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from the President...
Highlights from the ANA Idaho Nurses Conference, November 6, 2015

A present-day Florence Nightingale may live in Idaho. At this year’s annual ANA Idaho conference held in Boise, we had the privilege to recognize and celebrate Grace Jacobson, PhD, RN. Dr. Jacobson has committed more than 50 years to the nursing profession. In this time, she has provided care to people not only within Idaho communities but also to communities abroad. She has taught, trained, and mentored hundreds, but more likely thousands, of nurses who have successfully received their nursing education at Idaho State University in Pocatello. In addition to her focus here in Idaho, she has had many years of service in the U.S. Army Nurse Corps, including an active duty tour in Desert Storm. To top it all off, Grace has been an INA/ANA member for 40 years. Grace is an excellent example of someone who is fully investing in her career. Thank you Grace!

At the ANA Idaho nurses conference, in addition to celebrating Grace’s many accomplishments, we had the great privilege of hearing from four other speakers including the ANA Idaho Executive Director, Robin Schaefter, RN, MSN, CAE, who visually recapped the Idaho Nurses Association’s past accomplishments in the presentation, “INA: The State of the Association.”

Our keynote speaker, Marla Weston, PhD, RN, FAAN, Chief Executive Officer of the American Nurses Association, presented “Nurses Transforming Healthcare.” Dr. Weston shared a cutting-edge perspective of the professional nurse trajectory, focusing on the opportunities that nursing has to become an integral part of healthcare. As Dr. Weston noted, we have more opportunities within our communities to be present as board members than ever before. Our current healthcare model is depending on the increase of advance practice RN’s and their ability to practice to the fullest of their licensure. Lastly and most importantly, Dr. Weston emphasized and reaffirmed that local and national leaders do hear OUR nursing voices.

At the conference, the remainder of the day included inspiring words from Alex Chamberlain, Chaplain and Ethicist, at St. Luke’s Regional Medical Center, on the ethical dilemmas we as healthcare providers face each day. Chaplain Chamberlain explained the role and goals of an ethics committee in ensuring the needs and the voices of our patients are represented fairly. Following this presentation, our afternoon was filled with hearing the very personal experiences of a corporate comedian, Sharon Lacey, whose mother had recently passed away and who was touched by the care of her mother’s nurses.

The conference ended with the reunion of our plenary speaker, Brandon Kelly, with a nurse from St. Alphonsus Regional Medical Center who had cared for him 20 years ago after he suffered a life threatening car accident. Brandon waited a near lifetime to thank his nurse publicly for having faith in him and for tirelessly working to heal him through many months of rehabilitation.

Needless to say, we had a great conference! Thank you to all who participated and/or attended.
Guidelines for Submissions to RN Idaho

RN Idaho (RNI), the official publication of ANA Idaho, is a peer-reviewed journal that is published quarterly. Views expressed are solely those of the authors or persons quoted and do not necessarily reflect ANA Idaho’s views or those of the publisher, Arthur L. Davis Publishing Agency, Inc. The RNI Editorial Board oversees this publication and welcomes nursing and health-related news items, original articles, research abstracts and other pertinent contributions of 200 to 800 words. Authors are not required to be ANA Idaho members.

For information about manuscript format, submission of photographs, publication selection and rights, and advertising in RNI, please visit the ANA Idaho website at http://www.idahonurses.org under “News/Links.” You may also contact the ANA Idaho at rnidaho@idahonurses.org or by phone 1-888-721-8904.

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Join ANA Idaho Today

We need you!

Membership application http://nursingworld.org/joinana.aspx

For more information contact Beth Geitz, Nurse Manager and recruiter:
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New Hospital, Great Location

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at the BOISE CENTRE

Collaborating for Health Building Blocks for a Healthier Idaho

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Registration opens in February

Early Bird Registration: $75.00 until March 31st
For more details visit www.collaboratinghealth.dh.idaho.gov

Topics Include:
Population Health Equity Policy, Systems and Environmental Change Collective Impact

“Continuing Education Credits pending”

INA Welcomes New Members

September - November 2015

Ammon, Idaho
Luanne Powers
Boise, Idaho
Carrie Anstrand
Mary Barlow
Ann Bult
Kathleen Daniels
Ashlee Dean
Jessica Emery
Linda Erlanson
Shawn Forseth
Jessica Hadfield
Bobbie Hernke
Cindy Koster
Christine Ludhiam
Cynthia Malinowski
Nancy Nadesoki
Eve Palmer
Amy Roberts
Anna Rostock
Carmen Salyer
Nichole Santarone
Nicolete Sessk
Erica Vager
Caldwell, Idaho
Jordie Booth
Clarkston, WA
Tracie Freeman
Couer D Alene, Idaho
Luke Emerson
Cindy Womeldorff
Emmett, Idaho
Lisa Isaksen
Idaho Falls, Idaho
Shelia Murdoch
Julietta, Idaho
Janice Hamilton
Kuna, Idaho
Kimberly Braun
Meridian, Idaho
Faith Chennette
Melissa Ward
Moscow, Idaho
Jodi Bice
Nampa, Idaho
Terri Blackburn
Pamela Drake
Brianne Kingsbury
New Plymouth, Idaho
Sara Mahler
Pocatello, Idaho
Marcie Brown
Janice Hammond
M. Michele Pond-Bell
Rathdrum, Idaho
Belinda Childers
Sandpoint, Idaho
Sharon Bistodeau

We need you!

Membership application http://nursingworld.org/joinana.aspx

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CARROLL COLLEGE OPENING
Chair, Department of Nursing

Complete position announcements can be found at www.carroll.edu/employment.
RN Idaho Editorial Board Member Changes for 2016

At the start of this new year, the RN Editorial Board wishes everyone good health and happiness. Current Board members are Dr. Tracy Flynn, Anna Hossong, Kim Watt, and Dr. Barbara McNeil, editor. In 2016, we will have changes in membership for the Board but continue to encourage you to send in your manuscripts or reports.

After publication of this current issue, Kim Watt, BSN, RNC-NIC, CPNN, will leave the Editorial Board. We wish to thank Kim for her wisdom and outstanding contributions to our newsletter’s editorial work. For many years, she has dedicated her time to the Editorial Board and consistently reviewed manuscripts for publication. Her critical analysis and keen insights in reviewing submissions have been valuable assets to RN Idaho. We will miss you, Kim, and send you good wishes.

On a positive note, we have gained a new Editorial Board volunteer, Carrie Anstrand, MA, BSN, RN, LCCE, IBCLC. She received her BSN from Boise State University in 2006 and her Master of Arts in Communication in 2006 with emphasis in Health Communication. Her areas of nursing specialty began in pediatrics; she worked for over 10 years at Texas Children’s Hospital in the Houston Medical Center. Currently Carrie is focused on women’s health and has a private practice as a lactation consultant and Lamaze birth educator. She also works for St. Luke’s Health System in Women’s Administration as the Coordinator for Women’s Health Special Projects. Carrie explained that her reason for volunteering to serve on the Editorial Board is twofold: to “sharpen my writing and editorial skills and to grow in critical analysis and keen insights in reviewing submissions.”

Some nurses may complain that Mrs. G. is not very intelligent or does not “comply” with their instructions for self-care. However, maybe Mrs. G. has a different personality or does not “comply” with their instructions for self-care. Mrs. G. is a 71-year-old white woman who says she went to school through the 9th grade. She has come to the clinic because she has a complaint of frequent urination with burning. She says that she thinks she may have weak kidneys because she found that she has some of the symptoms listed on a website called Herbcures.com. She ordered some herbs and has taken them for two weeks, but her symptoms have not improved. Mrs. G. is very tentative in her speech and keeps apologizing for bothering the nurse. She is worried that her son will be angry that she did not go to the doctor sooner. The nurse explains to Mrs. G. that she needs to go into the bathroom and collect a urine sample so that the lab can test it for the presence of bacteria and leukocytes. Then the nurse gives her verbal instructions for collecting the sample. Mrs. G. spends a long time in the bathroom, and when she comes out, the container is empty. She asks the nurse to repeat the instructions, and then returns to the bathroom to obtain the sample. At the end of the visit, the nurse hands Mrs. G. a patient handout about bladder infections and a prescription for an antibiotic, and tells her to take 3 tablets per day. Mrs. G. goes home and takes the tablets at 8 a.m. when she gets up, at noon when she eats lunch, and at 4 p.m. when she has a cup of tea and a snack.

Some nurses may complain that Mrs. G. is not very intelligent or does not “comply” with their instructions for self-care. However, maybe Mrs. G. has a different challenge – low health literacy. Health literacy (HL) is a construct that describes the many factors that affect “the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions” (Center for Health Literacy Promotion, n.d.).

The Health Literacy Skills framework (Squires, Peinado, Berkman, Boulewyns, & McCormack, 2012) is one model of the interconnectedness of factors that affect an individual’s HL. It takes into account not only an individual’s HL skills, but also the family, healthcare system, culture, and media factors that influence HL and health outcomes. HL and health-related behaviors are affected by a patient’s print and numerical literacy level, ability to communicate, information-seeking skills, health status, emotions, motivation, social support, access to healthcare, and the quality of the print and verbal messages they receive from healthcare providers (HCPs). Mrs. G.’s story illustrates how some of these factors affect her health behavior.

Health Literacy and Patient Outcomes

Only 12% of adults in the U.S. have proficient HL (U.S. Department of Health and Human Services [DHHS], 2012). Low HL can lead to many problems: less favorable health outcomes; low compliance rates; health disparities; incorrectly taken medications; worse mental health; less effective communication with HCPs; seeking out and using information from inaccurate sources; and increased medical costs, hospitalizations, ED use, and mortality rates (Berkman, Sheridan, Donahue, Halpern, & Crotty, 2011; Bevan & Pecchioni, 2008; Roett & Wessel, 2012; Wynia & Osburn, 2010).

Patient outcomes affect the financial well-being of medical institutions. Low HL adds an additional $106 to $238 billion to healthcare costs in the U.S. per year (Vernon, Trujillo, Rosenbaum, & DeBuono, 2007). The relationship between HL and hospital readmissions within 30 days of hospital discharge is pertinent because Section 3025 of the Patient Protection and Affordable Care Act (PPACA) requires hospitals to provide patients with a discharge plan that includes information on health literacy and health effects of low literacy, as well as “specific language as to how the plan is being communicated to the patient” (U.S. Department of Health and Human Services [DHHS], 2012).

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To Improve Patient Care continued on page 15
WE INVEST IN NURSES..... BECAUSE YOU’RE WORTH IT!

by Robin Schaeffer, MSN, RN, CAE
Executive Director of ANA Idaho
Email: ed@idahonurses.org

Year after year, the member volunteers and staff of ANA Idaho work tirelessly to meet your statewide professional needs. Every membership dollar we receive is invested back into interests that advance the nursing profession and promote a healthy Idaho. Please take some time to review our 2015 accomplishments and plans for 2016. Keep in mind that our work could not be done without collaboration and partnerships and the amazing work of our parent organization, the American Nurses Association (ANA). Be sure to check out the tremendous resources available to every nurse at http://www.nursingworld.org.

THE MOST TRUSTED PROFESSION... WHERE DO YOU FIT IN?

For 14 years in a row, the public has rated nurses’ honesty and ethical standards. This year 85 percent of Americans rate nurses as very high or high, 17 percentage points above any other profession! “It’s essential that we leverage this trust to lead and implement change in the health care system,” said Pamela F. Cipriano, PhD, RN, NEA-BC, FAAN, president of the American Nurses Association (ANA). “Hospitals, health care systems and other organizations are lacking an important perspective and can’t make fully competent decisions if they don’t have registered nurses at the board table or in the C-Suite. That’s why ANA is a member of the Nurses on Boards Coalition, working to place 10,000 nurses on boards by 2020.”

EVERY BOARD WOULD BENEFIT FROM THE UNIQUE PERSPECTIVE OF A NURSE.

The Nurses on Boards Coalition (NOBC) represents national nursing and other organizations working to build healthier communities in America by increasing nurses’ presence on corporate, health-related, and other boards, panels, and commissions.

With close to 50% of the current workforce (baby boomers) slated to retire in the next 10 years, health economists predict a nursing shortage. Job vacancies for experienced nurses have already started to increase in Idaho. Keep updated on the latest Idaho nursing workforce statistics at the Idaho Nursing Action Coalition: http://www.futureofnursingid.com.

WHAT EVERY NURSE NEEDS TO KNOW

In 2015, ANA released a revision of its Code of Ethics for Nurses with Interpretive Statements, a cornerstone document of the nursing profession that reflects many changes and evolutions in health care. It addresses the most current ethical challenges nurses face in practice. The release was just one component of the “Year of Ethics,” a series of activities emphasizing the importance of ethics in nursing practice. For more information: http://www.nursingworld.org. To order a copy of the book: http://www.nursesbooks.org/
STAFFING WHITE PAPER: A MUST READ

The 2015 3rd edition of the Nursing Scope and Standards of Practice contains 17 national standards of practice and performance that define the who, what, where, when, why, and how of nursing practice.

The Nursing Scope and Standards of Practice informs and guides nursing practice and is often used as a reference for quality improvement initiatives, certification and credentialing, position descriptions and performance appraisals, classroom teaching and in-service education programs, boards of nursing members’ orientation programs, and regulatory decision-making activities.

It also outlines key aspects of nursing’s professional role and practice for any level, setting, population focus or specialty, and more!

CULTURE OF HEALTH

Cultural Assessment Framework

QUALITY, SAFETY, AND STAFFING

Nurses are key to building a culture of health in their communities. The theme of the 2015 Campaign for Action Summit was Leading Change & Building Healthier Communities. The Robert Wood Johnson Foundation rolled out their Culture of Health Action Framework. Look for 2016 updates from our Idaho Nursing Action Coalition on this important initiative: http://www.nurseleaders.org/idaho-nursing-action-coalition/

CULTURE OF SAFETY

It’s been 15 years since the Institute of Medicine rocked the nation when it issued the call for a safer health care system in its landmark reports, To Err Is Human: Building a Safer Health System and Crossing the Quality Chasm: A New Health System for the 21st Century. Since then, nurses have been instrumental in improving the quality and safety of U.S. health care over the past decade and a half, but we have to ask whether we are now truly practicing in a culture of safety.

ANA President Cipriano as she kicks off a yearlong drive into a culture of safety that focuses on patient and nurse safety: http://www.nursingworld.org. The campaign will also highlight how patients, communities, and the nursing profession can benefit from efforts to foster a culture of safety in health care.

IDaho Nurses

Help us spread the word about Women’s Health Check

Women’s Health Check offers FREE Pap tests and mammograms to eligible women

For more information, or to find a screening location, call the Idaho CareLine at 2-1-1 or visit www.womenshealthcheck.dhw.idaho.gov

University of Idaho

Adult, Organizational Learning & Leadership Program

Program Faculty:
Laura Holyoke, Ph.D
Associate Professor, Moscow
Jean Henscheid, Ph.D
Clinical Asst. Professor, Boise
Michael Kroth, Ph.D
Associate Professor, Boise

The Adult, Organizational Learning and Leadership (AOLL) program prepares leaders in a wide range of careers including higher education, business, government agencies and nonprofit organizations. You will be able to attain skills to become a leader in your field of expertise.

This program is designed for working professionals with flexible schedules and online courses. Areas of interest including adult learning, organizational learning, leadership, and human resource development.

For more information: Web: http://www.uidaho.edu/ed/leadershipcounseling/aoll
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Benefits and discounts

If you are a member of ANA Idaho, you have choices: Pick one, two, or all: Professional Liability Insurance, Auto Insurance, Long Term Care Insurance, Term Life Insurance, Financial Planning: http://www.nursingworld.org. If you are not a member, please join us and support the work we do for your profession.

Your Rural Healthcare Opportunity Awaits...

Rural Hospital RN

Join our high caliber staff of RN’s and live in the beautiful high desert of Eastern Oregon! 24-bed Critical Access Hospital seeks licensed RN’s for full time. Broad training opportunities to facilitate your growth as a quality RN. Small patient to nurse ratio and great medical staff who complete our care team. Prefer experience in med/surg, ER or OB. Salary FT $29.56-$45.13 DOE, night and weekend differentials.

Call Denise Rose, Harney District Hospital 541-573-5184 or apply at harneydh.com

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If you are a member of ANA Idaho, you have choices: Pick one, two, or all: Professional Liability Insurance, Auto Insurance, Long Term Care Insurance, Term Life Insurance, Financial Planning: http://www.nursingworld.org. If you are not a member, please join us and support the work we do for your profession.

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533 W. WASHINGTON • BURNS, OR 97720
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Heather Healy, MS, APRN, FNP-BC, NEA-BC, was a member of INA until she moved to Spokane, Washington to become Chief Nursing Officer for Deaconess Hospital, Rockwood Health System. Heather gave an excellent update of the ANA’s Nursing Scope and Standard of Practice, 3rd edition. For more information about this updated publication see page 5.

American Nurses Association’s CEO Maria Weston, PhD, RN, FAAN, immediately captured the interest of the audience during her keynote address: Nurses Transforming Healthcare. Her presentation was followed by audience questions and discussion.

Alex Chamberlain, Ethicist, presented the audience with many ethical scenarios during his presentation: When Family Says ‘Do Everything’ and We Believe That the Requested Treatment Is Futile.

Comedian Sharon Lacey presented Life Should be an Adventure: How to Overcome Change and Beat Stress. Weaving in real nursing experiences along with audience participation, Sharon was the perfect after lunch speaker! Here she is with Gary Dokter, conference participant.

Closing speaker Brandon Kelly presented Elevating Your Efforts so That You Can Elevate Your Excellence. Brandon is a master at triumphing against all odds. He fought and won a battle against cancer twice. In this picture Brandon is re-united with one of the St. Alphonsus nurses that cared for him during a prolonged hospitalization when he was just 2-years old and just barely survived a car accident caused by a drunk driver. You can see 2-year-old Brandon in the picture behind the speaker.

Waiting for the next session to start. Glad to have a day off from work and down-time with their friends and colleagues.

Mentoring our future nurses: Grace Jacobsen (right) sits with Jessica Daugharty-Sterner (left). Jessica is the current president of the Idaho Student Nurses Association.

Anna Rostock and Brienne Sandow take a moment to pose for the camera.

We had many nurses join ANA Idaho on conference day. Here are the 3 lucky winners of our new member raffle.

Board of Director members meet prior to the ANA INA Annual Conference: Sitting around the table from the left: Holly Carlson, President; Kim Froelich, VP, Pres-Elect; Tonia Walston, Secretary; Becky Lambrecht, Liaison, Idaho Student Nurses Association; Margaret Henbest, Executive Director, Nurse Leaders of Idaho (guest); Toni Sparks, Membership Assembly Representative; Debby Wood, ANA Idaho Staff and Traci Gluch, Treasurer.
Proposed Legislation

The Board’s three proposed bills, when adopted, will:

1) Enact the “enhanced” Nurse Licensure Compact (NLC), which will replace the current NLC, of which Idaho has been a member since 2001 and which is currently in effect in 25 states. The “enhanced” NLC adds an amended version of the current NLC, an interstate compact modeled after the Driver’s License Compact that provides the mechanism for member states to recognize nurse licenses mutually, thereby alleviating the need for licensed practical nurses and licensed registered nurses to hold multiple licenses. The “enhanced” Nurse Licensure Compact incorporates language agreed to by the 50 states and four U. S. territories, addressing concerns about public protection as well as operational and governance issues with the current Compact.

2) Enact the Advanced Practice Registered Nurse (APRN) Compact, modeled after and complementary to the NLC, that will allow APRNs to hold one license issued by the primary state of residence that grants the privilege to practice as an APRN in other APRN Compact member states, both physically and via technology. Adoption of the Compact will increase patient access to qualified APRNs licensed in another state who choose to practice, either physically or electronically, in another Compact member state.

3) Amend the current definition of “practice of nursing” to more accurately reflect the functions nurses perform and what the practice of nursing means in Idaho. Practice of nursing, as amended, will mean “the autonomous and collaborative performance of acts and services requiring specialized knowledge, judgment, and skill that assist individuals, groups, communities or populations to promote, maintain, or restore optimal health and wellbeing throughout the life process. Nursing practice encompasses a broad continuum of services delivered in, but not limited to, areas of clinical practice, education, administration, research, and public and volunteer service. Nursing practice occurs at the physical location of the recipient.”

Pending Rules

The Board is presenting two separate administrative rule docketts that were introduced for comments in July, revised as necessary based on comments received, and are now pending approval by the Legislature as the last step toward becoming final.

1) Pending Rule Docket 23-0101-1501 requires RNs and LPNs seeking to renew their licenses to demonstrate their continued competence to practice nursing in Idaho. The rule establishes methods and criteria to comply with this obligation.

2) Pending Rule Docket 23-0101-1503 amends Board of Nursing Rule 402 (IDAPA 23.01.01.402) to update and clarify provisions regarding registered nurses functioning in a specialty area of nursing.

The Board especially appreciates the Idaho Nurses Association’s careful review and input on the proposed legislative bills and administrative rules as well as the organization’s indicated support for each document. These exciting initiatives will maintain the currency and relevance of the Idaho Nursing Practice Act and Administrative Rules of the Board, the primary structural elements that support the Board’s mission to protect the public.

Other Updates

The nine-member, governor-appointed Board of Nursing meets quarterly for the conduct of regular business. At their October 1-2, 2015, meeting, Board members Susan Odom, RN, Moscow; Chair; Vicki Allen, RN, Pocatello; Vice Chair; Whitney Hunsaker, consumer member, Boise; Christopher Jenkins, RN, Homedale; Jan Moseley, RN, Coeur d’Alene; Carrie Nutsch, LPN, Jerome; Rebecca Reese, LPN, Post Falls; Clay Sanders, APRN, CRNA, Boise; and Merrilee Stevenson, RN, Wendell. —Approved new/revised internal policies related to 1) practice remediation for nurses who have been absent from practice and are seeking initial or reinstatement licensure and 2) Board member and staff in- and out-of-state travel;

— Granted continued approval to nursing assistant training programs at the College of Southern Idaho; College of Western Idaho; Eastern Idaho Technical College; Idaho State University; Lewis-Clay State College; North Idaho College; and Stevens-Henager College/Idaho Falls;

— Approved a major curriculum change to the AD/ RN program presented by Eastern Idaho Technical College;

— Continued their discussion of Board member qualifications and set this as the primary topic for the Board’s 2016 Business Retreat in May;

— Received an update report on the Idaho Nursing Action Coalition’s (INAC) initiative to “Position Idaho to Best Meet the Future of Nursing Workforce Needs,” presented by Dr. Randy Hudspeth, Project Director;

— Discussed the potential impact of the recent U. S. Supreme Court decision on North Carolina Board of Dental Examiners vs. Federal Trade Commission; Received an informative report on Idaho’s State Health Innovation Plan (SHIP) from representatives of the Idaho Department of Health and Welfare; Continued work on revision of the Board’s Vision statement;

— Engaged in robust dialogue on emerging treatment modalities for substance use disorder, including agonist therapy, and implications for participation in the Board’s Program for Recovering Nurses as well as Board decisions related to licensure eligibility.

In addition, the Board discussed the evolving role and educational preparation of LPNs, lifelong learning and continued competence requirements for nurses, and training needs for unlicensed assistive personnel in various settings, with several members of the public in attendance at the October meeting during the scheduled Open Forum on October 2.

Next Board of Nursing Meeting

The Board invites the public to attend scheduled Board meetings and participate in the Open Forum held on the second day of each meeting. The Forum provides an opportunity to dialogue with the Board on issues of interest about which they are not necessarily on the published agenda. The Board will not take action on issues introduced during the Forum, but may choose to address them at a later scheduled Board meeting.

Future meetings of the Board are tentatively scheduled for April 21-22, July 21-22, and October 20-21, 2016, in Boise at locations to be determined. For further information, visit the Board’s website at www.bcn.idaho.gov or contact Lyn Moore at lyn.moore@bcn.idaho.gov or 208.577.1200.

Update from the Idaho Board of Nursing

February, March, April 2016

by Sandra Evans, M.A.Ed, RN, Executive Director

Email: sandra.evans@ibn.idaho.gov

Second Regular Session of the 63rd Idaho Legislature

The second Regular Session of the 63rd Idaho Legislature will be in full swing by the time you receive this issue of RN Idaho, and, as in previous years, the Idaho Board of Nursing will be enthusiastically engaged during the Session. this year, the Board will be:

• Introducing three pieces of legislation, each amending the Nursing Practice Act;

• Presenting two administrative rule docketts;

• Presenting the Board’s FY2017 budget request;

• Monitoring bills that impact the Board as an agency of state government and also the safety, health and welfare of patients and the public; and

• Responding to requests from policymakers for information and bill analysis as they maneuver through the complex task of lawmaking in the brief period of time they are in Boise doing “the work of the people.”

Proposed Legislation

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Educating the Idaho Nursing Workforce of the Future: Creating Opportunities for Life-long Learning Among Nurses of Traditionally Under-Represented Populations

by Andrea Lambe, Boise State University, DNP Student
Email: andrealambe@u.boisestate.edu

A landmark report, published by the prestigious Institute of Medicine [IOM] (2010), recommends that 80% of nurses be baccalaureate prepared by the year 2020. Additionally, the report calls for the provision of strategically aligned pathways to facilitate academic progression from recruitment to admission, graduation, and licensure of a culturally diverse nursing workforce. State-based implementation (SIP) grants funded by the Robert Wood Johnson Foundation (RWJF) and the American Association of Retired Persons (AARP) awarded grants to 31 states, including Idaho.

The purpose of this paper is 1) to introduce the fourth objective of Idaho's SIP grant, which is the creation of opportunities for life-long learning among nurses of traditionally under-represented populations and 2) to give a preliminary status report of this objective.

Current Status of Diversity Among Idaho's Nurses

By 2043, minority populations are projected to become the majority, necessitating a diversified nursing workforce to narrow the gap of healthcare disparities nationwide (American Academy of Colleges of Nursing [AACN], 2013a). Current data indicate that Idaho falls short of achieving a diversified nursing workforce based on the percentage of licensed practical (13.4%), licensed registered (11.6%), and advanced practice nurses (10.5%) with minority backgrounds practicing in the state (Idaho Department of Labor, 2015, p.56). Ethnic or racial minorities account for 37% of the general U.S. and 17% of Idaho's population (Idaho Department of Labor, 2015). Approximately 13% of Idaho's nursing workforce stems from traditionally under-represented populations and, therefore, reflects Idaho's diversity demographics more closely than those of the United States (Idaho Department of Labor, 2015).

National data suggest that 30.1% of undergraduate and 31.9% of graduate nursing students have a minority background (AACN, 2013b), indicating a 4%-7% rise in minority baccalaureate and graduate nursing students over the last decade (AACN, 2015). A snapshot of Idaho’s four AACN member academic institutions' points to the fact that only 10% of baccalaureate students come from traditionally under-represented populations while an additional 15% are male nursing students, who, due to low enrollment, are often considered a minority group (AACN, 2015).

Faculty positions, nationwide, appear to equally lack diversity as minority nurses hold only 13.1% of positions available (AACN, 2013a, 2013b; National Advisory Council on Nurse Education and Practice (NACNEP), 2013). Diversity statistics for Idaho's nursing faculty are unknown. Because of the aforementioned data, Idaho must continue to strive for a nursing student and faculty demographic that meets the nation's demands of a diversified, baccalaureate healthcare and nursing workforce by 2020.

Proposed Action Items

Structured Pipeline Program

Admission into Idaho's schools of nursing (SON) remains highly competitive due to a shortage of clinical sites and faculty in the face of existing funding cuts for public institutions of higher education. Creating a diversified nursing workforce and student population must include targeted recruitment strategies for minorities to ensure a diversified student body and future workforce. Research indicates that students from under-represented populations often face science and math preparation gaps, are less likely to enroll in a health science major, experience a lack of paternal guidance during the college application process, and experience language difficulties leading to avoidance of degree seeking (Brooks Carthon, Nguyen, Pancir, & Chittams, 2015). Despite significant interest in diversification, these authors found that only a small number of nursing programs had implemented a structured pipeline program to increase minority student representation.

Pipeline programs focus on the provision of financial, academic, and psychosocial support, which includes diversity workshops, career development, research opportunities, and community partnerships between distance learning, counseling and mentoring. Carthon et al. (2015) note that every minority group requires different support systems. Hence, a "one size fits all" approach is not appropriate and nursing as well as other healthcare professional programs are encouraged to explore and engage in diversity pipeline programs that appreciate the swath of experiences and cultural nuances of minority students and their contribution to the institution, student body, and community.

Holistic Review Admission Process

Historically, admission processes provided advantages for Caucasian students with a focus on grade point average and standardized testing results (Hassouneh

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March 19, 2016

We know nurse certification and the continuing education required to maintain certification contribute to the creation of an environment of professionalism and a culture of retention.

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Thank you to all our certified nurses.
The challenge amidst a growing, diversified population is for healthcare workers to provide the type of culturally-competent patient care that has been directly linked to organizational effectiveness and safe patient outcomes. Hence, the American Nurses Association (ANA) and the Idaho Nurses Association advocate for “culturally congruent practice” as part of the revised ANA Scope and Standards of Practice (2015) for nurses.

In 2007, the Association of American Medical Colleges (AAMC) endorsed a holistic review initiative, and recently published the Roadmap to Diversity and Educational Excellence delineating holistic admission processes for Schools of Medicine (AAMC, 2014). This review process incorporates four principles that allow for a broad selection criteria other than standard admission processes. These criteria include (a) a candidate’s fit with an institution’s mission and goals, (b) his/her life experiences, personal attributes and academic metrics (“EAM”), (c) the consideration of the applicant’s race and ethnicity as well as (d) each candidate’s contributions to the academic institution and profession (Glazer, Bankston, & Clark, 2015).

SON that have implemented this holistic review in their admission processes have seen the number of attempts by students to pass licensing exams either improve or remain unchanged (Glazer, Bankston, & Clark, 2015). Additionally, holistic admission practices improve student engagement within the community, cooperation and teamwork among students, and increased the students’ openness to ideas or perspectives other than their own. Therefore, Idaho’s healthcare employers and SON face a great opportunity to dialogue on the integration of holistic review processes and the creation of a diversified influx of baccalaureate-prepared nursing students.

Diversity Measurement

The Sullivan Commission (2004) charged schools to set measurable goals and promote the training in diversity and cultural competence for students, faculty, and healthcare professionals. Bleich, MacWilliams and Schmidt (2015) ask that SON advance diversity through inclusive excellence by creating partnerships with minority groups and organizations. Diversity measurements, for example in the form of race or ethnicity specific data, can be utilized to support such inclusive excellence to institute data-driven planning and development initiatives that will address the challenges of old and emerging demands that are not adequately reflected in the incremental changes that have occurred in the past.

Idaho Nursing Action Coalition’s Contribution

To answer the call for a diversified nursing workforce based on migration and population projections as well as anticipated and identified gaps in healthcare, national attention has been given to the development of diversity engagement strategies in healthcare education programs. Accrediting agencies, educational institutions, professional organizations, and employers agree to close this gap and Idaho is making significant strides towards this goal.

Thus far, the Idaho Nursing Action Coalition (INAC) has assessed Idaho’s progress towards attaining an 80% baccalaureate prepared nursing workforce by 2020 and continues to support inclusive practices to promote diversity in our state in accordance with the Campaign for Action (2015). The design and implementation of diversity engagement practices is no small feat, but INAC is dedicated to continue an open dialogue between stakeholders on the development of migration strategies that will include and respect state-based, as well as school-based, variables. For Idaho, healthcare employers and regional differences will play an important role in defining the healthcare sector’s particular needs for a diversified nursing workforce.

What Is Next?

In 2015, the Idaho Board of Nursing implemented a new licensure database and diversity-specific data should become available in January of 2016. Thereafter, Idaho nurse leaders, educators as well as healthcare employers are called upon to denote Idaho’s status as it stands in terms of diversity engagement and formulate specific implementation strategies for a culturally diverse nursing workforce for Idaho. The new data and potential diversity engagement strategies will be presented and opened up for discussion at the June 2016 INAC regional meeting in Boise, Idaho.

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References


Strategies for Nurses Encountering Patients at Risk for Addiction or Substance Use Disorder

by Deborah A. Thomas, M.Ed., LPC, CADC, Chief Executive Officer
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Addiction is a chronic, progressive, primary disease that left untreated will lead to an early death. According to the American Society of Addiction Medicine (ASAM) (2011, Definition of Addiction, para 1), addiction “is characterized by an inability to consistently abstain, impairment in behavioral control, craving, diminished recognition of significant problems with one’s behaviors and interpersonal relationships, and a dysfunctional emotional responds.”

As the first step in helping a person at risk for an addiction or with a substance use disorder (SUD), the nurse must recognize that there is an addiction problem. When encountering these adolescents and/or adults, a nurse may feel manipulated and experience an active addict’s playing on the nurse’s emotions with lies, complaints, or even appealing to the nurse’s sympathies in order to continue to obtain the reward the addict may be actively seeking. Oftentimes a nurse will not know how to interact with these patients. Even worse is that those persons at risk for addiction or with a SUD will not know what to do with themselves. It’s a frustrating situation. It can seem hopeless at times for the patient, the patient’s family, and the nurse.

How Nurses Can Intervene

In interactions with persons at risk for addiction or SUD, nurses may not know the words that will help these individuals or their family. From a nurse’s perspective, it may be challenging to determine whether a patient at risk for addiction or with SUD needs inpatient or outpatient treatment. The challenge is not that the nurse would not assess or treat these patients, but instead should make a referral to an addiction treatment center. Nurses should be aware however that this might lead to upset patients and/or family members. The person at risk for addiction or with SUD needs to hear that there is hope, that there is someone that can provide options, and that life can get better.

At the addiction treatment center, the addiction specialist will conduct a multidimensional assessment of the individual using the American Society of Addiction Medicine Criteria (see Figure 1). According to ASAM (2011. ASAM Criteria, para 1), these criteria are a “comprehensive set of guidelines for placement, continued stay and transfer/discharge of patients with addiction and co-occurring conditions.”

Nurses play a pivotal role in ensuring the patient receives the best treatment. By facilitating the referral, nurses plant the seed to initiate change, which may turn around the life of these individuals and assist them toward sobriety and ultimately to become a productive, motivated contributor to society. Residential facilities such as The Walker Center in Gooding, Idaho, can help treat adults over 18 who are at risk for addiction and/or who abuse drugs and alcohol. The underlying emotional or behavioral issues are addressed through gender-specific and gender-sensitive treatment such as cognitive behavioral group therapy.

When a Family Says, “Do Everything,” And We Believe That the Requested Treatment Is No Longer Beneficial

by R. Alex Chamberlain, Coordinator of Clinical Ethics
St. Luke’s Regional Medical Center, Boise, Idaho
Email: chambera@slhs.org

One of the greatest challenges in health care arises when we believe that we are doing something “to” a patient rather than “for” them. This surfaces when we face the age-old ethical dilemma of noticing when we can do something, but are wondering if we should do it in the face of diminishing returns in terms of patient benefit.

One Approach

Some states, Texas for example, have formulated a legal algorithm when the patient or his/her surrogate decision makers want to continue treatment that the medical team has deemed no longer medically beneficial (e.g., futile, to use a traditional term.) After a diligent search for an alternate provider, and with concurrence of an ethics committee, the medical team is allowed to remove non-beneficial treatment over the surrogate’s objections. This is similar to a process that is built into the policies of many individual hospitals as well. The solution is largely unsatisfactory, because most hospital ethics committees consist of members who appear indistinguishable from the clinicians themselves...rendering the perception that ethic committee members are impartial. Knowing that our fallback position is to override the family sets up an adversarial relationship.

Maintaining Heartfelt Presence Alongside the Family

As difficult as it will be for us, a more ethically sound approach can be made to it that we will struggle with the family amid these decisions rather than make a unilateral pronouncement that “they are done” and proceed to treatment withdrawal, make a patient DNR, or otherwise move away from an aggressive plan of care. We don’t have to “fix” the clash between us and the surrogate decision makers. In fact, we should not be surprised that the patient’s family may be slow to find that a solution arises more quickly than if battle lines are drawn. As our working relationship with the family members is developed and trust grows, we may find that a solution arises more quickly than if battle lines are drawn. Each individual patient story that involves an ethical dilemma may benefit from an ethics consultation and many hospitals have an ethics committee with trained members who will come alongside to offer their perspective.

Nursing’s Role

By turning on its head the standard maxim “the patient comes first,” it is my conviction that the first priority of the nurse facing ethical dilemmas should be the survival of the nurse. If we don’t recognize our moral distress and seek the support of our peers and the interdisciplinary team, we will become depleted and no longer be able to continue to serve our patients and one another. One way to avoid this involves joining with the family in expressing dismay and looking forward to a sigh of relief with them...rather than in spite of them.

References


SAVE the DATES for 2016 Activities!

by R. Alex Chamberlain, Coordinator of Clinical Ethics
St. Luke’s Regional Medical Center, Boise, Idaho
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Collaborative Testing in Nursing Education

by Michelle Critchfield, RNC, BSN
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The author reports no potential financial or other conflicts of interest and no commercial affiliation.

In keeping pace with changes in health care and following the call by the Institute of Medicine (IOM) (IOM, 2011) and the American Association of Colleges of Nursing (AACN) (AACN, 2011) for collaboration, a primary goal of nursing education must be preparing future nurses to work in collaborative teams (Sandahl, 2010). Nursing education also must meet the needs and learning styles of the students enrolled in nursing programs. Nurse educators must recognize that today’s college-age students utilize a unique approach to learning, drastically different from that of current nurse faculty. This younger generation of future nurses has grown up in a technologically-rich society and prefers teamwork, innovative learning strategies, the use of technology, and experiential activities (Hanson & Carpenter, 2011, p. 270). The purpose of this paper is to analyze the collaborative testing strategy, and describe the benefits and potential drawback of this educational strategy for use in nursing education.

Collaborative Learning

In collaborative learning, students work together to achieve learning goals. This type of learning strategy is active and student-centered (Sandahl, 2009) and allows the learner to interact with other individuals while developing skills like creativity, flexibility, personal problem solving (Bloom, 2009). Collaborative learning allows students to work in small groups and promote each other’s learning by explaining, sharing, and discussing (Hanson & Carpenter, 2011). Collaborative learning activities are varied and can include discussions, group case studies, research teams, peer-teaching activities, and testing (Sandahl, 2009). Five key components have been identified to make collaborative learning a successful learning strategy: face-to-face interaction, individual and group accountability, interpersonal and small group skills, positive interdependence, and group processing (Hanson & Carpenter, 2011).

Collaborative Testing

Collaborative testing is an educational strategy that utilizes the five key components of collaborative learning. This educational strategy gives student nurses the opportunity to reinforce nursing knowledge and theory while practicing teamwork and collaboration skills (Sandahl, 2010). Collaborative testing consists of small groups of students working together to come to a consensus on examination questions. Collaborative groups can be chosen by the instructor or be student-selected; students can remain in the same groups over the course of many exams or groups may change with each assessment (Pandey & Kapitanoff, 2011).

The type of exam utilized in collaborative testing can also be varied; unit exams, final exams, or both types of exams may be offered. Collaborative exams may be used exclusively or may be utilized after an exam has been taken on an individual basis. The variety of options allows the learning strategy to be tailored by the instructor to meet the students’ learning needs (Bloom, 2009).

Positive Benefits of Collaborative Testing

Retention of Knowledge

One benefit of collaborative testing is retention of content. When students collaborate to answer exam questions, they discuss and reason with another, becoming more skillful in critical thinking through communication. Knowledge, in general, is social, and constructed from cooperative efforts to learn, understand and solve problems. “Group members exchange information and insights, discover weak points in each other’s reasoning strategies, correct one another, and adjust their understanding on the basis of others’ understanding” (Bloom, 2009, p. 219).

Student Perceptions

Student perceptions of collaborative testing are consistently positive (Sandahl, 2010). Students believe they learn more with collaborative testing when compared to individual examinations (Woody, Woody, & Bromley, 2008) and collaborative testing has been shown to reduce learner test anxiety. Collaborative learning activities result in a more positive relationship among students and create healthier psychological regulations than do competitive or individualistic learning practices (Bloom, 2009). Students prefer group discussion; it was ranked first on a list of 11 possible teaching approaches (Woody et al., 2008) and the group format has been shown to enhance the learners’ satisfaction with the overall learning process (Bloom, 2009).

Individual Student Preparation and Motivation to Learn

Research shows that when collaborative testing is utilized, individual student preparation is increased (Shindler, 2004). Students reported increased motivation to prepare in collaborative conditions than they might have in an individual exam context. They related their increased preparation to the fear of letting down their group mates (Shindler, 2004). In this lower anxiety, positive, collaborative testing environment, students are more likely to study and retain information being reviewed prior to the exam. This positive attitude towards course work and peers can be a motivating force to improve study habits and exam preparation (Sandahl, 2009).

Improved Exam Scores

One benefit from collaborative testing that has been supported overwhelmingly in research is the improvement of exam scores. Students working together and utilizing a collective knowledge base perform significantly better than when being tested individually (Bloom, 2009). In the collaborative format, students were more likely to change wrong answers to correct answers than the reverse (Giuliodori, Lajan, & DiCarlo, 2009). Research also showed that when collaborative testing was utilized in the course, individual exam scores also increased (Bloom, 2009). Researchers cited decreased anxiety, more positive learning environment, and increased preparation that collaborative learning environments provide as reasons for the individual exam improvements (Bloom, 2009).

In situations where students were administered a collaborative exam after completion of an individual exam, the collaborative exam served as a posttest review. This double testing method provided answers to lingering questions from the initial individual exam, corrected erroneous thinking, and provided an additional learning opportunity of the course content (Peck, Stuble-Werner, & Raleigh, 2013). Posttest reviews in this format were positive, constructive, and educational, whereas some faculty will describe traditional posttest reviews as negative and argumentative. The students were reinforced in their correct thinking or corrected in their erroneous thinking by peers in a learning environment (Centrella-Nigro, 2012). This also eliminated the need to utilize subsequent class periods reviewing exam items and allowed more time to focus on new content (Bloom, 2009).

Drywall to Collaborative Testing

Beneficial to Selected Students Only

Collaborative testing is not an effective learning strategy for all learners, despite the improved test scores for most participants. Some students describe themselves as introverts and prefer to do all course work alone; other students cite a lack of trust and friendship within the cohort group as a reason to shy away from group learning activities (Peck, et al., 2013). Solitary and high achieving learners often prefer to rely on their own preparation and knowledge for exam strategies (Haberyan & Barnett, 2010).

Possible Grade Inflation

Collaborative learning may result in individual grade inflation. While both high and low achieving students reported collaborative testing as a positive experience, lower achieving students benefited the most from the group testing experience (Centrella-Nigro, 2012). This is not surprising as low performers have more to learn from high performers than vice versa (Dahlstrom, 2012). Less prepared and lower achieving students can rely on the efforts of more prepared and higher achieving students and the collaborative exam grade may not reflect the individual learner’s actual knowledge of the content (Giuliodori et al., 2009).

Non-Acceptance by Educators

Some educators are unfamiliar with collaborative testing strategies and see the strategy as less sound than traditional forms of assessment (Shindler, 2004). Others

Collaborative Testing continued on page 12
argue that collaborative testing does not prepare students to be successful on national certification exams (Peck et al., 2013). Many nursing curricula are designed towards successful attainment of a passing grade on the NCLEX-RN. In these circumstances, collaborative testing is seen as contrary or non-preparatory for this goal (Centrella-Nigro, 2012).

Preconceptions of Students

A barrier to collaborative learning and collaborative testing is the students’ pre-conceived notions about traditional education and learning strategies. Even though teaching-learning strategies for younger students’ learning utilize cohort groups and collaborative learning, the students may be unfamiliar with these strategies in formal education. They may be uncomfortable to try an unfamiliar tool like collaborative testing, when they have no previous experience with the strategy. Instructors may utilize class time creating “buy-in” or encouraging students to utilize collaboration for learning, instead of focusing on the learning objectives. Students can also have expectations that instructors will provide all the learning and information and they may hesitate to listen to classmates’ ideas and perspectives and may continually seek support and reassurance from the instructor (Smith-Stoner & Moller, 2010).

Application to Nursing

As cited in Giuliodori et al (2009, p. 24), the American Association for the Advancement of Science strongly recommends, “science be taught as science is practiced.” It can be taught, modeled, and utilizing a student’s preferred learning strategy (Smith-Stoner & Moller, 2010). As part of that is collaboration (Giuliodori et al., 2009, recommends, “science be taught as science is practiced.” It can be taught, modeled, and utilizing a student’s preferred learning strategy (Smith-Stoner & Moller, 2010). It can be taught, modeled, and practicing in nursing education to prepare student nurses to function on interdisciplinary teams and meet the challenging needs of diverse health care patients. Nurses can facilitate collaboration in nursing education by utilizing collaborative testing.

Conclusion

Collaborative learning is a useful educational strategy, based in scientific research and learning domains, with many positive benefits to nursing education. Nurse educators can utilize collaboration to prepare future nurses to seamlessly transition into inter-disciplinary health care teams while strengthening their nursing knowledge by utilizing a student’s preferred learning strategy (Smith-Stoner & Moller, 2010). It can be taught, modeled, and practicing in nursing education to prepare student nurses to function on interdisciplinary teams and meet the challenging needs of diverse health care patients. Nurses can facilitate collaboration in nursing education by utilizing collaborative testing.

References


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Central District Health Department

Idaho District 4

Central District Health Department is seeking an energetic, independent RN with good interpersonal skills to provide clinical services 5 days per week for our Immunization and Communicable Diseases program in Mountain Home. Duties include: supervising clinic staff, assessing immunization records and administration of vaccines, organizing flu clinics and other community outreach, assisting with Reproductive Health Clinic and follow-up. Requires a valid license to practice in Idaho. No on-call. State benefits and malpractice included.

Visit www.dhr.idaho.gov for more information and to find nursing jobs in your area. Contact us today!

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Finances 101: Impact of Your Health on Your Wealth

by Peggy L. Farnworth, CPA, CFP, CSA, Securities and advisory services through KMS Financial Services, Inc.
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We have all felt the pinch of the rising costs of health care. According to the Centers for Medicare and Medicaid Services (CMS), past and national health expenditure projections for 2012-2022, our health care costs are on a path to $4.8 trillion by 2021, up from $2.76 trillion in 2010 and $757 billion in 1970. Health care is fast approaching 20% of the U.S. economy. What does that mean to you personally and to your patients? It means spending a considerable sum every time you visit a doctor or professional health care costs leave families with considerably less cash to spend. But what are the options? What can we do differently?

PricewaterhouseCoopers (2010) calculated that up to half of all health care spending results from waste. That waste can be divided into 2 areas. One area of waste is excessive, defensive medicine that orders redundant, inappropriate or unnecessary tests. What can you do to prevent this? We can ask questions, challenge the “why,” get second opinions, and look for less expensive options for the same procedure.

We can also control the other major area of waste—our own work. We can take medication as prescribed. We can stop smoking and drink alcohol moderately or not at all. We can eat healthy whole foods and stay physically active to maintain a healthy weight. We can very significantly reduce our chances of suffering from chronic diseases such as diabetes and heart/lung problems. The growing burden of chronic diseases adds significantly to escalating health care costs. Researchers predict a 42% increase in chronic disease cases by 2023 (Partnership to Fight Chronic Disease, 2009); this adds $4.2 trillion in treatment costs. Much of this cost is preventable, since many chronic conditions are linked to unhealthy lifestyles.

We need to become more responsible consumers of health care if for no other reason than poor health is a huge opportunity cost. Poor health makes us miss work, possibly miss promotions. Poor health costs us money that we could spend elsewhere and poor health makes it harder to save money.

Olivia Mitchell, the head of Pension Research Council at the Wharton School of Business at the University of Pennsylvania, said in a 2007 Money Magazine interview that if a couple in their 50s and 60s with an average income develop chronic health problems, it will slow their savings by half the rate of their healthy counterparts. She adds that a healthy 65-year-old couple would save $295,000 to cover insurance premiums and out of pocket medical expenses over an average life span (or about 20 years). Add an additional $150,000 for a couple with chronic illnesses.

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ANA Idaho is pleased to honor deceased registered nurses who graduated from Idaho nursing programs and/or served in Idaho during their nursing careers. Included, when known or when space allows, will be the date when deceased and the Idaho nursing program. The names will be submitted to the American Nurses Association for inclusion in a memorial held in conjunction with the ANA House of Delegates. Please enable the list’s inclusiveness by submitting information to idahonurses.org.

Barrett, Agnes Earthree. July 10, 2015. Agnes earned an associate degree in nursing from the University of Minnesota in Duluth in 1950. Because she valued education, she later attended Lewis-Clark State College in the 1980's and earned a Bachelor's degree, one of her proudest accomplishments. Agnes worked in the pediatric office of Dr. Mannschreck and Dr. Olson in Lewiston, caring for hundreds of children over the years.

Bayer, Judith Mary Coppage. August 29, 2015. Jude completed her nursing education at Troy State University in Alabama and worked 30 years for the University of California-Los Angeles Medical Center neuropsychiatric unit as a certified psychiatric nurse. She later moved to Lewiston, where she worked in the psychiatric unit at St. Joseph Regional Medical Center. Jude's lifelong passion was nursing. She loved mentoring younger co-workers to help them embrace the nursing profession.

Beben, Shirley Geraldine. September 23, 2015. Shirley studied nursing at Fairview Nursing School in Minneapolis from 1939 to 1942, then moved to Seattle where she worked as the right hand for a urologic surgeon. Although she retired from nursing when she married in 1948, she never stopped volunteering her time and energy. Shirley was a loving, faith-filled example to her friends, children and grandchildren who she loved so dearly.

Bottle, Ronda Lee. October 9, 2015. Ronda was a charge nurse at Clarkston Care Center until retiring in 2000. She entered public health nursing in Lewiston, where she was assigned to the Nez Perce Indian reservation. She was then recruited by a former instructor to teach at the Odessa Jr. College in Odessa, Texas. She later returned to the Public Health Department in Lewiston and Moscow. While Carol always put family first, she made time for community service and worked with pregnant and parenting teens until she retired in 2000.

Bradley, Charlotte. October 25, 2015. Charlotte graduated from Lewis-Clark State College as a registered nurse in 1972 while raising her children. She was a charge nurse at Clarkston Care Center until retiring in 1995. As a young girl, Charlotte played clarinet with the Los Angeles Orchestra for background music in newswreels. Charlotte was a mother to many and would take in any in need. She worked from sunup to sundown and laughed and played in between.

Buckingham, Linda. November 15, 2015. Linda was a registered nurse at Cascade General Hospital in Rexburg and joined the Air National Guard in 1976. As a young girl, Linda played clarinet in the Idaho Falls Municipal band. After retiring from the nursing profession, she devoted herself to volunteering with the Boys and Girls Club of Idaho Falls.

Bush, Lucille. December 15, 2015. Lucille worked at a Kaiser hospital in Oakland, CA, and at the Lawrence Livermore General Electric Lab in Livermore, CA, before moving to Lewiston. While working at St. Alphonsus Hospital, Lucille graduated to the St. Alphonsus Hospice care team in 2000. She continued to work as a hospice nurse until her passing in 2015.

Candace, Laidace Kaye. June 20, 2015. Candace achieved her nursing degree at Boise State University and worked as a licensed practical nurse. She had a natural talent for making people laugh, and her humor was contagious. Caring for her loved ones was what she did best.

Charlton, Lynn. June 20, 2015. Lynn was a registered nurse at Ricks College and the LDS Church where she served faithfully in many callings.

Churchill, Charlotte. December 15, 2015. Charlotte was a mother to many and would take in any in need. She worked from sunup to sundown and laughed and played in between.

Circelli, Constance. June 10, 2015. Connie was a native Idahoan and attended primary and secondary school in the Treasure Valley. She attended Whitworth College for one year before returning to Idaho to begin her nursing career.

Locklear, Louise L. July 18, 2015. When her children were well along in school, Louise elected to join the Alphonsus Hospital surgical teams before retiring in the mid 1970's. She loved working with the patients she served so well.

Roth, Dorothy. October 25, 2015. Dorothy was a registered nurse at JFK Medical Center in Idaho Falls. She died peacefully in her sleep on October 25, 2015, after a long and fulfilling life caring for those in need.

Stenberg, Shirley Geraldine. September 23, 2015. Shirley studied nursing at Fairview Nursing School in Minneapolis from 1939 to 1942, then moved to Seattle where she worked as the right hand for a urologic surgeon. Although she retired from nursing when she married in 1948, she never stopped volunteering her time and energy. Shirley was a loving, faith-filled example to her friends, children and grandchildren who she loved so dearly.

Van Maanen, Trudy. November 12, 2015. Trudy was born and raised in Holland. After immigrating to the United States she attended Mercy Medical Center and received her registered practical nurse license. For many years she worked at the Idaho State School and Hospital, where she greatly enjoyed caring for the residents. Trudy wrote the book “Under the Shadow of His Wings” and continued working on her computer until just before her death.

Vogel, Dorothy Anne. October 22, 2015. Dorothy attended St. Alphonsus Nursing School and graduated in 1942, then served as the community health resource in Fields, Oregon. After retiring from nursing, she moved to the State of Idaho and became a volunteer at the Salvation Army. She continued to give of herself to those in need.

Wickel, Eloise Hedges. October 23, 2015. Eloise was a charge nurse at the Deaconess Hospital in Spokane, WA, before moving to Lewiston, where she worked as an RN at a Kaiser hospital in Oakland, CA, and at the Lawrence Livermore General Electric Lab in Livermore, CA, before moving to Lewiston. While working at St. Alphonsus Hospital, Lucille graduated to the St. Alphonsus Hospice care team in 2000. She continued to work as a hospice nurse until her passing in 2015.
Many Nurses Lack Knowledge About Health Literacy 

There are over two million nurses in the U.S. who can help prevent these costly readmissions by educating themselves about HL and intervening appropriately. Unfortunately, researchers have found that nurses frequently are not trained to understand and address the HL of their patients. Many nurses overestimate their patients’ HL levels, view HL as a low-priority problem for their patients, and do not know how to implement low HL interventions (Caferio, 2013; Macabasco-O’Connell & Fry-Bowers, 2011). In an era when patients and their family members are asked to perform medical/nursing tasks (Reinhard, Levine, & Samis, 2013); to manage complicated medication regimens; and to navigate a complex healthcare system with shortened office visits, fragmented care, and an increasing amount of insurance paperwork (Ferguson & Pawlak, 2011), it is imperative that nurses know how to assist patients who have limited HL.

The Nurse’s Role and Interventions 

Nurses should play a leading role in improving HL. The National Action Plan to Improve Health Literacy (U.S. DHHS, 2010) strives to connect HL to public health, clinical care and education and calls for pilot tests and demonstration projects to be expanded for use in organizations, population groups, and geographic regions. Nurses should assume that all patients have low HL until proven otherwise because HL does not always correspond to educational attainment, and adults often mask their HL problems. Also, the complex healthcare system and the stress of illness can put anyone at risk for HL challenges. Nurses should be aware that cognitive impairment, poor vision, age, lower education, low acculturation, and less frequent use of English might signal low HL.

Nursing interventions should address these areas: spoken and written communication, self-management and empowerment, and support systems. The AHRQ Health Literacy Universal Precautions Toolkit (AHRQ, 2015) addresses each of these areas and provides specific tools and resources for HCPs (available at http://www.ahrq.gov/professionals/quality-patient-safety/literacy-toolkit/index.html).

Health Literacy From the Patient’s Perspective 

HCPs have a tendency to view healthcare from their own perspective. A 2009 study (Shaw et al., 2009) of 321 cardiac patients found the majority of patients, regardless of their level of HL, wanted the doctors to use simpler language and to use verbal communication to build trust in the relationship. Many patients stated that they either did not read the patient education materials or became confused and anxious when they did.

In a study of readmitted diabetes patients, although not one patient possessed adequate knowledge of their diabetes or of the discharge instructions they received, almost all of the patients stated that they did not have any questions while being discharged, and that they understood the discharge information. The studies and the personal and financial costs of low HL, provide evidence that all nurses have an obligation to learn about HL, to make HL a priority in their practices, and to navigate a complex healthcare system with shortened office visits, fragmented care, and an increasing amount of insurance paperwork (Ferguson & Pawlak, 2011), it is imperative that nurses know how to assist patients who have limited HL.

References 

Almost one out of six of your adult patients has or is at risk of developing diabetes. Diabetes control achieved through diabetes self-management education can improve health outcomes. Refer your patients to an ADA recognized or AADE-accredited Diabetes Self-Management Education (DSME) Program. With a referral, it’s covered by Medicare, Medicaid, and most insurance plans.

There are DSME Programs statewide. Find one near your practice: diabetes.idaho.gov

Idaho’s Best Choice for a Career in Healthcare

A strong, professional nursing staff is at the heart of St. Luke’s. We engage nurses at every level of the organization as leaders, caregivers, and scientists. Opportunities for career advancement abound—from community hospital care to rural clinic practice to leading-edge tertiary services.

We offer a competitive compensation program with outstanding benefits, including relocation assistance and an employee wellness program. Grow in your personal life, in your career, and in your community, at St. Luke’s.

Make meaningful connections every day. Visit us online for more information on how to join the St. Luke’s team. stlukesonline.org/careers