The
Oklahoma Nurse

Volume 57 • Number 3 • September, October, November 2012

ONA Legislative Report 2012

Pages 5-7

Have You Ever Had a Terminal Degree?

Page 14

ONA 2012 Convention

Our Health. Our State. Our Nurses.

Page 16

The Official Publication of the Oklahoma Nurses Association

Circulation 58,000 to All Registered Nurses, LPNs, and Student Nurses in Oklahoma

President's Message

Linda Fanning, BSN, RN, MS

Recently, I joined six other Oklahoma nursing professionals at the American Nurses Association's House of Delegates meeting in Maryland. This group included Lana Bolhouse from Oklahoma Baptist University, Mercy's Devyn Denton, Jane Nelson of the Oklahoma Nurses Association, Robin Potter-Kimball of Partners in Mental Health, and the University of Oklahoma's Cindy Lyons and Francene Weatherby.

Linda Fanning

The purpose of these sessions was to streamline the ANA's governance structure to more quickly address nursing issues and to better meet the needs of our nurses. In addition to reelecting Karen Daley as the ANA president, we made some important changes that will do exactly this.

These changes include:

- Retiring the House of Delegates, Congress on Nursing Practice and Economics, and the Constituent Assembly and replacing them with a Membership Assembly and Professional Issues Panels. This group will meet annually and serve as the ANA's governing and voting body.
- Creating ad hoc Professional Issues Panels comprised of nurse subject matter experts. This will help the ANA respond more quickly to important issues.
- Reducing the size of the Board of Directors from 15 members to nine. This change goes into effect in 2014 and will ensure the ANA can quickly address member needs.

These and other changes support the Institute of Medicine's recommendations to advance the nursing profession by helping us become full partners in redesigning healthcare in the United States.

They also point to a need for Oklahoma to partner with surrounding states in order to gain a greater constituent presence and voting power at the national level.

The problem with healthcare in America is that there isn't enough funding to properly care for our patients. Nursing's input on this issue is critical because we offer solutions on how to overcome this obstacle, which is why a strong, unified voice representing nursing at the national level is so important.

But these are only my thoughts. I thought it would be interesting for you to read what some of the others in my group took away from these meetings. Here's what they had to say:

"Positive transition is what comes to mind when I think of the recent ANA changes. These changes that streamline the decision-making process empower all nurses. The changes directly reflect the IOM recommendations and continue the process of allowing all nurses to practice at their full potential. The changes will be fun and creative for those of us who are technically challenged and provide opportunity for the profession to embrace the new technology and still continue the face-to-face interaction."

"The individual state and specialty organizations will play a crucial role to provide opportunities for education and face-to-face networking! I am so proud and honored to have been a part of this

President's Message continued on page 4

Inside this Issue

Oklahoma Nurses Association Regions and Regional Presidents

Region 1:
President: Eileen Stephens
Email: stephpe@osuokc.edu

Region 2:
President: Brenda Nance
Email: Brenda-Nance@ouhsc.edu

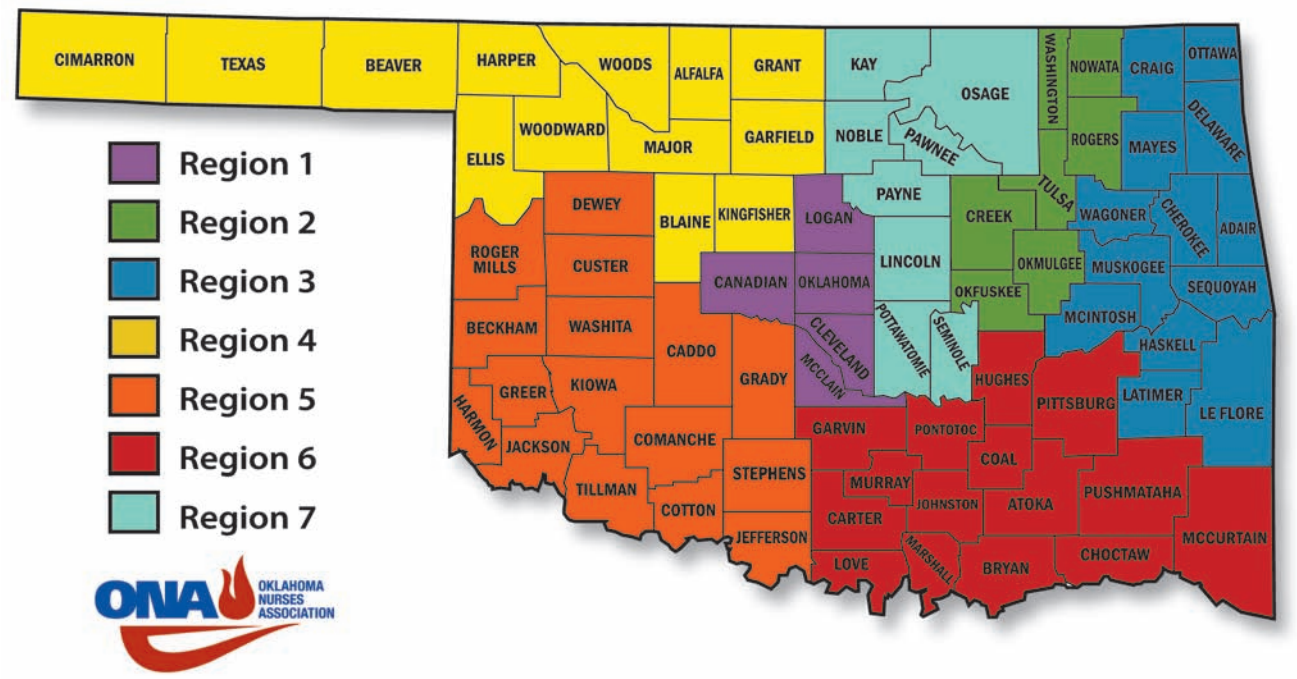
Region 3:
President: Arlene Siereveld

Region 4:
Vacant

Region 5:
President: Flo Stuckert
Email: flo.stuckert@duncanregional.com

Region 6:
President: Joe Catalano
Email: jtcatalano@egmail.com

Region 7:
President: Terry Baartman
Email: tbaartman@stillwater-medical.org



Region 1
419 Members
Canadian
Cleveland
Logan
McClain
Oklahoma

Region 2
266 Members
Creek
Nowata
Okfuskee
Okmulgee
Rogers
Tulsa
Washington

Region 3
131 Members
Adair
Cherokee
Craig
Delaware
Haskell
Latimer
Leflore
Mayes
McIntosh
Muskogee
Ottawa
Sequoyah
Wagoner

Region 4
38 Members
Alfalfa
Beaver
Blaine
Cimarron
Ellis
Garfield
Grant
Harper
Kingfisher
Major
Texas
Woods
Woodward

Region 5
89 Members
Beckham
Caddo
Comanche
Cotton
Custer
Dewey
Grady
Greer
Harmon
Jackson
Jefferson
Kiowa
Roger Mills
Stephens
Tillman
Washita

Region 6
105 Members
Atoka
Bryan
Carter
Choctaw
Coal
Garvin
Hughes
Johnston
Love
Marshall
McCurtain
Murray
Pittsburg
Pontotoc
Pushmataha

Region 7
65 Members
Kay
Lincoln
Noble
Osage
Pawnee
Payne
Pottawatomie
Seminole

(8/05/2010)

Oklahoma Nurse Editorial Guidelines and Due Dates

Submittal Information for "The Oklahoma Nurse"

View online: http://www.oklahomanurses.org/displaycommon.cfm?an=1&subarticlenbr=137

Manuscripts are due on the second Monday of January, April, July, and October for consideration of publication in the following respective issue. Below, please read the revised submission guidelines.

Email a word processing document to ona@oklahomanurses.org; file extensions should be *.doc, *.txt, or *.rtf.

- Include: Suggested title, authors, author affiliation, ONA membership status, and appropriate references pertaining to the content of the article.
- Format: APA Style, (6th ed, 2010), "Running Headers" are not required.
- Sub-headings are expected where indicated and tables/illustrations are encouraged to summarize key points as appropriate.
- Photographs should be of clear quality and in a digital format with appropriate resolution for printing.
  - Black & white photographs are preferred but not required.
  - Email images with the correct name(s), place/event, date, and descriptions.
  - Images are not guaranteed to be run even if submitted.

Space limits: Due to space limitations, the following lengths are strongly recommended. While ONA will make every effort to publish articles in their entirety, ONA reserves all editing rights prior to publication.

- Feature articles: 500 to 750 words preferred, exceptions may be granted to 1,000 word max.
- Research articles: 1,000 to 1,500 words; exceptions may be granted to 2,000 word max.
- Regular Reports: 500 words (Executive Director, President)
- All other submissions: 250 to 500 words, content dependent, please include a clarifying statement if you are submitting an article exceeding these guidelines, such as special report on Mortality or Board of Nursing Annual Report.

The Oklahoma Nurses Association thanks you in advance for your contributions to our official quarterly publication. As always your support is appreciated. If you have any questions, please respond via email or phone to the office.

Thanks for making Nursing Positively Possible!

www.oklahomanurses.org

Published by:
Arthur L. Davis Publishing Agency, Inc.

Oklahoma Nurses Association
Editor:
ona@oklahomanurses.org

ONA 2011-2012 Board of Directors:

President – Linda Fanning
President Elect – Cindy Lyons
Vice President – Jackye Ward
Secretary/Treasurer – Deborah Wipf
Education Director – Jani Hill
Disaster Preparedness and Response Director – Janet Gallegly
Practice Director – Linda Huffman
Political Activities Director – Lynn Sandoval
Eileen Stephens – Region 1 Representative
Leslie Brown – Region 2 Representative
Joyce Van Nostrand – Region 3 Representative
Vacant – Region 4 Representative
Flo Stuckert – Region 5 Representative
Joe Catalano – Region 6 Representative
Terry Baartman – Region 7 Representative
Rachel Schupp – ONSA Consultant

ONA STAFF

Jane Nelson, CAE – Executive Director
Lanita Lukens – Bookkeeper
Kathy Hefton - Editor, Development Director
Dr. Betty Kupperschmidt, RN – Editorial Committee Chair

Association Office:

Oklahoma Nurses Association
6414 N. Santa Fe, Suite A
Oklahoma City, OK 73116
405/840-3476
Subscriptions:
The subscription rate is $20 per year.

THE OKLAHOMA NURSE (0030-1787), is published quarterly every March, June, September and December by the Oklahoma Nurses Association (a constituent member of the American Nurses Association) and Arthur L. Davis Publishing Agency, Inc.

INDEXED BY

International Nursing Index and Cumulative Index to Nursing and Allied Health Literature.
Copies of articles from this publication are available from the UMI Article Clearinghouse. Mail requests to: University Microfilms International, 300 N. Zeeb Road, Ann Arbor, MI 48106.

ADVERTISING

For advertising rates and information, please contact Arthur L. Davis Publishing Agency, Inc., 517 Washington Street, PO Box 216, Cedar Falls, Iowa 50613, (800) 626-4081, sales@aldpub.com. ONA and the Arthur L. Davis Publishing Agency, Inc. reserve the right to reject any advertisement. Responsibility for errors in advertising is limited to corrections in the next issue or refund of price of advertisement.

Acceptance of advertising does not imply endorsement or approval by the Oklahoma Nurses Association of products advertised, the advertisers, or the claims made. Rejection of an advertisement does not imply a product offered for advertising is without merit, or that the manufacturer lacks integrity, or that this association disapproves of the product or its use. ONA and the Arthur L. Davis Publishing Agency, Inc. shall not be held liable for any consequences resulting from purchase or use of an advertiser's product. Articles appearing in this publication express the opinions of the authors; they do not necessarily reflect views of the staff, board, or membership of ONA or those of the national or local associations.

Contact the ONA

Phone: 405.840.3476 • Toll Free: 1.800.580.3476
E-mail: ona@oklahomanurses.org
Web site: www.oklahomanurses.org
Mail 6414 N. Santa Fe, Ste. A, Oklahoma City, OK 73116

Questions about your nursing license?
Contact the Oklahoma Board of Nursing at 405.962.1800.

Want to advertise in **The Oklahoma Nurse?**
Contact Arthur L. Davis Publishing Agency, Inc.
at 800.626.4081 or email at sales@aldpub.com.

ONA Core Values

ONA believes that organizations are value driven and therefore has adopted the following core values:

Code of Ethics for Nurses
Cultural Diversity
Health Parity
Professional Competence
Embrace Career Mobility and Professional Development
Human Dignity and Ethical Care
Professional Integrity
Quality and Safe Patient Care
Committed to the Public Health of the Citizens of Oklahoma

ONA Mission Statement

The ONA is a professional organization representing a community of nurses across all specialities and practice settings.

Teaching with Technology: A Clinical Instructor's Journey

Donna Fesler, MS, RN, CPAN; Faculty at University of Oklahoma Health Sciences Center College of Nursing

It is a Tony the Tiger Greaaaaaaat Thing to be an early adopter of new technology considering the pace at which technology is advancing. Many would say that I fall into the early adopter classification: no argument from me there! As a clinical instructor for undergraduate nursing students, I found a sacred cow that has been an ongoing part of clinical rotations before I went to nursing school. I have that sacred cow in my crosshairs. I was looking for something more than the mundane Pre-conference, Lunch, and Post-Conference (PLP) routines.

The healthcare setting is changing rapidly and so is the patient population of patients admitted to the hospital. Nursing education, inside and outside of the classroom, is also changing at a rapid pace, hopefully to produce nurses that are prepared for rapid change and continuing education in healthcare and the nursing profession. Technology is a major part of the changes in healthcare so our future nurses must learn to be early adopters as well. That does not mean that they have to purchase the latest and greatest technology, only that they are aware of the capability of the technology that is available. I do hope to lead by example when it comes to using technology.

There are so many options for improvements in the PLP routine that would squeeze more learning into the day for students during their clinical rotation. This is where my journey began and my students have followed quite willingly (as if they had no option). Pre-conference is now the "Sunrise Session" (SS); lunch is "Lunch and Learn" (L&L); and post conference is "Room for Ruminating" (R4R).

Background

The clinical setting proved to have a few brick walls when it came to accessible equipment, suitable locations for the use of technology and for privacy in order to follow HIPAA guidelines. There have been a few changes concerning locations since I began this journey two years ago. I do appreciate all of the unit managers that have readily facilitated our location needs.

The only technology needed that I did not have in my personal collection was a projector. After hours of watching and reading reviews, I shelled out $140 for a Pico Projector (pico meaning small). Projectors are built in to some smartphones or are available as a blue tooth attachment.

There are multiple applications for "smart" devices (phones, tablets, pads, readers, pods, etc.) that have proven most helpful on this journey. Obviously, there is a niche for teaching on the fly in the world of applications. Most applications that I have used were low or no cost to add to my smart devices. All smart devices do tend to open Microsoft Office files with little to no change in formatting, but if you want the bells and whistles of a presentation, you will be investing $10 to $40 on those types of applications.

Cons

There have been few cons to teaching in the clinical setting with technology thus far; rather, there have been many lessons learned. Do not depend on the facility's wireless network for your content. Download a copy to your device or invest in a mobile hotspot device. My favorite application, eClicker and eClicker Presenter (Big Nerd Ranch, 2012), allows for the instructor (host) to create quizzes that can be delivered over the same Wi-Fi network to any device with a browser (free for the students). Sometimes security on Wi-Fi networks will not allow this to occur. The "work around" was that I had to bring my MacBook in order to create a Wi-Fi network for everyone to connect to. Since then, I invested in a $20 freestanding secured wireless network. It is the size of a deck of playing cards but weighs much less. This device does not provide Internet access unless it is wired into a Local Area Network (LAN).

Be sure to have all of your equipment fully charged. The room or location that your clinical group meets in may not have an available or conveniently located electrical outlet. Thus, assure you have a bright flashlight as part of your equipment because most available spaces may not have desirable lighting for projectors and contending with a light switch in a dark room may not prove to be safe. Having a secure location to store your equipment until it is needed is important. Some unit managers will allow instructors to store equipment on the Units in secure locations the day of clinical. Networking is your best friend in the clinical setting.

Pros

From personal experience, students have proven to be more inquisitive during small group discussion in the clinical setting compared to the classroom setting. Lunchtime is an excellent time to sequester students away in order to provide an L&L or to do an R4R, or a combination thereof. Allowing the students to present utilizing technology during any of the aforementioned sessions has proven quite interesting in the past. The anonymous surveys that students complete at the end of the semester have displayed positive data to support this ongoing technology journey. Equipment I have used include pocket projector, smartphone and/or tablet, portable speaker, stylus, small flashlight and a room with a large light colored or white wall.

Teaching with Technology continued on page 4

Teaching with Technology continued from page 3

Future Possibilities and Research

I continue to review the literature for data on the use of technology to enhance learning in the clinical setting. I have found very little literature to date. Clicker systems in the classroom and at nursing conferences have proven to increase engagement in the content (Solecki, Cornelius, Draper, & Fisher, 2010; Mareno, Bremner, & Emerson, 2010). For the purpose of continuing education, other healthcare professionals within the facility may also like the opportunity to present content to students coming from the perspective of their discipline to facilitate interdisciplinary learning. If the clinical facility provides a large enough room and necessary equipment (hint, hint), nursing staff and other healthcare disciplines can attend selected sessions with the nursing students as continuing education.

The possibilities are endless when it comes to utilizing technology to facilitate learning in the clinical setting for future nurses and other healthcare disciplines. There is obviously a need for more research on this process as well. It is time to break out of the PLP routine and think outside of the box but continue to use the experiences that are in the PLP box. ★

Big Nerd Ranch. (2012). *Nerd* applications. Retrieved July 7, 2012 from http://www.bignerdranch.com/software/mobile/eclickerpresenterios

Mareno, N., Bremner, M., & Emerson, C. (2010). The use of audience response systems in nursing education: best practice guidelines. *International Journal Of Nursing Education Scholarship, 7*(1), 1p. doi:10.2202/1548-923X.2049

Solecki, S., Cornelius, F., Draper, J., & Fisher, K. (2010). Integrating clicker technology at nursing conferences: an innovative approach to research data collection. *International Journal Of Nursing Practice, 16*(3), 268-273. doi:10.1111/j.1440-172X.2010.01840.

Put Your Money Where Your Scores Are HCAHPS and VBP

Letha Grellner, MS RN, Administrative Director, INTEGRIS Baptist Medical Center

For those of us who work in the hospital environment, VBP (Value-Based Purchasing) is now a well-known term. It signifies the first hospital "pay-for-performance" program associating quality performance to Medicare inpatient payments. Acute care hospitals paid under the inpatient prospective payment system (IPPS) will be reimbursed based on the hospital's performance in the proposed domains as set forth by CMS (Centers for Medicare and Medicaid Services).

Where Does HCAHPS Fit In?

For fiscal year 2013, VBP includes clinical core measures and patient's perception of care (Hospital Consumer Assessment of Healthcare Providers and Systems / HCAHPS) to determine the hospital's reimbursement scores.

- Twelve core measures = 70% weight
- Eight HCAHPS composited measures = 30% weight

This means the HCAHPS results in the eight selected measures will determine 30% of the hospital's VBP score for reimbursement. The eight measures include:

- Nursing communication
- Doctor communication
- Responsiveness of staff
- Pain management
- Communication of medications
- Discharge information
- Cleanliness and quietness of hospital environment
- Overall rating

Although "willingness to recommend" will continue to be reported it will not be included in the VBP reimbursement formula.

What's at Risk?

The Medicare reimbursement dollars at risk begins with 1% in fiscal year 2013 and grows to 2% by fiscal year 2017. The baseline benchmarking for hospital's performance period has already happened. So, it's already too late to impact the data that CMS will use to calculate the first round of reimbursement for fiscal year 2013. More importantly, the top box, which is the highest rating possible for each item on the survey, is the only answer that gives credit with VBP. Thus any other response besides "always" and "yes" counts as a zero. All of this can feel very insurmountable for the nurse leader. How can we engage all of the staff members and our patients? How can we gain the discipline and consistency to reach maximum outcomes? The challenge can be huge because while you and your staff may be working feverishly in your department, if the rest of the individuals in the organization fail to be as equally committed, the results will be less than stellar.

What Can We Do?

There are some common traits and characteristics surfacing in high-performing HCAHPS organizations. It boils down to ownership, accountability, and building a culture of patient-centered care.

- Strong connections between senior leaders who are visible, lead by example, and communicate a vision for articulating patient-centered care.
- Engaging the staff at all levels with training, designing, and accountability as the organizations' core components for providing an exceptional patient experience.
- Patients and their families are considered as partners in every level of care.
- The results and data are at the forefront of the organization's scorecard to provide feedback and enable learning opportunities from high-performing areas.

Putting it in a Positive Perspective

It drives me back to a strong commitment to our nursing Code of Ethics. It's about creating a compelling culture of "it's the right thing to do for our patients." By inspiring a culture of excellence, the staff can see themselves as "owners" of the hospital recognizing that as time goes by their organization's success is directly related to the care they provide for their patients every day. The use of the data results is crucial in understanding the journey towards a culture of doing the right thing every time. The front line staff have to see and understand the data to comprehend that what the patients are perceiving and saying will drive their success. There is a mountain of success stories and best-practice strategies that has emerged in this arena. Exploring and examining these tactics can help with achieving your own organizations' pathway. Engaging in success stories can be immensely inspiring and set the culture for great outcomes. It is an on-going process where maintaining momentum will be necessary to succeed. ★

References:

Bush, H. (2011). Doubling down on the patient experience. H & HN Hospitals & Health Networks, 85(12), 22-25.

Health Care Leader Action Guide to Effectively Using HCAHPS. Health Research & Educational Trust. Chicago: March 2012. Accessed at www.hpoe.org

Studer, Q., & Robinson, B.C., & Cook, K. (2010). The HCAHPS Handbook Hardwire your hospital for pay-for-performance success. Gulf Breeze, FL: Fire Starter Publishing.

President's Message continued from page 1

historic event, but at the same time sad. The sad is the realization that change is included in all areas and that the face-to-face networking is limited! So say goodbye to the old way and let's get on with the new organization!"

Robin Potter-Kimball

"ANA's work and the recommendations from the Future of Nursing Report are aligned. Much of the work ANA and the states have been doing focused on these recommendations before the Future of Nursing report was issued. However, much of ANA's work was directed by the resolutions passed by the House of Delegates, which only met every two years. This system didn't allow for the ANA to be able to react offensively to current trends, environmental factors and other changes affecting nurses and the profession."

Jane Nelson

Jane pointed out some of the other benefits of the recent ANA changes, which include:

- *A structure that will allow the organization to meet all nursing needs*
- *Quick responses to issues affecting nurses, nursing and the profession*
- *Greater focus and efficiency as an organization*
- *Organizational flexibility to better meet the needs of its members – nurses and state nurse organizations*

Regardless of whether you're beginning your career as a nurse or are a veteran, the ANA changes help to advance our profession in order to better serve our patients and to help us contribute to reshaping healthcare for the 21st century.

If you work with nurses who aren't yet members of the ONA, take a moment to encourage them to join. Nursing needs their voices, and I'm certain they'll enjoy being a part of an organization that is working to advance our profession. ★

ONA LEGISLATIVE REPORT 2012

Vickie White Rankin Political Consulting

The 2012 Legislature saw rays of hope dawn on the barren landscape of prior sessions, as news broke of a slightly improving state economy. Many grassroots organizations descended upon the Capitol pleading their case to restore funding to their programs, cut in prior years, while others sought to prevent further damage.

As the Legislature convened, the Governor announced her intentions to "pass the most significant tax cut in state history, giving Oklahoma the lowest income tax rate in the region besides Texas, and reducing the seven tax brackets we currently have to three lower, flatter rates." As the session progressed, her dreams became a memory of hopes dashed by quarreling factions of legislators, including critical members of her own party.

Together, both houses of the Legislature introduced over 2,000 bills and joint resolutions, of which a mere 171 Senate measures and 221 House measures made it entirely through the process to become law. Governor Mary Fallin vetoed a surprising 11 measures. Four state questions were referred to the people for a vote in November, along with two previous measures that had been referred in the 2011 session. Many issues that failed to make it through the legislative process were caught in the daily drama of evolving internal political struggles that continue to shape the Legislature, public policy, the political landscape and the character of the debate in current elections. This certainly impacted legislation affecting nurses and health care, as both good and bad bills fell victim to the maelstrom.

After enormous struggles and a vote on the House floor in which the appropriations bill actually failed on a 47-47 tie, the FY '13 budget was finally passed. It is $253 million or 3.8% more than the FY '12 budget, but remains 3.8% less than the FY '09 budget. Of the 78 state agencies, 46 were appropriated the same or less than in FY '12. Despite valiant attempts to eliminate unnecessary tax credits, such efforts failed as they were caught in the controversy surrounding the tax reduction and reform package. Bond proposals for $200 M in repairs needed for the State Capitol building, and the Native American Cultural Center, also failed in the fray.

The Legislature faced a daily balancing act on a tightrope. As legislators tried to balance the needs of constituents for core services amid the vocal cries for change of Tea Party candidates preparing

to run in primaries against sitting conservative members of the majority party, large numbers of bills failed. Majority party initiatives collapsed as in-fighting ensured their demise. The House of Representatives became a riveting political theater on a daily basis, as it appeared that there were no longer two parties in power, but three. As each day dawned, a new chapter in Oklahoma political history was written. Ultra-conservative "Tea Party" candidates occasionally succeeded in pulling the majority party to the right, although a number of ultra-conservative initiatives failed, as well. With a divided house, it became extraordinarily difficult to obtain a clear majority on controversial bills, and almost impossible to win emergency clauses on many measures. Many House Democrats quipped that they had a majority of their own, as their numbers allowed them to move as a block either with the majority in leadership or the Tea Party, on any given day, effectively deciding the outcome of controversial measures. In any case, it was a challenging session in which to move legislation forward.

Despite the divisions in the Legislature, there were some tremendous success stories to come out of this session. Nurses can be proud of improvements in funding for mental health and substance abuse services, long term care, health care and social services, to name a few. The passage of the 2013 Budget avoided major cuts to state agencies, and in fact, provided an additional $315 million to "core state service functions" which include mental health and substance abuse services, long term care, health care, common education, transportation and social services.

Access to Health Care

SB1580 creates an Anatomical Gift Registry and Board allowing for the donation of bodies and body parts for education and research and authorizes the State Anatomical Board to register anatomical donor programs and non-transplant tissue banks. Signed by the Governor.

HB2270 This bill authorizes the Health Care Authority to seek approval of a federal waiver removing the cap on the Nursing Facilities Quality of Care Fee. This will finally allow Oklahoma to draw down significantly more federal revenue for nursing homes, returning many millions of taxpayers' dollars to our state for the care of the elderly, and the employment of nurses in nursing facilities! The bill further provides that per approved federal Medicaid Waiver, the assessment rate for all state-licensed continuum of care facilities will remain the same as the assessment rates that were in effect prior to January 1, 2012, if the continuum of care facilities made application to become a continuum of care facility prior to January 1, 2012, and received the license as a continuum of care facility on or before September 1, 2012. Any Continuum of Care Facility that does not have their appropriate license by this date will be assessed at the rate established by subsection c of the bill, along with all other nursing facilities. While this bill goes into effect on November 1, the OHCA will forward increase rates for nursing facility providers beginning on September 1, but will wait to begin collection of the new QOC fee on November 1, as permitted in the legislation. This will allow nursing facilities to experience some relief as soon as possible, months in advance of the actual implementation date. Signed by the Governor.

SB 1059 would allow the Oklahoma Insurance Department to enter into agreements with one or more states to allow the sale of insurance across state lines. The bill exempts any insurers based out of state from the minimum benefits that Oklahomans are entitled to under existing state law. Oklahoma requires insurance companies to cover a handful of basic benefits. These benefits, or 'mandates,' ensure that health insurance plans

ONA Legislative Report continued on page 6

ONA Legislative Report continued from page 5

cover essential health services. The state's mandated benefits cover preventive health services for children (immunizations), women (mammography and bone density screenings, maternity care, and annual pelvic exams and cervical cancer screenings), and those with chronic conditions (diabetes supplies, mental health treatment). ONA opposed this bill. It died in House conference for lack of support by conferees.

SB 1629 is the measure containing language that sought to establish Insurance Exchanges to comply with the Affordable Care Act. This bill would uphold our state's ability to develop our own health insurance marketplace. Despite the fact that we had support from over 40 statewide organizations representing business, insurance, health care and community leaders, the vocal opposition of the Tea Party led the Legislative leadership to decide not to have their own bill heard. ONA was supportive of the bill.

SB 1618 amends the Small Employer Health Insurance Reform Act to allow a small group market of 50 or fewer employees, to offer incentives to encourage wellness, including tobacco cessation. Despite the fact that there was no opposition to the bill, it was not heard on the House floor due to the delays in process on the last day of session.

SB 178 authorizes the State Board of Health to adopt rules to establish adaptive standards of care where an extreme emergency exists, as defined in the Oklahoma Emergency Response Act. Signed by the Governor

SB 1366 establishes that if there is no advance directive for mental health treatment, an advance directive for health care or durable power of attorney with health care decision-making authority will include mental health treatment. Signed by the Governor.

HB 3052 requires persons convicted of a felony to submit to a mental health and substance abuse risk evaluation, the results of which may be considered in sentencing. Signed by Governor.

SB 1083 requires certain state agencies to provide debriefing and counseling services for state employees who are affected by violent or traumatic events that occur in the workplace. Signed by the Governor.

Practice Issues

HB2266 provides that registered nurses are authorized to use physician-approved protocols to provide public health services when performing duties as an employee or as a contractor, on behalf of city-county health departments, county health departments, and the State Department of Health. Signed by the Governor.

HJR1109 made our January 31, 2012 Board of Nursing Rules permanent. It also provides that any Board proposed fee increases in Title 59 must be approved by the Legislature. If they are not approved before adjournment, they will be considered disapproved. Signed by the Governor.

HB1401 requires nursing facilities, assisted living facilities, residential care homes and specialized facilities to have an emergency evacuation plan in place and on file with the local emergency management agency and OSDH. The State Department of Health is authorized to develop rules and regulations pursuant to this act. HB1401 also prohibits licensed facilities, physicians, APRNs, Physician's Assistants, and state employees from referring any clients to unlicensed providers of personal care services or companion or sitter services. This bill will protect the integrity of our licensed providers. Signed by Governor.

Health Status Issues

SB1686 Allows Commercial airport operators to prohibit tobacco use anywhere within 175 feet of a commercial airport. Signed by the Governor.

HB2521 Allows all charitable clinics, those providing services there, and the services they provide, to be protected under the Volunteer Professional Services Immunity Act. Signed by the Governor

HB2941 Updates restrictions on the procurement of pseudoephedrine; changes purchasable amounts of pseudoephedrine; authorizes OSBI to transmit information on methamphetamine offenders. Ensures participation in a national database. Signed by the Governor.

Governance and Regulation

SB 1866 is part of a larger consolidation effort by the state legislature. It transfers from the State Department of Health to the Department of Labor all powers and duties related to regulating locksmiths, closed circuit televisions, access controls, burglar alarms, fire alarms, and sprinkler and nurse calls. In providing for the transfer of classified and unclassified personnel, the measure prohibits reductions in salary and benefits or a change in classification without written consent of the employee. Licenses, registrations, certifications and accreditations will remain in full force and all board and committee members will retain their appointments. The measure transfers future appointment power of the eight-member Alarm and Locksmith Industry Committee to the Governor and requires the Senate to confirm future appointees. Effective November 1, 2012.

SB1386 by Sen. Brian Crain and Rep. Doug Cox – Allows the Oklahoma Attorney General to pursue suspected cases of Medicaid fraud. Effective November 1, 2012.

HB2241 by Faught and Sykes would have provided that any rule which establishes or increases fees or any rule by an agency, board, or commission receiving authority from Title 63 of the Oklahoma Statutes would require approval by the Legislature by joint resolution. This, for example, would have affected the Oklahoma Board of Nursing. This was one of the eleven bills that Governor Mary Fallin vetoed.

Long Term Care Facilities

HB 2582 strengthens the process for screening applicants for employment who will have direct access to patients in places such as nursing facilities, assisted living centers, adult day care centers and through employment with home health and hospice agencies. The bill requires these employers to submit certain identifying information to the Oklahoma State Department of Health (OSDH) for the purpose of conducting a check of all relevant registries established by federal and state law to determine if there are any findings that would prohibit an applicant's employment. The measure also directs the department to submit fingerprints to the Oklahoma State Bureau of Investigation for a criminal history check on applicants whose registry check doesn't reveal any basis to deny employment but who do not have a monitored employment record. The OSDH is required to establish a database to store records of an employer's prospective and current employees, the results of the screening and criminal arrest records search and to include a process that will allow the department to be notified if a subsequent criminal arrest record matches a set of fingerprints previously submitted. Effective November 1, 2012.

HB2566 Allows residents of assisted living centers to choose their physicians and suppliers of medical services without financial penalty. The measure will be subject to rules promulgated by the State Department of Health. Effective November 1, 2012.

Revenue and Tax Legislation

Taxes, tax cuts and tax credits were a central theme throughout the 2012 Legislative Session.

ONA Legislation Report continued on page 7

ONA Legislative Report continued from page 6

The 2012 Session opened with Governor Fallin's Legislative address calling for a significant personal income tax cut accompanied by corresponding offsets from revenues generated by the elimination of tax credits, various tax exemptions and a handful of deductions. As enthusiastic as our leaders were for tax cuts, Gov. Fallin, Senate President Pro Tempore Bingman and Speaker Kris Steele all expressed their desire to have tax cuts that still allowed for the protection of the core services and functions of state government.

A variety of bills were introduced to eliminate certain tax credits, exemptions and deductions, all of which were discussed at length by various legislative bodies, in committees and on the floor, before disappearing into the vast suspended wasteland of unwanted bills for which there is not enough political will for passage. Without these measures, there would not be sufficient offsets to cut the personal tax rate as deeply as the Governor and Legislative leaders had hoped.

Cutting personal tax revenue without providing corresponding offsets could be devastating to our economy as well as to critical core services like health care, aging services and education, to name but a few. Approximately one third of all general revenue funds in our state are derived from personal income tax. To cut this tax without offsets could bring harm to our most vulnerable citizens, and have unintentional and deleterious effects upon our economy, according to many experts. Providing offsets in the original plan appeared to have been well-reasoned.

Of course, any tax cut proposal could have a deleterious impact upon appropriations, and legislators as well as advocacy organizations were ever mindful of the delicate balancing act they were faced with.

The original tax plan would not fly without the repeal of the tax credits and other offsets. After many days of intense negotiations between the Governor, the House and Senate leadership, another somewhat balanced tax cut and reform package was proposed. While this measure passed the Senate, it ran into major obstacles in a fractured House, as members from both political parties opposed it for differing reasons. Many felt that a portion of the tax reform proposal would result in a tax increase for a small category of tax payers, a problem they could not withstand in an election. Ultimately, the House of Representatives felt they had no choice but to walk away from their agreement. Attempts were made to float other tax cut and reform proposals, but it became increasingly clear that the divisions were too deep for a reasonable, workable agreement to be reached this session. The Legislature may have sine died (closed its session) without a personal income tax cut, but they did pass a handful of property tax reform bills with large tax cut implications.

Appropriations and Budget Overview

The Legislature increased total appropriations $253 million for FY2013, from the FY2012 budget. The appropriation of $6,855.8 million provided for a standstill budget with 78 agencies receiving appropriated funds, of which 46 received the same amount or less than they were provided a year ago.

A few agencies received increases for targeted funding priorities. The health and human services appropriations area of the budget were favored, as increases were provided for long-term care, specifically for Adult Day Care and Advantage Waiver Services. Perhaps the largest percentage increase was provided to the Department of Mental Health and Substance Abuse Services to provide critical behavioral health services. This includes the $118 million that was taken from the Health Care Authority and given to DMHSAS to manage existing Medicaid behavioral health programs, revenue for an additional mental health crisis center, funding to begin Justice Reinvestment initiative screenings, and a $6.2 million Systems of Care grant.

What began, and indeed evolved, as one of the most challenging legislative sessions in our state's history, bore some real miracles at the end of the day. Our advocacy efforts made a difference for those we serve every day!

To review the complete ONA Legislative Report, visit www.oklahomanurses.org. ★

Health Literacy

Carol Baldridge RN, BSN Candidate
Rogers State University

"Health literacy is a better predictor of one's health status than age, income, employment, ethnicity, or education level" (Kathiresen, 2004). Health literacy is "the degree to which individuals can obtain, process, and understand the basic health information and services they need to make appropriate health decisions" (Berkman, 2011). It involves the abilities to read, work with numbers, and verbal communication. It doesn't necessarily reflect a person's education preparation. Studies have suggested that as many as 90 million adults in the United States have limited health literacy levels. This has a significant impact on the healthcare system. Persons with lower health literacy have higher incidents of: skipping necessary medical tests, forgoing preventative health measures, chronic conditions, emergency services utilization, and hospitalization (IOM, 2004). Low health literacy costs the U.S. healthcare system approximately $73 billion annually (IOM, 2004).

Nurses are cautioned to be alert to clues that may indicate low health literacy. Persons with limited literacy levels often have adopted coping strategies i.e. may identify medication by color and shape rather than reading prescription bottle labels. Another clue may be taking an inordinate length of time to complete forms. To facilitate communication, approach the patient in a calm unhurried manner and foster an open shame-free environment. If family members are present, include them in the educational process. After assessing patient needs, provide information at the patient's level of understanding. Short term memory has limited storage capacity, so identify one or two key concepts and make sure the patient understands those before leaving the room. Some people are visual learners and posters or models may be helpful. Use of the teach-back technique or return demonstration can ensure your message was received. Avoid asking 'Do you understand.' Many people will say 'yes' but their understanding may not be the message that was sent. (American Medical Association, 2010)

Health literacy must be addressed on an organizational level. Many have already started lowering the literacy level of patient education material. Recently, the IOM released the discussion paper *Ten Attributes of Health Literate Health Care Organization* which gives additional direction:

1. Leadership that makes health literacy integral to its mission, structure, and operations.
2. Integrates health literacy into planning, evaluation measures, patient safety, and quality improvement.
3. Prepares the workforce to be health literate and monitors progress.
4. Includes populations served in the design, implementation, and evaluation of health information and services.
5. Meets the needs of populations with a range of health literacy skills while avoiding stigmatization.
6. Uses health literacy strategies in interpersonal communications and confirms understanding at all points of contact.
7. Provides easy access to health information and services and navigation assistance.
8. Designs and distributes print, audiovisual, and social media content that is easy to understand and act on.
9. Addresses health literacy in high-risk situations, including care transitions and communications about medicines.
10. Communicates clearly what health plans cover and what individuals will have to pay for services. (Brach, 2012)

Nurses are in a unique position to impact health education of patients. By addressing health literacy, the nurse can guide patients toward improved self-management and enhance patient outcomes. ★

Resources

American Medical Association. (2010, August 27). *Health Literacy and Patient Safety: Help Patients Understand*. You Tube: http://www.youtube.com/watch?v=cGtTZ_vxjyA

Berkman, N. S. (2011, March). *Health Literacy Interventions and Outcomes: An Updated Systematic Review*. Agency for Healthcare Research and Quality: http://www.ncbi.nlm.nih.gov/books/NBK82423/?report=printable

Brach, C. K. (2012, June 19). *Ten Attributes of Health Literate Organization*. Institute of Medicine: http://iom.edu/Global/Perspectives/2012/HealthLitAttributes.aspx?utm_medium=etmail&utm_source=Institute%20of%20Medicine&utm_campaign=06.19.12+Perspective+Alert&utm_content=Roundtable%20on%20Health%20Literacy&utm_term=Unknown

IOM. (2004). *Health Literacy: A Prescription to End Confusion*. Institute of Medicine: http://www.iom.edu/~/media/Files/Report%20Files/2004/Health-Literacy-A-Prescription-to-End-Confusion/healthliteracyfinal.pdf

Kathiresen, A. &. (2004). *Health Literacy*. American Medical Association: http://www.ama-assn.org/ama/pub/about-ama/our-people/member-groups-sections/medical-student-section/community-service/health-literacy.page

"Spooky Laughs"

by Diane Sears, RN, MS, ONC

What are you going to be for Halloween?

"I made a Harry Potter costume for my primary baby-all 1200 grams of him! He had a robe, broomstick and 'scar' on his forehead made of Duoderm… His mother said that was the day she finally started to believe that he was going to be okay." (Sarah, RN, Nurses Calendar)

New internal med MD & his wife at Halloween Party: "After considerable thought, we bought a soldier's camouflage uniform from an Army-Navy store. I wore the shirt and hat, he wore the pants and shoes. We went as Upper and Lower GI." (Jessica Johnston, in All in a Day's Work)

"My ventilator-dependent patient says he should be Darth Vader for Halloween. "Luke… *ventilator whoosh* I am your father *ventilator whoosh* …" (allnurses.com)

"I dressed up as a veterinarian for a Halloween costume party. I had the lab coat. I got a couple of stuffed animals for patients and put bandages on them."(Tracy Chapman)

Halloween Riddles

What's a vampire's favorite fast food? A guy with very high blood pressure...
What does a vampire fear the most? Tooth decay.
Where did the vampire open his savings account? At a blood bank.
What do you get when you drop a pumpkin? Squash [!].
What do you call a ghost with a broken leg? A hoblin goblin.
How do you mend a broken Jack-o-lantern? With a pumpkin patch.
Why did Dracula take cold medicine? To stop his coffin.
How do ghosts begin their letters? "Tomb it may concern...."
Why was the mummy so tense? He was all wound up.
How do you know if a ghost is lying? You can see right through him.
How is a werewolf like a computer? They both have megabytes.
What do you get when you goose a ghost? A handful of sheet.
Why do ghosts like to ride elevators? It raises their spirits.
What kind of mistakes do spooks make? Boo boos
What kind of protozoa likes Halloween? An amoeboo.
Where's the most dangerous place to go trick-or-treating? On the psycho path!
(e-mail)

Halloween One Liners

Vampire pick-up line: "What's your type?"
A vampire joined the ER staff, so he could learn the correct way to get a stake out. (humormatters.com)
Conversation between two elderly bats hanging upside down on a limb: "Do you know what I fear the most about aging? No, what? Incontinence." (Cartoon)
The nurse walked into the doctor's office and said, "Doctor the Invisible Man is here." The doctor replied, "Sorry, I can't see him."

Maxine

"Vampires sleep all day, fly wherever they want for free, and can't see themselves in a mirror. Where do I sign?
Tonight's a full moon huh. Well at least tonight my howling won't seem so out of place.
What really scares me at Halloween is knowing that all the family holidays are coming up.
Every Halloween I pretend to be the same thing…not at home.
Fall is a tough season for weather forecasters. It's too cool to scare us with the heat index and too warm to scare us with the wind chill."

"Top Ten" reasons you know you are too old to Trick or Treat:

10. You get winded from knocking on doors.
9. You have to have a kid chew the candy for you.
8. You ask for high fiber candy only.
7. When someone drops a candy bar in your bag, you lose your balance and fall over.
6. People say: "Great Boris Karloff Mask," And you're not wearing a mask.
5. When the door opens you yell, "Trick or..." and can't remember the rest.
4. By the end of the night you have a bag full of restraining orders.
3. You have to carefully choose a costume that won't dislodge your hairpiece.
2. You're the only Power Ranger in the neighborhood with a walker.
1. You keep having to go home to pee. (e-mail)

"A vampire bat came flapping in from the night covered in fresh blood and parked himself on the roof of the cave to get some sleep. Pretty soon all the other bats smelled the blood and began hassling him about where he got it. He told them to knock it off and let him get some sleep but they persisted until finally he gave in. "OK, follow me," he said and flew out of the cave with hundreds of bats behind him. Down through a valley they went, across a river and into a forest full of trees. Finally he slowed down and all the other bats excitedly milled around him. "Now, do you see that tree over there?" he asked. "Yes, yes, yes!" the bats all screamed in a frenzy. "Good," said the first bat, "Because I DIDN'T!" (Sherrye, humormatters.com) ★

Interesting Times: Leave it to Leah to Pose a Different Perspective

Betty Kupperschmidt, EdD, RN, NEA-BC., Associate Professor, Director, Nursing Administration Program University of Oklahoma Health Sciences Center, College of Nursing

Introduction: Interesting times

Authors disagree as to which term, complex or chaotic, best describes today's healthcare workplaces. Enter Leah Curtin (2011) who describes today's health care environment as *interesting*, environments in which there are strong pressures to change, chaotic events, ambiguous objectives, and order that, if it is emerges, emerges on its own, environments that demand quantum leadership.

Contrasting Newtonian and Quantum Paradigms

To further develop her discussion of work environments and leadership, Leah contrasts Newtonian thinking, a paradigm dominating modern management for decades, a paradigm that viewed organizations and systems as predictable and controllable, with quantum thinking. Quantum thinking recognizes units, for example, as both separate and connected with dynamic energy that links with other units. Quantum thinking emphasizes relationships and integration, a holistic view of organizations and systems.

Curtin (2011) addresses an aspect of organizational behavior frequently absent in many texts: Spirituality. She asserts that leaders using a Newtonian paradigm tend to view people as separate and rational beings that compete with each other, mitigating a sense of belonging, whereas a quantum paradigm emphasizes relationships and strives to improve how people relate to one another, fostering community inclusiveness.

Newtonian paradigms acknowledge and reward employee actions useful in furthering the work of the organization. A quantum paradigm is holistic in the sense that it values both the professional and private selves, both employees' work-related attributes and emotional and values dimensions. Curtin (2011) reminds the reader that humans are hardwired psychologically to focus on what is wrong and missing, concentrating on inequities and dysfunctional aspects of rewards. Thus, in her opinion, external reward systems deteriorate as a source of motivation and may become sources of grievance.

Leaders acting from a Newtonian paradigm tend to focus on external rewards; however, leaders using a quantum paradigm contribute to engagement and spirituality because they strive to create conditions that acknowledge the expression and development of both the professional and private selves of employees (Curtin, 2011).

The Newtonian paradigm is useful in situations that are predictable and subject to managerial control whereas the quantum paradigm is useful for understanding unfamiliar events in complex, turbulent environments, useful for leadership in *interesting* times.

Summary and challenge

In summary, Leah (2011) cautions leaders not to be trapped into thinking that quantum thinking is the answer to most if not all of their leadership questions. Instead, today's quantum leaders must appreciate the contribution of each paradigm to explaining different aspects of their work environments and employee issues and become adept at reframing leadership issues from both points of view.

Leah believes that leaders' success absolutely depends upon this adeptness! (Emphasis is Leah's). I strongly recommend that all leaders read this provocative article. Leave it to Leah to challenge leaders once again with her unique perspective. ★

Reference

Curtin, Leah. (2011) Quantum leadership: Succeeding in interesting times. Nurse Leader 9 (1); 35-38.

Mastery Learning in Nursing Education

Submitted by Teressa Hunter, PhD, RN
Director, School of Nursing
Langston University

The concept of mastery learning has been around for over 40 years but it is yet to be fully embraced by the world of adult learning. According to Bloom (1968), mastery learning is a concept that emphasizes outcomes (Florida State College, 2012). Students should be given detailed description of the content and enough time to complete the activities. When this is done, students will be better equipped to demonstrate mastery of the concept.

Can the principles of mastery learning be applied to nursing education? It would require an educational and cultural shift where time would be spent helping the students understand how they learn. Students are often taught using instructional strategies that are not individualized based on their specific learning needs. The mastery learning instructional process involves organizing the concepts and skills that the students would need to learn. Assessment and feedback can be used to empower students to address their learning needs and correct learning errors (Guskey, 2007).

The two essential elements of mastery learning include: 1) feedback, corrective activities, an enrichment process, and 2) instructional alignment (Guskey, 2007). After the information has been taught, the students would be given a formative assessment that will give feedback on their learning needs (Guskey, 2007). The feedback will help the students identify the time needed on the concepts that are more difficult, thereby allowing the students to manage their time more efficiently. The formative assessment will help guide the formulation of corrective activities that will allow students to remediate the concepts or skills that are not mastered. The corrective activities may include a variety of resources such as using different textbooks, workbooks, videos, simulation lab, skills lab, and online resources (Guskey, 2007). This will allow students who have different learning styles to be able to master the content by using the activities that work best for their learning styles. Students should also be encouraged to engage in an enrichment process that can broaden their learning experiences (Guskey, 2007). Enrichment activities can include academic games, problem solving, case studies, discussions, and group activities. All of these activities must be well planned in order for the student to develop higher level skills. Those higher level skills include application, analysis, and synthesis of knowledge.

Instructional alignment requires the instructor to decide what concepts or skills are most important for the students to learn (Guskey, 2007). Students have been required to test over all the information included in a chapter and are not given focused or essential "need to know" objectives. The instructor would then assure that the students could focus their attention on what is required for mastery.

Mastery learning, with effective planning and goal setting, can positively impact self-confidence, students' motivation and success, and program completion rates. It could also improve students and instructor satisfaction. Therefore, using the concept of mastery learning can conceivably address the nursing shortage. ★

References

Copperman, R. (2011). Mastery learning in the adult classroom. *American Society for Training & Development,* 65(6), 52-57. Retrieved from http://web.ebscohost.com.

Florida State College, 2012. Learning through interactivity. Retrieved from http://bb.fscj.edu

Guskey, T.R. (2007). Closing achievement gaps: Revisiting Bemjamin S. Bloom's "learning for mastery." *Journal of Advanced Academics,* 19(1), 8-31. Retrieved from http://www.eric.ed.gov/PDFS/EJ786608.pdf.

Spanbauer Appointed to Physician Manpower Training Commission

Mercy executive director of patient care services brings hospital experience to board

OKLAHOMA CITY – Governor Fallin has appointed Pam Spanbauer, registered nurse, to the Physician Manpower Training Commission (PMTC), a seven-member board committed to enhancing medical care in rural and underserved areas of the state.

Pam Spanbauer

"We are pleased that Governor Fallin appointed Pam to serve as a board member of the Physician Manpower Training Commission. Over the long history of the Commission there has never been a member who has represented the hospital setting," said Rick Ernest, PMTC executive director. "Mrs. Spanbauer's experience in the health field and especially in the area of nursing will be a tremendous asset to the Commission as we continue to assist in producing the most qualified medical and health personnel to serve the citizens of Oklahoma, especially rural Oklahoma."

Spanbauer has experience in metro and rural hospital settings, currently serving as Mercy Hospital Oklahoma City executive director of patient care services. In her early years in medicine, she traveled across Oklahoma as an emergency medicine technician, in an ambulance. Specifically, she went to rural hospitals to pick up babies who needed to be transported to a neonatal intensive care unit at a bigger hospital.

"I always felt bad for the moms we had to leave behind," said Spanbauer. "What I've learned over the years is we've got to find a way to help patients stay closer to home. When they leave home, they leave their support system and come to a place where they don't know anyone. Even if their families can leave home to visit them at the hospital, the family is left trying to pay for hotels, food and travel. Patients worry about their families and they don't need that stress while they're trying to recover."

As a registered nurse, Spanbauer has seen first-hand evidence of the need to equip rural hospitals with the technology that providers need to give patients the best care possible.

"I've listened to the frustrations of nurses and doctors who want to serve the rural communities they love, but who move to larger cities to work," said Spanbauer. "I'm excited to be a part of this Commission, because we are going to find ways to address health care needs in rural Oklahoma. My role at Mercy will help me bring solutions to the table, based on successes Mercy has had helping rural hospitals take advantage of technology, like telemedicine and electronic health records, to better meet their community's health needs."

Spanbauer, a Mercy co-worker for 27 years, previously served as director of nursing and nurse manager at Mercy Hospital Oklahoma City. She earned her Bachelor of Science in nursing from Central State University and her Master of Education in adult education from the University of Central Oklahoma.

The Commission is made up of seven members appointed by the Governor. Five must be practicing physicians and two are non-physicians. Commission members serve five year terms and must be confirmed by the state Senate. Spanbauer will serve a five-year term, ending June 5, 2016. ★

###

About Mercy: *Mercy is the sixth largest Catholic health care system in the U.S. and serves more than 3 million people annually. Mercy includes 31 hospitals, more than 200 outpatient facilities, 38,000 co-workers and 1,600 integrated physicians in Arkansas, Kansas, Missouri and Oklahoma. Mercy also has outreach ministries in Louisiana, Mississippi and Texas. For more about Mercy, visit www.mercy.net.*

About Physician Manpower Training Commission: *The MISSION of the Physician Manpower Training Commission is to enhance medical care in rural and underserved areas of the state by administering residency, internship and scholarship incentive programs that encourage medical and nursing personnel to establish practices in rural and underserved areas. Further, PMTC is to upgrade the availability of health care services by increasing the number of practicing physicians, nurses and physician assistants in rural and underserved areas of Oklahoma.*

Nurses Specializing in Vaccine Promotion Earn ANA Immunity Award

SILVER SPRING, MD – The immunization coordinator for the Tulsa (Okla.) Health Department and a nurse educator at the Fort Hood (Texas) military base have earned the American Nurses Association's (ANA) Immunity Award for their efforts to raise immunization rates and improve vaccine program efficiency for the populations they serve.

Katherine Sebert

ANA's national award, part of the Bringing Immunity to Every Community project, coincides with the Centers for Disease Control and Prevention's (CDC) National Infant Immunization Week April 21-28, which seeks to mobilize parents, caregivers, and health care professionals to ensure that infants are protected against 14 vaccine-preventable diseases.

Katherine Sebert, BA, RN, coordinator for the Tulsa Area Immunization Coalition, has organized numerous vaccination events in the Tulsa area, including business-sponsored immunization drives and back-to-school clinics. Sebert also leads a statewide coalition that is developing collaborative arrangements and model practices to increase immunization rates throughout Oklahoma. Additionally, Sebert spearheads a collaborative effort with bordering Kansas to promote continuing education for health care professionals on immunization issues.

Rose Herrera, education nurse at Fort Hood's Thomas Moore Health Clinic, has helped organize immunization efforts and ensure that vaccine records for 16,000 Army soldiers and family members who attend the clinic are captured in electronic health records and are accessible to military officials worldwide. She educates nursing staff in immunization competencies. She has developed standardized procedures for immunization administration and helps enforce standing immunization orders for dependents of more than 46,000 soldiers at the base.

Bringing Immunity to Every Community is a collaborative project between ANA and CDC to maximize the role of nurses in increasing vaccination rates and reducing incidence of vaccine-preventable diseases. The project seeks to increase nurses' knowledge and competency in immunization, encourage nurses to be vaccinated, and position nurses as leading advocates for immunization among peers, patients, and the public. ANA and CDC promote vaccination programs as among the most effective and cost-efficient ways to prevent disease and death, and to protect entire communities from the spread of infectious diseases. ★

###

ANA is the only full-service professional organization representing the interests of the nation's 3.1 million registered nurses through its constituent and state nurses associations and its organizational affiliates. ANA advances the nursing profession by fostering high standards of nursing practice, promoting the rights of nurses in the workplace, projecting a positive and realistic view of nursing, and by lobbying the Congress and regulatory agencies on health care issues affecting nurses and the public.

The Kit: Identifying and Reducing the Problem of MRSA

Authors: Caitlin Weaver-Kaiser BSN, R.N., Allison Bacon BSN, R.N., Danielle Labeau BSN, R. N., Casi Strickler BSN, R.N., Tammy Yoes MS, R.N., CCRN, CNE University of Oklahoma

The authors presented this information at the University of Oklahoma's 2012 Evidence Based Practice Symposium instructed by Tammy Yoes. The primary author, Caitlin Weaver-Kaiser is planning to work in the Neuro-Trauma Intensive Care Unit at St. John's Medical Center.

The Problem

No one can deny nosocomial infections are one of the biggest issues hospitals face today. The problem lies not only in the major discomfort and extended stay patients and families experience, but also in the lack of reimbursement for the hospitals from major providers like Medicare and Medicaid. Climo et. al. estimates that 20% of patients admitted to intensive care units (ICUs) develop a healthcare-associated infection during their stay (2009) and Methicillin-resistant *Staphylococcus aureus* (MRSA) is one of the biggest offenders. MRSA is responsible for 60% of hospital staphylococcus infections (Murillo & Tsang, 2008). Furthermore, once contracted, MRSA is particularly difficult to treat because of its multi-drug resistance to methicillin and other common antibiotics used to treat non-resistant staff infections. Unfortunately, the problem does not just lie in difficult treatment. MRSA has been found to survive on inanimate objects for over 38 weeks, living in many areas in the hospital setting (Halcomb, Griffiths, & Fernandez, 2008), thus establishing itself as a rather obstinate bacteria! One study found MRSA present on 25% of staff pens (Halcomb, Griffiths, & Fernandez, 2008), while another found MRSA on tourniquets, stethoscopes, case notes, bed control handsets, and other commonly used staff and patient items (Davis, 2010). With such high contamination rates, it is safe to say that current contact precautions are but feeble attempts to contain the multi-faceted problem that is MRSA.

So what does this all mean in terms of people and money, you ask? It is estimated that 126,000 people are hospitalized annually with MRSA and 19,000 people die annually from it (Murillo & Tsang, 2008). This number is staggering when one considers that MRSA is usually a secondary or nosocomial (hospital acquired) infection. The final bottom line is the completely avoidable expense of MRSA. It is estimated that MRSA costs $27,083-$34,900 per case and $3.2-$4.2 billion for each hospital annually (Murillo & Tsang, 2008).

Solution: The Kit!

From compliance to cleaning, the issue of MRSA prevalence has multiple faults and therefore needs multiple solutions. Fortunately for the reader, the authors focus on one comparatively simple solution: the Kit. As mentioned above, strains of MRSA are easily found on many commonly used nursing and staff items. The Kit would provide all of those things most commonly used by nurses and other staff, therefore avoiding cross contamination. The Kit would be available at the bedside and stocked with items such as pens, scissors, pen lights, hemostats, and tape. All items in the Kit are disposable or easily cleaned. The estimated cost would be well under $10, with a great likelihood of being under $5 per patient stay. The Kit could be prepared prior to its being needed and placed on the isolation cart in central supply before its journey to the patient's room. Individual stethoscopes in isolation rooms are already standard; why not include other typically used items as well? The reduction in infection rates would more than compensate for the cost of the Kit in addition to decreasing length of stay for patients, helping patients and families avoid the pain and inconveniences commonly associated with MRSA, and increasing hospital revenue.

Conclusion

As noted above, it is estimated that MRSA costs $27,083-$34,900 per case. When compared to the potential cost of $34,000, what is just $10 for prevention? ★

References

Climo M, Sepkowitz K, Zuccotti G, Fraser VJ, Warren DK, et al. (2009). The effect of daily bathing with chlorhexidine on the acquisition of methicillin-resistant Staphylococcus aureus vancomycin-resistant Enterococcus, and healthcare-associate bloodstream infections: results of a quasi-experimental multicenter trial. *Critical Care Medicine*; 37(6):1858-1865.

Davis, C. R. (2010). Infection-free surgery: How to improve hand hygiene compliance and eradicate methicillin resistant Staphylococcus aureus from surgical wards. *The Royal College of Surgeons of England, 92* (4), 316-319.

Halcomb, E. J., Griffiths, R., & Fernandez, R. (2008). Role of MRSA reservoirs in the acute care setting. *International Journal Of Evidence-Based Healthcare, 6* (1), 50-77.

Murillo, J., & Tsang, P. (2008). Faster laboratory detection of MRSA translates to cost savings for hospital. *MLO: Medical Laboratory Observer, 40* (11), 20-24.

Have You Ever Had a Terminal Degree?

Janet Jackson APRN-CNS, CCRN, CPHRM, Assistant Professor, Tulsa Community College and House Supervisor, Saint Francis Hospital – South, and Current DNP student at the University of Oklahoma Health Sciences Center, College of Nursing

When I graduated with my Master's of Science with Nursing Major, I thought my road to graduate education was complete. The road took a turn when I saw that a new turn in the road, the turn that leads to a Doctor of Nursing Practice (DNP), would affect my standing as an Advance Practice Registered Nurse (APRN). The American Association of Colleges of Nursing (AACN) responded to the call from the Institute of Medicine and other national groups for doctorally–prepared clinicians who would be better prepared to address today's healthcare needs. The AACN responded by developing a profoundly sound document titled *The Essentials of Doctoral Education for Advanced Nursing Practice*. These essentials provide the curriculum framework, the educational track, for the practice-focused doctoral program. This Doctoral program is called the Doctor of Nursing Practice (DNP).

DNP and PhD. Differences

As the names state, there are major differences in a research-focused doctoral education and a practice-focused doctoral education program: The research-focused doctoral education programs require an in-depth research study that results in a dissertation and the expectation that graduates share their research in publications and poster and podium presentations. The practice-focused doctoral education comprises a final DNP project or capstone project in which the student addresses gaps in knowledge and gaps in practice. Students address these gaps in the format of a clinical problem that demands a high level of evidence-based clinical practice, interdisciplinary collaboration, and organizational and policy dynamics. The practice-focused doctoral education program also includes integration of curriculum content, such as evaluation measures, leadership, complexity and systems thinking, and of course, content required to support evidence-based practice. DNP graduates are uniquely suited to assume leadership roles in addressing population health issues, work to change policy at the state and national levels, as well as formal leadership roles in professional organizations.

AACN Essentials for DNP Education

As noted above, the AACN developed a curriculum for preparation of doctoral of nursing practice graduates. This curriculum is comprised of eight Essentials of Doctoral Education for Advanced Nursing Practice (AAC, 2006). The essentials are: I.) Scientific underpinnings for practice, II.) Organizational and systems leadership for quality improvement and systems thinking, III.) Clinical scholarship and analytical methods for evidence-based practice, IV.) Information system/technology and patient care technology for the improvement and transformation of health care, V.) Health care policy for advocacy in health care, VI.) Interprofessional collaboration for improving patient and population health outcomes, VII.) Clinical prevention and population health for improving the nation's health, and VIII.) Advanced nursing practice (AACN, 2006).

THE OBN Response

Beginning January 1, 2016, the Oklahoma Board of Nursing will change the requirements for licensure as an Advance Practice Registered Nurse. According to the Oklahoma Nursing Practice Act (November 1, 2011, p. 11), applicants applying for APRN licensure must meet the following: 1.) Submit a completed written application and appropriate fees as established by the Board; 2.) Hold a current Registered Nurse license in this state; 3.) Have completed an advanced practice registered nursing education in one of the four advanced practice registered nurse roles and a specialty area recognized by the Board. **Effective January 1. 2016,** the applicant shall have completed an accredited graduate level advanced practice registered nursing education program in at least one of the following population foci: family/individual across the lifespan, adult-gerontology, neonatal, pediatrics, women's health/ gender-related, or psychiatric/ mental health; 4.) be currently certified in an advanced practice specialty certification consistent with educational preparation and by a national certifying body recognized by the Board; and 5.) Provide any and all other evidence as required by the Board in its rules (Oklahoma Nursing Practice Act, November, 2011).

Summary

In closing, I thought I had a terminal degree when I proudly wrote MS after my name. Soon this APN will write DNP after her name! I will have my terminal degree. On second thought, in nursing, do we ever stop learning whether or not we earn more initials to write after our names? ★

References

American Association of Colleges of Nursing [DNP Essentials Task Force]. (2006, October). *The essentials of doctoral education for advanced nursing practice*. Retrieved from American Association of Colleges of Nursing: www.aacn.nche.edu.education-resources/essential-series.

Chism, L. A. (2013). *The doctor of nursing practice* (2nd Ed.). Burlington, MA: Jones & Bartlett Learning.

Oklahoma Nursing Practice Act [Unofficial Oklahoma Statues, Title 59, Chapter 12, Section 567.1]. (2011, November 1). Retrieved from Oklahoma Board of Nursing: www.ok.gov/nursing/index.html

Preventing Medication Errors: Acronyms as Strategies

Tammy Yoes MS, RN, CCRN, CNE
Faculty, University of Oklahoma Health Sciences College of Nursing

Problem

Despite the many advances in technology aimed at preventing medication errors, as many as "one out of five doses" is incorrect according to a literature review done by Brady, Malone, & Fleming (2009). Medication administration is a primary nursing responsibility, one that carries a significant risk not only to the patient, but also to the nurse. Nurses are devastated when they become aware that they have made an error that has caused harm to their patient. In addition, there is the financial aspect for patient, nurse and society because of fatal medication errors. According to a recent study (Dollinger & Dollinger, 2012), registered nurses are more likely to be "sued individually when they are involved in medication error cases." The five medication rights are the mechanism most frequently used to promote accuracy; however, over the past decade, there has been a 500% rise in drug errors (Brady, Malone, & Fleming, 2009).

Strategy: Three Acronyms

Nurses are accountable to their patients, the healthcare team and the Board of Nursing for the medications they administer. Nurses must obtain all necessary information prior to administering potentially harmful chemicals to patients. The information presented in Table 1 categorizes the necessary information and puts the information with the context of 'padding' and using the following acronym: Pad **(PAD)** the process with verification of **P**atient, accurate **A**ssessment, and **D**rug verification to ensure that the correct patient is receiving the correct drug, that the patient can tolerate the effects of the medication, and provide vital information with which to make nursing judgment.

Another acronym that may help increase medication safety is use of the DRT method: The DRT method stands for **D**ose, **R**ationale, and **T**ime **(DRT).** Addressing all three factors is vital to prevent sentinel events that could result in the patient being **D**ead **R**ight **T**here! The dose is very specific; one decimal point could cause major harm or even death. The ordered dose should be accurate when one puts the dose in context of the patient's condition at the time of administration. Age, size and metabolism can have a significant impact on the appropriate dose. Thus, it is very important that the nurse know the expected outcomes of each drug they administer. Knowing the purpose and intended outcome of the drug should assist the nurse in determining whether to administer the medication. Knowing how to evaluate the effectiveness of each medication provides vital data to assist the nurse in determining when to notify the physician. Nursing judgment is essential with scheduling medications based on assessment data and patient circumstance.

The last acronym to be discussed that may assist nurses' efforts to administer drugs more safely is REED. REED means nurses should REED all of the information and judge accordingly whether to question the order, or administer the medication as ordered. REED includes **R**oute of administration, **E**ducation of the patient, **E**valuation of patient response to the medication, and **D**ocumentation as the final steps in the process. Nurses must be aware that the rate of absorption is dependent upon route. Intravenous medications absorb much more quickly. Documentation is essential in recording the events that will be assessment data in the future.

Hospitalized patients and/or caretakers should be encouraged and educated to take responsibility for knowing medication regimen because they will be the "managers of the meds" after discharge. The patient must know how to evaluate the effectiveness of each medication and when to notify the physician.

Conclusion

It is important for nurses to be able to contextualize the medication administration process, anticipate potential for harm, and to intervene on the patient's behalf. Nurses have the unique, final opportunity to rescue patients from a potentially fatal medication error. As the last line of defense for the patient, it is imperative that nurses embrace the responsibility of ensuring safe medication administration. Nurses must insist that hospitals support them in their efforts to have uninterrupted time to prepare and administer medications. Medication errors have a profound impact on the healthcare system and the people it serves. By 'padding' the threats with information, preventing sentinel events, "reeding," and contextualizing the information, nurses can have a significant impact on the reduction of medication errors. Nurses are patient advocates, and the last line of defense in the final moment prior to medication administration. ★

Table 1. Summary of the Three Acronyms

Right	Information
Patient	• Use two identifiers such as name and date of birth (Lilley, Rainforth Collins, Harrington, Snyder (2011).
Assessment	• Allergies. Current VS, pain levels, trends, Ht, and Wt. • Lab values (specific to medication effects) • Mental status. • Respiratory status. • Heart rate and rhythm. • Gastrointestinal status (ability to swallow and metabolize) • Renal status • Is the patient taking any other medications that could enhance or decrease the effects of this medication?
Drug	• Use generic vs. trade names for consistency. • Check expiration date.
Dose	• Size, age, condition appropriate.
Rationale	• Patient condition warrants medication.
Time	• Last dose, verify with patient. • Planned procedures that may require change in schedule.
Route	• Is the route appropriate based on medication dose and patient condition? • Position and patency of line or tube if administered IV or per gastric tube.
Education	• Patient knowledge. • Symptoms to report.
Evaluation	• Did medication have intended effect? • Why or why not?
Documentation	• Include all information obtained, administration process, evaluation of effects and patient education.

References:

Benner, P., Sutphen, M., Leonard, V., Day, L., (2010). *EDUCATING NURSES: A Call for Radical Transformation*. San Franciso, CA: Jossey-Bass.

Brady, A.-M., Malone, A.-M., Fleming, S., (2009). A literature review of the individual and system factors that contribute to medication errors in nursing practice. *Journal of Nursing Management 17, 679–697*

Dolinger M.L., Dolinger R.A., (2012). A New Legal Interpretation of Duty for Registered Nurses. *Journal of Nursing Regulation, 3(1), 24.*

Lilley L., Rainforth Collins S., Harrington, S., Snyder, S. (2011). *Pharmacology and the Nursing Process* (6th ed.). St. Luis, MO: Mosby Elsevier.

Overcoming Challenges to Improving the Quality of Nursing Care in an Era of National Health Care Reform

Keynote Presentation by
Peter Buerhaus, PhD, RN, FAAN
2012 ONA Convention
Thursday, October 25
Hyatt Regency, Tulsa, OK
8:30 am

Dr. Peter Buerhaus

Dr. Peter Buerhaus is a nurse and a healthcare economist. He is the Valere Potter Distinguished Professor of Nursing at Vanderbilt University School of Nursing, and Director of the Center for Interdisciplinary Health Workforce Studies, the Institute for Medicine and Public Health, at Vanderbilt University Medical Center.

Dr. Buerhaus maintains an active research program involving studies on the economics of the nursing workforce, nurse and physician workforce forecasting, developing and testing measures of hospital quality of care, and determining public and provider opinions on issues involving the delivery of health care. Professor Buerhaus has published more than 90 peer-reviewed articles with five publications designated as "Classics" by the Agency for Healthcare Research and Quality (AHRQ) Patient Safety Network. Other publications have ranked as the most widely accessed articles published in the health policy journal *Health Affairs,* (the most widely accessed in 2006, sixth most accessed article in 2009 and tenth most accessed in 2010). Dr. Buerhaus is co-author of the 2008 book *The Future of the Nursing Workforce in the United States: Data, Trends, and Implications*.

On September 30, 2010, Dr. Buerhaus was appointed to Chair the National Health Workforce Commission, which was established under The Patient Protection and Affordable Care Act. Among other responsibilities, the Commission will provide advice to the Congress and to the President on national health care workforce policy. ★

ONA 2012 Convention Quick View

Our Health. Our State. Our Nurses

Wednesday, October 24, 2012
All Events on Wednesday are held at the *Hyatt Regency, Tulsa, OK*

Registration Opens
Noon

House of Delegates
1:00 – 4:00 p.m.
This is why we call it a convention! ONA's convention has been the designated annual meeting for regional nursing leaders to "convene" in one place to determine the priorities of the organization. Whether you are an observer or Delegate, please join us and strengthen the direction of the Oklahoma Nurses Association.

Exhibitor Move-in and Set-up
4:00 – 7:00 p.m.

Oklahoma League for Nursing
Reception
4:00-5:00 p.m.

Oklahoma Nurses Foundation
Educational Dinner Session
5:00 – 5:30 p.m. (networking)
5:30 – 7:30 p.m. (Dinner/Program)

Meet the Board of ONA
Reception Open to All (Suite Number TBD)
7:30 p.m.

Emerging Nurses Mix & Mingle
Licensed less than 5 years? Join us!
8:30 p.m.-??

Thursday, October 25, 2012
All Events and Sessions on Thursday are held at the *Hyatt Regency, Tulsa, OK*

Current Issues Forum – Current Issues and Events
7:30 - 8:15 a.m.

Exhibit Hall
Open 8:00 a.m.–4:30 p.m.

Opening Plenary Session
Overcoming Challenges to Improving the Quality of Nursing Care in an Era of National Health Care Reform
Peter Buerhaus, PhD, RN, FAAN
8:30 - 10:00 a.m.

Meet the Presenters (Speakers & Posters)
Exhibit & Networking Break
10:00 – 10:45 a.m.

Concurrent Session I:
10:45 – 11:45 a.m.

Awards Luncheon *(Exhibit Hall Closed During Lunch)*
12:00 p.m. – 1:15 p.m.

Concurrent Session II
1:30 – 2:30 p.m.

Concurrent Session III
2:45 – 3:45 p.m.

Exhibit and Networking Break
3:45 – 4:00 p.m.
(Exhibit Hall Closes at 4:30)

Concurrent Session IV
4:00 – 5:00 p.m.

CE Evaluation: 5:30 – 6:00 p.m. *(Return Forms to Registration Desk)*

Networking Finale: Rush Hour Reception
5:00 – 6:30 p.m.
Nurses on the RUN-way competition
Design a unique outfit from materials found in your facility/office (and win fabulous door prizes). Register your team at Convention. *(Be present to win)*

Our Health. Our State. Our Nurses.

Oklahoma Nurses Association
6414 N. Santa Fe, Suite A
Oklahoma City, OK 73116
Phone: 405.840.3476
www.OklahomaNurses.Org
ONA@OklahomaNurses.Org

How To Be Your Own Advocate

Margaret Selby, BSN, JD

Nursing is a highly stressful profession and sometimes brings out the worst in our colleagues. The term "hostile work environment" has gained new strength in recent years. Bullying and hostility from co-workers are frequent issues for a number of nurses who have sought assistance from the ONA Workplace Consultant.

There are a number of resources and tools that address this issue. Both the ANA and ONA have adopted position statements on promoting healthy work environments. Theoretically, these statements are outstanding in defining a healthy workplace, but as a practical matter, how can nurses protect themselves from such negative behavior?

In advocating for ourselves, we have the same tools that we use to advocate for our patients: communication, education and documentation.

Communication

Communicate with colleagues to develop respectful relationships. This is easier said than done when hostilities arise. Maintaining a professional demeanor is critical to the process of resolution, so set emotions aside and focus on the facts. Involve only the necessary people in the discussion so as not to foster gossip. Articulate the specific issue or behavior that initiated the hostility and try to engage in active listening during the discussion. Try to be a part of the solution, not the problem.

On a broader scale, communicate your concerns with your legislature. Share your story. Join professional organizations such as ANA and ONA to connect with others in the field. Utilize the ONA consultation service for assistance in addressing workplace hostility. This service is available to all nurses practicing in Oklahoma.

Documentation

When a difficult situation arises, document the facts. If applicable, have others record their observations pertaining to the incident(s). This will enable you to separate the data from the drama and can also be useful in the event of an investigation by supervisory or HR personnel.

Education

Familiarize yourself with the position statements of the ANA and ONA on promoting healthy work environments. The ONA incorporates the International Council of Nurses definition of abuse which is behavior that humiliates, degrades, or otherwise indicates a lack of respect for the dignity and worth of an individual. The ONA position statement recognizes a number of professional organizations that have also adopted positions supporting health work environments.

Identify your workplace's policies on bullying. These should be clearly delineated, but if not, should be evident in the institution's Mission Statement. If you are unable to resolve the hostilities, you can consult with your human resources department and share your factual observations with them.

Be the nurse who promotes healing at your workplace, and many will benefit. ★

Speak Out for Nursing – How to Get Involved

Every day, ANA's communications department proactively seeks media opportunities and responds to media calls from reporters all over the U.S. who want to interview nurses on important health care issues. The ANA Media Speakers Program has been created to meet that demand. The program includes a database of nurse experts who are ready to share their knowledge and speak out about issues that are important to nursing.

Open to ANA members only, to join the program please fill out the Media Speaker's Questionnaire at http://nursingworld.org/speakersform. For more information about joining ANA's Media Speakers Program, please contact Stacy Prince, ANA senior public relations specialist, at (301) 628-5038 or stacy.prince@ana.org.

Another way to get involved is to join ANA's Nurses Strategic Action Team (N-STAT), which makes it easy for you to unite with your colleagues across the nation and let lawmakers know how you feel by keeping you up to speed on key bills as they move through Congress and letting you know when your e-mails, phone calls, and letters will make the most impact. Sign up today at www.rnaction.org. ★

Ways ONA Members Can Get Involved—How NURSES Can Make a Difference!

- Be a Member of both ONA and your Specialty Nursing Organizations
- Attend Nurses Day at the Capitol
- Serve as Nurse of the Day
- Talk with your District's Representative and Senator
- Work on Election Campaigns
- Respond to Legislative Alerts
- Attend ONA Convention—Oct 25 and 26, 2012
- Share Research or Best Practices by presenting at the ONA Convention either a Concurrent and/or Poster Session
- Write an article for the *Oklahoma Nurse*
- Serve on an ONA Committee
- Serve as a Region Officers
- Work to Build a Community such as the *Emerging Nurses* or in another area
- Serve on the ONA Board of Directors
- Represent ONA on State or Community Board or Council

American Nurses Association/Oklahoma Nurses Association Membership—It's Your Privilege!

Online Registration is available at www.OklahomaNurses.org

6414 North Santa Fe, Suite A • Oklahoma City, OK 73116-9114 • Phone: 405-840-3476 • 1-800-580-3476 • Fax: 405-840-3013

Please type or print clearly. Please mail your completed application with payment to: ONA.

Last Name_____ First Name _____ Middle Initial _____

Street or PO Box Number _____

City_____ State_____ Zip_____ County _____

Last Four Digits of Social Security Number _____ Email _____

Home Phone_____ Work Phone_____ Cell Phone _____

Home Fax _____ Work Fax _____ Pager _____

Employed at _____ as _____

Employer's Address _____

Academic Degree(s) _____ Certification(s) _____

Graduation from basic nursing program (Month/Year)_____/ _____ RN License # State _____ Date of Birth _____/_____/ _____

Membership Categories (please choose one category)

❑ **ANA/ONA Full Membership Dues**
Employed full or part-time **$22.63 per month** or $265.50 annually. Includes membership in and benefits of the American Nurses Association, Oklahoma Nurses Association and the ONA District Association.

❑ **ANA/ONA Reduced Membership Dues**
Not employed RNs who are full-time students, newly-licensed graduates, or age 62+ and not earning more than Social Security allows **$11.56 per month** or $132.75 annually. Includes membership in and benefits of the American Nurses Association, Oklahoma Nurses Association and the ONA District Association.

❑ **ANA/ONA Special Membership Dues**
62+ and not employed, or totally disabled **$6.04 per month** or $66.38 annually. Includes membership in and benefits of the American Nurses Association, Oklahoma Nurses Association and the ONA District Association.

❑ **ONA Individual Membership Dues**
Any licensed registered nurse living and/or working in Oklahoma **$11.21 per month** or $128.50 annually. Includes membership in and benefits of the Oklahoma Nurses Association and the ONA District Association.

American Nurses Association Direct Membership is also available. For more information, visit www.nursingworld.org.

Communications Consent
I understand that by providing my mailing address, email address, telephone number and/or fax numbers, I consent to receive communications sent by or on behalf of the Oklahoma Nurses Association (and its subsidiaries and affiliates, including its Foundation, District and Political Action Committee) via regular mail, email, telephone, and/or fax.

Signature _____ Date_____

Dues Payment Options *(please choose one)*

SIGNATURE REQUIRED BELOW
❑ **Automatic Monthly Payment Options**
This is to authorize monthly electronic payments to American Nurses Association, Inc. (ANA). By signing on the line, I authorize ONA/ANA to withdraw 1/12 of my annual dues and any additional service fees from my account.
*SEE AT RIGHT

_____
Automatic Monthly Payment Authorization Signature

❑ **CHECKING ACCOUNT:** Please enclose a check for the first month's payment, which will be drafted on or after the 15th day of each month using the account designated by the enclosed check.

❑ **CREDIT/DEBIT CARD:** Please complete the credit card information at right and this credit card will be debited on or after the 1st of each month (VISA and MasterCard Only).

❑ **Annual Payment**
Make check payable to ONA or fill out credit card information below.

SIGNATURE REQUIRED BELOW
❑ **Automatic Annual Credit/Debit Card Payment**
This is to authorize annual credit card payments to American Nurses Association, Inc. (ANA). By signing below I authorize ONA/ANA to charge the credit card listed below for the annual dues on the 1st day of the month when the annual renewal is due.
*SEE AT RIGHT

_____
Automatic Annual Payment Authorization Signature

Charge to My Credit/Debit Card
❑ VISA (Available for Annual or Monthly Draft Payments)
❑ MasterCard (Available for Annual or Monthly Draft Payments)

Number _____
Exp. Date_____
Verification Code _____
Signature_____

* By signing the Automatic Monthly Payment Authorization or the Automatic Annual Credit Card Payment Authorization, you are authorizing ANA to change the amount by giving the undersigned thirty (30) days advance written notice. Undersigned may cancel this authorization upon receipt by ANA of written notification of termination twenty (20) days prior to deduction date designated above. Membership will continue unless this notification is received. ANA will charge a $5.00 fee for any returned drafts or chargebacks.