

NATIONAL BLACK NURSES ASSOCIATION

# NBNA

## NEWS

### NBNA 2018 CONFERENCE



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## NBNA NEWS

The NBNA News is printed quarterly; please contact the National Office for publication dates.  
NBNA News • 8630 Fenton Street, Suite 910 • Silver Spring, MD 20910 • [www.NBNA.org](http://www.NBNA.org)  
Yolanda M. Powell-Young, PhD, PCNS-BC, CPN, Editor-in Chief

### *Advocacy, Voting and Health*



Greetings All,

The St. Louis Union Station Hotel in St. Louis, MO was host for the NBNA 46th Annual Conference. Members of the NBNA, presenters and sponsors from across the nation gathered to support a resoundingly successful conference. Workshops and education sessions fostered innovative ideas and meaningful dialogue to advance the future of nursing and health care. Moreover, the weeks' long conference provided a platform for nursing clinicians, leaders, researchers, administrators, and educators to not only disseminate valuable insights but provide vital mentoring. A grand thank you to our attendees and contributors who made this event such a success.

We reaffirmed that the psychological and physiological health and welfare of all the nations' citizens should be a foremost consideration. Sustained advocacy for the health of our communities and country was a universal conference thread. Advocacy, in all its forms, seeks to ensure that people, particularly those who are most vulnerable in society, are able to be heard and have a voice about what impacts them. Recent events have demonstrated that the NBNA mission of advocacy and our role as advocate remains relevant and crucial in advancing health in our current climate of heightened awareness, challenge and transformation.

Our health and our vote are inextricably linked. Recently, we have witnessed unprecedented attacks on survivors of assault and violence; discussed the probable revisit and dissolution of Roe v Wade; observed an intentional sabotage to the Affordable Care Act open enrollment cycle; and watched devastating attacks on civil and human rights policy. All of these assaults have striking and sustained implications for health and well-being for millions of men, women and children. Make no mistake, the decisions and policy that are made today have far-reaching, generational health implications for us all.

Many are currently casting ballots in absentia. Many more shall cast ballots on November 6, 2018. As advocates to and for our communities, we should be ready to inform why and how our political motivations significantly impact health and wellness. In our advocacy, continue to discuss issues like the rising cost of health care, the impact of prohibition on the use of herbal remedies to improve quality of life, and the psychological detriments and associated economics of child internment. Ensure that our stakeholders recognize how the transformation of our health care system has and shall always be determined at the polls. To be informed is to be empowered.

Respectfully,

**Yolanda M. Powell-Young, PhD, PCNS-BC, CPN**  
Editor-in-Chief

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# *Mentoring Future Healthcare Advocates*

**Eric J. Williams, DNP, RN, CNE, FAAN**  
President, National Black Nurses Association



**T**he 46th Annual Institute and Conference of the National Black Nurses Association (NBNA), Inc. was a resounding success. From July 31st through August 5th, 2018, the St. Louis Union Station Hotel was host to a grand affair. From the inspiring pre-conference sessions to the grand opening ceremony and lively exhibits, the array of seminars and presentations, and local attractions, conference attendees were provided opportunities for intellectual stimulation and entertainment. I would like to thank the members of the Board, the Executive Director, membership, staff, speakers, sponsors, and hosts for making this celebration a memorable success.

A striking conference standout was the screening and subsequent conversation of Henrietta Lacks' life story. Not because of the many, many accolades garnered from conference attendees but because of its significance to the current political climate and healthcare landscape. From a science perspective, it is the story of how a biological "contribution" can transform medicine. From a human perspective it is the story of our similarities. How the immortal cells harvested from a Black woman have been used for more than a century to advance healthcare treatments and technologies for all men, women and children. From a cultural perspective, it is a story of grievous exploitation unto a marginalized and vulnerable family and patient. From a social perspective it is an example of the weaponization of institutional knowledge against individual unawareness. How different the story of Henrietta Lacks if only she or her family had --- known; had been -- informed; had been -- reassured.

The mission of the NBNA is a referendum for the many facets of empowerment and against the many aspects of concealment. As we mentor our future nursing leaders, it is critical that they understand the meaning of advocacy in their role as healthcare leaders and ambassadors. Advocates act on behalf of their stakeholders through the championship of social justice. Advocates assist our communities and their members to make choices and decisions based on fact and knowledge. Advocates provide and foster the intellectual tools needed to make those choices a reality.

Knowledge is power. But, understanding how to mobilize knowledge into action is an accompanying power. November 6, 2018, is a time for mobilization. A time to take what we know and use it toward advancement and change. The NBNA will continue our advocacy efforts by continuing the tradition of providing opportunities and platforms that support mentoring and thus, advancement toward a national healthcare culture of wellness and inclusivity. A heartfelt Thank You to each member for all you do in supporting the mission of our great organization.

**Eric J. Williams, DNP, RN, CNE, FAAN**  
12th NBNA President

# In the News

## — Student Nurse of the Year —

### 5 questions with...

## National Black Nurses Association Student Nurse of the Year Edward C. Bennett Jr.

*July 6, 2018*

As a sophomore nursing student, Edward C. Bennett Jr. stepped into an elevator one day feeling overwhelmed. By the time he stepped out, he'd gained two new mentors and a clear sense of direction.

Bennett had given then-postdoctoral scholars Kathy Wright (now at Ohio State University) and Lenette Jones (now at the University of Michigan) his literal elevator pitch. In turn, they directed him toward research opportunities and gave him insight into the nursing field.

With guidance from Wright and Jones, and adviser Diana Morris, Bennett, now a senior who expects to graduate in December, has flourished. Most recently, he won the National Black Nurses Association Student Nurse of the Year Award.

When Bennett had that impactful elevator conversation a few years ago, he had just switched his major.

Upon arriving at Case Western Reserve University in 2014, he intended to study political science and follow the pre-medical track. But after an internship as part of the Summer Medical and Dental Education Program at Duke University, his focus shifted.

"Everywhere I looked, there were nurses and nurse practitioners doing exactly what I wanted to do: interacting with the patient, advocating for the patient and having that really hands-on experience," Bennett said.

In changing his major, Bennett also was following in his mother's footsteps.

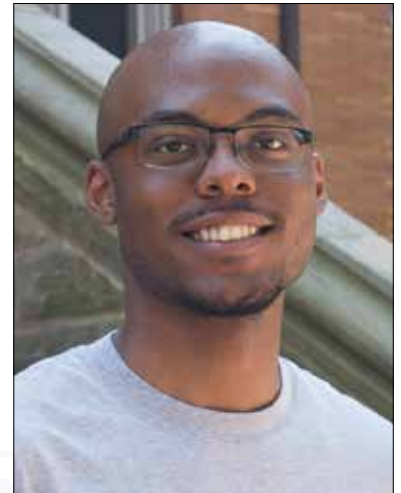
"She was shocked at first, but really happy at the end of the day," Bennett said.

Though she has been a nurse for about 30 years, even his mother was surprised by the myriad opportunities available for her son in the field. Bennett has taken advantage of as many of them as possible.

He estimates that, upon his graduation, he will have completed more than 1,000 hours of clinical work. In addition to the clinical experience all students get at the Frances Payne Bolton School of Nursing, Bennett has worked with several other local institutions in several areas, including case management and the cardiovascular intensive care unit.

His work at local institutions has not only helped him enhance his skills, but it's also placed him in situations in which he can advocate for his patients.

"I want to be that advocate who says, 'I don't care who you are, I don't care where you come from, I'm going to treat you with the best care that I can and make sure that you have the best experience that you can so you come back and get that treatment that you need,'" Bennett said.



Edward C. Bennett, Jr.

# In the News

## — Student Nurse of the Year —

After one interaction with a patient, Bennett was inspired to do more than just provide in-the-moment treatment—he wanted to help provide better lasting care.

The patient, who had sickle cell disease, felt as though his voice often wasn't heard in health care settings. It was a feeling with which Bennett was familiar, especially as a double-minority in the nursing field as an African-American male.

Inspired by that experience, Bennett now is working to improve care for patients with sickle cell disease, with hopes of implementing a fast-track system for those with the disease, so they can get the immediate care they need.

"That experience really made me see how I could use my nursing knowledge and my nursing skillset to be an advocate for patients with this disease," Bennett said.

Take a moment to learn more about Bennett in this week's five questions..

### 1. What do you like most about Cleveland?

I really appreciate the opportunities it has for young people. I'm originally from Buffalo, New York, and when I came to Cleveland, I saw that young people are involved in so many different things, getting the skills and tools they need to succeed, as well as internships. It really makes me proud to be living in Cleveland. Every time I see the investment that Cleveland puts into its youth, I am in awe.

### 2. What's a hidden skill or talent you have that most people would be surprised to know?

I really enjoy writing, whether it's writing for the newspaper, writing poetry or writing articles on LinkedIn. One of my joys is writing and editing.

### 3. Who is the best teacher you've had throughout your education?

I was a political science major before I switched to nursing and I really enjoyed Professor Pete Moore and his comparative politics class. That class was amazing. He's a great professor.

### 4. What moment in history do you wish you could have experienced firsthand?

Malcolm X actually made a speech in Cleveland in 1964 called "The Ballot or the Bullet," and that was a very influential speech. I think it kind of sets the stage for what we're experiencing in 2018 as far as election season.

### 5. What's your favorite thing about Case Western Reserve?

My favorite thing is probably the accessibility for a wide variety of different people. Case Western [Reserve] has a ton of opportunities locally involving hospitals, but also just being able to engage and interact with people from across the world, whether it be China, India, Canada, etc. I've had the pleasure of becoming friends with a ton of different people who I don't think I would have met in any other situation.

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"Reprint from Case Western Reserve University, Frances Payne Bolton School of Nursing. Edward C. Bennett was elected as the Student Representative to the NBNA Board of Directors, July 2018."

# In the News

## OCTOBER IS NATIONAL BREAST CANCER AWARENESS MONTH



The National Black Nurses Association is proud to participate in National Breast Cancer Awareness Month. Breast cancer is the most common kind of cancer in women after skin cancer. About 1 in 8 women born today in the United States will get breast cancer at some point.

The good news is that most women can survive breast cancer if it's found and treated early.

- If you are a woman age 40 to 49, talk with your doctor about when to start getting mammograms and how often to get them.
- If you are a woman age 50 to 74, be sure to get a mammogram every 2 years. You may also choose to get them more often.

Talk to a doctor about your risk for breast cancer, especially if a close family member of yours had breast or ovarian cancer. Your doctor can help you decide when and how often to get mammograms.

For more information visit:

<https://healthfinder.gov/HealthTopics/Category/doctor-visits/screening-tests/get-tested-for-breast-cancer>

<https://www.cancer.org/cancer/breast-cancer.html>

<https://www.cancercenter.com/breast-cancer/learning/>

[https://www.cdc.gov/cancer/breast/basic\\_info/index.htm](https://www.cdc.gov/cancer/breast/basic_info/index.htm)

<https://ww5.komen.org/BreastCancer/AboutBreastCancer.html>

<https://www.nationalbreastcancer.org/breast-cancer-facts>

<https://medlineplus.gov/breastcancer.html>



# NBNA Conference – 2018



Dr. Eric J. Williams, President, NBNA Board of Directors and NBNA Past Presidents at Business Meeting



NBNA 40 and Under Forum hosted by VITAS Healthcare



# NBNA Conference – 2018



Captain Beverly A. Dandridge of the U.S. Public Health Service received the Uniformed Services Nurse of the Year Award.



Dr. Linda Burnes Bolton, NBNA Past President, received a Special Presidential Award.



Dr. Wayne A.I. Frederick, President, Howard University, was the Keynote Speaker at the Opening Ceremony.



Dr. Ayana Elliott, Keynote Luncheon Speaker, hosted by Gilead Sciences.

# NBNA Conference – 2018



Joseph Sardano, President and CEO, Sensus Health, Dr. Millicent Gorham, NBNA Executive Director, Dr. Brian Berman, Anthony Perkins and Dr. Eric J. Williams, NBNA President, session sponsored by Sensus Health.



Dr. Foluso Fakorede, Dr. Icilma Fergus, Dr. Eric J. Williams, NBNA President and Dr. Jonathan Butler Representing the Association of Black Cardiologists, session sponsored by The Association of Black Cardiologists.



# NBNA Conference – 2018



Board Member Thomas Hill, Yolanda Scipio-Jackson, Dr. Eric J. Williams, NBNA President, Carter Todd, Deborah Zimmerman.



Tamara Holness, Dr. Layla Qaabidh, Dr. Natalia Cineas (Awards and Scholarship Chair GNYC-BNA), Jose Perpignan, Dr. Kamila Barnes (2nd VP of GNYC-BNA), Dr. Sheldon D. Fields (President GNYC-BNA), Dr. Julius Johnson (1st VP of GNYC-BNA), Jewel Adams, Monique Tarrant (Corresponding Secretary GNYC-BNA), Sabrina Newton (Membership Chair GNYC-BNA).



# NBNA Conference – 2018



Forget Me Not Play, Joni Lovelace, NBNA Board Member and Chair, Ad Hoc Committee on Fund Development.



NBNA and American Red Cross Sponsor Blood Drive at the 2018 NBNA Conference, St. Louis, MO



Forget Me Not Play sponsored by African Americans Against Alzheimer's



# Chartering of New NBNA Chapters



Lola Denise Jefferson, First Vice President, Bowie, Maryland BNA, Dr. Birthale Archie, Founding Member and Dr. Eric J. Williams, NBNA President.



Greater New York BNA President Dr. Sheldon Fields and Sabrina Newton



Dr. Constance Hendricks, 2nd from right



Louisiana Capital President Steven Jackson, Jr.

# Chartering of New NBNA Chapters



Columbia Area BNA President Whakeela James



Lola Denise Jefferson, 2nd VP, Max Parker, President, Central Texas BNA, Dr. Eric J. Williams, President



Capitol City BNA California President Carter Todd



# Chartering of New NBNA Chapters



Southwest Michigan BNA President Deborah Spates



Southeastern Louisiana BNA President Rachel Weary



Oklahoma City BNA President Irene Phillips

# Chartering of New NBNA Chapters



Shore BNA, Illinois President Mary Harris-Reese



Mid-Missouri BNA President Dr. Ann Marie McSwain



Lake County Indiana BNA President Michelle Moore



# Chartering of New NBNA Chapters



Emory BNA President Dr. Jill Hamilton



Illinois South Suburban BNA Dr. Carol Alexander



# NBNA Conference – 2018



NBNA Board Members, Dr. Patricia McManus, Dr. Martha Dawson, Trilby Barnes-Green, Kendrick Clack, Dr. Birthale Archie, Lola Denise Jefferson



NBNA Board Members, Kim Scott, Kim Cartwright, Dr. Angela Allen, Dr. Sheldon Fields, Thomas Hill, Deborah Jones and Joni Lovelace



# NBNA Conference – 2018



## NBNA Past Presidents

Dr. Carrie Rogers Brown, Ophelia Long, Dr. C. Alicia Georges, Dr. Eric J. Williams, Dr. Linda Burnes Bolton, Dr. Betty Smith Williams, Dr. Hilda Richards and Reverend Deidre Walton



NBNA Trailblazer Awardees Dr. Randolph Rasch, Dr. Wallena Gould, Dr. Diane Barber Dr. Cheryl Taylor, Dr. Eric J. Williams, NBNA President, Dr. C. Alicia Georges, NBNA Life Time Achievement Awardee

# NBNA Conference – 2018



Doctorate Symposium Speakers Dr. Derrick Glymph, Dr. C. Alicia Georges, Dr. Wallena Gould, Dr. Donte Flanagan, Dr. Sheldon Fields



Exhibitor - Novartis



Exhibitor - Pfizer, Inc.



# NBNA Conference – 2018



Plenary Session I, Angela Patterson, Chief Nurse Practitioner, speaking



Lyn Peugeot of VITAS Healthcare offers the Ending Session Keynote



Honorary Members of NBNA Diane Deese of VITAS Healthcare, Dr. Eric J. Williams, NBNA President, Melissa Bishop-Murphy of Pfizer, Inc.

# »» KNOW YOUR RIGHTS

Health insurance companies take numerous steps to control their costs. This can mean your patient's health plan won't cover certain prescribed treatments or the plan requires them to take a number of steps before their treatment is approved.

There are states and federal laws that may protect your patient from these practices, and there are things your patient can do if their health plan won't pay for their medical treatment or delays their care.

To empower patients to take these steps, Aimed Alliance launched the "Know Your Health Insurance Rights" campaign to help them with the below challenges.

**To find out if your insurer or PBM may have acted improperly, ask yourself these questions:**



### **Prior Authorization**

Before I can fill or refill a prescription, do I need to get approval from my insurer?



### **Step Therapy**

Did my insurer make me try a different treatment before covering the medication that my health care provider prescribed?



### **Nonmedical Switching**

Is my insurer forcing me to take a different medication, even though my current medication works well, by refusing to cover it any longer or increasing my co-pay?



### **Adverse Tiering**

Do I have to pay either a percentage of the costs or a very large co-pay for my medication?

**My insurer refuses to cover a treatment that my health care provider prescribed to me.**

**What can I do?**



### **Appeal the decision**

If your insurer denies your claim, you have the right to an internal appeal.



### **Request an external review**

Under law, you are entitled to take your appeal to an independent third party for an "external review," meaning your insurer no longer gets the final say over whether to approve a treatment or pay a claim.



### **File a complaint**

If there are still problems after the external review process, you can file a complaint with the insurance commissioner or attorney general in your state.

Visit [www.coveragerights.org](http://www.coveragerights.org) to learn more.



# Malnutrition is a Patient Safety Issue and Nurses are Pivotal in its Management

Michael Chapple, MS  
Albert Barrocas, MD, FACS, FASPEN

**N**urses are key to improving the quality of health care through patient safety interventions and strategies. The Agency for Healthcare Research and Quality (AHRQ) Patient Safety Network emphasizes that nurses, of all the members of the health care team, “play a critically important role in ensuring patient safety.”<sup>1</sup> Patient safety is defined as the prevention of harm to patients.<sup>2</sup> One patient safety area where more attention is needed is nutrition, particularly the prevention of malnutrition and its associated complications. “Appropriate provision of nutrition” was identified over 15 years ago as one of 11 practices rated most highly in an AHRQ report examining strength of evidence for improving patient safety.<sup>3</sup>

Today, a focus on nutrition remains vital as there continues to be an increasing body of evidence that malnutrition, especially under-nutrition, contributes to avoidable harm of those in our care.<sup>4-6</sup> Malnutrition occurs in about one of three patients on hospital admission.<sup>4</sup> The prevalence is higher in the >65 years old and minority populations. The challenge of malnutrition is further exacerbated during hospital stays, where up to 69% of patients may experience a decline in nutrition status.<sup>5</sup> While total eradication of malnutrition is not possible in the hospital due to underlying disease (including end-of life conditions such as cancer and advanced dementia) it behooves the entire health care team to evaluate all patients in a timely manner. Such review will identify individuals who should not or do not want special nutrition interventions. Nurses, being at the bedside 24/7 are adept at recognizing the need for these types of ethical considerations.

There are several reasons why poor nutrition status can be a problem for hospital patients. Acute or chronically ill or injured patients require more nutrition (protein in particular) than usual so

they can properly allocate nutrients to essential processes during periods of stress. In contrast to fats and carbohydrates, protein is not stored in excess in the body. Cahill demonstrated that 30% loss of the body’s protein is fatal.<sup>7</sup> During stress—in addition to increased demands—the usual energy substrates, e.g., carbohydrates and fat are inadequately utilized. To meet the demand, essential protein (important for function, structure, enzymes, antibodies) is broken down to provide elements for carbohydrate production. This process often referred to as “auto cannibalism” or “proteinaceous piracy” leads to direct harmful outcomes such as reducing immunity and making patients susceptible to infections and death; it is perhaps better understood by referring to it as NAIDS (Nutritionally Acquired Immunodeficiency Syndrome). Additionally, increased frailty and risks of falls and delayed wound healing are observed. Indirect harmful effects which also impact costs of healthcare include increased length of stay, increased rates of readmissions, and resource overutilization.<sup>8-10</sup>

Several foundational elements have been outlined as components of a strong hospital patient safety program<sup>11</sup> and these are critical for quality malnutrition care too.

Safety is a core value: Good nutrition should be a core institutional value as well, particularly to support older patients; the National Institute on Aging recommends “maintaining a healthy weight and getting needed nutrients is one of the most important factors for healthy aging.”<sup>12</sup>

Safety is led from the top: Nursing is on the frontline for monitoring and working to improve nutrition intake in collaboration with physicians, dietitians and other health care professionals.<sup>13</sup> There is an opportunity for hospital nursing leadership to engage with hospital and medical staff leadership to help ensure that quality malnutrition care is part of the ongoing patient safety initiatives that nursing may lead. Nurses are pivotal in assuring optimal nutrition care, not only because they are at the bedside 24/7, but also because they initiate the process through the admission nutrition screen which is part of the initial nursing assessment. Nurses must assure that the appropriate referral is made to a dietitian for a proper nutrition assessment, leading to a diagnosis, treatment plan and transitional care by the physician. Nurses are also important in continuing to monitor the patient’s nutrition care during the hospitalization, which is part of their role of being a patient advocate.

Safety events are reported: The American Society for Parenteral and Enteral Nutrition estimates that every 60 seconds, 10 hospitalized patients with malnutrition go undiagnosed.<sup>14</sup> This represents an important gap in clinical care and underscores the need for malnutrition to be better identified, diagnosed, and treated in the hospital and post discharge.



**Michael Chapple, MS** is a Kent State graduate student



**Albert Barrocas, MD, FACS, FASPEN**

Safety is transparent: One of the ways to help increase transparency around the issue of malnutrition and its diagnosis is through the implementation of malnutrition quality measures. The Academy of Nutrition and Dietetics and Avalere Health developed the first-ever malnutrition electronic clinical quality measures (eCQMs) in 2016. They also worked with other stakeholders—including nurses—through a Malnutrition Quality Improvement Initiative to release an open-access toolkit (<http://www.mqii.today>) that supports implementation of the eCQMs through hospital quality programs.<sup>15</sup>

Safety events are disclosed: The National Black Nurses Association adopted a Nutrition as a Vital Sign resolution in 2015, that included the recommendation for use of malnutrition quality measures in public and private accountability programs.<sup>16</sup> Similarly, the Centers for Medicare & Medicaid Services, in their Fiscal Year 2018 Inpatient Prospective Payment System Final Rule, commented that malnutrition screening and assessment are important for better patient outcomes, and that there is an opportunity for hospitals to improve nutrition screening and assessment practices.<sup>17</sup>

Currently, patient safety organizations or PSOs (there are over 80 listed by AHRQ at <https://www.pso.ahrq.gov/listed>) register areas such as informed consent, infectious disease, and adverse events as high priority topics with no present regard for malnutrition. However, PSOs do provide a potential focus for future malnutrition partnerships and initiatives as malnutrition impacts all three long-term patient safety goals set forth by AHRQ:

1. reducing preventable hospital admissions and readmissions
2. reducing the incidence of adverse health care-associated conditions, and
3. reducing harm from inappropriate or unnecessary care.<sup>18</sup>

In summary, integrating quality malnutrition care into patient safety programs across the continuum of care provides an opportunity for nurses to help in the early screening, assessment, diagnosis and management of malnutrition.

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# Being a Cervivor – The Importance of Cervical Cancer Awareness and Advocacy

Tamika Felder  
Founder, Cervivor



I was 25 years old when I received a diagnosis of cervical cancer. It was absolutely devastating. No one at that age expects to hear that you have a health problem, let alone a life-threatening cancer. After my treatment, which was successful, I came to a realization that I was lucky to be in a position to move forward with my life. I wanted to make my survivorship count, and that is why I founded Cervivor in 2005.

Cervivor is a non-profit advocacy group for women living with cervical cancer and those who have survived the disease. Since founding the group, I've learned how to encourage women to open up and share their stories – to speak to the impact that cancer has had on their lives and to provide help to other women going through treatment.

What I realized shortly after surviving my disease is that no one was talking about cervical cancer, even though in the United States a woman dies every two hours from this disease<sup>1</sup>. It did not have a profile like breast cancer, with people wearing pink and talking about the need for regular mammograms and self-exams. I think this may be because cervical cancer involves a part of the body that is so intimate and invisible to most that it's difficult to address. I've also learned through conversations with many, many women over the years that there are two common misconceptions about cervical cancer. Many think that cervical cancer only happens to a certain "type" of woman; that being promiscuous is somehow a cause. Many also think that cervical cancer is not really that serious.

As nurses, I know you and I agree that cervical cancer is an equal opportunity disease and that it is indeed life-threatening. You are in a position to educate the women in your care. They may be more

comfortable speaking to you than a physician, and I encourage you to incorporate a discussion of cervical cancer screening into your conversations with patients.

Coming from a patient perspective, I would also like to share that there is much that nurses can do within the exam room to increase patients' comfort level. The gynecological exam, in particular, can be intimidating to women, who are asked to expose their most vulnerable and private selves. Something as simple as offering a patient the opportunity to remain dressed until meeting the doctor or to get dressed post-exam before having a conversation with the doctor can be extremely helpful in making women more confident and comfortable. Suggesting that women write down their questions or even supplying them with a few helpful questions is another good idea to ensure that patients get what they need from conversations with their doctors.

The women I work with every day through Cervivor are very knowledgeable about cervical cancer, but that is only because of the ordeal that they are going or have gone through. Most women have heard of the Pap test but may have no idea that, according to guidelines from medical societies such as the American College of Obstetricians and Gynecologists, they should also be receiving an HPV test if they are between the ages of 30 and 65. The combined approach, known as co-testing, has been shown in large clinical studies to detect more cancer and pre-cancer than either test alone, but "co-testing" is not part of the average woman's vocabulary. I cannot overemphasize the importance of educating the patients in your care about the need for screening – more than half of new cervical cancer cases occur in women who have never or rarely been tested.<sup>2</sup>



For your patients who are diagnosed with cervical cancer, I would like them to know that Cervivor is a resource for them. We have a number of members who volunteer as patient “navigators” – these are women who have survived cervical cancer or are currently in treatment, who will meet with your patients and help them to understand their options, what to expect, and how to manage their care. And if you should meet a survivor, please do not hesitate to encourage them to reach out to our organization, or to reach out to us directly yourselves. We maintain an active Speaker’s Bureau and are always welcoming to new members. Lastly, please keep in mind that September is Gynecologic Advocacy Health month and January is Cervical Cancer Awareness Month – these represent excellent opportunities to be speaking and educating those around you, both patients as well as professional peers.

Following my diagnosis and treatment, it became clear to me that I needed to become a mobilizer – to be my sister’s keeper. Please join me in raising the profile of cervical cancer so that more women will understand the importance of screening and early detection. Our legacy will be the lives that we save.

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## Nurses, Be Counted!

You may know that the Nurses on Boards Coalition is in the midst of its annual campaign to register nurses’ board service. If you serve on a board, and haven’t already registered, please visit the [Nurses on Boards Coalition website](#), and be counted.

The mission of the Nurses on Boards Coalition is to improve the health of communities and the nation through the service of at least 10,000 nurses on boards by 2020.

Please also share with other nurses in your network, and on social media. Suggested tweets are below:

I’ve reported my board service with @NursesonBoards. Have you? [www.nursesonboardscoalition.org/](http://www.nursesonboardscoalition.org/) #10kNurses #RNBeCounted

Help @NursesonBoards reach its goal of getting #10kNurses on boards by 2020. [www.nursesonboardscoalition.org/](http://www.nursesonboardscoalition.org/) #RNBeCounted

Learn more about @NursesonBoards goal of getting #10kNurses on boards by 2020 by visiting: [www.nursesonboardscoalition.org/](http://www.nursesonboardscoalition.org/) #RNBeCounted



# What's The Helix An Introduction to Genetics and Genomics Resources



**Dr. Yolanda Powell-Young** is a Professor of nursing. She is the architect for the "What's the Helix" features, joint founder of the NBNA ProGENE Institute, and Editor-in-Chief of the NBNANews.

Yolanda M. Powell-Young, PhD, MSN, PCNS-BC, CPN

It is imperative that as advances in genetic and genomic medicine continue to unfold first-line providers remain up-to-date with current resources. This document is intended to provide a brief reference list of useful resources. All of the resources listed are accessible to the public and free of charge.

## ADVOCACY, COUNSELING & SUPPORT

### A. National Human Genome Research Institute

Information available on the Web about genomics, health and patient support organizations and resources.

<https://www.genome.gov/11510370/genetic-counseling-support-and-advocacy-groups-online/>

### B. National Newborn Screening & Global Support Resource

Provides information and related resources to benefit national and international newborn screening stakeholders

<http://genes-r-us.uthscsa.edu/resources/consumer/support.htm>

### C. Genetics Home Reference

A comprehensive list of patient support and advocacy groups

<https://ghr.nlm.nih.gov/about/support-advocacy-groups>

### D. Genetic Alliance Advocacy

Resources related to individual, family, community and organization advocacy

<http://www.geneticalliance.org/advocacy>

## CLASSROOM RESOURCES

### A. Bookshelf

Bookshelf provides free online access to books and documents in life science and healthcare. Search, read, and discover.

<https://www.ncbi.nlm.nih.gov/books/>

### B. Essential Nursing Competencies and Curricula Guidelines for Genetics and Genomics

Provides information on frequently asked question regarding the nursing essential competencies and curricula guidelines. A copy of the competencies and guidelines in .pdf format is available for download.

<https://www.genome.gov/17517146/essential-nursing-competencies-and-curricula-guidelines-faq/>

### C. Genetics/Genomics Competency Center (G2C2)

Provide high quality educational resources for group instruction or self-directed learning in genetics/genomics by health care educators and practitioners. G2C2 solicits, reviews and organizes resources through an interdisciplinary collaborative exchange.

<https://genomicseducation.net/>

### D. Teach Genetics

Resources and information aimed at helping educators bring genetics, bioscience and health alive in the classroom.

<https://teach.genetics.utah.edu/>

### E. Deciphering the Genetic Code

A web exhibit devoted to the work of Marshall Nirenberg and his colleagues at the National Institutes of Health. Their careful work, conducted in the 1960s, paved the way for interpreting the sequences of the entire human genome.

<https://history.nih.gov/exhibits/nirenberg/>

### F. Understanding the Human Genome Project

A web-based resource outlining the major history and developments of genomics.

<https://www.genome.gov/25019879/online-education-kit-understanding-the-human-genome-project/>

## GENERAL INFORMATION

### A. Genetics Home Reference

Consumer-friendly information about human genetics from the U.S. National Library of Medicine.  
<https://ghr.nlm.nih.gov/>

### B. Your Genome

From simply understanding what a genome is to exploring individual and population health issues. This website is produced by scientists at the Wellcome Genome Campus. The campus hosted the UK's contributions to the Human Genome Project and is home to leading international scientists in the field of genomics from the Wellcome Trust Sanger Institute and EMBL European Bioinformatics Institute.  
<https://www.yourgenome.org/>

### C. The New Genetics

A science education booklet explains the role of genes in health and disease, the basics of DNA and its molecular cousin RNA, and new directions in genetic research.  
<https://publications.nigms.nih.gov/thenewgenetics/>

## GENETIC TESTING

### A. Baby's First Test

Houses the nation's newborn screening clearinghouse. The clearinghouse provides current educational and family support and services information, materials, and resources about newborn screening at the local, state, and national levels and serves as the Clearinghouse for newborn screening information.  
<https://www.babysfirsttest.org/>

### B. MedlinePlus: Genetic Testing

The National Institutes of Health's Web site for patients and their families and friends. Produced by the National Library of Medicine, MedlinePlus is the world's largest medical library.  
<https://medlineplus.gov/genetictesting.html>

### C. Genetic Testing Registry

The Genetic Testing Registry (GTR®) provides a central location for voluntary submission of genetic test information. The goal of the GTR is to advance the public health and research into the genetic basis of health and disease.  
<https://www.ncbi.nlm.nih.gov/gtr/>

## RESEARCH PARTICIPATION

### A. Genetic and Rare Disease Information Center

Provides comprehensive information on genetic clinical research studies. Topics are comprehensive and include finding a disease specialist, current clinical trials and financial assistance.  
<https://rarediseases.info.nih.gov/guides/pages/119/how-to-get-involved-in-research>

### B. NIH Clinical Trials and You

The NIH Clinical Trials and You website is a resource for people who want to learn more about clinical trials.  
<https://www.nih.gov/health-information/nih-clinical-research-trials-you/basics>

### C. All of Us

The All of Us Research Program is a historic effort to gather data from one million or more people living in the United States to accelerate research and improve health.  
<https://allofus.nih.gov/>



# The Economics of Healthcare and Breastfeeding

Cynethia Bethel-Jaiteh, DNP, APRN, CPNP, CLC

*The purpose of this paper is to examine the economic value of breastfeeding. Breastfeeding is a cost-effective strategy for reducing direct and indirect health care costs. It has numerous health benefits for mothers and infants. Breastfeeding rates have improved over the last 25 years after several global and national initiatives; however, rates are still low particularly among African American mothers. Efforts to eliminate breastfeeding disparities and realize economic benefits require multi-layered interventions.*



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University of Louisville School of Nursing where she teaches child health nursing and informatics. She is a certified Pediatric Nurse Practitioner (CPNP) at Park Duvalle Community Health Center in West Louisville. She is passionate about reducing breastfeeding disparities, lactation counseling and increasing health equity.

Compare to other industrialized countries, the level of healthcare spending by the United States is considerably higher (Organisation for Economic Co-operation and Development, 2016). The health care expenditures in the United States (U.S.) totaled \$2.6 trillion, with a per person cost of \$9,523 in 2014 (Centers for Disease Control and Prevention [CDC], 2017). In 2015, it reached \$3.0 trillion, or \$9,990 per person – a 15% increase from the previous year (Centers for Medicare and Medicaid Services [CMS], 2015). The federal government financed 29% of the healthcare spending (CMS, 2015).

The source of the rising healthcare spending is multifactorial. Chronic diseases are the leading cause of death and disability in the United States and account for much of the spending. In 2008, 107 million Americans reported having chronic illnesses (Office of Disease Prevention and Health Promotion, 2017). Chronic diseases including heart disease, cancer, diabetes, asthma, chronic obstructive pulmonary disease, arthritis, and obesity are the top offenders. Obesity is an epidemic that accounts for two-thirds of U.S. adults and approximately one-third of children (The National Institute of Diabetes and Digestive and Kidney Diseases, 2017). An estimated annual medical spending for an obese person has been \$3,271, compared to the \$512 for an individual with an ideal body weight (Cawley and Meyerhoefer, 2012). The other stated causes for the rising cost of healthcare are the reward for health services, health innovations, third payer healthcare system, and the mergers of hospital systems (Paralkar, 2009; Appleby & Kaiser Health News, 2012).

Healthcare spending has a direct economic impact on families. Although health insurance coverage is a choice for some families to ease financial risk related to health care costs, many families experience financial burden regarding medical cost. Children being present in the family increases the risk that the family will experience problems with paying medical bills. Approximately 25% of households experienced economic burden due to health care and families with children are more likely to experience this burden at 36% (Cohen & Kirzinger, 2014).

## Support for Breastfeeding

Breastfeeding is the gold standard for infant feeding. Breastmilk has a combination of proteins, fats, vitamins, and carbohydrates that are best for a developing child. It has germ fighting properties and includes enzymes and hormones that make breast milk the perfect nutrition for optimal growth and development and has known health benefits. It is recommended that an infant is breastfed for at least the first year of life and exclusively for the first six months (American Academy of Pediatrics, 2012). The World Health Organization recommends breastfeeding for at least the first two years of life. However, the majority of infants' nutrition consist of formula.

According to Healthy People 2020, 74% of infants born in 2006 were ever breastfed and 79% in 2011 (Office of Disease Prevention and Health Promotion, 2015). There has been a slight increase in breastfeeding over the last 15 years. However, breastfeeding rates are below the target for Healthy People 2020 goals and breastfeeding rates have lagged mostly in African American mothers living in the Southeast. Over 15 years ago, the Surgeon General made a call to action to reduce racial and ethnic disparities in breastfeeding (U.S Department of Health and Human Services,

2011). However, initiation rates among African American are approximately 20% lower than their counterparts (CDC, 2015). In six states including Kentucky, the prevalence of initiation was less than 45% (Office of Disease Prevention and Health Promotion, 2015). Increasing breastfeeding initiation and continuation of breastfeeding rates is a challenge for healthcare providers.

The data suggest that most of the healthcare spending increase has been driven by the growth in the treatment of chronic and preventable diseases, powered by an overall increase in population risk factors. Healthcare dollars spent could be significantly reduced directly and indirectly if more infants were breastfed. Babies who are breastfed have a significant reduction in risks of lower respiratory tract diseases, asthma, gastroenteritis, otitis media, atopic dermatitis, obesity, diabetes, childhood leukemia, sudden infant death syndrome, and necrotizing enterocolitis (Duijts, Jaddoe, Hofman, & Moll, 2010; Ip et al., 2007; Metzger & McDade, 2010; Sullivan et al., 2010). Maternal benefits include lower risks for diabetes, hypertension, hyperlipidemia, postpartum depression, breast and ovarian cancer (Horta & Victora, 2013; Ip et al., 2007). Breastfeeding aids societies by reducing health-care costs (Bartick & Reinhold, 2010). Therefore, supporting breastfeeding is a public health goal of many countries including the United States.

## Suboptimal Breastfeeding

Suboptimal breastfeeding in the United States is associated with an additional 3,340 premature maternal and child deaths. Using a simulation model, Bartick et al. (2016) estimated the cost of suboptimal breastfeeding in 2014 U.S. dollars was \$3 billion for total medical costs, \$1.3 billion for non-medical expenses, and \$14.2 billion for costs associated with premature death. Illnesses that affect children had a total lifetime medical cost of \$604,573,116 and \$7,142,820,265 of premature death cost. There was a markedly larger impact of breastfeeding on women's health, as many excess deaths and direct health costs from suboptimal breastfeeding were related to women's health outcomes. Maternal total costs were significantly higher at more than \$2.4 billion. However, there was a lower premature death price tag of \$7 billion. If recommendations to breastfeed exclusively for six months were followed in the United States, it would save billions and prevent hundreds of infant deaths.

The reduced health care costs for breastfed infants translates into lower medical insurance claims. Babies who are not breastfed visit the physician more often, spend more days in the hospital, and require more prescriptions than breastfed infants. One cost analysis study found that for every 1,000 babies who were formula fed (never breastfed), there were 2,033 extra physician visits, 212 extra hospitalization days, and 609 additional prescriptions for ear, respiratory, and gastrointestinal infections (Ball & Wright, 1999). This additional cost did not include claims for numerous other childhood

illnesses and infections, or women's diseases which are reduced when a mother breastfeeds.

Given the disparity in breastfeeding among African American women, it is essential that breastfeeding is even more promoted and supported in this population. African Americans experience many health disparities and have a high prevalence of morbidity and mortality in childhood and adulthood (Centers for Disease Control and Prevention, 2011). In the African American population, newborns are more likely to die compared to white newborns. They are twice as likely to die from Sudden Infant Death Syndrome than white infants. African American children are twice as likely to have asthma and die from asthma. African American children are 73% more likely to be obese. African Americans have a disproportionate burden of death and disability from cardiovascular disease. African Americans have the highest rate of hypertension compared to all other ethnic groups. Cancer is the second leading cause of deaths for African Americans. Also, mortality from cancer is twice as high as their counterparts. Diabetes is a chronic illness that is prevalent in the population with an estimate 60% likely to be diabetic in their lifetime (Families USA, 2014). The literature implies these illnesses are reduced for breastfed infants and women who breastfeed. Breastfeeding could have a positive impact on the health of the African American population and provide huge cost savings to the healthcare system.

## Summary

Lifestyle change is the primary treatment modality for many of the illnesses that contribute to the high cost of healthcare in the United States. Breastfeeding results in a reduced risk of illness for children and mothers which would decrease morbidity and mortality as well as healthcare costs across the lifespan. Efforts to eliminate breastfeeding disparities and realize economic benefits require multi-layered interventions. Achieving our national goals for increasing the incidence and duration of breastfeeding will save money and is worth the return on investment. The cost savings to the healthcare system cannot be compared to lives saved from illnesses and premature deaths.

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# Asking Women about E-cigarette Use

Betty J. Braxter, PhD, CNM, RN, TTS



**Dr. Betty Braxter** is an Assistant Professor at the University of Pittsburgh. Her clinical focus is the care of women across the reproductive lifespan. Research interests target tobacco use including electronic cigarettes among childbearing age women, and maternal mortality. She is the co-chair of the NBNA Ad Hoc Committee on Women's Health.

**N**urses have assessed client's smoking status by asking "Do you smoke?" The question typically asks about traditional combustible cigarettes. Overwhelming evidence exists linking smoking traditional combustible cigarettes to cardiovascular and respiratory problems, and nicotine addiction among adults with African Americans disproportionately affected compared to other ethnic/racial counterparts.<sup>1,2</sup> The burden of smoking is most critical for women during the childbearing years with clear health disparities also noted. An African American pregnant smoker compared to other racial/ethnic counterparts is more likely to experience

- Preterm birth
- Chronic hypertensive disorders
- Placental complications<sup>3-5</sup>

Because of the well-known problems associated with smoking traditional combustible cigarettes, the rate of current smoking among adult women is 13.5%, an all-time low. Additionally, among pregnant African American women, the current smoking rate is at 6.8%, another all-time low.<sup>6-7</sup> The drop in the smoking rate is good news. However, a potential problem exists with the emergence of electronic cigarettes (e-cigarettes) given the product is marketed as a safe alternative to smoking traditional combustible cigarettes.

The e-cigarette is a non-tobacco product that delivers vaped nicotine, a flavorant, and other additives (e.g., propylene glycol). An LED light similar in appearance to the glow of a traditional combustible cigarette is at one end of the e-cigarette and at the other end is a mouthpiece. Between the two ends is a cartridge holding e-liquid or e-juice with varying amounts of nicotine, an atomizer that serves as a heating element, and a battery. The term 'vaping' is used because upon inhalation by a user, a sensor within the chamber/cartridge triggers air flow that initiates the process of heating nicotine and additives found in the cartridge to form vapor.<sup>8</sup>

Although e-cigarettes entered the market place in the United States within the past decade, the product has become quite popular among youth, young adults, and adult smokers trying to quit. The 2011-2015 findings from the National Youth Tobacco

Survey suggest that ever use and past 30-day use had significantly increased among youth.<sup>9</sup> Ever use approximately doubled from 2013 to 2014 among young adults (18-24 years) according to the findings of the National Adult Tobacco Survey. E-cigarette use was highest among Latino and White youth. More males than females have used e-cigarettes among young adults with the lowest rate reported by African Americans.<sup>10</sup> Recent former smokers (55.4%) were more likely to use e-cigarettes compared to long term former smoker (i.e., quit smoking more than a year) according to data from the 2014 National Health Survey.<sup>11</sup>

Advertisements on the Internet and social media outlets tout e-cigarette use as a safe alternative to smoking traditional combustible cigarettes even though long-term health effects are unknown. Potential adverse effects associated with e-cigarette use include nicotine exposure and exposure to additives found in the vapor. The exposure does appear lower among e-cigarettes users compared to those who continue to use traditional combustible cigarettes.<sup>12</sup> Propylene glycol, an additive in the electronic cigarette, however, has been linked to upper and lower respiratory symptoms and reduced lung function.<sup>13</sup> Vapors from electronic cigarettes have also been found to contain toxic and carcinogenic carbonyl compounds (e.g., nickel carbonate).<sup>14</sup>

Advertisements also make claims that e-cigarettes are smoking cessation aides even though limited, available evidence exist. A 2013 study reported that e-cigarettes were somewhat effective in helping smokers to quit.<sup>15</sup> Non-randomized studies have yielded mixed results on the efficacy of electronic cigarette to assist smokers to quit.<sup>16-19</sup> More randomized trials are needed.

With limited evidence on the health effect of e-cigarettes, public health leaders are concerned. The concerns expressed by public



health leaders related to e-cigarette use mirror those of health providers offering care to women specifically pregnant women. Public leaders and practitioners both worry that advertisements touting the safety of e-cigarettes have the potential to renormalize acceptance of smoking and dependence. The advertisements implying e-cigarettes as smoking cessation aides may be particularly appealing to pregnant smokers. Traditionally, more women try to quit smoking during pregnancy than any other time. A recent qualitative study found that pregnant and postpartum women viewed e-cigarettes as less harmful than traditional combustible cigarette and useful smoking cessation/cigarette reduction aides.<sup>20</sup> Two other studies with pregnant/postpartum women also found that pregnant women perceived e-cigarette use as less harmful than traditional combustible cigarettes. However, both studies reported that sample participants felt e-cigarettes were unsafe during pregnancy.<sup>21-22</sup>

Given the evidence presented on e-cigarette use, nurses querying women of childbearing age and those who are pregnant about e-cigarette use appears warranted. If the client's response to the question is "No", the nurse should congratulate the client on not using e-cigarettes. The nurse may add a follow up question- Do you live with someone who vapes? As previously noted, vapors emitted by e-cigarettes have been linked to respiratory problems. However, if the response to the e-cigarette use question is "Yes", the nurse needs to probe to determine the client's rationale for the use. If the client is using e-cigarette as a cessation aide, the nurse may share the effects of e-cigarette use as a smoking cessation aide have not been determined. Furthermore, the nurse should share that the potential exists that e-cigarette use may be harmful to the client and those exposed to e-cigarette vapor. The nurse may also utilize the 5 Major Steps to Treating Tobacco use commonly known as The "5 A's" if the client is ready to stop vaping:

- **Ask** about e-cigarette use
- **Advise** the client to quit
- **Assess** willingness to quit
- **Assist** by providing counseling and or referring for pharmacotherapy
- **Arrange** with the focus on follow-up contact<sup>23</sup>

Finally, the nurse needs to follow-up on the e-cigarette use at each nurse-client encounter.

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## Seeking Candidates for Chairperson with expertise in health and community systems

The University of Pittsburgh School of Nursing invites nominations and applications for the position of Chairperson, Department of Health and Community Systems. This full-time tenure-stream position should be a nurse scholar who will assume responsibility for the academic and administrative leadership of a department with faculty responsible for community health nursing, psychiatric nursing, geriatric nursing, nursing education, research, and informatics.

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# Maternal Mortality: A Call to Action

Betty J. Braxter, PhD, CNM, RN, TTS



**Dr. Betty Braxter** is an Assistant Professor at the University of Pittsburgh. Her clinical focus is the care of women across the reproductive lifespan. Research interests target tobacco use including electronic cigarettes among childbearing age women, and maternal mortality. She is the co-chair of the NBNA Ad Hoc Committee on Women's Health.

**A** maternal death is defined as the death of a woman during pregnancy or within forty-two days following the end of the pregnancy irrespective of duration.<sup>1</sup> A report from the World Health Organization (WHO) suggests that the United State (US) has the highest rate of maternal mortality compared to other industrialized countries. Although the US spends more on health care than other countries, the maternal mortality rate is even higher than less affluent countries (e.g., Libya, Turkey). The maternal mortality rate between 1990 and 2013 doubled from 12 to 28 maternal deaths/100,000.<sup>2</sup> A report from the CDC shows that each year about 700 women die from a pregnancy or delivery related complications. Based on the annual number of deaths, each day approximately 2 women die with African American women being the most vulnerable group. The maternal mortality among African American women is more than two or three times the rate compared to their Euro American and Latina counterparts. Most disturbing is data that suggest up to 60 percent of the death are preventable. Additionally, another 50,000 women experience complications (e.g., severe morbidity) linked to pregnancy and postpartum.<sup>3-5</sup>

The 'Lost Mother's' series presented by ProPublica and NPR provides a detailed overview on the lives of the women lost. ProPublica reporters Nina Martin, Adriana Gallardo and Annie Waldman with NPR correspondent Rene Montague have examined as of July 2017 the lives of 134 women through interviews with family members. The interviews spotlight the impact of the death on the women's families including the children left behind.<sup>6</sup> Additionally, the reporters assessed reasons behind the lives lost. Many of the women featured are African American. Ms. Sharon Irving's story is an exemplar of the women lost. Ms. Irving was a vibrant African American woman who served as Lieutenant Commander in the Corps of the U.S. Public Health Service. She was an epidemiologist at the CDC and her research examined the effect of inequality, trauma and violence on health. Her pregnancy was uncomplicated. Three weeks after the delivery of her daughter, Sharon collapsed and died due to complications linked to high blood pressure.

What factors contribute to the deaths experienced by women like Ms. Irving? As a highly college educated woman, the risk of

death should have been low as possible. However, data suggest that typical protective social and economic advantages do not eliminate or mitigate the risk of maternal mortality among African American women. Through the interviews with women who had experienced complications or 'near misses' one recurrent theme emerged - feeling of being devalued and disrespected. Different from the theme captured in the 'Lost Mother's' series, a Report from Nine Maternal Mortality Review Committees cite three common factors contributing to maternal mortality: patient/family factors (e.g., inadequate knowledge related to warning signs/delay in seeking care); provider factors (e.g., misdiagnosis and inadequate care); and systems factors (e.g., absence of coordination between providers).<sup>7</sup> A Health Resource & Service Administration (HRSA) Summit targeting maternal mortality held June 19 thru June 21, 2018 also listed the impact of institutionalized racism as a factor contributing to the deaths specifically deaths of African American women. Ms. Wanda Irving, the mother of Sharon Irving, also addressed maternal mortality disparities within the US at the summit.

The recommendations to turn the tide on maternal mortality in the U.S. proposed by the Report from the Nine Maternal Mortality Review Committees (MMRCs) include: 1.) implementation of a system that levels maternal care, 2.) improving prevention initiatives, 3.) enforcement and adoption of procedures targeting obstetric hemorrhage, and 4.) improving policies targeting patient management.<sup>6</sup>

Nurses, specifically, African American nurses are integral to turning the tide on maternal mortality. Nurses are known for sharing information with clients related to risks. African American nurses who interact with women of childbearing years during the duration of a pregnancy, during postpartum follow-up, and routine assessments (e.g., family planning assessment) should constantly repeat risk



factors associated with pregnancy, labor/delivery, and postpartum. In response to provider factors cited in the report from the Nine Maternal Review Committees, nurses must continue to advocate for their clients, and support clients to advocate for themselves. Nurses must share with clients that they do have options if their providers are dismissive or non-responsive to concerns. Because of the holistic framework that guides nursing practice, nurses can serve as navigators linking the varied members of the health care team (e.g., obstetricians, maternal fetal medicine specialists, physician assistants) in a seamless manner to provide coordinated health care. Finally, nurses must actively work with other members of the health care team and other stake holders to establish local, state, and or regional MMRCs and serve on the established MMRCs. MMRCs will provide opportunities for more in-depth assessment of the processes and factors leading to maternal deaths.

Finally, what can nursing organizations do? First, nursing organizations support establishment of Maternal Mortality Review Committees in each state by working at the national level with policy makers. Next, organizations can generate a position paper or a resolution in support of establishment of MMRCs. Finally, during conference held by the nursing organization the topic of maternal mortality could be highlighted.

It is time for nurses and nursing organizations to act to prevent or reduce the number of women who die from a pregnancy or postpartum complication. For the women who have lost their lives and those at risk, we as African American nurses must act now.

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# Missed Opportunities for Genetic Testing: The Importance of Family History



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**Deidra A. Brown-Brinson, RN, MSN, ARNP-BC**

**O**n May 24, 2018, I had a robotic laparoscopic total hysterectomy. I had pelvic pain and a slightly thickened uterus. No, this is not a story about gynecological pathology but about the importance of family history and cancer risk. It's a story of overcoming fear and hopefully self-empowerment, cancer prevention and cancer risk reduction.

Over the last several years I began to inquire about my family medical history a little closer. I first began to notice the number of my elders who had died with late onset Alzheimer's and then more common problems like heart disease and diabetes. I observed every detail I could learn. What stood out the most was the number of maternal relatives who had been diagnosed with cancer. They included a cousin with breast cancer at 42, another cousin in her 40s with pancreatic cancer, male cousin with brain cancer (originally I was told this was an abscess) in his 40s, two cousins with uterine cancer in their 40s, two uncles with prostate cancer at 60 and 62, aunt who had breast cancer in her late 50s. Two years ago while standing in the church during the funeral of another cousin who had suddenly died from a gastrointestinal problem that we assumed was complications from diverticulitis, another cousin who was 60 whispered in my ear and said she had just been diagnosed with a very aggressive renal cancer. Before I could talk to her about genetic testing, she died two months later.

I approached one of my cousins a few months ago who is a 78-year-old retired teacher with no children and had been diagnosed with early uterine cancer to see if she was interested in genetic testing. She wasn't interested and didn't seem to understand the significance of the family history. Most of those with cancer were her sisters and brother. She was the oldest in a line of 15 brothers and sisters, 5 of which had died. Her mother who was my maternal aunt never had cancer and just died at age 97 in 1/18. There were no paternal cancer histories. She owned a 280-acre farm and I

initially thought that the cancers in the family could have been due to pesticides but I learned that the farm was organic before the term became popular. Almost all of the other women in my family had early prophylactic hysterectomies for various reasons. I wondered if this relatively common surgery among African American women (fibroids and atypical cells) was actually saving them from being diagnosed with cancer later in life. The only other survivor who had an early cancer and still living is a 91-year-old maternal, but she has early dementia. I am trying to decide how to convince her daughters to allow her to have genetic testing to help them.

So often, the questions on medical forms are surprisingly limited and only ask about 1st degree relatives concerning medical history. Missed opportunities for a thorough history are common when you do not consider the next generation or 2nd degree relatives. A family with all males won't have female cancers to list. Vague answers like "some kind of stomach problem, stomach was full of fluid" could have been an ovarian cancer. The scar across a man's chest could have been a mastectomy from breast cancer that no one ever talked about. How many men would rather go to their graves than let anyone know about prostate cancer and definitely wouldn't have treatment if it meant the possibility of impotency. Think about the many people who died with cancer without ever being diagnosed or worse, misdiagnosed in the African American community.

Last fall, Colors Genomics, an on-line cancer genetic company, offered a 30+ multi-gene panel test for the sale price of \$99.00 until October 2017. I decided to check the technology out and test my curiosity. My mother and grandmother and none of my siblings ever had cancer. My father developed colon cancer at 75 and I don't know anything about his family medical history. A month later I finally looked at the email and discovered that I had a BRCA 2, CHEK2 and APC gene variant of unknown significance. The BRCA 2 gene was predicted to be deleterious. BRCA 2 gene mutations

are associated with a significant elevated risk of breast, ovarian, pancreatic, melanoma and prostate cancers. CHEK2 mutations are associated with breast, uterine, thyroid and renal cancers. APC genes are considered low penetrance genes but are associated with colon cancers. I have been getting colonoscopies since I was 30. My college roommate died at 32 from colon cancer. I've never had a polyp.

At first, I was in shock when I saw the test results and feared that cancer was already present someone in my body. Fortunately, we have a genetic counselor in my office. She calmed me down by saying..." Deidra, you were born with these genes, nothing has changed except for new revelation. Calm down and let's plan out a strategy". Within an hour I turned that fear into action and called my gynecologist to schedule an appointment. I wanted her to order a transvaginal ultrasound to check out my uterus and ovaries and then I wanted an MRI breast. My mammogram was stable 6 months prior. I already knew what the screening surveillance guidelines were for my listed gene VUS. I knew one needed good insurance and a diagnosis code that the insurance company would authorize. Genetic susceptibility of disease (specify) and family history with an associated symptom would do it. I also had an MRI abdomen to check out my pancreas. My GYN called me with the T/V ultrasound results and advised me to have a uterine biopsy. I told her to just perform a hysterectomy because it would be the 2nd biopsy in 5yrs. She is a GYN/ONC and frequently perform hysterectomies for our BRCA positive patients. She completely understood how I felt. I decided to have another genetic test with a well know established company often used by oncology medical centers that my health insurance would pay for with my family history. I got those results back even quicker and instead of the 3 original genes listed, there was another 4th gene variant detected, PTEN. PTEN mutations are associated with breast, ovarian, gastric, colorectal, pancreatic, melanomas, prostate, endometrial and others. Variants of unknown significance are common although we have been testing patients for the last 20yrs and I've never seen anyone with four VUS.

Genetics is a rapidly advancing field and we have to keep up with the changes and challenges. Testing has improved over the years

with the expansion of gene panels called next generation testing. Being limited to only BRCA 1&2 allowed us to sometimes miss the chance to identify a mutation. Those earlier tested patients who had negative test must be retested.

A substantial number of African Americans do not receive any form of genetic counseling. This highlight an unmet need. Genetic counselors are needed and are very important. Knowing an individual's risk of cancer can give someone the chance to prevent, stop or improve cancer with targeted therapy. Systems to streamline referrals to genetic counselors are needed. Detecting cancer early can improve the odds of survival, especially with pancreatic cancer.

On-line testing companies and at home test kits will make it possible for ANYONE to have a genetic test without doctors or insurance regardless of how we feel about it. The cost of testing will no longer be a deterrent for many. Quality of the individual test will be one of the greatest challenges.

African-Americans and Hispanics are 4-5 times less likely than western European descendants to undergo testing. An affordable direct-to-consumer test for underserved populations with financial medical assistance for surveillance, preventive intervention when test is positive will be a major game changer in assuring everyone an equal chance at life saving influences.

Back to beginning of my story. Yes, I had a total hysterectomy to prevent uterine and ovarian cancer. It was the quickest and easiest surgery to give me some sense of control. My next plan is to decide when to have bilateral prophylactic mastectomies. I will have q 6 month alternating mammograms/Us -MRI breast until in the meantime. MRI abdomen will alternate with EUS every other year. Colonoscopy every 3-5yrs depending on polyp load if present. Labs will include tumor markers : CEA, CA 27-29, CA 125 and CA 19-0, I am planning to have a baseline thyroid u/s and eliminate as much ionizing radiation as possible. A healthy diet and exercise and avoidance of estrogen products will help round out my plan for prevention. Last but not least. I will pray daily for strength, grace and favor from GOD and avoid stress as much as possible. I will maintain a job with great benefits so that I can hopefully afford it all.



# Dimensions of Race in Predicting Physical Activity in African American Women

Elaine Hardy, PhD, RN



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of Illinois at Chicago, College of Nursing. Dr. Elaine Hardy received her PhD in Nursing with a concentration in Women's Health at University of Illinois at Chicago in 2011. Dr. Hardy conducts research focused on disparities in health experienced by midlife African American women and physical activity, as well as improving workforce diversity in healthcare and higher education.

**T**he annual number of deaths in the US due to physical inactivity has been estimated at more than 250,000<sup>1</sup>, with projected costs estimated at \$190.2 billion annually<sup>2</sup>. Sufficient physical activity for adults has been defined as the accumulation of 150 minutes of moderate-intensity physical activity per week, or 75 minutes of vigorous-intensity physical activity per week<sup>3,4,5</sup>; preventing and managing numerous obesity related diseases, and improving general well-being<sup>6,4</sup>. Compared to white women, African American women have been disproportionately affected by chronic illnesses due to a lack of being physically active. Few studies have been completed with African American women and physical activity,<sup>7,8,9,10</sup> leaving a gap in what is known. Therefore, identifying facilitators of physical activity in midlife African American women is an important public health goal.

Most of what is known about physical activity in African American women is based on cross-sectional studies with predominantly White middle-class women,<sup>8,11,12,13,14</sup> with researchers viewing African Americans as a single homogeneous group. However, several studies have shown that distinctions in Black culture (e.g. sense of connection to Africa, preference for traditional Black culture, importance of race to one's sense of self) are differentially associated with a variety of health behaviors.<sup>15,16,17,18</sup> Identities are formed through experience with one's social environment, and racial identities contain information about the self in terms of what it means to be a member of a particular racial/ethnic group (e.g., Black, African American).<sup>19,20,21,22</sup> One study showed that women who identified as "Black" (rather than "African American") were opposed to engaging in behaviors that were consistent with being "White."<sup>17</sup> Five core racial identity dimensions were identified: 1) Black American (proud of her racial heritage; believes in educating self and family about African American culture and history); 2) Multicultural (appreciates the many ethnic groups and

cultures that exist in the world); 3) Bicultural (positive affirmation of race; perceives the world in a Black/White duality); 4) Afrocentric (strong connection to Africa); and 5) Racial Salience (importance of race to one's self-definition).<sup>15</sup> Various studies have identified environmental (access to facilities, neighborhood safety) and cultural factors (social support) as promoting physical activity in African American women.<sup>23,24,25,26,8,10</sup>

The purpose of this cross-sectional study is to determine whether dimensions of racial identity impact physical activity in midlife African American women over and above the effects of social support, neighborhood factors, and health variables (BMI and self-rated health). A convenience sample of 252 self-identified Black/African American women aged 40-65, residing in a predominantly Black community in Indiana, participated and completed the physical activity measures, racial identity measures, self-efficacy, social support, neighborhood factors, and health variables. Self-identification of race was divided, with 46% as Black, 46% as African American, and the remaining 8% using other terms (i.e., child of God, etc.). Although 61% of the participants self-reported engaging in sufficient levels of physical activity, 85% of the women were identified as overweight or obese based on BMI categories (underweight, <18.5kg/m<sup>2</sup>; overweight 25-29.9 kg/m<sup>2</sup>; obesity >30 kg/m<sup>2</sup>), and over 50% of the women reported 1-3 chronic illnesses. Dimensions of racial identity, controlling for social support for physical activity, BMI, self-rated health and neighborhood factors, was used to predict sufficient physical activity.

In our sample of 252 self-identified midlife Black/African American women, we found that two dimensions of racial identity influenced physical activity. First, having a strong identification with the multicultural dimension predicted higher levels of physical

activity. This was identified in a study with African American men and women with high Multicultural scores, that correlated with a higher level of intrinsic motivation to try new and different fruits and vegetables.<sup>15,21,22</sup> Second, having a strong identification with the Black American dimension predicted lower levels of physical activity. This is consistent with the findings of studies that show African Americans who strongly identify with traditional Black culture and are less likely to engage in positive health behaviors and more likely to have a strong pro-Black orientation for engaging in behaviors that have more negative health consequences.<sup>15,21,22</sup> The hierarchical multiple regression showed that dimensions of race explained 26.3%, of the total variance of physical activity, and was statistically significant.

The findings from this cross-sectional study provide foundational data necessary for future longitudinal work to examine the multidimensional role of racial identity on physical activity in midlife African American women. Ultimately, this work will lead to the development of a culturally specific, individually tailored intervention focusing on the dimensions of race to promote physical activity in midlife African American women as a way of decreasing the health disparities associated with physical inactivity.

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# The State of Sexual Health Among Adolescent and Young Adult Black Women



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**F**or many years, Black adolescent girls and young adult Black women, ages 15 to 24 years, have had the highest rate of unintentional pregnancy and sexually transmitted diseases (STDs) in the United States. Current rates of unintentional pregnancy are 45 per 1,000 women ages 15 to 44 years, 41 per 1,000 adolescents ages 15 to 19, and 81 per 1,000 young adults ages 20 to 24 years (Finer & Zolna, 2016). These numbers represent 45% of pregnancies among all women, 70% of pregnancies among adolescent girls, and 59% of pregnancies among young adult women. Furthermore, the unintentional pregnancy rate among Black girls and women is 79 per 1,000. This represents to 64% of all pregnancies experienced by this population (Finer & Zolna, 2016). Additionally, the current rates of chlamydia, gonorrhea, and syphilis among Black adolescent girls and young adult Black women are 1.3 to 39.9 times higher than any other age or racial group of women in the United States (Centers for Disease Control and Prevention, 2017).

The increased use of contraception, long-acting reversible contraception (LARC) in particular, has aided in the historic decrease of unintentional pregnancy among adolescent girls and young adult women. However, while non-barrier contraception works to effectively prevent unintentional pregnancy, it does not prevent STD transmission. So, all sexually active adolescents and young adults should be encouraged to use dual contraception—the simultaneous use of non-barrier contraception for pregnancy prevention and condoms for STD prevention. Unfortunately, the use of dual contraception is lower among LARC users than among

user of other forms of contraception (Pazol, Kramer, & Hogue, 2010) and lower among Black women than among women of other races (Daniels, Daugherty, Jones, & Mosher, 2015).

The causes of high STD rates among young adult Black women have historically included the location of primary residence, healthcare access and utilization, and socioeconomic status of sexually active women (Hogben & Leichter, 2008); high homicide & incarceration rates leading to a smaller pool of available male sexual partners (Chesson, Kent, Owusu-Edusei, Leichter, & Aral, 2012; Swartzendruber, Brown, Sales, Murray, & DiClemente, 2012; Thomas, 2006; Thomas, Torrone, & Browning, 2010; Valentine, 2008); high rates of concurrent relationships among men (Epstein & Morris, 2011; Waldrop-Valverde et al., 2013); incomplete reporting by health care providers (Beltran, Harrison, Hall, & Dean, 2011; Centers for Disease Control and Prevention, 2015); underreporting by health care providers (Tilson et al., 2004); and data collection bias among health care providers (Carter, Kraft, Hatfield-Timajchy, Hock-Long, & Hogben, 2011; Chow, de Bocanegra, Hulett, Park, & Darney, 2012; Farr, Kraft, Warner, Anderson, & Jamieson, 2009).

When considering behavioral interventions that may help to decrease high-risk sexual behavior, it is suggested that interventions be gender-specific and culturally-appropriate (Alleyne & Gaston, 2010; Centers for Disease Control and Prevention, 2014; Melnyk & Morrison-Beedy, 2012). Three interventions listed in the Center for Disease Control and Prevention's *Compendium of Evidence-based HIV Behavioral Interventions* (2018) have shown success in

increasing condom use among Black adolescent girls and young adult Black women. These interventions were created specifically for this population and may be implemented by health care professionals and health educators in community and outpatient settings. Each intervention is rated as a *good-evidence* or *best-evidence* risk reduction intervention based on its study design, follow-up period, retention rate, and efficacy.

The *Compendium* interventions for Black adolescent girls and young adult Black women include Healthy Love (Diallo et al., 2010), a group-level, multi-session intervention with a *good* rating; HORIZONS (DiClemente et al., 2009), a group-level, multi-session intervention with a *best* rating; and Sister-to-Sister, an individual-level or group-level, multi-session or single-session intervention with a *best* rating (Jemmott, Jemmott, & O'Leary, 2007). Each intervention is implemented by trained female staff who utilize discussion, videos, and demonstrations as teaching tools.

We have come a long way, as it relates to sexual health among Black adolescent girls and young adult Black women, yet we have so much further to go. Nurses must encourage adolescents and young adults of childbearing age to be particularly careful not to prioritize the prevention of unintentional pregnancy over that of STD transmission. Both aspects of sexual health are equally important. The use of monogamous relationships and dual contraception should be emphasized when seeing sexually active youth and young adults in in-patient and out-patient settings. Otherwise, it will not be a question of *if* unintentional pregnancy and STDs will occur, but rather a question of *when*.

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# The First National Health Agenda for Black Women

Tammy Boyd  
Black Women's Health Imperative



Tammy Boyd

Over the past year, there has been a resurgence of Black women voters who have begun to demonstrate their political power. And that surge is expected to continue through the 2018 and 2020 national and state elections. With 603 Black women running for elected office in 2018 the opportunity to leverage their voices could not be timelier. At the federal level alone there are a record 97 Black women running for Congress. This growing momentum has inspired the development and release of the Black Women's Health Imperative's (BWHI) *National Health Policy Agenda, (Policy Agenda)*—which can serve as a roadmap to inform lawmakers and candidates on critical issues that impact the health of Black women and girls. But it can also serve as an accountability tool to help voters access health issues that matters most to Black women during a time when many of our public policies and programs are under attack.

While the Policy Agenda is a new tool, our efforts to advocate for the health of Black women is not. BWHI, previously known as the *Black Women's Health Project*, has since 1983, worked tirelessly as the leading national organization dedicated solely to improving the health and wellness of our nation's 21 million Black women and girls – physically, emotionally and financially. BWHI advocates for federal, state and local policies that ensure Black women have access to quality health care. Our policy and advocacy team works to elevate and develop national and state policies to hold elected officials accountable for addressing issues most critical to Black women's health, especially regarding: breast and cervical cancers, diabetes, HIV/AIDS, intimate partner violence and sexual assault, maternal health and reproductive health.

The Policy Agenda was created to help inform, and partner with, policymakers and other stakeholders on the critical health policy issues that impact and improve the well-being of Black women. It also provides an opportunity for Black women voters to engage in substantive policy discussions, especially around key health policy

issues impacting Black women and girls, and to seek meaningful solutions.

As the first national health policy brief for Black women, the Policy Agenda provides guidance and recommendations on legislation that supports:

1. Access to quality, affordable, and innovative approaches to provide comprehensive health care for Black women and girls;
2. Equitable and adequate response for public health emergencies;
3. Sufficient diversity in clinical research;
4. Sustained financial support for Historically Black Colleges and Universities.

The Agenda can be adapted and expanded to include state-level policy especially for community organizations looking to engage and mobilize their base around specific policies that impact Black women and girls' health. BWHI is excited to release its inaugural legislative agenda to build upon Black women's political influence, ballot power, and commitment to civic participation for the upcoming elections.

The Agenda also serves as a pathway to developing policies that have meaningful impact, for key decision-makers who are being tasked with taking action on behalf of their constituencies. Our ultimate goal in developing the policy agenda is to ensure that Black women's health outcomes, from birth to death, are not an afterthought in the minds of our nation's leaders.

Over the years, the federal government has decreased investments in the care of women of color, in general, and for Black women, specifically. The drop in both policy and funding focus has accelerated in the past 18 months. Reductions, in turn, affect health

care coverage and reimbursement, public health and emergency response management, clinical research, and even the sustainability of Historically Black Colleges and Universities (HBCUs). The Affordable Care Act (ACA) has been consistently undermined and targeted for repeal without a sufficient replacement under the current Administration.

Despite notable improvements in health care through the ACA, including a significant decrease in the number of uninsured and underinsured Americans and an increase in access to preventive screening services, certain legislators continue to work toward its repeal, and this Administration has sought to undermine the program through regulation. Black women will disproportionately suffer from new insurance rules that allow insurance plans to offer minimal coverage and allow insurers to charge the beneficiary more due to age and gender. These new insurance programs are also intended to draw healthy and younger individuals away from the national health exchange increasing the costs for those who have benefited from ACA programs. State and federal legislators have sought to weaken the protections for pre-existing conditions and essential health benefits providing a very stark reminder of what is at stake.

Attacks on Medicaid also have a negative impact on Black women's health. As a lifesaving provider of health care for low-income individuals and families, Medicaid is also targeted for spending cuts, new work requirements, and coverage changes like the recent decision by Kentucky's Governor to drop dental and vision care. For the children, moms, disabled and elderly who depend on Medicaid for their care these changes beg the question: "who these public servants are serving with their legislative and regulatory efforts to dismantle Medicaid?"

BWHI seeks to empower our supporters in their advocacy on both the local and national levels through the dissemination and execution of the Agenda. Join us as we continue to leverage Black women's voices and leadership to push this agenda forward. Black women's health, the health of our families, and the health of the nation as a whole depends on it.

## Resources

1. <https://www.bwhi.org/2018/06/08/national-health-policy-agenda/>

## Social Media

1. Remember, when #BlackWomenVote, our health issues take top priority! Check out BWHI's 2018 National Health Policy Agenda Executive Summary here! #theAgenda <https://www.bwhi.org/2018/06/08/national-health-policy-agenda/>
2. The National Health Agenda for Black Women (#theAgenda) was created to make sure Black women have a #SeatAtTheTable to inform and partner with policymakers on the critical health policy issues that impact and improve the wellbeing of #Blackwomen! #BlackWomenVote
3. Do you care about #Blackwomenshealth? What about the environment? Supporting more diverse research? How about maintaining HBCUs? Check out BWHI's 2018 National Health Policy Agenda Executive Summary here! #theAgenda <https://www.bwhi.org/2018/06/08/national-health-policy-agenda/>

# *Uterine Fibroids: Benign Condition with a Significant Burden for Women*

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**U**terine fibroids (UF), also called leiomyomas, are benign tumors and are the most frequent pelvic tumors affecting women. Uterine fibroids are very common, and most women will have a friend or relative impacted by them. Most women who have UF are asymptomatic, but for those with symptomatic UF the most common concerns are heavy menstrual bleeding and pelvic pressure (American College of Obstetricians and Gynecologist [ACOG], 2008; Kjerulff, Langenberg, Seidman, Stolley, & Guzinski, 1996). African American (AA) women are three times more likely to develop UF when compared to other races (Stewart, Nicholson, Bradley, & Borah, 2013). It is estimated that >80 percent of AA women will have UF by the age of 50 (ACOG, 2008; Baird, Dunson, Hill, Cousins, & Schectman, 2003). This article will review UF prevalence, symptoms, causes, and their impact on quality of life for AA women.

Uterine fibroids are composed of smooth muscle cells, fibroblast and extracellular matrix (Stewart et al., 2016). They develop anytime between menarche and menopause and may cause significant side effects that often substantially impact quality of life (Stewart et al., 2016). As women become menopausal UF symptoms resolve due to the reduced levels of reproductive hormones. African American women are disproportionately affected by uterine fibroids. They develop UF earlier, are more symptomatic, and have hysterectomies earlier than women of other races and ethnicities (Baird et al., 2003; Kjerulff et al., 1996). Additionally, research has demonstrated decelerated UF growth in women as they approach menopause, but this does not occur as frequently in AA women (Peddada et al., 2008). The exact mechanism of these racial disparities is poorly understood but researchers believe it could be

linked to genetics, as well as, influenced by other environmental risk factors (Flake, Andersen, & Dixon., 2003).

Uterine fibroids are a multifactorial disease and researchers believe that their development is influenced by genetic factors and environmental causes. UF growth and development is dependent on the hormones estrogen and progesterone. Recent evidence suggests that rising estrogen levels increase progesterone receptors in the uterine fibroid tissue. Progesterone then binds to this increased receptor content and is believed to directly influence increased growth and maintain volume in UF (Ishikawa et al., 2010). Some women may have specific genes that predispose them to UF. These genetic mutations, when combined with lifestyle and reproductive factors, can influence growth and development of UF (Al-Hendy & Salama, 2006; Amant et al., 2004). Specifically, AA women exhibit a differential expression of genes involved in estrogen synthesis and metabolism, estrogen receptor levels as well as altered retinoic acid receptors, all of which may promote UF development (Catherino & Malik, 2007; Tsibris et al., 1999; Wang et al., 2007). Evidence also supports a role for vitamin D deficiency, which may lead to increased risk for UF in AA women (Nesby-O'Dell, 2002; Sabry, Halder, Ait Allah, Roshdy, Rajaratnam, & Al-Hendy, 2013). Continued research and better understanding of these mechanisms will provide insight into the genetic and environmental causes of UF formation that increase risk and burden for the AA population.

Clinical symptoms can vary depending on size, number and location of UF which can range in diameter from <1cm to the size of a grapefruit or larger. These may include heavy bleeding, anemia, pelvic pain, urinary frequency, constipation, and infertility. It is estimated that UF occur in 25-50% of childbearing aged women, with one quarter of women requiring treatment due to clinical symptoms (Laughlin-Tommaso, 2016). In a qualitative analysis of AA women, participants often experienced symptoms for years before seeking treatment due to limited awareness of UF, avoidance-based coping mechanisms, and normalization of their heavy monthly menses (Ghant, Senogoba, Vogelzang, Lawson, & Marsh, 2016). Furthermore, there are cultural barriers in the AA community about menstruation such as, regarding their menses as a needed anatomical cleansing process and limited communication between women due to a 'culture of silence' that surrounds the process of menstruation. Despite the severity of their symptoms and the impact on quality of life, women often still do not seek care until it becomes an emergency. The study also noted that while 40% of the participants described their blood loss as 'heavy' or 'very heavy' only one-third of them reported seeking care for their symptoms (Marsh et al., 2014).





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Uterine fibroids are a leading cause of morbidity in premenopausal women (Stewart et al., 2016). This is highlighted by hysterectomy being the most common treatment option for UF. In the United States, the lifetime prevalence of hysterectomy is 45%, with one-third to one-half of all hysterectomies related to UF (Stewart et al., 2016). For example, the rates of hospitalization and hysterectomy due to UF were 3.5 and 2.4 times, respectively, higher in AA compared to white women (Wechter, Stewart, Myers, Kho, & Wu, 2011). Women unable to control their symptoms, such as heavy menstrual bleeding and pain, often miss work and social events. The impact symptomatic UF have on their daily lives can also lead to emotional distress and relationship issues (Ghant et al., 2015).

Uterine fibroids have a significant prevalence in the AA community and the symptoms can have a profound negative impact on their lives. Women often are afraid to seek care for their symptoms when they fear they may have cancer or need a hysterectomy (Borah, Nicholson, Bradley, & Stewart, 2013; Marsh et al, 2014). Multiple options for treatment of symptomatic uterine fibroids are currently available that include both medical (oral contraceptives, hormonal IUDs, NSAIDs, antifibrinolytics, GnRH agonists and surgical (myomectomy, uterine artery embolization, endometrial ablation, MRI guided focused ultrasound surgery and hysterectomy) (ACOG, 2008; Stewart et al, 2016). Despite their increased risk in developing UF, more education is needed within the AA community to improve utilization of the healthcare system for symptomatic UF to positively impact quality of life for patients living with this condition.

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# Using Digital Health, Nursing Informatics, and Research to Improve Women's Health

CDR Derrick L. Wyatt,  
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CDR Derrick L. Wyatt is a Commissioned Officer in the United States Public Health Service Commissioned Corps and serves

as the Health Information Technology Grants Research Manager in the Center for Evidence and Practice Improvement (CEPI) within the Division of Health Information Technology (DHIT) at the Agency for Healthcare Research and Quality (AHRQ). In his role, he coordinates and oversees extramural research activities that build evidence on how health IT systems, tools, and practices support healthcare.

The U.S. National Library of Medicine defines women's health as "a branch of medicine that focuses on the treatment and diagnosis of diseases and conditions that affect a woman's physical and emotional well being."

Although there are public health programs, research agendas, and strategies to improve women's health, disparities in healthcare for women continue. Some factors to consider when evaluating women's health are:

- Women's health is unique due to biological and gender differences;
- Women face socio-cultural barriers to quality healthcare; and
- Women are disadvantaged and face many obstacles to receiving the best level of care.

## What resources and capabilities can be used to improve women's health?

A possible solution:

Using digital health, nursing informatics, and evidenced-based research to improve women's health.

Harnessing the capabilities of digital health, nursing informatics, and evidence-based research is an approach that has the potential to improve services, knowledge, communication, outcomes, quality, and efficiency of healthcare for women.

## What do you know about digital health?

Digital health is "the convergence of digital and genomic revolutions with health, healthcare, living, and society" as defined by author and leading technologist Paul Sonnier.

Digital health includes multiple technologies to improve access, healthcare, and health outcomes:

- Mobile technology
- Wearable devices
- Connected healthcare solutions (sensors, remote monitors)
- Health information technology (IT)
- Social networks
- Internet applications
- Telehealth/telemedicine

Digital health can improve women's healthcare by empowering women and their caregivers to better track, manage, and understand their health. This approach creates a shift from the current reactive model of treatment to a predict-and-prevent model, by addressing root causes, advocating behavioral and lifestyle changes, and promoting preventive care services.

You may be surprised to know that many women are already participating in digital health by using wearable technology and



apps to track and share health-related data such as exercise, nutrition, weight, sleep cycle, and glucose information. The power of these data, combined with historical personal health information, medical knowledge content, and other technological solutions in the digital health ecosystem can provide powerful insights for the clinicians and patients to choose a more holistic and personalized approach to care.

Now, imagine a woman experiencing preeclampsia using a cell phone, app, or smartwatch to automatically track critical health data; communicate electronically with providers; and receive automated individualized patient education, nutritional and dietary instructions, and reminder alerts to take medications and schedule appointments. Furthermore, envision her clinician using all available data to plan and deliver personalized care to improve her health outcomes. The example provided is a simple illustration of how digital health can facilitate and enhance care by using a 360-degree, person-centered approach to women's healthcare.

### **How can nursing informatics impact women's health?**

Nursing informatics, as defined by the American Nurses Association, is "a specialty that integrates nursing science, computer science, and information science to manage and communicate data, information, and knowledge in nursing practice." Nurses can play a pivotal role by implementing digital health innovations within the day-to-day operations of women's healthcare. Also, nurse specialists, known as nurse informaticists, can advocate for the use

of digital health at local and national levels, educating healthcare leaders and policymakers; assisting in the development, design, and usability of health IT systems; and researching and evaluating the effects of digital health on patients and clinicians.

### **Why is nursing research important to digital health and women's health?**

We need research to determine the evidence base around which digital health applications actually promote better health outcomes. Since nursing research has a tremendous influence on nursing practice, more research will be required to measure the effects of various digital approaches on nursing care in women's health. The Agency for Healthcare Research and Quality (AHRQ), whose mission is to improve the quality, safety, efficiency, and effectiveness of healthcare for all Americans, is committed to research that supports improved health outcomes.

The Division of Health Information Technology in the Center for Evidence and Practice Improvement at AHRQ offers funding opportunities soliciting research proposals in digital healthcare research.

The future of women's health will continue to prioritize patients' needs, values, and preferences. An evidence-based digital health approach to women's health has the potential to improve women's healthcare outcomes significantly. Nurses will continue to be at the forefront as technology, information, and people converge together to improve the quality of care.

# Hope for Black MOMMAs and all MOMMAs through the MOMMA Act

Linda Goler Blount, MPH



Linda Goler Blount, MPH, joined the Black Women's Health

Imperative (BWHI) as the president and chief executive officer in February 2014. Linda oversees BWHI's strategic direction and is responsible for directing the organization toward achieving its mission of leading efforts to solve the most pressing health issues that affect Black women and girls in the United States.

**B**lack women are dying. Dying during pregnancy, dying during childbirth and dying from childbirth complications. In fact, Black women are almost four times more likely to die during pregnancy and childbirth compared to white women. This racial disparity knows no boundaries. It persists across all levels of income, age, and education, and in far too many cases results in a perilous outcome on the journey to motherhood.

For the Black Women's Health Imperative (BWHI) maternal death is not just a health issue, its a human rights crisis, because choosing to have a child should never cost you your life. As the nation's leading organization on Black women's health we BWHI, we are committed increasing awareness, advocating for legislation and policies, and joining forces with our partners to address and drive down the rates of maternal mortality and morbidity. It's an imperative!

Maternal mortality rates are bleak for all women in the U.S. Given the advances in health and technology, it is difficult to comprehend why maternal mortality rates are higher in the U.S. than 63 other countries. The proportion of women in the United States who die during pregnancy and childbirth complications is worse than Libya, Iran, and Turkey. On average, 700 American mothers die each and every year. And it is estimated that at least half of these deaths are preventable. And while rates of maternal mortality are declining in other countries, it is alarming to know that our country is not among them -- as our rates of maternal mortality continue to trend up .

Amidst these disturbing numbers there is hope, which came in the form of legislation that was introduced earlier this year in May, by Congresswoman Robin Kelly (IL).

The legislation, H.R. 5977, the Mothers and Offspring Mortality & Morbidity Awareness Act – or the MOMMA Act, which was eagerly

endorsed by BWHI, is a comprehensive approach to eliminating maternal mortality and severe morbidity. In summation, the bill:

1. Standardizes maternal mortality and morbidity data collection across states, and authorizes a designated federal agency to aggregate those data;
2. Empowers an existing federal agency to provide technical guidance and publish best shared maternal mortality and morbidity prevention practices;
3. Authorizes evidence-based national obstetric emergency protocol and best practices to save mothers' lives;
4. Expands healthcare coverage for women who have given birth to the full post-partum period;
5. Ensures improved access to culturally-competent care training and workforce practices throughout the care delivery continuum.

This bill targets many of the leading causes of the maternal mortality crisis, such as provider bias and discrimination during care and delivery. Each component of the bill is designed to create systemic change from improving data collection to improving access to care and implementing training to make the places women give birth more responsive to their needs.

Through the combined efforts of health care providers, legislators, policy makers, advocates and our "mommas", we can begin to drive down the rates of maternal mortality.

H.R. 5977 and the expansion of Medicaid coverage for women from birth through the full post-partum period create a clear path

for more pregnant women to have safe and healthy pregnancies and childbirth. to tackle the diverse factors that contribute to poor maternal health.

Learn more about the MOMMA Act and how you can support passage of this measure to help improve maternal health for all women in this country, no matter the color of their skin or where they give birth.

## Resources

1. <https://blackmamasmatter.org>
2. [http://apps.who.int/iris/bitstream/10665/112682/2/9789241507226\\_eng.pdf](http://apps.who.int/iris/bitstream/10665/112682/2/9789241507226_eng.pdf)
3. <http://www.nationalpartnership.org/research-library/maternal-health/black-womens-maternal-health-issue-brief.pdf>
4. <https://www.bwhi.org/2018/05/09/bwhi-applauds-legislation-to-address-high-maternal-mortality-rates-for-black-women/>

Before joining BWHI, Linda served as the vice president of programmatic impact for the United Way of Greater Atlanta, where she led the effort to eliminate inequalities in health, income, education and housing through place- and population based work.

Prior to that position, Linda was the first ever national vice president of health disparities at the American Cancer Society. There, she was responsible for providing the strategic vision and leadership to the society and its 12 geographic divisions to reduce cancer incidences and mortality among underserved populations and to develop a nationwide health equity policy.

With more than 25 years of experience in the public, for profit and nonprofit sectors, Linda has a distinguished career that includes successful tenures at The Coca-Cola Company, leading strategic business initiatives, and the U.S. Centers for Disease Control and Prevention, as an expert scientist. She also has extensive international health expertise as a consultant to government ministries in Germany, South Africa, Zimbabwe, Malawi, Jamaica, and Trinidad and Tobago, where she lived for four years.

Linda is a prominent speaker and a member of the American Public Health Association and the National Association of Health Services Executives. She serves on the Community Health Charities Board, the University of Michigan School of Public Health Summer Enrichment Program Board and is the past chair of the University of Michigan School of Public Health Alumni Board of Governors. She previously served on the Emory University Center for Ethics Advisory Board, and the Morehouse School of Medicine Public Health Program Advisory Committee.

A Michigan native, Linda holds a Master of Public Health degree in Epidemiology from the University of Michigan and a Bachelor of Science in Computer Engineering/Operations Research from Eastern Michigan University.



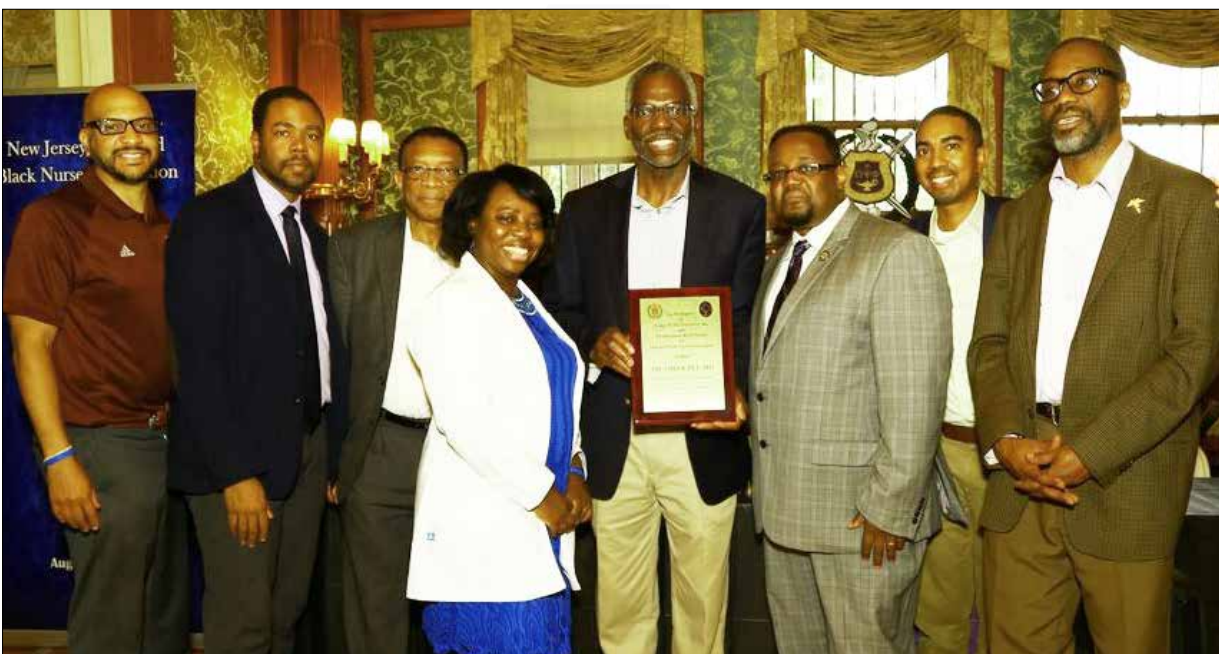
# Chapters On the Move

## New Jersey Integrated Black Nurses Association

In recognition of June as Men's Health Month the New Jersey Integrated Chapter of BNA partnered with Eta Pi Chapter of Omega Psi Phi, Fraternity, Incorporated to present "Brother Did You Know?" The program consisted of the Obey Your Doctor Health Ministry Team. This is a group of dynamic physicians who respond to questions from the audience, truly a community driven program. Hyacinth provided HIV/STD's and sexual health. Urban Health Initiative Program (UHIP) provided information about services provided in the community for those who may not have finances to cover health care cost, they provided special emphasis on their men health group sessions and other services offered. CarePoint provided blood pressures and Hgb A1C's. NJ SHaring Network discussed the importance of Organ donation. Chair massage was provided by Panache and Rutgers Brain Health (New Hope Men's Ministry) provided information about research and other programs as they relate to conditions affecting the mind. Transamerica financial entrepreneur discussed wealth meeting health. The Nurses provided poster boards, informational sheets, and



medical demonstrations. Information consisted of stroke, Opioid, colon cancer, kidney awareness, diabetes, prostate, and erectile dysfunction. Hands only CPR and AED training were demonstrated with an opportunity for those in attendance to perform a return demonstration. To see more pictures log onto: <https://njibna.nursingnetwork.com>.



# Chapters On the Move

## BBNA Members on the Move

Birmingham Black Nurses Association Membership Chair, Deborah Zimmerman, and Mentorship Program Chair, Jennifer Coleman conducted a presentation at Lawson State Community College in Birmingham on April 3. Mrs. Zimmerman provided information on BBNA membership opportunities and activities at the national level. Dr. Coleman presented an interactive discussion on NCLEX test-taking strategies, resume writing, interview skills, and career options. Twenty-one graduating seniors attended the presentation.

Dr. Jennifer Coleman, BBNA member and past president, received the Audrey Gaston Howard Award at the Samford University Annual African American Alumni & Friends Luncheon on April 9. The award is part of Samford's commemoration of the 50th

anniversary of integration at Samford and is in memory of the first African American student to enroll and graduate from Samford. The award recognizes African American alumni who have distinguished themselves through exemplary professional achievement and civic and community service. Twenty nine alumni were recognized at the luncheon.

In February 2018, BBNA members, Dr. Martha Dawson, Dr. Jennifer Coleman, and Mrs. Deborah Zimmerman presided over the pinning ceremony of students from the Nursing Academy 101 at Robinson Elementary School in Fairfield, AL. The ceremony was a celebration of the students' completion of the Academy's activities related to nursing and healthcare. During the students' enrollment in the Academy, BBNA members provided education on CPR, physical activity, health promotion, and the research process.

## Members on the Move



**Dr. Barbara Nichols, the first African American ANA President and Dr. Ernest Grant, President-elect, ANA**

# Members on the Move



Karen Carrington, Dr. Stephanie Myers, CEO, Black Women for Positive Change, U.S. Representative Gwen Moore, NBNA Executive Director Dr. Millicent Gorham and Dawn Williams met with the Congresswoman to address the week of Non-Violence hosted by the Black Women for Positive Change, October 13–22, 2018.



**Linda S. Thompson**, PhD, RN, FAAN, Dean of the University of Massachusetts Boston, College of Nursing and Health Sciences, has been named to the South Shore Health System Board of Directors.



North Carolina Agricultural and Technical State University has named **Lenora Campbell**, PhD, RN, Dean of the College of Health and Human Sciences (CHHS).



# Members on the Move

**Deidre Walton**, JD, MSN, BSN, RN, NBNA immediate past president, was honored by the March of Dimes as the Distinguished Nurse of the Year. The Distinguished Nurse of the Year winner was selected among the top finalists in all categories. Reverend Deidre was a finalist in the Nurse Leadership and Administration Category. The award was presented by United Health Group Center for Clinician Advancement. The event was held Friday, June 15, 2018 at the Camby Hotel in Phoenix, Arizona.

Southern Connecticut BNA Vice President **Andrea Murrell** was promoted to Patient Services Manager at Yale New Haven Hospital, in one of the large Heart and Vascular Center units.

**Ronald Hickman**, PhD, RN, FAAN, was promoted to Associate Dean of Research, Frances Payne Bolton School of Nursing, Case Western Reserve University, October 1, 2018. He received the Luther Christman Award from the American Association of Men in Nursing.



Trilby Barnes-Green, NBNA Treasurer, attended the 2018 National Coalition for Infant Health in Toronto, Canada.



Dr. Birthale Archie, NBNA Second Vice President, attended the Pfizer Multicultural Advisory Committee meeting in Kalamazoo, MI.

# Members on the Move

My name is **Ashley Hudson** and I'm a past NBNA Scholarship recipient. I'm reaching out to update you all on my educational endeavors and success. I recently graduated this past spring semester from Arkansas State University with my Bachelor of Science in Nursing (BSN). After transferring and having to spend a fifth year in college I continued to stay focused and work hard and as a result I was able to graduate with a 3.5 institutional GPA and a 3.7 cumulative GPA. I was also blessed enough to have multiple job offers and to accept one prior to graduation. I will be starting my nursing career working on a Women's and Children's unit at a local hospital in Arkansas. I'm currently using my summer to study and prepare to take my boards to become a Registered Nurse (RN) and am planning to begin working full time as soon as that is complete. It was important for me to reach out to you all, now that my undergraduate journey is complete, because I want you to know that your investment and support in my education is greatly appreciated and did not go to waste. Receiving this scholarship helped to make all of this possible and for that I am beyond grateful. I hope that I can one day do the same for others and contribute to helping young adults follow their dreams.

**Leonora Muhammad**, DNP, RN, wins seat on CCHP Board of Trustees. She is a member of the BNA of Greater St. Louis Area.

**Chris Bryant** received his DNP from Grand Canyon University in May 2018. He is a past president of the Eastern Colorado Council of Black Nurses and a former NBNA Board member.

## BBNA Members on the Move



June 8, 2018 Dr. Marie Etienne, 2nd VP of Miami BNA received Excellence in Community Service & Engagement Award from the Association of Black Nursing Faculty. Dr. Washington-Brown, Dr. Marie Etienne and Dr. Audwin Fletcher, ABNF President.



June 8, 2018 Dr. Washington-Brown, chair of NBNA Ad Hoc Vaccination Committee and Immediate Past President of Miami BNA presented on the Healthy Me Healthy Community Homeless Vaccination Project at the Association of Black Nursing Faculty (ABNF) Conference in London, England.

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