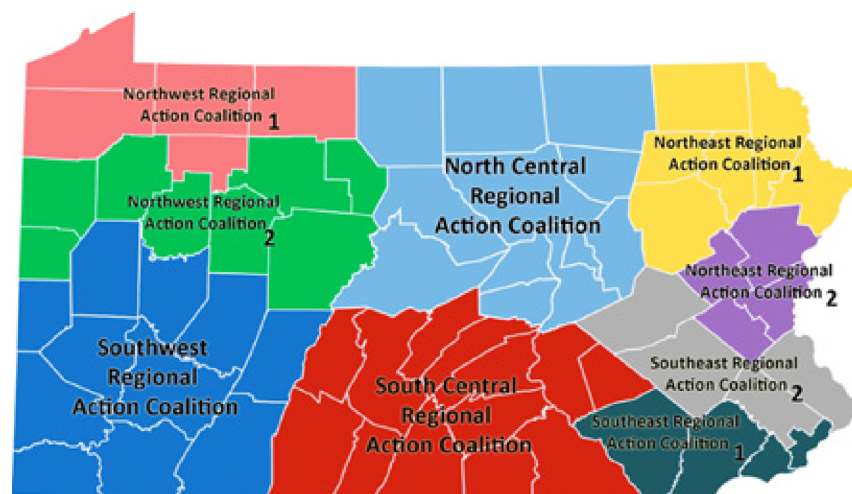

The Nebraska Action Coalition: Merging Leadership & Education to Implement IOM Recommendations in Nebraska

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LEADING CHANGE AND advancing health are two propositions Nebraska nurse leaders readily embraced in the fall of 2010. Their efforts led to the formation of the Nebraska Action Coalition (NAC) in March, 2011. By September, 2011 the state of Nebraska was recognized by the Future of Nursing: Campaign for Action (a collaboration born of the Robert Wood Johnson Foundation [RWJF] and American Association of Retired Persons [AARP]) as an official action coalition ready to lead efforts to address the recommendations from the Institute of Medicine's (IOM) 2010 report: The Future of Nursing: Leading Change, Advancing Health.

Led by the Visiting Nurse Association (Omaha) and HDR Architecture Inc., as Nursing and Non-nursing Co-Leads, the Executive Committee of the NAC laid the groundwork for the action coalition. A director was hired in February, 2012 to strategically coordinate work on the initiative spurred by the desire to address these challenges in Nebraska:

- Currently 13.8% of our population is 65 yrs as compared to12.4% in U.S.; projections to increase to 21% by 2030
- 42% of NE population lives in rural areas. 65% of all counties are currently federally designated as health professions shortage areas as compared to 51% in 2009
- One-third of 93 counties have no APRNs; 11 have no primary care physicians
- A barrier to practice for APRNs is the restriction of independent practice, especially in rural areas. 17 states including Iowa, Colorado, and Wyoming do not have this barrier. We lose nurses to these states because of restrictive barriers in Nebraska
- The nearly 10% nurse shortage is expected to grow to 20% in 2020
- Faculty shortage was cause for turning away 402 eligible applicants in 2010; only 1% of NE nurses have a doctorate

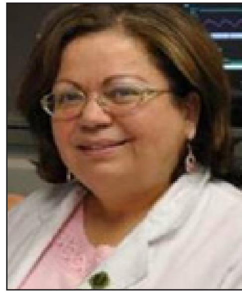
Reasons for celebration in the first year included:

- Fund development - $78,000
- Communication - interactive WordPress website www.neactioncoalition.org, Constant Contact for email blasts, Facebook, and Twitter.
- Team development - addition of Strategic Advisory Committee which includes nurse champions consisting of a physician, hospital CEOs, public health and AARP representatives.
  - Leadership: Held an energizing 40 Under 40 reception and Leadership Conference/Summit as back-to-back events in September, 2012. The forty honorees will be important to forging new leadership roles inside and outside of nursing, succession planning, and workgroup formation within the NAC.

The NAC continues its work with the RWJF State Implementation Program (SIP) grant award received in February 2013. The grant deliverables and action plans focus on the following IOM Recommendations:

- Recommendation 4: Increase the proportion of nurses with a baccalaureate degree to 80 percent by 2020. NAC's deliverable: Percentage of RNs age 20-40 with a BSN will increase by 10% by Dec., 2014. A few action items follow:
  - Developing competency-based education model in collaboration with Nebraska Assembly of Deans and Directors to be finalized in June, 2013.
  - Regional focus groups and development of statewide network of "champion employers of nursing" who promote/incentivize higher education
  - Develop Minority Recruitment Toolkit and educate employers and educators about best practices in recruiting ethnic minorities
- Recommendation 7: Prepare and enable nurses to lead change to advance health. NAC's deliverable: 10% increase of the number of nurses on decision-making bodies/boards. Action item implementation includes:
  - Survey Nebraska nurses (RNs and LPNs) on their involvement on decision-making bodies/boards. (Completed 4/5/13 with over 1100 respondents).
  - Regional focus groups to assess opportunities/barriers/attributes of nurses seeking leadership roles.
  - Create statewide mentoring and leadership pilot program
  - Partner with Omaha Black Nurses Association, help restart Hispanic Nurse Association, and collaborate with Area Health Education Centers (AHEC)

Nebraska's nurses number 32,000 and are vital to health care delivery: we know the importance of being at the table. Though advancing education and leadership will push this initiative to transform health care, the work cannot be accomplished by nurses alone; it relies on public/private sectors, consumers, and legislators working together to transform delivery of care with better outcomes for all. We believe Nebraska's healthcare depends on nurse-led collaborative partnerships to improve access, quality and cost-effectiveness in our state. That's our mission! To the future of nursing and patient-centered care!



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Electronic Health Records: A Mandate for Change in Health Care and Academic Institutions – A Critical Interface with an Associate Degree Nursing Program

THE FUTURE OF NURSING lies in the hands of innovators who design and implement projects that positively effect change and assure quality care for the communities they serve. The federal mandate to implement Electronic Health Records (EHR) nationwide led to the 2006 Technology Informatics Guiding Education Reform (TIGER) summit to transform nursing based on evidence and informatics. Most hospitals have purchased or are in the process of deciding on an EHR system to meet the 2014 federal mandate expecting hospitals to use EHR documentation.

Since nursing comprises of fifty-five percent of the health care force, the plan was to prepare the next generation of nurses to practice in automated health care systems (DuLong, 2008). EHR is a workplace reality for nurses and nursing students who are expected to improve the quality of patient care (Kelly, Brandon & Docherty, 2011). Advantages include: a single consolidated record per patient, capacity for data interfaces and alerts, improved interdisciplinary communication, and evidence-based decision support. However, EHR can add to work complexity by forcing better documentation of previous unrecorded data (Robles, 2009). Health information technology (HIT) and EHR are vital requirements for nurses to provide holistic and competent nursing care. The future of safe, effective health care necessitates incorporating clinical informatics in nursing education programs while serving to bridge a gap between academic and clinical institutions.

Although EHR can improve the quality of care, the extent is unknown due to the dearth of studies (Kelly, Brandon & Docherty, 2011). There is a chasm between what nurses currently learn in nursing programs and what is needed in workplaces with new graduates expected to function competently (Messmer, Braggs & Williams, 2011). Nurses play a key role in EHR implementation and adoption and are in a unique position to champion EHR. Among 137 physician practices, the adoption rate for the practice was 83% higher when a nurse was the primary user of the EHR, than when no nurse was involved (Mihalko, 2012). Nursing education is challenged preparing graduates with 21st century knowledge and skills for practice in a complex, emerging technologically sophisticated, consumer-centric, global environment (Warren & Connors, 2007). The Institute of Medicine (IOM) recommended nurses-in-training should experience, reflect upon, and develop the knowledge, skills, and attitude creating competence in patient centered care, evidence-based practice, quality improvement, safety, and informatics (http://www.iom.edu).

Health care delivery is promising a future of constant change in health care technology; thus, it is imperative that nursing promotes HIT competency to assure that we are capable of meeting the health care needs of our growing communities (Simpson, 2010). As 2011 Health Information Technology Scholars (HITS), our goals included developing innovative, evidence-based strategies incorporating technology (EHR and HPS) to enhance the Miami Dade College (MDC) nursing curriculum, an urban college in Miami, Florida. Our project increased nursing student's knowledge of patient safety and their skill competencies using new technologies and teaching strategies.

The project incorporated HIT and EHR into all components of an Associate Degree Nursing program (ADN) while encompassing cultural sensitivity for our diverse students. The project addressed the National League for Nursing (NLN) and Quality and Safety Education for Nurses (QSEN) competencies to ensure that nursing students and faculty utilize them in their practice, providing safe and high quality patient care. The project was based on Miami Dade College's Vision—an exceptional learning environment in which students are challenged and empowered through innovation, state-of-art technologies, teaching excellence, and student support program. The program prepares each student with the knowledge, skills, and values to succeed in a dynamic world (MDC Planning and Effectiveness, 2010). The nursing dean and faculty embraced our project because of its value and the timing of the IOM Report: The Future of Nursing: Leading Change, Advancing Health (IOM, 2010). We capitalized on the strengths of the faculty champions and maximized the use of the Human Patient Simulation (HPS) laboratory and EHR to develop case scenarios tailored for nursing students. Selected courses included Adult Health Assessment, Fundamentals of Nursing Specialties, and Medical-Surgical Nursing with plans for Pharmacology while addressing cultural diversity and gerontological needs of the patients.

Components of the nursing curriculum demonstrated a seamless interface with the integration of HIT and EHR into the ADN program. Proposed projects include advancing this technology into all components of the ADN and integrating simulation into the RN-BSN program curriculum. Skiba (2006) articulated a call to action: preparing the next generation of nurses to use emerging technology and the need for higher education to ensure literacy in information technology. With the limited number of available nursing positions in the area, these ADN graduates should be more marketable and motivated to

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Quality Improvement in Mental Health: Telemental Health

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THE QUALITY AND AVAILABILITY of mental health services are often reduced in rural and underserved areas. This is due to limited mental health specialty providers, cost, and use of non-mental health providers to provide mental health care. As a result, patients are forced to drive long distances or not receive the mental health services that are needed. In an effort to eliminate disparities and improve quality in mental health care, the use of telemental health is increasing.

Telemental health is a subspeciality of telemedicine that uses telecommunication technology to provide cost-effective mental health/ behavioral health services to rural and underserved areas. In 1959, the University of Nebraska was the first to document telemental heath in the United States and in 1961 the first report was published by Wittson, Affleck, and Johnson (Godleski, Nieves, Darkisn, & Lehman, 2008).

Telemental health services are comprehensive and include the following:

- patient evaluations
- case management
- medication management
- crisis response
- pre-admission and pre-discharge planning
- treatment planning
- individual and group therapy
- family therapy
- mental status evaluations
- court commitment hearings
- case conferences
- family visits
- family and consumer support groups
- staff training
- administrative activities

The benefits of telemental health are considerable. One of the major benefits is increased access to care for a reduced cost. Clients who would not typically receive care are able to get needed services at a reduced cost as they do not need to travel. In addition, telemental health is useful in circumstances where transporting the patient to the health provider is problematic, for example in forensic settings. An added benefit of this technology to the mental health providers is that they can easily consult with and/or provide supervision to each other.

Telemental health uses several forms of technology such as electronic mail (e-mail), online self help groups, chat rooms, blogs, and websites. However, telemental health is most associated with video teleconferencing (VTC). VTC is a real time technology that allows a patient and clinician in two different locations to each view a monitor to see and hear each other. Methods such as psychotherapy by e-mail have not been extensively studied and are viewed as controversial (Morland, Green, Ruzek, & Godleski, 2007). As a result, telemental health guidelines have been established by the American Telemedicine Association to serve as a best practice reference based on clinical experience and educational tool to provide quality care to patients (Grady, Myers, & Nelson, 2009).

Although there are many benefits to telemental health, there are barriers to the use of this technology. Barriers such as technological illiteracy and resistance to change by individuals and organizations have been identified (McGinty, Saeed, Simmons, & Yildirim, 2006). In addition, cost is a huge factor. In examining the costs, several factors must be considered. This includes the cost of equipment, technical support costs, the distance the treating provider must travel to conduct the in-person service compared to the cost of support staff for the telemental service, volume of cases treated, and reimbursement rates (Gangure & Hyler, 2003).

In 2004, Ruskin et al. estimated marginal costs at $86.16 for telemental health sessions and $63.25 for in-patient services. However, O'Reilly et al. (2007) estimated the cost for telemental health was $88,311 compared to $108,549 for face-to-face services. This is an average cost of $394 per patient for telemental health sessions and $439 per patient for in-patient services.

Patient and provider satisfaction with telemental health services have been measured. Patient satisfaction surveys indicate that patients are satisfied with telemental health services and no difference in satisfaction ratings were noted when comparing those receiving telemental health services to in-person treatment (Ruskin et al., 2004). Patients of all age ranges appear equally satisfied and most patients rate the experience positively (McGinty et al., 2006). In contrast, provider satisfaction has had mixed reviews. Provider satisfaction was lower in the video teleconferencing treatment group versus the in-person treatment group (García-Lizana & Muñoz-Mayorga, 2010). However, rural provider satisfaction is reported as higher than that of suburban or urban providers (McGinty et al., 2006).

Clinical barriers in telemental health are worth noting. Providers are not physically present to handle behavioral health crises such as suicidal thoughts and aggressive behaviors. In addition, it may be difficult to assess nonverbal cues such as poor hygiene. Although patients were satisfied, they commented that clinician interactions were impersonal and perceived little empathy from the clinician. Other issues identified include lack of direct eye contact, poor sound quality, difficulty hearing instructions, and poor imaging (McGinty et al, 2006). Currently, insufficient evidence exists to determine the effectiveness of telemental health technology. More studies are needed to demonstrate effectiveness in treatment and to examine cost and clinical implications. After

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Quality Improvement (continued)

effectiveness is demonstrated, large scale funding is required to provide quality equipment and training for healthcare professionals. Federal and state policies also are needed to ensure reimbursement, protection of patient privacy issues, provider licensure across states issues, and assurance of service quality. Despite the need for effectiveness trials, the future of telemental health is viable as it assures access of these services to people who would otherwise be unable to receive mental health care.

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Electronic Health Records: (continued)

pursue additional academic opportunities. Curriculum, design, faculty and student orientation, implementation strategies were addressed along with the proposed impact on nursing practice. This project will serve as a model for other programs to emulate.

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Yamina Alvarez, DNP, ARNP, is an Associate Professor, Senior at Miami Dade College, School of Nursing Medical Campus. Dr. Yamina Alvarez holds a Doctor in Nursing Practice (DNP) from University of Miami (2009) and has served as the Chair and Co-Chair for the Nursing Resource Technology Committee during the last three years at Miami Dade College.

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Advancing Innovations & Leading Change in Nursing: A Call to Action

Teri A. Murray, PhD, APHN-BC, RN, FAAN, Dean, Saint Louis University School of Nursing

HAVE YOU USED a typewriter, VCR, telephone booth or manually changed a television station lately? You may have if someone had not begun to think differently and question the status quo. Change requires thinking differently and necessitates breaking out of established patterns and routines in order to look at things in a different way. In order to lead change you must take people to new and different places. Places where one may not ordinarily go on his or her own and usually beyond one's comfort zone. Change in any given profession is difficult if the best minds are still enthralled to an older way of seeing and thinking that was better suited for a world decades ago.[1] Oftentimes, the more successful an individual, company, or profession becomes the more difficult it is to recognize the need for change[2]. As leaders we must avoid stewardship over the status quo and forgo attempts to preserve the "dinosaurs of yesterday." Leaders are obligated to develop the capacity to conceive and manage change[3]. Leaders acknowledge what was good about the past but recognize his or her responsibility for shaping the future.

We use evidence-based practices in our work environment. Using best practices is laudable albeit best practices are current practices. Next practices are innovations which may change existing paradigms and have the potential to significantly alter the way things are done. To foster the development of next practices, leaders must question the implicit assumptions behind the current practice[4]. Great opportunities for innovation and change result from asking the questions "why or why not." Disruptive innovation challenges traditional thinking and can be expected to provoke controversy but the disruption is valuable because it stimulates dialogue, advances innovative thinking, and transforms practices[5]. As leaders we must encourage disruptive innovations to foster the development of next practices[6].

Leadership is not about holding an administrative title but is about affecting change within your sphere of influence. As a nurse leader are you working in your respective community to lead change in one or more of the recommendations from the Institute of Medicine's (IOM) landmark report, "The Future of Nursing: Leading Change, Advancing Health?[7]" Are you working with your state action coalition to advocate for nurses to practice to the fullest extent of their academic training and in equal partnership with physicians and other healthcare professionals? Are you advocating for nurses to achieve higher levels of education with paid release time and tuition support? Are you working with your state workforce health centers to ensure that your state has an appropriate number and mix of healthcare providers for a reformed healthcare system? Are you exercising the political efficacy and competency to improve education and practice with the appropriate stakeholders, legislators, and constituent groups?

I am doing my part at Saint Louis University School of Nursing. We offer entry level, advanced practice, and doctoral (PhD & DNP) academic programs and professional development educational opportunities consistent with several key recommendations from the IOM report[7]: Increase the proportion of nurses with a baccalaureate degree to 80 percent by 2020; double the number of nurses with a doctorate by 2020; ensure that nurses engage in lifelong learning; and prepare and enable nurses to lead change to advance health.

Now more than ever, this is our time to define our pathway forward by leading change and challenging business as usual. This is a clarion call for nurse leaders to distinguish the immutable nursing values from the historical practices that may have become obsolete. Are you capable of this type of leadership? Will you answer the call? What will the future hold as the return for your professional citizenship?

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Dr. Murray is actively involved in governmental affairs at state and national levels. She skillfully used regulatory, public, and legislative policy to promote and lead innovation in nursing education. She is a fellow in the American Academy of Nursing, the Robert Wood Johnson Foundation Executive Nurse Fellows Program, and a recipient of the Salute to Excellence Healthcare Award for Stellar Performance.

The Application of Servant & Transformational Leadership in Nurse Leaders

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I HAVE BEEN A NURSE since 1980. Since graduating from University of Maryland School of Nursing, I've seen changes in healthcare with a shifted focus toward safety and quality. Over the course of my career, I have worked at several hospitals each of which displayed different leadership styles. One utilized a classical model of leadership, another was driven by servant leaders and the last had transformational leaders and was a Magnet facility. As a result, when I retuned back to school for my advanced studies, I decided to examine the relationship between the Chief Nursing Officer's (CNOs) leadership characteristics and the achievement of Magnet designation.

From my experiences, it seems that a combination of both transformational and servant leadership significantly contribute to the phenomenon of each nurse leader's lived experience. In order to appreciate and acquire the leadership acumen that is needed to plan, leaders use their life experiences to reshape their vision and to achieve the mission of the organization.

The CNO is challenged to: transform and motivate their employees using creativity and innovation, create a positive relationship, strengthen their leadership by increasing business acumen, incorporate organizational change theory to create a culture of excellence, be influential within the organization, and manage the consumer's expectations. As a leader, the role of the CNO is to be a systems thinker, innovator and transformer (American Nurses Association, 2009). As Senge (1990) describes the learning organization, he describes five disciplines that are essential for a leader and for development of a learning organization. All five disciplines which are: 1) System thinking; 2) Personal mastery; 3) Mental model; 4) Building shared vision; and 5) Team learning, are tools that are identified within the ANA (2009) scope of practice for the nursing administrator.

A quality of good leadership is seeking constant self-improvement and assisting others with the same. Maslow introduced a theory which explained that people were motivated to fulfill essential or survival needs prior to being motivated to accomplish any more complex needs. He also developed a theoretical model that he named The Hierarchy of Basic Needs in the form of a pyramid that demonstrated how a person was motivated to meet physical needs such as food and water before other needs would be met. The pyramid had five levels, the needs were divided into deficient needs and growth needs. The deficient needs included physiological, security, and psycho-social needs. If the deficient needs were not met a person would demonstrate undesired behavior. The more complex needs which included esteem and self-actualization were exhibited when a person was motivated toward self-improvement (Maslow, 1971).

Ryan and Deci (2000) expanded the intrinsic work of Maslow (1971) and developed the Self-Determination Theory (SDT). Their research focused on the intrinsic motivation factors that promoted social development and well-being. Through the continued research of Ryan and Deci (2000) they were able to identify three underlying needs of personality integration which were essential for enhanced performance.

Further research by Gagne and Deci (2005) focused on the degree of satisfaction needed for personality integration and for the employee to experience competence, relatedness and autonomy within the social environment of work.

Their work provided an additional rationale that supported Bass' (1985) transformational leadership theory which suggested that the transformational leader incorporates idealized influence, inspirational motivation, intellectual stimulation and individualized consideration into practice as an essential method to motivate employees. Not all CNOs have the characteristics of the transformational leader, however. In the absence of these qualities and executive leadership development how does the CNO change their organization's culture to produce quality and nursing excellence?

As a result of noticing these differences, I intend to explore the leadership characteristics, as perceived through the lived experience of the CNO at Magnet designated hospitals.

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Improving Support of Minority Advance Practice Nurses

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INADEQUATE REPRESENTATION of ethnic minorities in the Healthcare workforce has created a host of health related issues for many members of low income and disadvantaged socioeconomic populations (Boulware, Cooper, Ratner, LaVeist, & Powe, 2003). Some patients find more satisfaction when being taken care of practitioners who look like them, speak their language, or are from a similar ethnic background. Marginalization of low income and urban communities add to the vulnerabilities these populations face related to access to care (Lynman & Cowley 2007). Some health risks these populations face include discrimination, gaps with access to care, severe illness, trauma, and unmet health needs. In order to continue to bridge the disparity gaps among minorities, funding opportunities need to become available for education of minority Advance Practice Registered Nurses. This article will review some of the barriers related to recruiting minority advanced practice nurses as well as solutions and recommendations to sustain a diverse workforce.

The diversity of ethnic groups in the nation is changing rapidly. By 2050 it is estimated that minorities and members of disadvantaged backgrounds will make up over 48% of the general population (www.census.gov). Racial and ethnic disparities cause a significant problem when addressing the health of the nation. There continues to be huge implications for members of the healthcare workforce in providing culturally competent and appropriate care. The effects on healthcare and its budget are profound in that the uninsured and underinsured populations may have better access to primary prevention services thus decreasing the use of emergency facilities and reducing health care costs. With the impending implementation of the Patient protection and affordable care act, it is estimated that over 32 Million more patients will have access to primary care (Lucero, Rauch, & Berkowitz 2012). For over 50 years Nurse Practitioners have been utilized to provide primary care to traditional underserved communities. The Institute of Medicine report, 2002 cited issues related to the health care system including bias and prejudice of providers, and cultural and language barriers.

Members of the minority communities have reported experiencing forms of racism in the health care delivery system. The mistrust in the medical community by minorities also stem from the Tuskegee Syphilis experiment that was instituted by the American government form 1932-1974 (Kennedy, Mathis and Woods, 2007). For this reason African Americans and minorities seem to have a preference of providers of their own race or ethnicity (Smedley, Stith, & Nelson 2002).

The underrepresentation of minorities in nursing and healthcare may have an effect on the overall health outcomes on patients of disadvantage backgrounds. Today minority nurses make up 11.6% of the U.S. nursing workforce (National Advisory Council of Nurse Education and Practice, (NACNEP) 2010). Furthermore African American nurses make up less that 5% of the US nursing workforce (NACNEP, 2010). A study by Cooper & Powe, 2004 found a correlation between racial and ethnic compliance as well as patient satisfaction and adherence to treatment with patients who were attended by practitioners of the same or similar background.

The cycle of underrepresented minorities in the work force is perpetuated by the underrepresentation of nurses in faculty and education. (NACNEP). Minority nurses are essential in helping to bridge the health care disparity gap in ethnic populations. They also help to facilitate the dissemination of culturally competent care. The Theory that most supports the need to improve in these areas of Health Care Delivery is Madeline Leningers culturally congruent care model (Ciesielka, Schumacher, Conway, &Penrose 2005). This model charges nursing to focus on all aspects of care including respect of personal and cultural beliefs as well as practices.

Some barriers that continue to exist to increase and improve the amount of talented underrepresented minorities include lack of representation in the admissions committees, costs, admissions criteria, as well as subpar academic salaries (The Sullivan Commission 2004). The American Association of College of Nursing (AACN) recommends the following strategic plans to include minority students in the various degree programs:

- Presenting and inclusive image
- Reaching out to diverse student populations
- Making connections at the baccalaureate level
- Supporting students through the application proves
- Mentoring as the key to retention
- Facilitating student access
- Launching coordinated outreach campaigns (Stanley, Capers, & berlin 2007)

According to the Sullivan commission report entitled, Missing Persons: Minorities in the Health Profession, there are several issues that need to be addressed concerning heathcare quality and access for the Nations' diverse population. There were specific recommendations outlined to help increase and improve the amount of advanced practice minority nurses. The recommendation includes supportive programs and institutional policies to encourage and expand student diversity and appreciation of diversity among nursing school students, faculty and administration.

There would need to be an increase in diversity in the health professions, new and non-traditional paths to the health professions as well as commitments must be at the highest levels of institutions to follow.

In order to implement a successful pipeline of prepared diverse health care professionals institutions' must look in to funding programs in t7he form of scholarships as opposed to loans

CONTINUED

Improving Support (continued)

to help fund the education of these nurses. Bridge programs and partnerships among two year nursing programs as well as baccalaureate programs must be formed. Leadership succession plans and mentorship of minority and underrepresented health care providers should be implemented. Colleges and Universities must engage and encourage enrollment of socio-economically disadvantaged student who express interest in the health care profession. The presence of a diverse faculty should be represented among health professions' institutions to ensure representation of underrepresented minority professionals.

The SAFER model is an approach being used by Swinney and Dobal 2004, which helps to encourage and support students of diverse backgrounds to remain in nursing. It includes social support, academic support, financial support, empowerment of students, and responsibility by students. This also supports the push for appropriation of funds for advance practice nurses. The Health Resources Services Administration, HRSA, continues to provide retention grants as well as loan repayment in return for service in primary care and underserved communities. It is important to retain students that come from underserved communities because they will most likely return to work in these underserved populations. The key topics in sustaining involvement of advanced practice minority nurses are recruitment, retention, empowerment, and mentorship. If the Nursing workforce is to one day resembling the population in which it serves, the next step would be to take a stance in support of future minority health care providers.

In 2013 The National Black Nurses Association (NBNA) set forth an agenda Legislative day on Capitol Hill. One of its areas of focus included the Appropriation of federal funding for Nurses. The reference bill included was Title VIII, The Nursing workforce development program, which ensured an adequate pipeline of qualified nurses that can provide care in rural and underserved communities and increase access to primary care services.

The bill would also be in support of education and faculty repayment programs. In 2012 the senate appropriations committee approved $231.099 million dollars. The same amount was approved for 2013 and the members of the NBNA were requesting an amount of $251.099 for 2013. This addition funding would continue to aid in the aligned vision of the organization in the support of advance practice minority nurses, which would ultimately help contribute to the health of the nation.

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Social Networking, Personal Branding, and Bridging the Generational Gap of Nursing

Sasha DuBois, RN, Secretary, New England Regional Black Nurses Association

FACEBOOK, TWITTER, AND LINKEDIN are three of the most popular social networking sites that people associate with today. Their insignias are almost on every brand, organization, or company in the public eye. These insignias aid in further advertising, develop brand recognition, and increase buyer/consumer loyalty. Here, you will learn why social networking is a vital commodity to navigate these tools for personal and professional branding, and to advance the nursing profession.

What does this mean for nursing?

Nursing goes beyond the bedside, and there are several changes that are occurring that are shaping healthcare delivery and policy. The Institute of Medicine (IOM) released a report on the Future of Nursing. Goals and needs for nurses include improving care through evidence-based practice, advancing education for all nurses, and improving workforce planning and policy. Social networking can be used as a tool to bring new/tomorrow's nurses on board with goals and guidelines to advance the profession. The generational gap within the profession of nursing suggests that healthy mentoring relationships be created and fostered, in addition to welcoming technology advances to narrow the gap.

The Future of Nursing is Online!

A vibrant profession looks forward to the advancement of the field. In addition, a vibrant profession also reaches back to mentor and teach younger and would-be professionals for constantly evolving practice guidelines and reducing burnout.

With the already looming critical nursing shortage, nurses are needed in clinical and academic areas. Concerns include the large group of baby boomer nurses retiring and well as a lack of clinical faculty to teach students. In turn, the lack of clinical faculty forces nursing schools to place caps on the number of incoming students, leaving many to be on year long (or more) waitlists, or change their major altogether.

Social networking can be used to retain student and younger nurses' interests in the profession. In addition to retention, social networking allows for the nurses to actively engage in similar interests and dialogues that speak to the profession. Social networking is a free way to reach your colleagues and others to promote yourself, your chapter, or your company. As you evaluate which social networking tools are best, consider your target audience, and how you plan to use this tool to have you and your younger/older colleagues on the same team.

Skeptical about social networking? Aside from being free of charge, it allows you to reach a worldwide network of people within seconds. Also, you can use this network of people for future business while staying updated on their recent professional changes or accomplishments. Although significant, social networking can decrease person-person interaction, from the information oversaturation that the sites bring.

Tools of the Trade

On Facebook and Twitter, personal profile, or page, is not necessary. You are able to reach an unlimited number of people, or a specific cohort with a professional or group page. These social networking sites foster a targeted interest of your product, organization, business, and/or company. On LinkedIn, use your personal profile as an online professional resume. New or seasoned, this is a perfect way to market yourself as well as increase your visibility and positively build a personal brand.

Limited time? Twitter can automatically post/share your conversations to other social networking sites for people to see with a simple click. If you have a smartphone, you can use the device to download the application and have immediate access for advertising, or quickly contacting your interested cohort. An information technology personnel can maintain, add social network tabs to website, but it is in your best interest to know how to operate and navigate through the sites yourself in anticipation for staff turnover. Staff or colleagues that are delegated to operate the site(s) may leave your company or chapter for professional or educational endeavors. This turnover may potentially lead to unanswered emails, posts, and a declining captive audience due to decreased activity and responsiveness.

What is your personal brand? Are you increasing the visibility of yourself, your chapter, or company? Are you incorporating your younger/older colleagues? Take the next step and be nurse leader of tomorrow. Lessen the bridge!

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Fierce and Under 40 Forum

Jamise C. Herbert, RN, WHNP-BC, Chair, Fierce and Under 40 Ad Hoc Committee

WOW! IF YOU MISSED IT, then start planning to attend the 2012 NBNA Fierce and Under 40 Forum in Orlando, Florida, the brain child of Immediate Past President Dr. Debra A. Toney. The new and upcoming group to the National Black Nurses Association is Fierce and Under 40. The group held its first forum, Thursday July 14, 2011, at the NBNA's 40th Anniversary Institute and Conference held in Indianapolis, Indiana. The forum was convened by Jamise Herbert, RN, WHNP-BC from Fort Bend County Black Nurses and Dr. Romeatrius Moss, DNP, APHN-BC from Mississippi Gulf Coast Black Nurses Association.

Sixty-five nurses arrived to participate in a fun full filled afternoon of networking and roundtable discussions. Everyone who was anyone was in the place. Nurses from all chapters came to show their support. Individuals ranged from nursing students, nurse practitioners, clinical nurse specialist, educators, administrators, midwives, and entrepreneurs alike. It was amazing! We were an awesome group! We want to thank everyone who came out for this first meeting.

Immediate past President Dr. Debra A. Toney, arrived and charged the group to take initiative and become active participates within the organization, by either running for a local or national board position. It was exciting to have the NBNA newly elected President Reverend Deidre Walton and Dr. Irene Daniels-Lewis to attend and gain first-hand knowledge of this newly formed NBNA powerhouse group. The group felt largely supported.

The goal of Fierce and Under 40 is to recruit nurses under 40, who are attending nursing school or are currently a licensed nurse to get involved in the NBNA. We are striving to uphold the mission of NBNA and to show the organization that we are here and ready for the challenge to participate in this national organization. We are prepared to participate in change efforts necessary to progress the organization.

Some of the other topics of interest discussed among group participants during the roundtable discussion included mentorship, networking, research and publishing. We look forward to staying connected through the year and developing an agenda for Orlando. The use of social media will assist us to expand our reach to new members and effectively communicate our issues.

NBNA Fierce and Under 40 Forum Summary

Topics Discussed

1. Student Chapter
2. Mentorship
   - A. Developing a 501 (c) (3)
   - B. Community involvement
   - C. Help with career change
3. Network (national level)
   - A. Robert Wood Johnson Foundation Executive Nurse Fellows Program
   - B. Fellow of the American Academy of Nursing
4. Network
   - A. Social media- Facebook
   - B. Roster with credentials:

     Dr. Romeatrius Moss will work on it
5. Publications
   - A. Publications - how to get started
6. Educational resources
   - A. Different APN tracks
   - B. BSN, MSN, PhD, DNP

Nursing Leadership

Judith Wright, BSN, RNC

THERE ARE MANY DEFINITIONS of the word leadership. In my view, leadership is a mindset. It involves ones attitude and how they chose to respond to their circumstances. It is not just a desire to change a situation, but actually taking action. The resulting outcome should have a positive impact on the lives that are affected. Leaders are proactive. They engage others and influence their environment through vision. They seek out better ways of doing things and are open to change and new ideas. Leadership requires individuals to be alert and responsive to situations that require change. It calls for individuals to look at themselves and what they have to offer, to stay passionate and to care about what they do. Leadership requires an inward journey that must take place in order to be effective and to have a positive impact on the organization or group that one represents. In order to be a leader, one has to first see them self as a leader.

Over the years, the nursing profession has been shaped by the views of many leaders. The views of nurse theorists have been the basis for nursing practice. They have defined the role of nursing and shaped the way nursing care is delivered. Leaders in the nursing profession often learn lessons from other leaders who are not in the healthcare field. This is a good thing to do because it allows us to get new ideas and continuously look for ways to improve. This leads to better ability to provide quality care and improve patient satisfaction. It also allows for professional growth and career satisfaction.

Nurse leaders should be committed to providing excellent care to consumers. However, a good nurse leader is concerned with more than just the daily tasks associated with caring for the sick. They are always promoting the basic principles of autonomy, beneficence and justice. They promote respect and care for all patients regardless of status and they remain nonjudgmental and accepting. As a nurse, it is important to uphold ethical values and beliefs, be accountable for actions and to work within the scope of practice. Nurse leaders also realize the importance of collaborating with other disciplines in order to enhance the care we provide. They realize the importance of teamwork and the use of evidence based practice to improve care and outcomes. It is important to be culturally sensitive and to embrace changes within the profession.

Nurses have a duty to themselves and their profession. They should therefore lead by example. Nurse leaders should always make every effort to promote the nursing profession in a positive way. It is important for nurses to be motivated and take pride in the profession. Nurses should also realize that there is no such thing as just a nurse and that a leader does not need a title in order to lead. Therefore, nurses should always be committed to professional growth through continuing and higher education and other means of self improvement. In order to affect positive changes in the nursing profession and encourage leadership, it is also very important for nurses to support each other through mentorship, networking and membership in professional organizations.

Character Statement

Leadership requires an inward journey that must take place in order to be effective. Leaders in the nursing profession often learn lessons from other leaders who are not in the healthcare field. This allows us to get new ideas for providing quality care. It also allows for professional growth and career satisfaction. This article focuses on the importance of leadership and explores some of the qualities that are necessary for nurses to become leaders in the profession.

Judith Wright, BSN, RNC, is an active member of Concerned Black Nurses of Newark. She is a graduate student at the College of Saint Elizabeth in Morristown, NJ.

Parliamentary Tidbits: The Electronic Meeting

Azella C. Collins, MSN, RN, PRP

THE *11TH EDITION OF ROBERT'S RULES of Order Newly Revised* was released in late September 2011. Because all NBNA chapter bylaws state that their parliamentary authority "is the current edition of *Robert's*," the 11th edition is now the parliamentary authority. This new edition contains 122 major changes. The information below on electronic meetings highlights changes that may impact the NBNA meetings.

There are several types of electronic meetings: audio-conference, teleconference, webinar, Skype, and chat rooms. To have a legal meeting other than an in-person meeting requires authorization in the bylaws. Meetings should allow for "simultaneous aural communication among all participating members equivalent to those meetings held in one room or area." Depending on the modality used there will be a need to develop certain rules to ensure that business is properly expedited. In the 11th edition there is a new sub section on Electronic Meetings containing the following subjects:

- Extension of Parliamentary Law to Electronic Meetings
  - Must be properly authorized in the bylaws
  - If authorized there should be rules which govern the meeting process
  - The business must be transacted in a properly called meeting
- Types of Electronic Meetings
  - Audio-conference, teleconference, webinar, Skype, chat rooms
  - Wording of the bylaws must be very precise
  - Postal mail, fax, email and chat rooms are not recommended
- Electronic Meetings in Committees
  - Committees that are expressly stated in the bylaws can hold a valid electronic meeting only if authorized in the bylaws
  - Special and ad-hoc committees that are not expressly established by the bylaws can utilize an electronic meeting format by development of a standing rule of the parent organization, or by the motion that established the particular committee
- Additional rules for electronic meetings are recommended in the 11th edition. Some of the subjects that must be covered in the rules include:
  - How the secretary or chair will ensure that a quorum is established
  - How the chair will ensure the maintenance of the quorum
  - How members will seek recognition
  - How to handle interrupting motions
  - How to submit motions in writing
  - How to take and verify votes
  - How to properly call electronic meetings including a description of how to participate
  - How to avoid having uninvited participants on-line

The additional rules can be in the bylaws, special rules of order, standing rules or instructions to a committee. Technology is rapidly developed. This writer would caution to avoid placing the administrative rules in the bylaws therefore necessitating a bylaws change.

The section on how to send electronic meeting notices propels the opportunity to save chapter funds. Depending on the number of members monthly mailing cost averages $5 to $100 for NBNA chapters. Sending out notice of meetings using the postal service can be very expensive. The new edition allows notices to be sent electronically (email or fax) if the member agrees to it being sent that way. Notices could also be sent via text. When chapter presidents submit their roster for credentialing an additional column can be added requesting permission to send all notices electronically. A box can be added to each membership application for each member to check granting permission.

Whatever method utilized should also include the statement that the permission will remain in effect until the member notifies the organization to discontinue sending electronic meeting notices.

Electronic meetings with proper rules and skilled facilitators decrease travel time, the amount of funds spent on meetings, and increase attendance at meetings.

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Branding Your Way to Success!

Dr. Funmi Aiyegbo

WE ARE ALL FAMILIAR WITH household brands like Tide, and designer brands like Polo. Starbucks is now synonymous with coffee but what is your personal brand? One purpose of branding is to secure a market share, and eventually become a market leader. As nurses in the technology age we need to take advantage of the resources we have to establish our brand. Nurses at every level of practice can establish a professional brand.

Step 1

Nurses have core competencies that are general and applicable across the board to every professional nurse. Developing a brand requires you to carve out a niche. Decide on an area of expertise and develop unique skills. Your goal is to become a specialist within your area of practice. Avoid stereotypical roles and ideas of what a nurse is or does. Step out by promoting your individuality. What do you offer that is dynamic and unique? Promote your uniqueness. When employers and costumers look at you, what sets you apart? Have a 30 second biography that highlights who you are, where you are professionally, and what your next destination is.

Step 2

Package and display your brand. Packaging and presentation are significant to the success or failure of your brand. Your expertise should be displayed in a resume, on your social networking pages, blog postings, professional website, business cards, and by your professional references. Your resume should reflect not only your current status but you should mention your future aspirations, and the activities that you are engaged in that propel you towards those future goals. When using Facebook, Linkedin and other social media keep in mind that both professional and personal contacts may have access to your postings. Be aware of what you post and the fact that your personal online persona and professional online persona should be consistent with each other in order for your professional brand to have credibility. Remember that references and referrals are valuable to your brand. Manage relationships well in order to maintain the respect and reputation for your brand.

Step 3

Aggressive marketing builds brand recognition. Start on your current job. Take each day as an opportunity to increase your knowledge, hone in on specific skills, and network. Attend and present at professional conferences and trade shows. Practice your “sales pitch”. Speak to as many people as possible about your brand. The process of marketing your brand may expose some weaknesses. Stay true to your passion but remain open to constructive criticism. Most ideas need some sort of revision before they reach their final perfection. Keep in mind that many brands get reformulated, become “the new improved” or “same formula new packaging”. Be bold and fearless in your pursuit of success and believe in your brand.

Dr. Funmi Aiyegbo is a board certified family nurse practitioner. Her career has included clinical practice in specialty areas including maternal-child health, infectious disease, hematology oncology, and psychiatry. She is the owner and Chief Nursing Officer of Ardent Home Healthcare in NJ.

Prescription Drug Abuse: The Nation's New Drug Epidemic

Janice Phillips, PhD, RN, FAAN
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PRESCRIPTION DRUG ABUSE is now the country's fastest growing drug problem. While prescription drug abuse, misuse and diversion are not new, this growing epidemic has stimulated a call to action on a number of fronts including the United States Congress. During the 112th Congressional session, lawmakers introduced several legislative proposals in response to this growing epidemic. While each legislative bill seeks a solution to prescription drug abuse from a different perspective some offer a comprehensive approach to this complex issue. OxyContin and Vicodin are among the most frequently abused prescription painkillers and Xanax and Valium are the most frequently abused central nervous system depressants. Concerta and Adderall are among the most frequently abused prescribed ADHD medications. Sadly, more and more people are abusing over the counter drugs such as DXM (dextromethorphan), the active cough suppressant found in many over-the-counter cough and other cold medications.1

Recent data reveal that 7.0 million persons reported past month use of non-medical psychotherapeutic drugs, this equates to 2.8% of the U.S population.2 The same survey revealed that prescription drug use was highest among young adults aged 18-25, with 6.3% reporting nonmedical use of prescription drugs in the past month prior to the survey. Older adults are another high-risk population. Persons age 65 and older are particularly at risk because they are more likely to be prescribed long term and numerous medications. Other vulnerable populations include individuals taking multiple controlled substances from multiple providers, people who take high daily doses and those who abuse numerous abuse prone prescription drugs, low income individuals residing in rural areas. The increased availability of prescription drugs, the push for aggressive pain management along with misconceptions regarding the addictive potential of prescription drugs in part, are contributing to this epidemic.

This growing public health epidemic has resulted in numerous legislative proposals in Congress. Legislation introduced during the 112th legislation includes a focus on stricter penalties for "pill mill" operators, education for providers with prescriptive authorities, consumer education and state funding to better support state drug monitoring programs. The author worked on Senate Bill 507 during her Fellowship in the office of Senator John D Rockefeller. Briefly, S 507, The Prescription Drug Abuse Prevention and Treatment Act of 2011 (now updated to 2012) addresses prescription drug abuse by: 1) Recommending mandatory education for providers before they can be licensed to prescribe controlled substances; 2) Educating consumers on the safe use of painkillers and preventing of diversion and abuse; 3) Using basic clinical guidelines for safe use and dosage of pain meds including Methadone; 4) Increasing federal support for state drug monitoring programs and; 5) Improving opioid death registries.

Similarly, the 2011 Prescription Drug Abuse Prevention Plan, an extension of the Obama Administration's National Drug Control Strategy, includes an emphasis on consumer and provider education, implementing state prescription drug monitoring programs, facilitating safe and proper disposal of medications and enforcing stricter law and legal actions to eliminate improper prescribing practicing and mill mil operators. Numerous legislative initiatives are underway in state and local governments as well. As we seek to find solutions, all parties must consider the balance between drug control and appropriate pain management.

As the legislative process continues to unfold, the nation stands to benefit from the Secure and Responsible Drug Disposal Act of 2010. President Obama signed this into legislation fall of 2010 as part of the Administration's efforts to combat prescription drug abuse. Briefly, this legislation provides consumers with a means to dispose of unused and expired medications at a safe designated place at select times during the year. Referred to as National Take Back Days, the next National Take Back Day is scheduled for April 28, 2102 from 10am - 2pm. Since the inception of these events the DEA, and its state, local, and tribal law-enforcement and community partners have removed 995,185 pounds (498.5 tons) of medication from circulation in the past 13 months.

Combating prescription drug abuse should be everybody's business. The current epidemic is impacting urban and rural communities nationwide. Our various chapters and members are well positioned to provide patient and community education on the safe use and disposal of prescription drugs as well as promote the national take back initiative. For detailed information and related locations, members are encouraged to visit: http://www.deadiversion.usdoj.gov/drug_disposal/takeback/index.html

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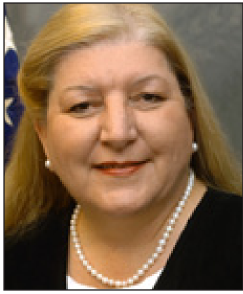

Information for Pregnant Women Taking Prescription Drugs: The Food and Drug Administration Office of Women's Health Pregnancy Exposure Registry Website

Gallauresi, Beverly, MPH, RN

THE FOOD AND DRUG ADMINISTRATIONS (FDA) Office of Woman's Health (OWH) mission is to protect and advance the health of women through policy, science, outreach and to advocate for the participation of women in clinical trials and sex-specific analyses.

Pregnant women have a desperate need for additional information regarding medications prescribed by their health care providers. Approximately 64% of pregnant woman are prescribed one or more drugs during pregnancy, excluding vitamins and minerals. Many enter pregnancy with chronic health problems that require continuous or intermittent use of prescription medication.

The recognized gold standard essential to defining the safety and effectiveness of medications are adequate and well-controlled clinical trials. However, because pregnant women are rarely included in clinical trials, pregnancy exposure data in product labeling are often inadequate to fully evaluate safe use. .Pregnancy exposure registries (PERs) address this gap by collecting ongoing observational pregnancy and fetal outcomes data; clinically relevant human data that will improve product labeling so that healthcare practitioners and their patients can make better informed decisions about prescription drug use while pregnant

Although PERs are not a new concept, health care providers and the public are woefully unaware of their existence. In addition, because PER listings are scattered throughout numerous manufacturer websites it is difficult for providers to locate a PER. Consequently, pregnant patients are rarely encouraged to enroll in these registries.

So while pregnant women are advised to discuss medication use with their health care provider, the prescriber actually has little clinical safety and efficacy data to advise the patient. Because "we don't know, what we don't know" there is reluctance both to prescribe and to take medications, even when the drug is necessary to manage serious disease. FDA OWH has developed a compendium of PERs which provide clinically relevant prospective observational pregnancy and fetal outcomes data. This unique and innovative tool is the only consumer web site that lists all available PERs in one site. There are currently 57 registries listed specific to a medical condition/ disease or product. The FDA OWH PER website was established as a direct result of FDA's Guidance's for Industry in 20022 .This guidance explains the importance of pregnancy exposure registries, describes how to create a registry, and encourages patient participation The website defines pregnancy registries and provides specific registry contact information. By consolidating all available pregnancy exposure registries into one centralized website; it is much easier for health care providers and pregnant women to locate and make use of this important tool

The FDA OWH PER website is a multi-phase project. In Phase I a website was created as an outreach tool to raise consumer and health care provider awareness about the registries. In Phase II, usability testing was conducted via focus group assessment to help refine the content and organization of the website. Phase III continues to promote awareness about the website, the value of pregnancy registries and facilitates the review of collected data toward potential labeling changes for these products. This FDA OWH website addresses an unmet need through the collection and analysis of safety and exposure outcomes about prescription drug use during pregnancy.

The FDA OWH PER is both unique and innovative as it is the only web site that lists all Pregnancy Registries in one easy to use site located at http://www.fda.gov/ScienceResearch/SpecialTopics/WomensHealthResearch/ucm251314.htm. This consumer web site is relevant to any health care provider and can also be used to encourage pregnant women to participate in PERs. As nurses and healthcare providers; please consider telling your pregnant patients taking prescription medication about the PERs website and encourage their participation.

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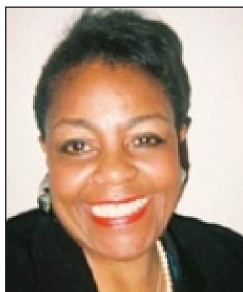

Parliamentary Tidbits: Your Role Has Been Cast

Azella C. Collins, MSN, RN, PRP

ORGANIZATIONAL PRESIDENTS are dependent upon many individuals: committee members, chairs, and officers—both elected and appointed. Most members are probably more familiar with the duties of the secretary than with other officer because the secretary is more visible in the performance of duties during meetings. According to *Robert's Rules of Order, Newly Revised, 11th Edition*, (RONR), the secretary, "is the recording officer of the assembly and custodian of its records, except those specifically assigned to others..." There are eleven duties listed for the secretary on pages 458-459 of RONR. If you are a secretary, make sure you read the list as well as your organization's bylaws. The secretary should be an individual who is organized and detailed oriented. Minutes should be prepared promptly after a meeting when the details are fresh. The secretary should make a list of tasks to be completed after a meeting and check them off as they are completed. Additional duties are listed in *The Complete Idiot's Guide to Robert's Rules*, by Nancy Sylvester. In organizations where there is more than one secretary, the bylaws should specify the duties of each position.

Many people think that the treasurer is the most important officer. RONR page 461 states, "The treasurer of an organization is the officer entrusted with custody of its funds. The treasurer, and any other officers who handle the organization's funds, should be bonded for a sum sufficient to protect the organization from lost." The duties of the treasurer will vary depending upon the size of the organization and the complexity of its finances; but this officer cannot disburse funds except by authority of the organization or as the bylaws so prescribe. Once the board or members have adopted the budget, it is the treasurer's responsibility to make sure the organization spends within the established budget. It is important for the treasurer to keep accurate records and to make deposits and promptly pay bills. When writing checks, the treasurer should use a gel pen, which is more difficult to 'wash' than ballpoint pens. The treasurer is required to make a full financial report as prescribed by the bylaws or rules. The treasurer's report should include, but is not limited to: balance on hand at the beginning of the reporting period; all income; all disbursements; and balance on hand at the end of the reporting period. This report is for information only and is never adopted, but filed pending audit. For organizations with annual expenses of less than $50,000, an internal audit can be conducted by financial savvy members who are not officers or committee chairmen. *The Complete Idiot's Guide to Robert's Rules* page 224, provides a list of items that must be available for internal and or external auditors. If your organization has grants and/or monies from various foundations a *Grant and Finance Committee Procedure Manual* is needed.

The vice president—the understudy for the president—stands in the wings, prepared to fill in at the last minute or assume the position permanently if the president is unable to continue in the office, and many think that this is the most important office. "A vice president should always be prepared to take over for the president. Some ways of doing that include discussing with the president the agenda before each meeting; having an agenda, the bylaws, and parliamentary authority for all meetings; and arriving at the meeting early enough to be prepared for the start of the meeting. If a vice-president prepares in that manner, then in an emergency that delays the president, attendees won't have to sit around wasting time waiting for the president. The vice president can start the meeting on time." (Sylvester, page 23). In organizations where there is more than one vice-president, the bylaws should specify the duties of each position.

RONR page 462 devotes four lines to describing the duties of the historian, in the opinion of this writer the historian is the most important officer. The historian prepares a narrative account of the organization's activities during his or her term of office, which, when approved by the assembly, will become a permanent part of the organization's official history. The principal duty of the historian is to keep a continuous, systematic written record in chronological order of significant historical events and activities, for the term of his office. Most organizations require the historian to have other duties and responsibilities in addition to compiling a written history. Some organizations require the historian to keep a scrapbook or file of newspaper and publicity notices, pictures, reports, yearbooks, workshops, seminars Christmas brunches, etc. and other historically significant material.

In the age of computers, the reports should also be saved on a CD or memory card. Unfortunately, many organizations lose their history when a member dies and leaves no instructions for the family about what to do with the organization's material.

Committee chairpersons must obtain minutes of previous committee meetings, review annual reposts, newsletters, and member surveys if applicable. Their principal duties should be outlined in the organization's bylaws. The chairpersons must be the most knowledgeable person in the group. Plan the meeting, have an agenda ensure each member knows what business is being considered by discussing one item at a time. Allow for adequate discussion (when committee members begin to repeat issues tactfully limit discussion and bring the issue to a vote). Keep a list of action items and check them off as they are completed.

The most important people in any organization are the committee members who must understand their overall tasks and specific role. Majority rules: if you were not on the prevailing side, work hard to ensure group success, do not be a poor loser. You are the workhorses of all organizations. What role in the cast will you play? How do you prepare to fulfill your duties and responsibilities? How will you support your organization? Abigail Adams once stated, "Learning is not attained by chance. It must be sought for with ardor and attended to with diligence."

Men in Nursing: A Focus on Diversity-Pilot Study

CJ Hutto, RN, MHA, Director of Operations, Patient Care Services

NURSING IS ONE of the most respected professions in our country and yet this workforce continues to struggle with shortages of labor, an aging workforce, and a lack of diversity within that workforce. Men comprise a very small percentage of this workforce and men representing "under-represented minority groups" comprise an even smaller number. These men get distracted and discouraged by perceived or real barriers that prevent them from pursuing a career in Nursing. Moreover, those that do enroll in a nursing program will often drop out due to financial constraints and environmental or social influences. Pursing a degree in Nursing and strong obligation to provide for their families have not been co-existing thoughts for these men.

The Children's Mercy Hospital (CMH) in Kansas City, Missouri has a strong desire to understand these barriers and to learn, firsthand, from these unique men the conditions that must be in place in order for them to successfully achieve a bachelor's degree in Nursing and be awarded the credentials of a registered nurse. CMH provides a supportive environment that fosters professional achievement and higher education yet historically, this alone, has not been enough. Care assistants work side-by-side the nursing professionals they dream of being one day yet the barriers over-shadow the dream. They simply don't move beyond that dream. CMH realized that a partnership where industry, academia, and community work together was critical to understanding these conditions and to provide the comprehensive support these men needed.

The Children's Mercy Hospital, the University of Missouri-Kansas City (UMKC), and the Full Employment Council of Greater Kansas City joined forces to create and implement a Pilot Study where two men representing underserved minority groups are being supported financially, socially, and environmentally as they pursue a bachelor's degree in Nursing at UMKC. We are creating a new community that will sustain itself and promote diversity within the Nursing workforce and beyond. We have yet to realize the full impact this Pilot Study will have for these two men who are expected to join the Nursing workforce at CMH when they complete the Pilot Study. The transmission of knowledge, the transformation of two lives, and the creation of this new community where caring, compassionate, and highly motivated professionals are rallying together can only result in something wonderful. Two men together with this new found community will influence what happens today and what happens in the future and our patients and families will be the ultimate beneficiaries.

Marlon Butler (left) graduated from Kansas State University with a bachelor of science degree in Kinesiology over 5 years ago. He has been employed with Children's Mercy Hospitals and Clinics as a care assistant for the past 4 years in one of the outpatient clinics. He was recognized as Employee of the Month and Employee of the Year in 2011. Marlon's acceptance speech upon receiving this recognition will be marked as one of the most memorable in the history of the organization. Marlon gives much credit and appreciation to his mother, a retired school teacher, for all of his successes, both large and small. Marlon also has a very important older sister who is a respected leader in health care. The Pilot Study created the platform for encouraging professionals to instill in him the self confidence he needed to pursue a degree in Nursing. His desire to have a positive impact on the lives of people through care, respect, and service and his dream of becoming a nurse were already residing within him. Marlon will enroll at the School of Nursing at UMKC in the fall of 2013.

Christopher Garcia has been employed at Children's Mercy Hospitals and Clinics for over one year as an inpatient care assistant however he has a long history with the organization as a adolescent patient. He tells his story of being a cancer survivor and experiencing firsthand the care and compassion of a particular male nurse. He observed this nurse caring for him and relating to him at a level the female nurses simply could not. Christopher has a loving and supportive family consisting of his significant other and his parents. He describes his greatest pride and joy as his son and he speaks passionately about his commitment to love and support him. Christopher embodies care, respect, and service each and every day and this Pilot Study and the professionals around him are affording him the financial support and the encouragement he needed to pursue his dream of becoming a male nurse. Christopher will enroll at the School of Nursing at UMKC in the fall of 2013.

Arthritis: How Do We Address the Burden of this Debilitating Disease?

Kimberly Templeton MD, President & Nancy Baker, ScD, MPH, OTR/L, Chair, Experts in Arthritis Advisory Committee;

Janet Wyatt, PhD, RN, FAANP, Board member & Toby King, CAE, Executive Director, U.S. Bone and Joint Initiative (USBJI)

MUSCULOSKELETAL CONDITIONS are the most common reason for people to seek health care. It is estimated that these conditions occur in about half of the adult U.S. population (The Burden of Musculoskeletal Diseases in the United States, www.boneandjointburden.org). The goal of the U.S. Bone and Joint Initiative (USBJI), a network of some 100 patient and healthcare professional organizations, is to address the burden of these conditions through improved education and research. The USBJI is the national action network of the global Bone and Joint Decade, which is a global campaign to improve the prevention, diagnosis, and treatment of musculoskeletal conditions.

Arthritis and other rheumatic conditions are the second most common form of musculoskeletal diseases. Arthritis affects one in five adults in the United States, or an estimated 50 million people. This number is expected to soar, reaching 67 million by 2030. Osteoarthritis (OA), the most common form of arthritis, is estimated to affect 13.1 million adults in the U.S., while rheumatoid arthritis (RA) is estimated to affect 1.3 million. Arthritis is the most common cause of activity limitations, impacting the function and independence of older adults. Arthritis can be debilitating, affecting all aspects of daily life including a person's ability to work and care for their family. Work limitations are especially concerning, as about two-thirds of people with arthritis are under the age of 65. Pain and resulting disability from arthritis also affect the ability to treat other conditions, such as obesity, diabetes, and heart disease.

Arthritis is a disease that is of particular concern for minority populations. Although there is little difference among races in the prevalence of arthritis, minority populations report more severe joint pain, greater activity limitations, and nearly 2x the work limitations (http://www.cdc.gov/arthritis/data_statistics/race.htm). Unfortunately, minority populations are also less likely to receive services that can mitigate the effects of arthritis such as joint replacement therapies (Skinner et al, 2003) or participate in self-management programs (Bruce, Lorig, Laurent, 2007). Women of all races are also less likely to receive interventions to address their arthritis.

There is no cure for arthritis; however, current treatments and increased understanding about ways to manage the disease have created significant improvements in quality of life. People with arthritis have a critical role to play in the management of their disease. They need to be empowered to ask questions and to take advantage of the therapies and treatments available. To provide the information needed for people with arthritis to increase participation in their care, the USBJI developed an enduring, nationwide program that allows for direct interaction between people with arthritis and experts in the field. The goal of Experts in Arthritis is to provide information about arthritis-based interventions that will help to minimize the effects of arthritis on their daily lives, using a format that is client-centered and provides high quality up-to date, evidence-based information. As with other USBJI programs, Experts in Arthritis is built on partnerships with people with arthritis, healthcare professionals, and nationwide and local community organizations.

Patient advocates and healthcare professionals such as nurses, rheumatologists, physical therapists, orthopaedic surgeons, and occupational therapists present sessions covering current scientific evidence for the treatment and self-management of osteoarthritis, rheumatoid arthritis, and juvenile arthritis. The objective of Experts in Arthritis is to provide information about treatment options and lifestyle interventions, thus improving the ability of people with arthritis to manage their disease.

Through this public education program the USBJI works with communities to generate awareness and understanding of the advances that have and continue to be made to lessen pain, improve mobility, and restore function for those who live with arthritis. While there is still no cure for arthritis, the advances made through research now make it possible for people with arthritis to live their lives to the fullest, at home, at work, and in the community.

For more information about Experts in Arthritis, please visit www.usbji.org, or email usbji@usbji.org

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Getting to the Soul of the Matter

NBNA/United Health Foundation 2012 Scholar: CPT Angela Iyanobor, BSN

THE UNITED HEALTH Foundation currently has four priorities they're working on to include: Creating Healthier Communities, Expanding Access to Care, Nurturing Our Future Health Workforce, and Improving Medical Outcomes. As I sit in my nurse practitioner course, I am a little disgruntled because so many of the preventable diseases I am learning about have African American descent as a risk factor. "Why is that?" I ask myself and "What can I do personally to help my community live healthier, longer lives?" Well I decided to do what my grandmother always talked about which was to start at home.

I decided to start with the Creating Healthier Communities priority. The first thing that comes to mind for me is Soul Food. I am from Mississippi and oh how we love our food. I am also part Nigerian and oh how they love their food as well. It's our culture. We socialize and fellowship with food. That's how many mothers and grandmothers show their love for family and friends through cooking delicious (but often not so healthy) meals. Now we just need to find a way to turn those mouthwatering meals into healthier versions. When talking to members of my family, eating healthy was considered eating bland and tasteless foods.

Since I love to cook and plan family gatherings when I'm in town, I thought this would be a perfect opportunity to convince them otherwise. My menu included grilled shrimp cocktail with yellow gazpacho salsa, roasted vegetables, quinoa salad, crab empanadas with mango salsa, and for dessert fruit pizza. I did not tell them about my menu switch because I knew they would complain and beg for the usual fried chicken, candied yams, macaroni with cheese, and my famous banana pudding. Everyone showed up and whispered amongst themselves that Angela had gone off to Hawaii and lost her mind because there was no way they were going to eat this! As I playfully shoved a spoonful of quinoa salad into my favorite uncle's mouth, we all awaited his verdict. He chewed, deliberated, and chewed some more. And ta da! I got a smile and a nod of approval. Once everyone saw him fixing a plate they all began to fix their plates, some still with skepticism. I had a huge grin on my face as I was witnessing right before my eyes the start of something new!

I proceeded with caution but I began my lecture on how African Americans have the highest rates of hypertension, dyslipidemia, diabetes, and obesity; all of which can be prevented and/or controlled with proper diet and exercise. My sister suggested we incorporate new fruits and vegetables into our diet at least once a month. This turned into a recipe sharing conversation among the women.

There you have it! I was able to turn my Soul Food loving family into one that isn't afraid to try new foods, understands the importance of lifestyle modification, and will hopefully decrease their chances of being diagnosed with a preventable disease. This simple gathering has even caused a ripple effect. My family members are taking the new healthier recipes to work with them which it creating a buzz amongst their coworkers. Who knew people in the south would get so excited about their health!

Everyone can all take small steps to make our community healthier. Just starting with our own family and friends is a great and effective start. There are so many national initiatives already in place that we have endless resources at our fingertips. All it takes is one person getting disgruntled about seeing African American descent as a risk factor for yet another preventable disease. Hopefully I'll have a lot of disgruntled readers at the end of my article. God bless!

Nursing from the Eye of a New Nurse: A Personal Perspective

NBNA/United Health Foundation 2012 Scholar: Harpreet Singh-Gill, RN

NURSING IS an exciting profession that is constantly evolving in order to improve patient outcomes and increase the effectiveness of patient care. However, one aspect of nursing that remains consistent is the compassion and empathy that define the scope of nursing. In order to continue growing as health care professionals and improve patient care; change must begin within ourselves by means of exploring our thoughts and perceptions and how our underlying experiences and beliefs impact patient care. The idea of what we think we become is an interesting concept to consider both professionally and personally in the field of nursing.

As a nurse we come across people of different races, beliefs, religions, socioeconomic status, thoughts and perceptions every single day. While caring for patient's we oftentimes bring in our own beliefs of what is right or wrong and good or bad when it comes to providing care for our patients. It's human nature to have subconscious thoughts that arise about things and people we come across every day.

During my clinical experience as a nursing student I came across many experiences where I saw medical professionals making judgments about patients and at times I was guilty of this as well. I found myself thinking about how our own perceptions, beliefs, values and judgments may impact patient care. Are the women who live in poverty with no insurance treated differently than those who are successful? Our minds are so powerful that we can make ourselves believe anything we want and those believes in turn impact the way we interact and treat people. If you want to believe that the mother who has not seen her baby in intensive care for three weeks is a horrible mother you can convince yourself to believe that and based upon that belief our interactions may be different than if she came to see her baby every single day. Now the question to consider is why this mother has not been able to see her baby is she depressed? Has she had a previous miscarriage and cannot bear to deal with the possibility of losing another child? Perhaps she does not have transportation or a babysitter at home? We don't know her story.

It's so important to consider the values that nursing is based upon when providing care. Although we are all different and our life experiences shape the people we become. One aspect that remains constant is that we are all human beings have the right to be treated with dignity, respect and compassion regardless of our life story. Even though it may be human nature to make value judgments it is important to be aware of how these judgments, our own beliefs and perceptions can impact patient care. Through awareness we can begin to make a change within each of ourselves and work towards achieving a common goal of providing dignified, respectful and compassionate care for all patients.

Shreveport Black Nurses Association Conducts Health Education Classes

NBNA/United Health Foundation 2012 Scholar: Alyea Marnia Minter Pollard

ON ANY GIVEN Tuesday evening from August to October and then February to April, you will find members of the Shreveport Black Nurses Association at the Shreveport/Bossier Rescue Mission conducting Health Education Classes (HEC) for residents. Shreveport/Bossier Rescue Mission (SBRM) was founded in 1955 to provide shelter and a gospel service to men traveling through Shreveport, according to the SBRM website. As the need for more services grew, SBRM expanded and now, for over 25 years, has functioned as an ark of refuge for men, women, and families with children who are in need of food, shelter, and clothing. Pursuing the passion of Jesus Christ to lift up the hungry, homeless, abused, and addicted is the organization's mission and this mission is truly exemplified through every area of service provided at SBRM including the HEC taught and facilitated by devoted members of Shreveport Black Nurses Association (SBNA).

SBNA has consistently provided this service for four years through the leadership and facilitation of member, Pamela Simmons, RN, PhD. Amidst time constraints due to work, school, family, and other interests and priorities, members of SBNA remain strongly committed to providing the hour-long session once a week without fail. When asked, "Why she continues to spearhead this service project?" Dr. Simmons responded, "It truly fulfills a need in the community. Presenting the classes gives us an opportunity to share what we know with individuals who can benefit. And because it is a type of giving, we as members of SBNA, benefit by experiencing a sense of accomplishment and fulfillment – nurses love to help their fellow man or woman. It is a joy and privilege to serve the residents of the SBRM." SBNA President, Renee Lamb, RN commented,

"When Dr. Simmons presented the proposal to SBNA the organization recognized how the HEC fit with our mission statement. We are reaching an underserved population in our community. Our reward is by the participants verbalizing their thanks as well as by seeing the positive changes they make in their and their families lives from the information received." A wide array of health topics are presented through slide presentations including: Hand washing & Other Hygiene Tips, Heart Health: Hypertension/CHF/MI/Stroke, Diabetes, Mental Health: Bipolar, Depression, Stress & Addiction, Sexually Transmitted Infections, Healthy Eating, Nutrition Update, Respiratory Health: Asthma, TB, Flu, COPD, Dental Health and Hygiene Exercise, and Healthy Habits vs High Risk Habits. Male and female residents are taught in separate groups and each class consists of about 25 females and 35 males. HEC agenda includes a scripture, prayer, a pre-test, the lesson, and a post-test. Participants are given handheld devices called clickers to respond to pre- and post-test questions interactively so that responses can be logged and program effectiveness can be measured. The classes culminate with a celebration quiz bowl, which is always an exciting event. Residents are tested on all the materials presented in a fun, non-threatening way with personal items donated by SBNA members given as prizes.

Membership in SBNA helps to remind me of the importance of community service. I have also taught and facilitated Health Education Classes at SBRM. Compassion and empathy for people's lives follows Christ's model of love when He said in Matthew 22:37-39, we are to "love the Lord your God with all your heart and with all your soul and with all your mind. This is the first and greatest commandment, and the second is like it, love your neighbor as yourself." Understanding that concept helps me to realize that life is more than me and my agenda. There are people who are hurting and need help from all walks of life. I am assured of my place in society when I can view how my personal agenda and participation in SBNA initiatives makes the world better.

Alyea Marnia Minter Pollard, a native of Jackson, MS, is a graduate nursing student (concentration: Adult Nursing Education) at Northwestern State University in LA. She received her BS in Healthcare Administration from Jackson State University (2000) and BSN from Mississippi College (2003). She plans to further her studies to the doctoral level. She enjoys spending time with family, reading, and arts and crafts.

Childbed Fever

NBNA/United Health Foundation 2012 Scholar: Ralph Peyton

CHILDBED FEVER IS an infection of the womb which can lead to septicemia and death of a new mother. A few hundred years ago, long before microscopes and microbiology, an interesting story began to unfold. In 1846 an obstetrics physician, by the name of I.P. Semmelweis, noticed a persistent occurrence of a fever followed by a shortly ensuing death of a mother after childbirth. The Vienna Lying in Hospital had 2 maternity wards; one run by physicians and one run by nurse mid-wives. Dr. Semmelweis' statistical investigations revealed a rate of 11.25% mortality by physicians, and 2.85% mortality rate by nurse mid-wives. There was a simple reason for this difference; nurses washed their hands and physicians did not.

We now know that Group A Streptococcus was the main culprit in childbed fever and we refer to this phenomenon as nosocomial infections. There are many nosocomial infections still contribute to the morbidity and mortality of patient's under our care; MRSA, Influenza, E. Coli, RSV, Klebsiella and Norovirus just to name a few. Procedures that nurses routinely preform like Foley catheter insertion and intravenous line placement continue to place patients at risk of nosocomial infections. Appropriate hand washing is still the single most effective method for preventing the spread of these diseases today.

According to the CDC you should:

- Wet your hands with clean running water (warm or cold) and apply soap.
- Rub your hands together to make a lather and scrub them well; be sure to scrub the backs of your hands, between your fingers, and under your nails.
- Continue rubbing your hands for at least 20 seconds. Need a timer? Hum the "Happy Birthday" song from beginning to end twice.
- Rinse your hands well under running water.
- Dry your hands using a clean towel or air dry.

The human touch is rooted in the principles of nursing. Comprehensively washing the hands is the single most important procedure in the prevention of nosocomial infections. It is only appropriate that we embrace this history and continue to set standards excellence in patient care by washing our hands.

Stroke and African Americans

NBNA/United Health Foundation 2012 Scholar: Danielle Dawes, RN

STROKE, ALSO KNOWN as a brain attack occurs when a clot blocks the blood supply to part of the brain or when a blood vessel in or around the brain bursts causing parts of brain to become damaged. About 85% of all strokes are ischemic, in which blood flow to the brain is blocked by blood clots or fatty deposits. Hemorrhagic strokes occur when a blood vessel burst in the brain and blood accumulates and compresses the surrounding brain tissue. According to the CDC, one American dies every 4 minutes from a stroke. African Americans are more impacted by stroke than any other ethnicity within the American population. African Americans tend to have more strokes that occur earlier in life and an increased number of stroke survivors that become disabled or have difficulties with daily living and activities. This is why it is extremely important that we recognize the risk factors and make lifestyle changes to take preventative measures.

Hypertension is the leading risk factor for stroke and approximately 1 in 3 African Americans suffer from hypertension. Other risk factors that put people at a higher risk for stroke include smoking, high cholesterol, diabetes, obesity, poor diet and excessive alcohol use. Many strokes can be avoided and prevention is the key, there are several ways to reduce your risk and it starts with making lifestyle changes. You should have your blood pressure checked annually and be compliant with taking medications if diagnosed with hypertension. Taking control of your diet is another way to reduce your risk, you should reduce any excessive weight and maintain a diet low in calories, salt, saturated and trans fats. Alcohol should only be used in moderation and you should make an effort to stop smoking if you are currently a smoker.

The importance of learning the signs and symptoms of a stroke can make the difference in the amount of damage and the severity of the stroke. Stroke symptoms include:

- Sudden numbness or weakness of the face, arm or leg especially on one side of the body.
- Sudden confusion, trouble speaking or understanding.
- Sudden trouble seeing in one or both eyes.
- Sudden trouble walking, loss of balance or coordination.
- Sudden severe headache with no known cause.

An easy way to remember the warning signs of stroke is by using the acronym FAST:

Face: Ask the person to smile. Does one side of the face droop?

Arms: Ask the person to raise both arms. Does one arm drift downward?

Speech: Ask the person to repeat a simple phrase. Is their speech slurred or strange?

Time: If you observe any of these signs, call 9-1-1 immediately.

Noting when the first symptoms appear is extremely important, a clot buster medication to reduce long term-term disability can be administered if given within three hours of the first symptom for ischemic strokes. Few medications can treat hemorrhagic strokes but surgery may stop the bleeding. 1 in 8 stroke survivors have another stroke within 5 years so the focus should be placed on prevention and the importance to treat underlying causes, including heart diseases, high blood pressure, high cholesterol, or diabetes.

In conclusion, because African Americans are at an increased risk for stroke we must take control of our health and make a conscious effort to reduce our risk. Making the African American community aware of this increased risk is the first step to changing the statistics.

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Danielle Dawes, RN, graduated December 2012 from Lonestar College with an ADN degree. She is attending University of Texas at Arlington completing the BSN degree. She is working at Memorial Hermann Memorial City Medical Center in the Neuroscience ICU, Houston, TX.

Hypertension in the African American Population

NBNA/United Health Foundation 2012 Scholar: Mitzie Reagan

I AM VERY PASSIONATE about reducing complications due to hypertension in the African American population. During my senior practicum as a student nurse in the ICU, I saw many avoidable complications due to medication noncompliance, poor knowledge about proper diet, and a lack of appreciation about the seriousness of this disease. A CDC (2010) study reveals that deaths from hypertensive heart disease and hypertensive renal disease has increased in African American men and women over a five year period; also during that period, the death rate due to hypertension related complications was twice as much in African Americans than white Americans.

People stop taking their medications for many reasons; men in particular may have a side effect of impotence. As nurses we can educate male patients, by bringing up the topic in a hypothetical way; For example we could share "in some men this occurs, and if that is ever a problem let us know and we can change the medication". Many men are unaware of other options and will just stop taking their medications all together; this can lead to life threatening complications. Poor knowledge about the DASH diet (dietary approaches to stop hypertension), recommended exercise, and lack of health insurance are other reasons for treatment non-adherence. In some cases patients are not intentionally non-compliant; they may not know when or how to take medications. Some people think they only need to take their prescribed medications if they have symptoms or if their blood pressure is outside of the desired range; in these cases, patient education can help to alleviate misconceptions.

After taking note of which patients were on dialysis or vented due to cardiac arrest secondary to hypertension, it was alarming to see that the majority were black. It intrigued me to find out why the statistics are higher in my race. As a result I feel charged with lowering the morbidly and mortality numbers in African Americans due to high blood pressure. Through education and advocacy we can promote treatment compliance. Explaining the medication list, making nutritional referrals and answering questions at discharge can decrease the number of hospital re-admittance and death.

With resources I would establish periodic community health fairs in low income communities to monitor and teach patients with or at risk for hypertension. These health fair stations would include blood pressure checks, nutritional guidelines, cholesterol and blood glucose checks, medication teaching and promotion, a station to teach the signs and symptoms of a heart attack stroke, how to identify changes in urinary patterns, and urine testing for protein levels. I would invite nurses to volunteer their time and expertise for work in the designated stations.

The number of African Americans that become hospitalized or die from uncontrolled hypertension is increasing. We must emphasize the importance of treatment adherence to our patients and challenge ourselves to stop this epidemic.

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Mitzie N. Reagan is a student at Georgia Baptist College of Nursing, Mercy University, Atlanta, GA. She is a member of the Atlanta Black Nurses Association.

Licensed Practical/Vocational Nurses

Rhonda E. Ruben, LPN/LVP Representative, NBNA Board of Directors

FIRST LET ME THANK YOU for the opportunity to serve as your LPN representative on the NBNA Board of Directions. It has been a great experience, one I will always cherish. NBNA is one of the few professional nursing associations that are inclusive of LPN members.

Last year at the 40th Annual NBNA Conference, approximately 95 members were in attendance at the LPN/LVN session. Each year this session has exceeded its expectations and I am proud to say we have sustained tremendous success over the years. This is because we have had outstanding speakers who provide critical information that is important to our members and our patients. Last year's speakers Mr. Richard Lowery and Ms. Carthenia Jefferson who are both practicing attorneys, presented valuable information regarding, "The Legal Aspects Related to Nursing". In the same fashion at this year's conference, we will follow-through with the recommendation from the Institute of Medicine Report, The Future of Nursing: Leading Change, Advancing Health. The report is very clear that nurses must commit to lifelong learning in order to handle the complexities of healthcare today. This year's LPN/LVN session will again host two guest speakers; Ms. Latoya C. Scott, CEO of Principal Financial Consults who will present, "Significantly You: The Key to Being Financially Fit over 40" and Ms. Rhonda E. Ruben, "Staying Fit at Any Age."

The National League of Nursing cites that the nursing community must recognize the seamless career pathways that consider the LPN/LVN trajectory a key component of the nurse workforce advancement. The LPN forum supports this statement as we continue to practice the art and science of nursing. LPN/LVNs are critical to the healthcare system and are employed in numerous settings such as: hospitals, long-term care facilities, correctional nursing, physicians' offices and rehabilitation facilities. As you may know, many LPN/LVNs claim this level of nursing as a lifelong career with wonderful perks; while others are in advanced training to become RNs. Ultimately, it is a decision they must determine.

As a member of the National Black Nurses Association Board of Directors for the past three years, I want to applaud and acknowledge our LPN member Ms. Wilhenena Cothman who, has been in attendance at all NBNA conferences but most importantly, has been an LPN for 51 years. Thank you NBNA for the great opportunities you provide to all of your members. I look forward to seeing you in Orlando!

Success on the NCLEX-RN Examination

Marcia Lowe, RN, BSN, MSN

THE NCLEX-RN WAS first administered in July 1982, and the results were reported as numerical scores. In 1987, based on further research, the test blueprint was revised. Since January 1989, the NCLEX-RN results have been reported as "pass" or "fail" (Arathuzik & Aber, 1998). The NCLEX-RN attempts to ensure that a candidate possesses the minimum knowledge, skills, and ability to provide safe and effective nursing care at the entry level. The National Council of State Boards of Nursing (NCSBN) develops and administers the NCLEX-RN, while each state board of nursing releases results (Schwarz, 2005).

Nurse Educators are concerned about the performance of graduating student nurses on the National Council Licensure Examination (NCLEX-RN). Passing the NCLEX-RN is required for graduate nurses to become licensed nurses. Failure to pass the NCLEX-RN can be disappointing for the graduate and has serious consequences for the school of nursing. Nurse educators have the challenge of preparing nursing students who have the ability to think critically, problem solve, perform safely and provide quality nursing care.

The graduate's ability to achieve success on the licensure exam the first time it is taken is considered a viable measure of program quality—one that has many implications for both the student and the program. While students may not consider the licensure exam when they enter a nursing program, faculty are acutely aware of the need to begin preparation early and to take a proactive approach to preparing students for NCLEX-RN success (Davenport, 2007).

Nurse educators face many challenges in their efforts to prepare graduates for success on the NCLEX-RN) (Davenport, 2007). Nurse educators and administrators are concerned about the passing rate, given the fact that there is a nursing shortage. This is a critical issue in the healthcare arena. Students are deemed to be successful if they complete the nursing program in which they are enrolled and pass the NCLEX-RN.

Evidence from educational research has fueled the push for innovations in teaching and curriculum design. Unfortunately, such efforts are hampered by concerns that curriculum reform and substantive change in teaching practice could result in a drop in first-time NCLEX-RN pass rates. This issue extends to evaluation. Multiple choice test questions remain the primary method for testing.

Strategies that increase the likelihood that a graduate nurse will pass the NCLEX-RN the first time need to be explored. Faculty can develop a class for senior nursing students to review recommendations for successfully passing the NCLEX-RN (Higgins, 2005). Students should have experience with NCLEX-RN type questions as they progress through the nursing curriculum. Students should become familiar with the test plan and can be directed to http://www.ncsbn.org (the National Council of State boards of nursing) early in a nursing program. Some schools of nursing programs require that students pay for the Arnett Pre-RN Readiness Examination. Others rely on the Health Education Systems, Inc (HESI) Exit Examination scores. The HESI Exit Exam was designed to examine not only the accuracy of the examination in predicting NCLEX success but also the degree of risk for failure of the licensure examination associated with specific scoring intervals.

Passing the NCLEX-RN examination is the goal of all entering nursing students. Faculty and students should implement strategies, which may contribute to the retention, graduation of students, and the passing of the NCLEX-RN (Sayles & Shelton, 2005). This is an achievable goal for students, but requires early intervention immediately upon enrollment into a nursing program.

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Marcia is a member and past president of the Birmingham BNA, Inc. and currently serves as communications chair. She serves on the NBNA's Board of Directors.

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Nursing Students Educational Journeys

Increasing Diversity: Academic Success in Nursing School

TELLING ONE'S PERSONAL story is an excellent way of giving voice to silent issues and problems that could derail a student's career aspirations. If the profession of nursing is committed to improving workforce diversity, then, an evidence-based approach must be implemented that includes early screening, detection and interventions for students who need assistance to succeed. The goal must be to ensure admission, progression and graduation of underrepresented minority (URM) students. Helping students become successful in achieving their first degree can build their confidence to continue their education to the master's and doctorate level. This article summarizes the academic journeys of two recent graduate nursing students, and discusses academic barriers some students face once they matriculate from the pre-nursing phase into a nursing program.

I did not know, what I did not know.

May 19, 2012, I attended a professional nursing conference that was sponsored by the Black Nurses Association of Greater Cincinnati. The conference theme was "Pathways to Higher Education." As a nursing student, I was excited to be in the presence of professional nurses. The three speakers at the conference were outstanding. They talked about the future of nursing, the importance of life-long learning and the need for continuous professional development. Each speaker shared his/her struggles and joys of nursing schools, but more importantly, they discussed how to become a successful and productive professional and ways to give back to the profession and help others. Their stories of success opened my eyes and ignited my spirit; yes, I could and would achieve my dreams.

I am sharing my story in hope that others will read it and know not to give up when it seems impossible to obtain your goals. One of the speakers at the May 19 conference encouraged me to give my experience a voice to help others. My name is Cassie Gardner. I am a nursing student in an associate degree in nursing (ADN) program. This nursing program is operated as a hospital-based school. I, similar to one of the speakers, have always wanted to be a nurse. I had the academic credentials to boost my opportunities to achieve my goals of entering and graduating from nursing school. I graduated from high schools with a record of having earned A's and B's from grade school. With such an exemplary school record, my family and I assumed that my level of performance would continue and that I would excel in college.

In 2008, I started college and to my surprise, I learned that I struggled with test taking. Not only was I shocked that I was not performing well in class, but I was at a loss as to how to move forward and what should be my next steps. No one informed me of available resources. I did not know if there were tutoring or academic assistance programs available on campus. For the first time in my life, I found myself on a path of academic failure. One particular professor encouraged me to seek help for a "learning disability." How could I go from A's and B's to being told that I may have a learning disability; it was unbelievable. Of course, this feedback only added to my fear, confusion and frustration. Not having an academic support system led to my worse fear of failing nursing school. Although I passed my clinical course, I failed the theory course. The failure of the theory course led to my dismissal from the nursing program.

Being dismissed from nursing school started an entirely new set of emotions and experiences that were moving me farther and farther away from my dream, and the stress and sense of failure were making life less than what I had planned for my future. Then, in the summer of 2009, I was diagnosed with Combined Attention Deficit Hyperactivity Disorder (ADHD). Due to my previous outstanding academic history and no behavioral issues during my primary education years, my family and I were in a state of complete denial. I was considering the possibility of quitting, giving up on my dream and not living up to my full potential. My family and peers had always held high expectation of me. Therefore, I had the added pressure of letting them down. At least, the diagnosis gave me something to work with and a place to start correcting the issue. I tried different medications and treatment regiments. Finally, I found a medication that works for me. I was also fortunate to have nursing professors who did not give up on me.

For two years, my professors worked with me and helped me return to school to pursue my dream of becoming a nurse. Since returning to school, I have accepted some things, and these things have contributed to my progression in the nursing program. I have accepted that I am not your normal student and that I am a different learner. I have learned to adapt my study routines and seek out environments that are conducive to my learning style. My professors have nothing but excellent things to say about me clinically and personally. I owe my success to them caring, being patient and compassionate about their students. I know that I am one of the fortunate students to have had faculty members who cared beyond their classroom responsibilities.

At the Cincinnati Conference, not only did I receive encouragement, but I was also given a network and platform to graduate and become successful in continuing my education to achieve all

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Increasing Diversity (continued)

that I wanted to become as a professional nurse. I am glad to be where I am today. I graduated December 2012 with my associate degree in nursing. In January 2013, I started the second phase of my career by entering a registered nurse (RN) to Bachelor of Science in nursing (BSN) program. Dr. Martha Dawson spoke about the importance of continuing your education when she gave an overview of the Institute of Medicine (IOM), Robert Wood Johnson's Future of Nursing Report. I plan to continue my education to the doctorate of nursing level with the hope of becoming a certified nurse anesthetist. I was so impressed with the educational conference provided by the Cincinnati chapter that I attended the 2012 National Black Nurses Association Annual Education Conference in Orlando, Florida. It was an awesome experience.

Personal Adjustments to Avoid Failure

August 2009 was the beginning of my nursing school journey, and the onset of many challenges that I had to face. My name is Andretta Griffin-Maxwell. I am a recent graduate from a BSN program. During my nursing education, I was accepted into a federal government funded program that was supported by the Health Resources and Services Administration (HRSA) Workforce Diversity (WFD) grant. The program was Enrichment for Academic Nursing Success (EANS). I was selected with nine junior level nursing students to participate in the EANS program. My group was the third cohort of students to be selected for participation in this program. Faculty and staff of this program provided a three-day intensive orientation; they explained the requirements of what it took to be successful in nursing school. A panel of faculty, professional nurses, and previous and current nursing students shared their stories and journey with us. Nevertheless, after the first two to three weeks in the program, the challenges I faced in nursing school were so overpowering that I felt like I needed to change majors and change school.

I cried, which seemed like every day, because the workload was extremely demanding and seemed unbearable. I wanted to give up. I was devastated, depressed, and disappointed with myself for not being able to handle the challenge and the transition from pre-nursing to nursing school. As the weeks passed, things went from bad to worst. I fell behind in reading assignments; I could not comprehend the materials, and I was failing all tests, and my clinical performance had deteriorated. The EANS program faculty was meeting with students weekly to access their performance and provide assistance as needed. However, I continued to struggle with managing my time, course workload, and spiritual health. Although I was receiving support and help, I was suffering, and I needed more help. I wanted my life back; the joy, peace, happiness, motivation, and the determination I had in pre-nursing. I wanted the frown to reverse back into the smile I once had prior to entering the nursing program.

Therefore, I began to turn to my faith and pray. If I was going to be successful, I needed more help and guidance. The EANS project director (principal investigator) and the program faculty facilitator began to provide me with more individualized time. The project director was also my advisor. She and I had a crucial conversation where she explained upfront that some of things she would advise might sound hard and difficult for me to hear and accept. She quickly identified that extra curricula activities and time management were major factors contributing to my academic problems. She advised me, for financial reasons, to move out of my apartment and move back home. She discussed also the fact that I needed to withdraw from the ROTC, and met with the advisor and me. The ROTC was important to me because I wanted to join some branch of the arms services, and it was a major source of financial support to fund my education. Next, she explained that I needed to reduce the amount of time I was spending on my hair and nails. Although these decisions were tough and the advice sounded harsh, I trusted her advice because she had a caring attitude. She stated her advice was the same she would give her own daughter. I knew in order to be successful, I had to let go of some things and focus on what I wanted most in life. I followed all of her advice. She advised me to meet with the faculty facilitator and follow the action plan that they would put in place for me. She also arranged for me to have an independent study course with the faculty advisor.

The faculty facilitator was very passionate and was willing to help me with my academic struggles. We did weekly one-on-one study sessions. The study sessions helped me realize what I was doing wrong, and why I could not comprehend the material. I discovered that I was not actively reading the information, not paying attention to key words, ignoring medical terms that I did not understand, and using the wrong techniques for studying. Once we identified my problems, things started falling into place. I had begun to realize that the challenges were not to destroy me, but I had to unlearn some study habits, and learn new methods of understanding and apply the course content to clinical situations. One of the best lessons I learned was that I was not studying to pass an exam, but my performance on exams demonstrated that I had mastered the content so I could apply the knowledge to real life situations. As the project director reminded me studying and taking exams was not for earning a grade, but the grade was the by-product of my learning. By my third semester, my smile and self-confidence returned, and I begin to share what I had learned with other students. The support from the EANS program and faculty was the cornerstone of my success in nursing school. Since graduation, nurses in the Birmingham Black Nurses Association (BBNA) have become my professional mentors, support system, and the network for my first nursing job.

Lesson for Academia

Academic problems often surface for the first time when students start taking nursing courses and going to clinicals. Students might have difficulty with reading comprehension, test taking anxiety, knowledge application, time management and critical thinking skills. For many students, memorizing material has been their primary study method to prepare for exams in high school and in many of their pre-nursing college courses. Memorization does not lead to learning and successful test taking in science-based professions because course information is the building block for the application of learned content in clinical and lab settings. In addition, prior semester learning becomes the foundation for introduction of new ideas and concepts in the next semester and future courses. Therefore, information must be retained and used as knowledge by students as they progress in the nursing curriculum from fundamental to advanced

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Increasing Diversity (continued)

courses. Nursing programs and other professional schools do not allocate resources for remediation in basic college courses or provide tutorial assistance for struggling students. The Division of Nursing, Bureau of Health Professions, Health Resources and Services Administration is awarding grants to schools of nursing to increase the number of nurses from disadvantaged and minority population who successfully matriculate and graduate with a BSN degree. The goal is that by increasing diversity in nursing access to care, quality of care and the delivery of culturally competent care will improve.

Faculty must appreciate cultural and learning style differences that may affect students' performances. As was the case with Cassie and Andretta, great nursing professors and instructors will look for an underlying cause of a student's problem. Student-centered faculty also will provide unpleasant feedback in a way that is supportive and not demeaning. In A Blueprint for Reform: The Reauthorization of the Elementary and Secondary Education Act (2010), it was clearly stated that great teachers, not the color of students skin or their parents income, that determine student success. This report called for reform of the US education system to ensure that every student graduate ready for a college education and a career.

Smith, Williams-Jones, Lewis-Trabeaux, and Mitchell (2012) identified students' perceptions of facilitators and barriers that affect academic success. Theses authors reported that such factors as faculty encouragement, faculty availability, using different learning methods, obtaining assistance at the problem solving and analysis level, and self-directed learning behaviors were important factors to help students with their academic performance. Helping students from underrepresented backgrounds to identify and capitalize on their learning styles can be critical to success in matriculating and graduating from nursing programs. Some students may have to unlearn certain study habits and identify new learning styles to help them succeed. Peer-to-peer mentoring has also improved nursing students performance. The EANS program was designed so that senior cohorts would mentor incoming junior cohorts, and there were peer mentoring within the cohorts.

To improve their chance of admission to nursing programs and to successfully navigate the nursing curriculum, pre-nursing students should work with their college advisors to determine their areas of weaknesses, strengths, opportunities, and threats. If learning and academic deficiencies are identified early, students can receive help prior to entering nursing programs. Faculty and pre-nursing advisors must remember that schools in America are not all created equally, and many students arrive at college under prepared for the rigors of college level study and the demands of more self-directive learning behaviors from students. Therefore, these students should be guided to campus resources early in their college life. Pre-nursing advisors should help develop plans to address identified deficits and connect students to nursing advisors.

Nursing programs and the literature have documented that pre-nursing grades and performance in science courses are positive predictors of how well students will perform in nursing school and the likelihood the students will graduate (Seago, Keane, Chen, Spetz and Grumbach, 2012). Adding to the students' struggle to succeed academically are other barriers that have been well documented in nursing and other literature. Loftin, Newman, Dumas, Gilden, and Bond (2012) provided a thorough review of the literature that addressed barriers that URM students face in nursing schools. Their review included articles that studied experiences of African Americans, Native Americans, Hispanics, Asian, and international nursing students. The review identified a list of barriers that URM students face. These barriers included culture isolation and loneliness, family issues, emotional and moral support, financial needs, discrimination and racism. In their study, Smith, Williams-Jones, Lewis-Trabeaux, and Mitchell (2012) listed five factors that could contribute to students' failure to progress in nursing school. Factors identified in these author's study that could become barriers to student success included academic workload, test-taking anxiety, financial worries, family responsibilities, and working.

In conversations with the students highlighted in this article, each student reported experiencing at least four of these five factors or all five. Students from URM groups, including males, also reported stereotyping by their faculty, peers and patients. Many nursing programs are proactively trying to address the needs of URM students. Socialization, acceptance by peers and faculty, and a feeling of inclusiveness and being respected as a part of the team are also important contributors to students' success, (Smith, Williams-Jones, Lewis-Trabeaux, and Mitchell, 2012; Loftin, Newman, Dumas, Gilden, and Bond, 2012). A Blueprint for Reform: The Reauthorization of the Elementary and Secondary Education Act (2010), call for us to prepare students success, the rigor of learning and meeting the needs of students. Professional school must begin to learn why some students from URM excel and others do not. Our focus need to shift from what a student cannot do to helping students get ready to succeed.

Summary

To improve students chance of matriculating and graduating from nursing schools, a lot of work needs to occur prior to students' admission to nursing program. Therefore, nursing program administrators must begin to develop interprofessional curriculum designs that include exposing students to application and team-based style learning in their pre-nursing science and liberal art courses. Pre-nursing students must understand that their pre-nursing science and math courses provide the foundation for their nursing courses. Therefore, they need to understand the concepts presented in these courses to help them with knowledge application and learning in their core nursing classes.

Nursing associations can play a major role in helping URM students by developing tutoring and mentoring programs. Many chapters of NBNA have experience with designing, implementing, and supporting mentorship programs that are aimed at increasing the progression and graduation rates of students. These chapters have created partnerships with community colleges and universities. The NBNA and affiliated chapters have a critical role in increasing nursing diversity and helping the profession to achieve the IOM mandate of 80% BSN prepared nurses by 2020, and a 50% increase in the number of nurses with a terminal doctorate degree.

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Mentoring: Helping Minority Students Succeed

Dr. Jennifer J. Coleman

DESPITE THE FACT THAT one third of the current US population is comprised of racial and ethnic minorities, fewer than 23% of new graduate nurses in 2007 were from minority backgrounds (National League for Nursing, 2009a). If current population trends continue, the number of minorities in the US is expected to increase by 50% by the year 2050 (U.S. Census Bureau, 2010). This demographic change presents a challenge when providing health care for persons from diverse cultural groups. Nurses represent the largest segment of health care providers and most nurses are White females. Underrepresentation of nurses from minority backgrounds can directly impact the quality of care provided to African Americans and other racial and ethnic minorities. Although there are ongoing improvements in the health of Americans, minority groups continue to experience higher burdens of disease and mortality across all aspects of health. Disparities in health outcomes exist in preventive care and in the management of chronic disease. A critical factor contributing to these gaps in health care is the lack of diversity in the healthcare workforce. While the US population is becoming increasingly culturally diverse, the nursing profession is not reflective of this population trend. Thus, increasing the number of diverse and culturally competent health care providers is essential to improving the quality of care for racial and ethnic minorities.

The first step in increasing the number of minority nurses is to attract, retain, and graduate minority students in nursing. Most students admitted to nursing education programs are successful and retention of minority students is critical. The current nationwide shortage of nurses, more specifically minority nurses, threatens recent health reform laws that aim to diversify the nursing workforce as a step toward reducing healthcare disparities. The provisions of the Patient Protection and Affordable Care Act of 2010 include the need for increased health coverage for millions of uninsured and underinsured (US Department of Health & Human Services, 2010). Many Americans with limited or no health coverage are identified as members of racial and ethnic minority groups.

Despite a consistent upward trend in applications submitted to prelicensure nursing programs over the past few decades, enrollment has not kept pace with the nation's need for health care. In addition, the National League for Nursing (NLN) recently reported that significant numbers of qualified applicants continue to be denied admission to schools of nursing subsequent to a nationwide nurse faculty shortage and lack of clinical space. In its Annual Survey of Schools of Nursing, NLN reported that in 2008-2009 nearly 25% of qualified applicants were not accepted (National League for Nursing, 2009b). Part two of the survey further suggested that the number of qualified applicants denied admission might actually be as high as 40%. Specifically, 42% of qualified ADN applicants and 24% of qualified BSN applicants were denied admission to prelicensure nursing programs in the US in 2008-2009. While the acceptance rates for African Americans, Asians, and American Indians are comparable to that of the majority population, ethnic minorities represent a small percentage of nursing students. In 2008-2009 ethnic minorities represented 29% of students in all prelicensure nursing programs (National League for Nursing, 2009a).

Given the small number of minority nursing students enrolled in schools of nursing, it is imperative to identify and implement programs that increase the likelihood of successful completion of the nursing curriculum, and subsequent entry into nursing practice. Thus, facilitating minority nursing student retention is an important initiative of the Birmingham Black Nurses Association (BBNA). Current literature suggests that personal and professional support through a mentoring relationship can positively impact academic success of minority nursing students (Wilson, Andrews, & Leners, 2006). BBNA Mentorship Program, in existence since 2004 and revised in 2010, provides support and guidance for nursing students. The goals of the program are to increase the number of minority students graduating into the nursing profession and to foster professional growth of nursing students through involvement in professional nursing organizations. Formal program activities are planned to offer emotional support and encouragement and to share advice.

BBNA recruited minority nursing students from four prelicensure nursing education programs in the Birmingham area. Targeted schools of nursing include two BSN programs and two ADN programs. Each student in the mentorship program is assigned a BBNA chapter member as mentor. Students selected for the mentorship program identified personal and professional goals. Specifically students desired professional guidance, assistance with coursework, and the opportunity to ultimately make a difference in the lives of others. BBNA Mentorship Program participants meet monthly for scheduled sessions that focus on study skills, time management, test taking strategies, professional communication, image development, career planning, etc. BBNA chapter members who are faculty members at local nursing schools are also available at each meeting for students who desire assistance with coursework. In addition to formal monthly program meetings, each mentor-mentee pair is encouraged to network, socialize, and learn from each other. A critical component to BBNA Mentorship Program is role modeling and socialization into the role of professional nurse with the aim to positively impact minority health outcomes. Each mentee's membership in BBNA and participation in community outreach activities are components of the mentorship program. With regard to professional role development, BBNA plans to sponsor a minimum of two student mentees to the NBNA 39th Annual Institute and Conference in

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Increasing Diversity (continued)

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Mentoring (continued)

July 2011. Students will travel to Indianapolis with their mentors and other BBNA chapter members and participate firsthand in national networking and collaboration with nursing professionals.

BBNA has demonstrated an ongoing commitment and responsibility to the success of minority nursing students. The retention and professional development of prospective minority graduate nurses will ensure that the nursing work force is consistent with the demographics of the US population. A culturally diverse nursing workforce is likely to provide quality patient-centered care that will bridge the health disparities gap among ethnic minorities.

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The DREAMWork Program: Increasing Diversity in the Nursing Workforce

Martina S. Harris, EdD, RN

THE LATEST PROJECTION of the nursing shortage, suggests by the year 2014, the United States (U.S.) will need as many as one million registered nurses (RNs) to meet the healthcare needs of this country.[1] Coupled with the overall shortage of RNs, is the lack of racial and ethnic diversity in the nursing profession, compared to that of the general U.S. population. According to the 2010 U.S. Census, white persons made up approximately 63.7% of the U.S. population with minority representation totaling 36.3% of the population: (16.3%) Hispanic, (12.2%) African American/Blacks, (5.6%) Asian/Pacific Islander, American Indian, Hawaiian, Alaskan Native and (2.2%) two or more races—not Hispanic.[2] This same demographic configuration is not reflected in the national RN workforce data. According to the 2008 National Sample Survey of Registered Nurses (NSSRN), only 16.8% of all registered nurses were identified as being minority.[3] This inequality is mirrored in the demographic statistics for Tennessee.

Currently, minorities comprise 23.2% of Tennessee's population but only 9% of Tennessee's RN workforce is minority, with the largest group being African American (7.8%).[4] In an effort to address the underrepresentation of racial and ethnic minorities in the nursing profession, the University of Tennessee at Chattanooga (UTC) School of Nursing applied for and received a Health Resources and Services Administration (HRSA) Nursing Workforce Diversity grant.

DREAMWork Program

In the summer of 2007, the Diversity Recruitment and Education to Advance Minorities in the Nursing Workforce (DREAMWork) Program was implemented. The primary goal of the DREAMWork program is to increase nursing education opportunities for individuals who are from disadvantaged backgrounds and who are underrepresented in the registered nursing workforce. To be eligible to participate in the DREAMWork program students must be considered either educationally or economically disadvantaged. Educationally disadvantaged is defined as:

- first generation college student
- attend a high school where at least 30% of enrolled students are eligible for free or reduced price lunches
- graduate from a high school with significant lower SAT/ACT scores below statewide averages
- attend a high school where 50% or less of the graduates go to college
- reside in a rural area

Economically disadvantaged is defined as:

- Student whose family or individual annual income falls below a level based on low-income thresholds established by the current U.S. Department of Health and Human Services (HHS), Office of the Secretary, Poverty Guidelines.

The DREAMWork program consists of four distinct components: (1) pre-entry preparation cohort, (2) academic retention cohort, (3) financial support scholarship/stipend and (4) cultural competency. While all four components are highly interrelated and important to the success of the program, this article focuses on two of the four components; pre-entry preparation cohort and the academic retention cohort.

Pre-Entry Preparation

In an effort to promote awareness of nursing as a career choice to middle and high school students, DREAMWork staff partnered with four middle and seven high schools in Hamilton County to conduct monthly informational sessions and attend school career fairs. The primary goal of these outreach activities are to increase awareness in the profession. In addition to outreach for middle and high school students the pre-entry cohort also includes pre-nursing students currently enrolled full-time at the university. Pre-nursing students are defined as students not yet enrolled in the nursing major but taking pre-requisite courses. As part of the DREAMWork pre-entry cohort, the students are able to participate in a book loan program and are provided academic support for the math and science courses and individualized planning throughout the academic year. Students are paired with peer mentors from the School of Nursing and are required to meet face to face with the Project Director biweekly.

Academic Retention

This cohort includes those students currently enrolled in the nursing major. Once the student is admitted to the nursing program, many strategies are employed to ensure student success and graduation. Students in the DREAMWork retention cohort are required to participate in monthly seminars, small group study sessions, and are assigned a faculty mentor. Students are required to meet weekly with their assigned mentor. The DREAMWork mentoring program was developed utilizing the Campina-Bacote (2007) cultural model for mentoring.[5]

Since the inception of the DREAMWork Program fifteen students have graduated all have passed NCLEX on the first attempt.

Funding: This project was supported by funds from the Division of Nursing (DN), Bureau of Health Professions (BHPr), Health Resources and Services Administration (HRSA), Department of Health and Human Services (DHHS) under grant # D19HP08214.

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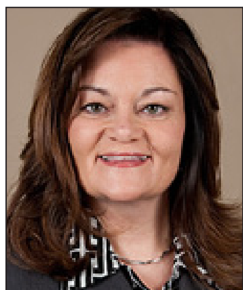

BSN Education and Beyond New LPN to RN Bridge Programs Make for Faster, More Affordable Career Advancement

Maggie Ozan Rafferty, MBA, MHA, RN

THE U.S. BUREAU OF LABOR STATISTICS expects demand for registered nurses to grow by more than 22% over the next seven years, creating more than 580,000 new jobs at hospitals and physician offices and in emerging markets, such as home healthcare agencies and community centers. In response, the American Society of Registered Nurses (ASRN) recently issued a call for a more educated workforce to meet the growing demand amid an increasingly complex healthcare environment.

For many licensed practical nurses (LPNs), achieving an RN degree is a logical next step on the path to enhanced career opportunities and higher compensation. While the laws that govern roles and job duties for LPNs and RNs vary state-to-state, RNs command a higher level of responsibility for patient care, including the ability to push meds and hang blood, and typically earn about twice as much as LPNs, on average.

In addition to the salary advantages, RNs also have more opportunity to take on leadership roles within their organization, giving them greater influence over the administrative function of the hospital or physician's office. This makes the LPN-to-RN transition an attractive proposition, especially given the hands-on experience so many LPNs may already have under their belt.

However, the time and cost involved to earn an RN degree can be a challenge. Many working LPNs simply do not have the funds nor the free time to pursue an advanced degree, especially when working various shifts while also juggling personal and family commitments. The idea of going back to school on nights or weekends for 18-24 months can be daunting for many.

Fortunately, as the demand for RNs grows, there are options for those looking to make the leap from LPN to RN with new programs that are actually manageable and affordable.

At some of its Florida and Minnesota campuses, Rasmussen College has launched the professional nursing mobility program that enables LPNs to become RNs in as little as 9 months. The full-time program is ideal for both newly-trained LPNs who want to start the RN program immediately, and for LPNs who have been on the job and now want to take their career to the next level.

Approved by the Florida and Minnesota Boards of Nursing, Rasmussen Professional Nursing Mobility students earn an associate's degree and sit for the NCLEX-RN exam, the national licensure examination for registered nurses. Upon successful completion of the exam, students are licensed to practice as an RN, opening up new doors of opportunity to a rewarding career no matter where life takes you.

In addition to its new Mobility program, the School of Nursing at Rasmussen College also offers an RN-BSN online degree for those looking to supplement their experience with management, clinical and strategic skills to further enhance their career. Incorporating nursing quality and safety, alternative and complementary therapies and nursing informatics, the program is designed to prepare students for a dynamic career in nursing management or perhaps as a foundation for more advanced training as a physician assistant, for example. The fully-online curriculum offers the flexibility to make completing the BSN degree fit within a busy lifestyle, all while enabling students to continue working in the field full-time.

Like so many other careers these days, the nursing field is continually evolving as advanced technologies and contemporary treatment and administrative modalities become part of the new standard of care. Furthering your education is the best way to keep up with the latest advances to enhance your career and salary potential. Thanks to new bridge programs that let you learn while you work, you don't have to put your entire life on hold to take your education to the next step.

Maggie Ozan Rafferty, MBA, MHA, RN, serves as Director of the School of Nursing for Rasmussen College. In this role, she is responsible for leading the College's Licensed Practical Nursing degree, Professional Nursing degree, and RN to BSN nursing degree program. Rasmussen College School of Nursing has an enrollment of more than 1,200 students on 13 campuses and is focused on preparing future nurses to serve in a variety of healthcare settings and advancing education and development of current registered nurses.

Prior to joining Rasmussen College, Maggie held national and international senior level healthcare leadership roles and served as the Vice President for Patient Care Services at Silver Cross Hospital. A registered nurse for more than 25 years, Maggie holds an Associate's Degree in Nursing from South Suburban College, obtained her Bachelor's and Master's degrees from Governors State University and an MBA from the University of Chicago Booth School of Business. She is currently pursuing her Doctorate at Central Michigan University.

DREAMWork Program (continued)

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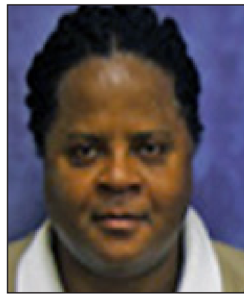

How Technology is Changing the Nursing Classroom: Embrace it!

G. Elaine Patterson, EdD, MA, FNP-C, CNE

Patrick Mattis, DNP, MSCS, RN-BC, CNE, CPHIMS

NURSE EDUCATORS are consistently exploring new ways of improving classroom experiences for their students. No longer is it acceptable to make excuses such as "there is just too much content to be covered." Neither is it acceptable to only lecture from the podium using the dreaded PowerPoint©. This article describes some innovative ways that nurse faculty are using technology to make learning more interesting and more congruent to the overall experiences of the younger generation of nursing students. It also introduces several not so frequently used technology tools that are now on the horizon.

Flipping the Classroom

Berret (2012) describes what is popularly known as the 'flipped classroom'. In this concept, students are held accountable for accessing course content outside of the classroom through faculty prepared audio visual lectures. Students have the option to gain the information from a variety of sources conducive to the way they learn best. This learning can take place in dramatic or modest formats e.g., voice overs, YouTube© or online searches. In the classroom, students get the opportunity to spend individual time working with professors on what they have learned so far. During this time variety of teaching/learning strategies such as case studies and narrative pedagogy are employed. This is an ideal way of learning for generation Y students who are known to respond well to coaching and reassurances as well as peer teaching. This 'flipped classroom' gives students the opportunity to express themselves in a less formal way, one in which they interact closely with peers as well as teachers. The literature reports many definitions, myths, and pros and cons of flipped teaching. Professors Tenneson and McGlasson of Evangel and Southwest Baptist universities summarizes the concept as one that "moves lecture material out of the classroom through online delivery... Extend conversation outside of class through threaded discussion, move 'homework' into the classroom where the instructor can serve as 'guide;' and use opened up time for discussion and practice." (Baker, 2000)

So how is this done? One way is for educators to use technology tools such as Camtasia©, or Screen Chomps© to pre-record lectures or brief learning objectives for students to view before class (Scott, 2012). These lectures are posted on a course management platform for student to access at their leisure. Homework managers, like CengageNOW© also provide tools to prepare your students before class. It is no doubt that 'Flipping the classroom' leaves more class time available for hands on, collaborative, active-learning experiences.

The Smart Classroom

A second approach is to develop a smart classroom in which the teacher self-assess his or her learning styles and match the teaching with the appropriate and available technology. There are several technology tools that can enhance the classroom presentation while covering vast amounts of content in an interesting way. Most faculty are committed to their PowerPoint© lecture, however this modality is quickly being replaced by Prezi© a unique program which enables the educator to engage the student using a concept map and storytelling approach.

Other smart classroom tools such as PollEverywhere© allow for immediate feedback in the classroom as well as a way to stimulate students into participation. Clickers© are also being widely used to obtain immediate feedback on learning.

The widely popular YouTube© is often used to show short videos of what is being taught. It is important however for faculty to preview the video to the end before introducing it to students.

For faculty who love to move around the classroom while teaching, the program Doceri© can be used to transform the iPad into a mobile presenter. Many publishers resources such as ElsivierEvolve© can be utilized via the iPad. Well known tools such as Google docs, Google sites and LiveBinder© are quite useful when group projects are assigned as they allow for tracking group participation as well as storage of project content.

Finally, tools such as Livescribe© Pen allow for recording of presentations for future discussion and grading. Skype© and Facebook© chats are also recommended for group work, collaboration, tutoring and exam reviews

Summary

These are just a few of the tools you can use in your Smart Classroom. There are many more available. Scott (2012) suggests when looking at technology tools for your courses, avoid using technology just because it is "new" or "cool". Instead define the tool's purpose, make sure it complements the activity, and aligns with your teaching style.

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Opportunities Abound for Advanced Nursing Careers for African-American Nurses

Dr. Ruena Norman

THE FUTURE LOOKS bright for career advancement opportunities for nurses. With the passage of the 2010 Affordable Care Act expected to create high demand for nurse practitioners, the value of a progressive nursing education has increased exponentially. The global policy think tank, RAND Corporation, estimates that the number of nurse practitioners will nearly double by 2025. This demand is further triggered by the critical shortage of primary care physicians of as many as 63,000 too few doctors by 2015, according to the Association of American Medical Colleges.

With tens of millions of previously uninsured Americans projected to enter the health care delivery system over the next few years, nurse practitioners are in a critical position to meet changing healthcare demands. As the anticipated shortfall of primary-care providers threatens the system's capabilities, more nurses will be expected to pursue advanced nursing degrees.

Given the high percentage of health disparities that occur in minority communities and chronic health conditions such as hypertension and diabetes, having the cultural competence and education can be more effective in preventative healthcare. As such, there will be greater need for African-American nurse practitioners who have training, expertise, and cultural sensitivity to effectively treat patients.

In response to this rising demand for nurse practitioners, the School of Nursing at Florida A&M University has already seen an increased interest in becoming nurse practitioners by our undergraduate student population. Our current graduate level curriculum incorporates competencies and standards essential for preparation as a nurse practitioner in one of two tracks - adult/gerontology and women's health.

As one of the few HBCUs to do so, we are now expanding our nursing program to offer an online Master of Science in Nursing (MSN). This provides an opportunity for nurses, particularly African-American, to prepare to meet primary health needs. Our online MSN program allows flexibility for nurses who want to advance their careers that already work in the field. Although it is online, the program emphasizes and requires the same rigor of clinical practicums, with supervised preceptors in the student's home location.

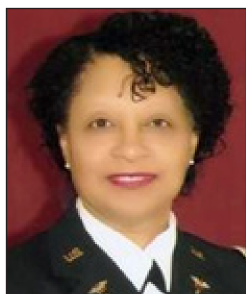
As African-American and minority nurses, it is important that we are continually aware of contemporary trends in health care and prepare to meet market demands. The future has never been better for career advancement as a nurse practitioner.

Dr. Ruena Norman
Interim Dean, Florida A&M University School of Nursing

How Technology is Changing (continued)

Dr. G. Elaine Patterson is a Professor of Nursing at Ramapo College of New Jersey and member of the Concerned Black Nurses of Neward. Dr. Patterson teaches in the graduate and undergraduate programs and is an expert in the area of maternal child health and high-risk perinatal nursing.

Dr. Patrick Mattis is a fulltime Assistant Professor & Director Technology Integration at the University of Medicine and Dentistry of New Jersey (UMDNJ) School of Nursing. He is a Dr. His main academic focus is on integrating technology into the nursing curriculum.



Lest We Forget: The Bachelor of Science in Nursing Conundrum

Sandra Webb-Booker, PhD, RN

THE GOLDMARK REPORT, recommended the Bachelor of Science in Nursing (BSN), as the entry level for professional registered nurses in 1923. Here it is almost 70 years later, and we continue to either read about or witness firsthand some objective as well as heated opinionated discussions regarding the entry level for "professional nursing practice." Most discussions cite data, regarding actual and projected figures regarding the supply and demand for nurses. Some additional factors influencing the "professional nursing practice" debate are: technology, healthcare outcomes and complexities, expansion of clinical nursing knowledge, and the need for increased autonomy in nursing.

Shifts in health care delivery, from traditional hospital-centered inpatient care to more primary and preventive care, have also played a significant role in these discussions. Nurses working in today's healthcare system, must practice across multiple settings- those within the hospital confines, as well as those within the community. They must also exercise higher levels of independence when problem-solving and providing clinical care, i.e. be it case management, supervision of licensed and unlicensed personnel, and/or the coordination of care and vital healthcare resources.

The educational preparation and scope of practice associated with the Bachelors' of Science prepared Nurse (BSN), has opened doors that can lead to professional certifications in specialty areas such as critical and emergency care and the assumption of expanded roles such as a clinical care provider, designer, manager, and coordinator. The BSN degree provides the foundation needed for graduate nursing education.

Whereas limitations in the present scope of ADN education has led to the creation of vulnerabilities for its graduates' future scope of professional nursing practice. The Associate Degree Nurse (ADN) is educationally prepared to function in various clinical capacities, but has a limited scope of practice in nursing leadership and management, wellness, and community health. Changes in the educational preparation of the ADN are needed to lessen these vulnerabilities and enhance ADN's viability in the healthcare climate of today and tomorrow.

The Future of Nursing Proposal advocates that at a minimum: The Registered Professional Nurse be required to obtain a baccalaureate degree in nursing (BSN) within 10 years after initial licensure. ADNs can not be content with the "status quo".

To date, three summits have been held, whereby nurses throughout the state of Illinois have come together to meet, and discuss their opinions and concerns relative to legislative proposals regarding the future "Professional Nurse " status in Illinois. The "summit" process is credited with facilitating "open dialogue amongst and between nurses of all communities (rural and urban) and all ethnicities, colors and creed". Lessons learned during the "1985 Entry into practice struggle, more than 25 years ago, has successfully been placed into action, and mutually productive working relationships exists between all parties.

However, for many CCNBNA members, redefining the educational needs of the "Professional Nurse", has been reminiscent of the struggle faced by many CCNBNA members, first hand in the 1980's. Hence, the notion of "mandating new educational requirements", for those nurses who have successfully earned the "Professional Nurse" licensure status, based on current and past legislation without the incorporation of a "grandfather clause" is an area of paramount concern for CCNBNA members.

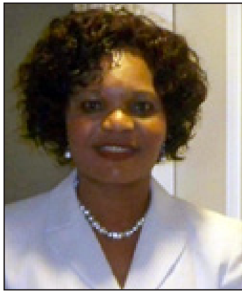
In reading the Robert Wood Johnson Foundation Initiative on the Future of Nursing at the Institute of Medicine we find that Recommendation #15. says: Four-year nursing programs should work with Community Colleges that offer the Associate Degree in Nursing (ADN) to develop articulation agreements that facilitate the transition of ADN graduates into BSN programs. This would incent existing ADNs to return to school to complete their baccalaureate degrees, while enhancing their education, preparation and longevity in the nursing profession. The National League of Nursing Accrediting Commission and the American Association of Colleges in Nursing (AACN) are encouraged to collaboratively work together for the development of accreditation standards which facilitate articulation agreements between ADN and BSN nursing programs.

The Chicago Chapter National Black Nurses Association supports the Institute of Medicine's recommendation to have professional nurses with Associate Degrees continue their nursing education and complete a Bachelor of Science Degree in Nursing through articulation initiatives with four year universities as stated in recommendation # 15.

To that end we strongly encourage community colleges, vocational programs and other educational support systems to provide the basic academic support needed to ensure minority and underserved persons desiring to become professional nurses, are prepared to meet the admission criteria that will enable them to be admitted to and successfully matriculate through BSN programs.

We moreover encourage the coordination of educational resources provided by professional organizations, universities and other stakeholders. One central cite is needed to house information pertaining to programs, grants and scholarships that provide financial assistance to ADNs matriculating in BSN completion programs.

The Chicago Chapter Black Nurses Association believes the establishment of the BSN as the entry level for "professional nursing practice" will also impact the salaries of all practicing nurses, once implemented. Institution of the BSN initiative should promote a reduction in the numbered of unlicensed personnel performing nursing skills in many patient care settings.



The Changing Healthcare Environment: Application of Technology in Nursing and Patient Education

Julia Ugorji, DNP(c), MSN, RN

INTRODUCTION

In the world where technology is not only becoming more complex, but resourceful, nursing education has been challenged to endorse the use of nursing informatics concept in practice and education. Advocating the ability to incorporate technology into nursing education, the American Nurses Association, the Association of Colleges of Nursing, and the Institute of Medicine, all strongly encouraged nursing schools to integrate the use of technology in their nursing curriculum (Ezell, 2011). Evidence-based research indicates that such technology enhances critical thinking while reinforcing core knowledge for practice.

Technology has influenced all areas of human endeavor including the way we learn and socialize. In today's healthcare environment, increased acuity of the patients and the use of technology at the bedside, prompted employers to prefer hiring nurses who have the skills necessary to practice clinical and non-clinical settings. Use of technology in clinical setting provides the student immediate access medical information. Therefore the nurse educator will have to be aware of the current technology and how it can be used to advance nursing education. Like any technology, there are advantages to each type of technology. While each item of technology may enhance the learning experience for students, it may also jeopardize the confidentiality of other students and clients. Faculty must be aware of these issues and employ every possible precaution to protect both patients and other students from violation of privacy.

Response to the transformation of health care and quality initiatives have resulted in integration of technology in nursing education curricula. Some technology tools used include simulation, interactive case studies, digital textbooks, online instructional mode, PDAs, electronic medical record and documentation systems. Technology can also help the faculty to deliver the course material effectively, improve student and faculty access to information and resources, reduce cost of learning and educational resources and enhance learning. Attitudes and willingness of the faculty to embrace new ideas in instructional design can help promote student learning outcomes.

Integrating technology into nursing curricula is much easier now than it was in the past. A majority of college students own mobile technology such as an iTouch or smart phone, reducing the initial hardware cost. Software leading providers is available for every platform including tablets such as the iPad. Software references are significantly less expensive than textbooks and if the software is required for coursework, financial aid typically will cover costs. Confidentiality agreements are overcoming barriers in facilities that have been reluctant to allow mobile technology due to potential privacy concerns. The vital role of mobile technology in patient safety can no longer be ignored. Nursing faculty can choose from hundreds of references and decide what best fits the needs of their specific student population and course. Increasing the use of technology such as PDA in the class room and clinical setting moves nurse educators closer to preparing nurses to meet the Institute of Medicine's core competencies (IOM, 2008), and the Joint Commission on Accreditation of Health Organization's patient safety goals (JCAHO, 2007).

CONCLUSION

Rapid changes in technology and intergenerational differences in learning bring a new focus on the needs of faculty to be able to engage students in the traditional face-to-face classroom. Faculty roles are changing as computer assisted techniques bring more autonomy to the students; students of diverse ages and background are expecting computer literacy from their instructors (Vandevee, 2009). The increased role of technology in healthcare and its transformational impact on that field, allowing nurses to understand current and future trends and thus, integrating technology into nursing education in order to effectively prepare students for a new, technologically-driven healthcare environment. In the future, the hope is to see nurses routinely synchronizing their handheld computers with strategically centralized database ports throughout a healthcare agency.

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Making a Difference in Nursing: Cultivating the Next Generation of Minority Nurse Leaders

Dorothy L. Powell, EdD, RN, FAAN

Brigit M. Carter, PhD, MSN, RN, CCRN

Julie Cusatis, BS

THE DUKE UNIVERSITY Making a Difference in Nursing II (MADIN II) Program is cultivating the next generation of minority nurse leaders. Adapted from the highly successful Meyerhoff Scholars Program (University of Maryland Baltimore County), MADIN II, a federally funded nursing workforce diversity initiative, seeks to increase the enrollment, graduation, and licensure rates of underrepresented minority students in the Accelerated Bachelor of Science in Nursing (ABSN) program at Duke University School of Nursing.

MADIN II scholars are high achieving/high potential recent college graduates from diverse and/or economically disadvantaged backgrounds. Stemming from the foundational program tenet 'to begin with the end in mind' (Stephen Covey), scholars have a commitment to leadership and desire to pursue the highest levels of nursing and healthcare service, research, education and practice.

MADIN II consists of pre-entry a (Summer Socialization to Nursing Program), retention (Succeed to Excellence Program), and financial support component. Committed to developing the whole person, MADIN II's methodology include provision of support services that contribute to the Scholar's academic success.

Seventeen students from MADIN II's 2011 and 2012 cohorts have matriculated into the Duke ABSN program and maintain GPAs ranging from 3.33 - 4.0. Four cohort 2011 scholars will be graduating in December 2012, and seven cohort 2012 scholars are successfully progressing through their first semester. Among the impressive accomplishments of these scholars:

- 2 Sigma Theta Tau Inductees
- 2 elected class leaders
- 3 participated in global health experiences:
  - 2 to City of Hope, Tanzania, Africa
  - 1 to Nicaragua
- 1 tutor for Pathophysiology
- 1 attended the WHO Summit in Geneva Switzerland
- 2 presented at NBNA Conference in Orlando, Florida

The MADIN II model shows promise of being a successful strategy for addressing the shortage of underrepresented minorities in the nursing workforce and as a mechanism for rapidly steering talented URM s toward advanced education and leadership.

MADIN II is currently accepting applications for cohort 2013. The application deadline is December 1, 2012. For more information visit: nursing.duke.edu/madin.

Duke University School of Nursing MADIN II Scholars-cohort 2012 (left to right) Shedeline Charles, Wana Lucate, Jessica Creel, Danna Alvarado, Monique Smith, Eiob Teklie, Anna Gonzales, Kevin Gulledge

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EXPECTED OUTCOMES	STRATEGIES
Aspire Toward Advanced Degrees	• Recruitment targets/strategies • Setting career goals and academic trajectory • Orient to MSN, DPN, and PhD education in Nursing; • Role models, research mentors
Achieve Academic Excellence	• Mentoring • Tutoring and writing assistance • Academic advising • Ongoing test taking strategies • Study groups
Experience NCLEX Success	• NCLEX prep • Study groups
Develop Leadership Attributes	• Building social & networking skills • Expanding comfort zones • Teambuilding • Professional Meetings • Delivery of scholarly papers • Interact with nurse leaders
Value Community Engagement	• Community service • Global experiences
Enhance Research Skills	• Mentored research project • Scholarly presentations
Assume Personal Responsibility	• Attendance/participation policies • Commitment to others
Strengthen Self Confidence Through Social Support	• Group, team, culture/social events • "Mama and Papa" Mentors • Spiritual enlightenment • MADIN II Program and ABSN faculty encouragement

Dr. Dorothy L. Powell is a Professor and Associate Dean for Global & Community Health Initiatives and Program Director, Making A Difference in Nursing (MADIN II) at Duke University School of Nursing in Durham, NC.

Dr. Brigit M. Carter is an Assistant Professor and Academic Program Coordinator, Making A Difference in Nursing (MADIN II) at Duke University School of Nursing in Durham, NC.

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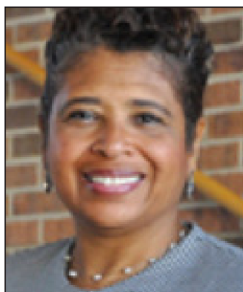

Embracing the Challenge of Increasing Workforce Diversity within the Nursing Profession

Clarise H. Ottley, PhD, RN, Faculty, Shepherd University, Department of Nursing Education

OVER THE COURSE OF many years, there have been numerous campaigns launched in support of the need to transform the nursing profession. One such campaign is Johnson and Johnson and the American Association of Colleges of Nursing (AACN) Minority Nurse Faculty Scholars Program, which was designed to increase the number of nurse educators from underrepresented minority groups. The Institute of Medicine's report (2010), The Future of Nursing: Leading Change, Advancing Health, examined the nursing workforce and how nurses can play a fundamental role in the support of transforming the profession. Opportunities to advance the nation's health needs must not lose site of the challenge to prepare a workforce that "mirrors the faces and values of those who seek care" (Wilson, Sanner, & McAllister, 2010, p. 144).

The nation's demographic population is changing. The United States Census Bureau (2010) projects a decrease in the number of Whites between 2010 and 2050, and an increase in the Hispanic or Latino population. The population in the United States is expected to reach 439 million by 2050, with a projection that 82% of this increase will be largely due to immigrant families.

A report released by the Sullivan Commission (2004) on Diversity in the Health care Workforce indicated that the nation's health professions have not maintained the needed pace of the changing demographics necessary to provide the kind of care that is needed for the population it serves. The lack of diversity in the nursing profession compared with the fast changing diversity in demographics may be a cause of disparities in health access and outcomes (Sullivan Commission, 2004)

The lack of diversity in the nursing profession is believed to be a result of the lack of minority nurse educators (AACN, 2001). There is a correlation between the number of minority nurse educators and the number of minority nursing students enrolled in nursing programs. Research indicates that a lack of minority faculty is a barrier to the recruitment and retention of culturally diverse nursing students (Zajac, 2011; Mills-Wisneski, 2005). AACN indicated that this need to attract diverse nursing students is paralleled by the need to recruit more nursing faculty from minority populations. It is encumbered upon nursing not only to actively recruit more minority nursing faculty, but also to collaborate on ways to retain them. Creative strategies must be developed that will provide both.

Mentoring of nursing faculty is one strategy that researchers have identified as key to recruitment and retention. The National League for Nursing (2006) indicated that mentoring as a strategy, will help recruit and retain qualified nurse educators because it helps establish healthful work environments.

Mentoring, defined as one-to-one reciprocal relationship between a more experienced and knowledgeable faculty member and a less experienced one, characterized by regular/consistent interaction over a period of time to facilitate the mentee's development (Haggard, Dougherty, Turban, & Wilbanks, 2011), is necessary for job satisfaction and faculty retention

According to authors Wroten and Waite (2009), in addition to guidelines for effective mentoring, the impact of race as a salient factor in development of mentoring relationships should not be overlooked. Both cross-race and same-race mentoring relationships provide career support for the faculty member. However, for minorities, whether nursing students or faculty, same-race relationship mentoring provides an added psychosocial support when considering trust and attachment that they may not find with cross-race mentoring.

The connection between the mentor and the mentee with same-race mentoring is vital to attracting minority faculty and students. Hubbard (2006) indicated that the most persistent and statistically significant predictor of enrollment and graduation of an African American graduate student is the visible presence of an African American faculty member. A barrier for this type of effective mentoring is the small pool of minority faculty who are in a position of leadership that can mentor other minority faculty and minority students.

In supporting the changing face of nursing, so that it is more reflective of a diverse profession and the current population, the establishment of opportunities for mentoring of minority faculty is a priority. There must be a commitment to increase diversity in nursing by actively recruiting minority faculty, and providing them with the environment that nurtures and supports them along each of their continuum. The belief is that visible nurse educators will send a signal to potential nursing students that nursing values diversity, and encourages support through same-race mentoring.

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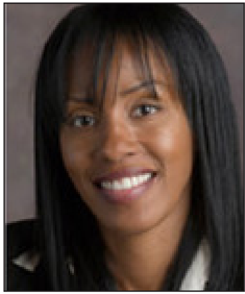

Strengthening the Ethnic and Racial Mix of Nursing Through Educational Reform

Kenya Beard, EdD, CNE, GNP-BC, NP-C, ACNP-BC, Assistant Professor

Despite numerous initiatives, federal funding, philanthropic support, and research findings that emphasize best practices to increase diversity in nursing, the nursing profession continues to struggle with graduating a population that mirrors the pluralistic society they serve. Specifically, the nursing profession has sought to increase the presence of underrepresented minorities (URM); African American, Hispanic and Native American. These URM constitute almost 30% of the United States' population (United States Census Bureau, 2011) yet the Bureau of Health Profession's (2010) 2008 survey of registered nurses reveals that they comprise less that 10% of the nursing workforce. High attrition rates, learning needs not being met and a shortage of minority faculty are just a few of the obstacles that continue to challenge efforts to increase minority representation in nursing.

It is widely accepted that increasing ethnic and racial diversity in nursing will help eliminate health care disparities. A diverse workforce is likely to improve the cultural climate of institutions and promote the delivery of culturally competent care. This does not suggest that only minorities can care for minorities. In contrast, it underscores the need for all health care professionals to increase their cultural competence so they are better positioned to meet the health care needs of a diverse population.

That being said, the National League of Nursing (2003) called for an educational reform that emphasizes the need for a change in paradigms. Reform efforts must include practices that consider the cultural competence of educators (National Education Association, 2008; Beard, 2009) and stress the significance of the teaching/pedagogy component of nursing education (National League for Nursing, 2003; Benner, 2009; American Association of Colleges of Nurses, 2011). Nursing institutions should adopt and evaluate reform measures that seek to promote a climate that is inclusive, meet the educational needs of all students and prepare students to deliver culturally competent care.

Multicultural education (ME) is a reform effort that has been used to restructure educational institutions and improve the cultural climate of schools. It has been used in teacher education and research suggests that it improves the academic outcomes of all students (Zirkel, 2008). It assumes that educators accept that diversity enriches our nation and provides us with opportunities to view perspectives from the experiences of others. It increases self-awareness and strengthens the educator's ability to create learning environments that meet the educational needs of diverse learners. More importantly, ME helps increase the graduation of a more diverse population.

With ME, two major paradigms are considered; deficiency and difference orientation. Sleeter and Grant (2009) reported that with deficiency orientation, some educators subscribe to the belief that URM are deficient in the right skills and knowledge. This approach to teaching supports low expectations and directs attention away from the evaluation and adoption of teaching strategies that promote equity in the classroom. Conversely, difference orientation recognizes the importance of having high expectations for all students and modifying instructional practices in a way that builds upon the strength of all students.

Banks (2008) conceptualized ME to help facilitate its adoption. He identified five dimensions of ME which include; Content Integration, Knowledge Construction, Prejudice Reduction, Empowering School Culture and Social Structure and Equity Pedagogy. Together these dimensions cultivate an environment that strengthens the cultural competence of both teacher and learner. The first dimension, Content Integration, examines the extent to which educators use experiences and beliefs of different cultures to illustrate key concepts. Knowledge Construction looks at how knowledge is created and helps faculty and students examine their personal attitudes towards diversity. Concepts are viewed from the perspectives of others and students are reminded that what is read is only one way of viewing things. The third dimension, Prejudice Reduction, focuses on eliminating destructive stereotypes and promoting cultural competence. With Empowering School Culture and Social Structure, institutions are challenged to uncover inequitable practices and hidden messages related to diversity that are silently portrayed to students. The last dimension, Equity Pedagogy, emphasizes and facilitates the modification of teaching methods in a way that facilitates the academic success of all students.

In closing, strengthening the ethnic and racial mix of nursing hinges upon the profession's ability to overcome numerous barriers to graduating URM. The Institute of Medicine's Report (2011), The Future of Nursing, Leading Change, Advancing Health, asserts that nursing education needs a transformation. However, it must be acknowledged that faculty play a pivotal role in this transformation and their willingness to implement requisite changes that facilitate the graduation of a diverse population is crucial. While ME is not a panacea, it provides a working plan to help advance the educational system. It empowers nurse educators to teach in a way that is culturally responsive, and enables them to graduate a diverse group of students who are better prepared to deliver culturally competent care. It is this author's hope that nursing will adopt ME and study its effectiveness in increasing diversity in nursing.

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How to Volunteer in a Disaster as a Nurse with the Red Cross

Terry B. Freeman, RN , Disaster Health Services Manager and Volunteer, Florida

EVERY YEAR THE AMERICAN Red Cross responds to more than 70,000 disasters — including approximately 150 home fires every day. Red Cross volunteers do "real work" for the American Red Cross, composing approximately 96% of the workforce; they provide relief to victims of disasters and help people prevent, prepare for, and respond to emergencies. Volunteer nurses, and other health professionals, who become Red Cross volunteers play important roles in providing these services.

Nurses can contact their local Chapter of the American Red Cross to become volunteers in Disaster Services, specifically the Disaster Health Services activity. Becoming a fully certified Red Cross volunteer prior to a disaster allows the nurse to perform from the very first hours of the disaster. Red Cross nurses must complete the volunteer registration process as well as a series of Red Cross classes in order to serve as a Disaster Health Services worker.

Steps to becoming an American Red Cross Volunteer in the Disaster Health Services Activity:

Contact your local American Red Cross Chapter

Becoming a Red Cross volunteer begins at your local chapter. You can find your local Chapter by visiting the American Red Cross website at www.redcross.org. Look for the "Find Your Red Cross" column, where you can search for the nearest chapter by your zip code.

Complete Volunteer Application Process and Orientation

Your local Chapter will ask you to fill out the volunteer application form, complete the background check process, and complete and sign agreement forms. Be ready to show the Chapter your driver's license or state ID card and your professional, nursing license. Many chapters have an intake process, which includes conversations about what sort of volunteer work you would like to do. Let the interviewer know that you are interested in Disaster Health Services. Next, you will need to complete the American Red Cross "Orientation". [NOTE: There are other opportunities for nurses in the Red Cross outside of disaster response to include Board membership, leadership positions, Preparedness Health and Safety Services instruction; Service to Armed Forces emergency communication, and program development.]

Disaster Services

Your next step is to begin working towards becoming a Disaster volunteer in Disaster Health Services. You will need to take "Disaster Services: An Overview" class first; this class is a prerequisite for all other training in Disaster Services. Ask your chapter about the other training you will need, including the "Disaster Health Services Response Workshop". Ask your Chapter what else you will need to do to become a Disaster Health Services Worker.

The Disaster Services Human Resources (DSHR) System

The Red Cross uses the DSHR system to manage the workers who can respond to disasters. Ask your chapter how you can enroll in the DHSR system. Whether you wish to volunteer to deploy to disasters outside of your home area or whether you wish to work locally, all disaster volunteers should enroll in DSHR. There is a separate application form and additional documents to be completed in order to enroll. Once you are enrolled, you must update the documents once a year in order to remain a member of the DSHR system.

You will be asked which activity you would like to work in. To work in disaster response, nurses can select Disaster Health Services or Disaster Mental Health with the appropriate specialty certification. Keep in mind that when asked to work a disaster outside of your home chapter's area, there may be a commitment for a minimum period of time (2 or 3 week assignments are common). The DSHR system keeps track of which disaster activity you wish to work in, your Red Cross and professional qualifications, the disasters your have worked on with the Red Cross, allows you to manage the times you are available, and is the one place you can keep your contact information up-to-date. When a disaster occurs, the Red Cross uses this system to find people who are qualified, trained, and available to respond NOW.

It does take a bit of planning and work to become a Red Cross Disaster Health Services volunteer. Many of us find the preparation and the work we do very rewarding. Please join our response efforts!

Bureau of Clinician Recruitment and Service, National Health Service Corps and NURSE Corps

THE HEALTH RESOURCES and Services Administration's Bureau of Clinician Recruitment and Service administers several loan repayment and scholarship programs as part of the National Health Service Corps (NHSC) and NURSE Corps. These programs provide funding to primary care clinicians and students in exchange for service in underserved communities experiencing critical shortages of health care providers, known as Health Professional Shortage Areas (HPSAs); and assist in removing financial barriers for health professionals interested in practicing a primary care discipline, enabling them to pursue a fulfilling, mission-driven, community-based career.

As a result of historic investments by Congress and the Obama Administration through the Affordable Care Act and the American Recovery and Reinvestment Act, the number of NHSC providers serving in the field has nearly tripled from 3,600 since 2008, providing care for millions of more patients than the Corps was able to serve just over three years ago.

Today, the NHSC consists of nearly 10,000 primary care medical, dental, and mental and behavioral health professionals who build healthy communities by providing care to approximately 10.4 million medically underserved individuals at nearly 14,000 NHSC-approved sites in urban, rural, and frontier areas throughout the U.S. and its territories. Corps members are practicing in all 50 states, Washington, D.C., and U.S. Territories, making an impact that lasts a lot longer than their loan repayments—more than four out of five continue to serve even after their obligation is over.

The number of nurses represented in the NHSC has increased more than 360 percent over the last four years: nurse practitioners quadrupled from 402 to 1,631; and certified nurse midwives nearly doubled, from 88 to 162. According to self reports, African American nurse practitioners represent 15.4 percent of NHSC nurse practitioners, and African American certified nurse midwives represent 17.7 percent of NHSC certified nurse midwives.

The NHSC Loan Repayment Program provides an initial, tax-free award of up to $60,000 for two years of full-time service in an underserved community, and the opportunity to pay off all health professional student loans with continued service. The NHSC Loan Repayment Program made 4,267 awards (both new and continuation contracts) totaling $169 million in Fiscal Year 2012. The NHSC Loan Repayment Program application cycle is expected to open later this month. The NHSC Scholarship Program provides tuition, required fees, other reasonable educational costs, and a monthly living stipend. Participants provide one year of service for each school year of financial support received, with a minimum two-year service commitment. The Scholarship Program made 222 awards (both new and continuation contracts) totaling $42 million in Fiscal Year 2012. The NHSC Scholarship Program application cycle will open later this spring.

HRSA offers loan repayment and scholarships to nurses who work in health centers, rural health clinics, hospitals and other types of facilities currently experiencing a critical shortage of nurses, through the NURSE Corps—formerly the Nursing Education Loan Repayment Program and Nurse Scholarship Program. As a result in investments in the NURSE Corps programs, as of September 30, 2012, over 2,900 nurse practitioners, certified registered nurse anesthetists, certified nurse-midwives, registered nurses, nurse specialists and other advanced nurses are working in communities where they are needed most; of which 8 percent self-reported as African American.

The NURSE Corps Loan Repayment Program offers loan repayment assistance to registered nurses and advanced practice nurses, such as nurse practitioners, working in a Critical Shortage Facility, or nurse faculty employed by an accredited school of nursing. Program participants receive 60 percent of their total outstanding qualifying educational loan balance (incurred while pursuing an education in nursing) in exchange for two-years of full-time service at an eligible facility. Qualifying participants may be eligible to receive additional loan repayment for an additional third year of service. There were approximately 1,500 NURSE Corps Loan Repayment Program awards made in 2012. The NURSE Corps Loan Repayment Program accepted application through February 28, 2013. Application information is normally available online at: www.hrsa.gov/loanscholarships/repayment/nursing.

The NURSE Corps is helping to train the next generation of nurses through the NURSE Corps Scholarship Program, which offers scholarships to students attending accredited registered nurse training programs located in the U.S., in exchange for at least two years of service. A funding preference is given to qualified applicants who have an Expected Family Contribution between $0 - $5,550, and are enrolled as full-time students in an undergraduate nursing program. There were 263 NURSE Corps scholarships made in 2012. The NURSE Corps Scholarship Program application cycle will open later this spring.

For more information on the National Health Service Corps and NURSE Corps loans and scholarship programs, go to: http://www.hrsa.gov/loanscholarships/index.html

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NEW JERSEY

CONCERNED BLACK NURSES OF CENTRAL NEW JERSEY (61)
Sandra Pritchard
Neptune, NJ
CONCERNED BLACK NURSES OF NEWARK (24)
Lynda Arnold
Newark, NJ
MID-STATE BNA OF NEW JERSEY (90)
Rhonda Garrett
Somerset, NJ
NEW BRUNSWICK BNA (128)
Barbara Burton
New Brunswick, NJ
NORTHERN NEW JERSEY BNA (57)
Rosemary Allen-Jenkins
Newark, NJ
SOUTH JERSEY CHAPTER OF THE NBNA (62)
Gail Edison
Williamstown, NJ

NEW YORK

NEW YORK BNA (14)
Jean Straker
New York, NY
QUEENS COUNTY BNA (44)
Hyacinthe McKenzie
Cambria Heights, NY
WESTCHESTER BNA (71)
Altrude Lewis-Thorpe
Yonkers, NY

NORTH CAROLINA

CENTRAL CAROLINA COUNCIL (53)
Helen Horton
Durham, NC

OHIO

AKRON BNA (16)
Cynthia Bell
Akron, OH
BNA OF GREATER CINCINNATI (18)
Marsha Thomas
Cincinnati, OH
CLEVELAND COUNCIL BNA (17)
Peter Jones
Cleveland, OH
COLUMBUS BNA (82)
Pauline Bryant
Columbus, OH
YOUNGSTOWN WARREN BNA (67)
Lynn Hines
Youngstown, OH

OKLAHOMA

EASTERN OKLAHOMA BNA (129)
Phyllis Collins
Tulsa, OK

PENNSYLVANIA

PITTSBURGH BLACK NURSES IN ACTION (31)
SOUTHEASTERN PENNSYLVANIA BNA (56)
Juanita Jones
Philadelphia, PA

SOUTH CAROLINA

TRI COUNTY BNA OF CHARLESTON (27)
Dr. Debbie Bryant
Charleston, SC

TENNESSEE

MEMPHIS-RIVERBLUFF BNA (49)
Linda Green
Memphis, TN
NASHVILLE BNA (113)
Shawanda Clay
Nashville, TN

TEXAS

BNA OF GREATER HOUSTON (19)
Vivian Dirden (Interim)
Houston, TX
FORT BEND COUNTY BNA (107)
Yvonne Olusi
Missouri City, TX
GALVESTON COUNTY GULF COAST BNA (91)
Leon McGrew
Galveston, TX
GREATER EAST TEXAS BNA (34)
Pauline Barnes
Tyler, TX
METROPLEX BNA (DALLAS) (102)
Dr. Becky Small
Dallas, TX
SOUTHEAST TEXAS BNA (109)
Denise Sanders Boutte
Port Arthur, TX

VIRGINIA

BNA OF CHARLOTTESVILLE (29)
Dr. Randy Jones
Charlottesville, VA
CENTRAL VIRGINIA BNA (130)
Janet Porter
Richmond, VA
NBNA: NORTHERN VIRGINIA CHAPTER (115)
Joan Pierre
Woodbridge, VA

WISCONSIN

MILWAUKEE BNA (21)
JoAnn Lomax
Milwaukee, WI
RACINE-KENOSHA BNA (50)
Gwen Perry-Brye
Racine, WI

DIRECT MEMBER (55)
*IF THERE IS NO CHAPTER IN YOUR AREA