Parting Thoughts...

by Holly Decker-Carlson, MS, CCRN
ANA Idaho President
Email: president@idahonurses.org

Helen Keller said “Alone we can do so little; together we can do so much.” As I reflect on the past two years, nearing my end as president of ANA Idaho, I am full of gratitude for the nurses of Idaho. Without your support, my efforts would have been a waste. I would like to share with you a few of the highlights of what we have accomplished through your engagement and commitment to the association during my presidency.

- Your Voice Was Heard:
  - Because of your interest and concern about the State Board of Nursing’s continued competency proposition, we were key stakeholders at the table for nearly a year working for a realistic solution to the legislation that was passed this year.

- Continuing Nurse Education Program Implemented:
  - ANA Idaho now offers a full service American Nurses Credentialing Center’s Commission on Accreditation (ANCC/COA) continuing nurse education (CNE) program. We are able to provide individual activity CNE credits as well as applications for those entities choosing to become an approved provider of CNEs. Historically you would have had to go to other state associations to access this service. Find more information at http://www.westernmd.org/MainMenu/CNE.

- Operational and Financial Sustainability Achieved:
  - The ANA Idaho Board structure was changed to ensure that not all board members were turning over at the same time. This year we are electing a president treasurer and the delegates. We implemented a president elect/vice president position instead of a president elect/vice president position and treasurer.

- Financials 101: The Tax Man Cometh!
  - Peggy L. Farnworth, CPA, CFP, CSA

- Safety 360: Taking Responsibility Together
  - Executive Director of ANA Idaho

National Nurses Week Theme for 2016

Safety 360: Taking Responsibility Together

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

National Nurses Week is celebrated each year from May 6 – May 12 (Florence Nightingale’s birthday). Many of your employers join in the recognition in various ways. Since 1996, the American Nurses Association (ANA) has recognized May 6 as National RN Recognition Day, although ANA honors all RN’s for their tireless commitment 365 days a year. In January 2016, ANA launched a year-long initiative, A Culture of Safety, to raise awareness about this important topic. The American Nurses Association (ANA, 2016) defined a culture of safety as the “core values and behaviors resulting from a collective and sustained commitment by organizational leadership, managers, and health care workers to emphasize safety over competing goals.”

Many of you remember the reports issued over 15 years ago by the Institute of Medicine (IOM): To Err is Human: Building a Safer Health System and Crossing the Quality Chasm: A New Health System for the 21st Century. Since that time, health care delivery has focused on quality and safety measures; however, recent studies suggest that we may have underestimated the number adverse events that the IOM suggested (Lattie, 2013).

Medical errors fall within this year’s theme. Other monthly topics range from fatigue and shift work to leadership, data, systems thinking, and more. Please visit www.nursingworld.org to access the topic of the month
Parting Thoughts...continued from page 1

of a past president position to ensure a smooth transition for the incoming president.

- Our association joined the Multi-State Division, a conglomerate of western states committed to the financial and operational sustainability of non-union association states. This has provided support services on a local level as well as a stronger voice at the national level.

- We moved our executive directorship away from an association management agency to an Executive Director (ED) who is a nurse with extensive experience in running nursing associations. This change was not only in the best interests operationally for our association, it has resulted in our operational cost cuts, on average, by $20,000.00 per year. That is a near 50% savings in overhead costs!

ANA Idaho has a bright future ahead. We have momentum because of your commitment not only to our Association but also to our profession. The progress we have made in the last two years will continue forward as ANA Idaho welcomes Kim Froehlich, M.S., R.N., as our new president beginning July 1st.

I ask one last time that you stay engaged. Support our nursing association. Provide extraordinary, safe, patient-centered care in your uniquely skilled way. Take good care of yourselves and thank you for trusting me with ANA Idaho.

Executive Director’s Report continued from page 1

and all archived information. If you are a member of ANA INA, you will get reminders of the great articles and webinars related to a culture of safety. If you are not a member, please consider joining because most webinars and articles are free.

References

Welcome New RN Idaho Editorial Board Members

We are fortunate to have two new ANA Idaho members join us as part of our six-person team that volunteers to provide their nursing perspective and their time to review and edit RN Idaho. Please welcome Beverly Kloepfer and Katie Laufenberg. Both Bev and Katie will add new perspectives to RN Idaho. We welcome their input and thank them for choosing to “give back” to their profession. Welcome Bev and Katie!

Katie Laufenberg, BSN, RN

Since 2015, Katie Laufenberg has been the Practical Nurse Coordinator/Assistant Professor at Lewis-Clark State College (LCSC) in Lewiston, Idaho. After earning her LPN, she completed her BSN in 2015 at Lewis-Clark State College. Her clinical experience has encompassed long-term care and hospice care in Rhode Island, Massachusetts, Virginia, Washington state. She served as the Clinical Resource Coordinator/Instructor at Lewis-Clark State College prior to her current position. Katie is working on her MSN degree concentrating on a nursing informatics specialty at Kaplan University. Her “beautiful 1 ½ year old daughter is the joy of my life.” She decided to join the RN Idaho Editorial Board because of her awareness of the importance of evidence based practice and as a way to review articles in order to “give back to nursing.” She sees the need for RN Idaho to provide “well-written articles that are meaningful in order to better nursing.”

Beverly Kloepfer, MSN, RN, NP-C

In 1985, I graduated from the diploma program at Good Samaritan School of Nursing in Portland, Oregon, and moved to Lewiston, Idaho, in 1993. In 2007, I completed my BSN from Lewis-Clark State College and then received an MSN with a focus on Nurse Practitioner: Family Health from Idaho State University. I have worked the majority of my career in critical care. Since 2005 and until 2010, I have taught at LCSC as an adjunct or full time instructor in the Practical Nursing Program. My current academic position at LCSC is as an Associate Professor of Nursing in the BSN Program. One day each week, I also work for LCSC’s Student Health Services as a Primary Care Provider. As time allows, I volunteer at the Snake River Community Clinic, serve on the Twin County United Way Board, and engage in various other volunteer activities. I have participated in multiple medical mission trips both with my church and with the LCSC nursing students. On a personal level, I have three in college, one grandson who is four months old, and my physician husband who works in the Emergency Room at Gritman Medical Center in Moscow, Idaho.

Are Opioids an Effective Long-Term Therapy for Chronic Non-Cancer Pain?

by April Telan, RN, BSN, CEN
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The author declares no conflict of interests.

Chronic pain is the leading cause for disability in adults in the United States (Finelli, Chaparro, & Compagnone, 2014). At the same time, the U.S. is experiencing “an opioid overdose epidemic” where 78 Americans die each day from an opioid overdose (CDC, 2016). The detriment of undertreating pain, overmedicating patients, and increasing rates of abuse, addiction, and diversion underscores the need to examine the clinical question of whether opioid therapy should be the intervention of choice (Chou et al., 2015).

The purpose of this paper is to review current research evidence and recommend pharmacotherapies for chronic nonmalignant pain. Investigating the comparative efficacy of opioid therapy to nonopioid therapy for long-term chronic pain will reveal current research evidence to direct safe clinical practices and offer our patients the opportunity for quality and functional lives.

Search Strategy

This author conducted a systematic literature search for current meta-analyses and meta-syntheses of quantitative/qualitative studies and individual randomized controlled trials (RCTs), non-RCTs, cohort studies, and case-control studies in the Cochrane Library database, PubMed, the Cumulative Index of Nursing and Allied Health Literature (CINAHL), and the National Guidelines Clearinghouse (NGC). Studies were selected using inclusion and exclusion criteria, which were determined “a priori.” The specific inclusion criteria for selection of studies were outlined with the PICOT format and are reported in Table 1.

Table 1. Study Inclusion Criteria by PICOT Elements

<table>
<thead>
<tr>
<th>PICOT Element</th>
<th>Inclusion Criteria</th>
</tr>
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<tbody>
<tr>
<td>(P) Populations will include:</td>
<td>Adult men and women defined as patients 18 years old and older presenting with chronic nonmalignant pain for at least one to two months.</td>
</tr>
<tr>
<td>(I) Interventions will include:</td>
<td>Opioid therapy as the primary, adjunct, or optional intervention for long-term management of chronic pain. Opioid analgesics routes could be IV, PO, a sustained release preparation, or sustained release preparation. Uses of opioid therapy could be routine, scheduled, PRN, breakthrough, and/or tapering dose.</td>
</tr>
<tr>
<td>(C) Comparison will include:</td>
<td>Long-term use of nonopioid pharmacotherapies in chronic pain control. Nonopioid pharmacotherapies include: Non-Steroidal Anti-Inflammatory Drugs (NSAIDs), Acetaminophen, and anti-convulsants for chronic pain management.</td>
</tr>
<tr>
<td>(O) Outcomes will include:</td>
<td>Improved efficacy of pain management demonstrated by reports that may be via a survey/questionnaire, physical assessment, or a quantifiable scale such as the numerical rating scale.</td>
</tr>
<tr>
<td>(T) Time Factors will include:</td>
<td>Medications must be scheduled for one to two months to achieve the outcome.</td>
</tr>
</tbody>
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Studied Exclusion Criteria

Studies were excluded from review if they included patients younger than 18 years old and older than 65 years because of differences in their pain experiences; if they examined acute pain and reported use of opioid analgesics for less than one month; if they centered on nonpharmacological interventions and focused on opioid addiction and misuse during treatment; and if they addressed only the risks of misuse of opioids as a negative effect on pain management, function, and quality of life.

Evidence Summary

Based on this review of eight studies and a systematic review of the literature, this research found minimal conclusive research on opioid therapy compared to nonopioid pharmacological therapies for chronic non-malignant pain. This was a consistent finding for various types of non-malignant pain such as back pain, rheumatoid or osteoarthritis, fibromyalgia, and diabetic neuropathy. The evidence was rarely sufficient enough to provide firm conclusions due to major flaws in study methodologies and unexplained heterogeneity (Noble et al., 2010, p. 16). Additionally, very few studies made direct comparisons between opioid and non-opioid medications for chronic pain. As noted by Chaparro et al. (2013, p. 22), studies which did make head-to-head comparisons were considered very low quality evidence.

The Centers for Disease Control and Prevention (CDC) recommendations and clinical practice guidelines were the only sources that provided firm conclusions. Though their results were different than opioid therapy studies in this review, their thorough and analytical process for review of evidence provides confidence in their findings.

Unlike other studies, clinical practice guideline recommendations discussed opioid analgesics’ definitive role and value as an alternative to pain control when other medications fail rather than promoting the potential of these medications. Clinical practice recommendations alongside other evidence for opioid use provided an intriguing conclusion that opioid therapy can be a viable therapy under certain conditions despite the many concerns over side effects (USDHHS, 2016).

Higher quality research studies avoiding bias are needed to determine the efficacy of opioid therapy versus nonopioid pharmacotherapy in chronic pain control. Further investigation of the effectiveness of long-term use of opioids and with concurrent use of non-opioid analgesics is needed.
Best Practices – New Clinical Practice Guidelines

Despite the inconclusive results in studies in this review, clinical practice guidelines recommend prescribing medication specific to the type of chronic nonmalignant pain the patient reports (Hooten et al., 2013; USDHHS, 2016). These guidelines specifically associate primary and secondary analgesics with the nature of the pain and how to select, dose, and discontinue opioids. Although Hooten et al. (2013, p. 12) reported that opioids are strong analgesics, their recommendations do not support opioids as the first choice in treating many types of pain such as inflammatory, mechanical, and compressive pain. Instead, Hooten et al. (2013, p. 12) stated that opioids are useful when other first line medications fail to provide pain control. Providers should consider the etiology of patients’ pain so that they can consider what analgesic medications to prescribe.

Of note, the recently published 2016 CDC recommendations (USDHHS, 2016, p. 16) on prescribing opioids for long-term noncancer pain advise clinicians to consider the use of opioid therapy “only if expected benefits for both pain and function are anticipated to outweigh risks to the patient.” The CDC guidelines further support the use of disease specific-analgesics as well as document the minimal research on long-term opioid use for nonmalignant pain. Unexpectedly, the recent CDC guidelines also state that if providers decide to prescribe opioids for long-term treatment, they should combine non-pharmacological (e.g., exercise therapy, weight loss, psychological therapies and others) and nonopioid therapy (CDC, 2016, p. 17).

A common theme among the reviewed studies and recent clinical practice recommendations is that pharmacotherapies should be managed on an individual basis. If clinicians are considering long-term opioid use for chronic nonmalignant pain, it is important that they weigh the “realistic benefits” and “known risks” with their patients (CDC, 2016, p. 16). Moreover, clinicians must create and revise treatment goals to determine if long-term use of opioids is aiding in the patient’s treatment goals and worth the risks (CDC, 2016).

Conclusions and Implications for Nursing

Importantly to nurses and providers, research studies and clinical guidelines underscore that the most effective way of treating chronic pain is to listen to patients and involve them in their pain management. Because each patient has different goals and levels of tolerance, by listening to patients, nurses are key to ensuring patient-centered care. Nurses can account for patient preferences by asking patients about their pain experiences and management goals. Over time, nurses should assess and account for patients’ pain levels and any changes to their management goals. By adjusting medication individually and keeping up to date on clinical practice recommendations, clinicians will ensure that patients’ care plans are tailored to fit care goals and that sufficient pain management is safely and effectively achieved.

References


Hooten et al. (2013, p. 12) stated that opioids are useful when other first line medications fail to provide pain control. Providers should consider the etiology of patients’ pain so that they can consider what analgesic medications to prescribe.
Legislative Update

The 2nd Regular Session of the 63rd Idaho Legislature will have adjourned by the time you read this issue of RN Idaho. Legislative year 2016 was an exciting and successful one for your Board of Nursing. Through both legislation and rulemaking, the Board addressed key state and national issues related to continued nurse competence; enhanced cross-border practice for LPNs, RNs, and APRNs; RN specialty practice; the meaning of ‘practice of nursing’; and relieving APRN reporting burdens imposed by an outdated 1998 law.

During the 2016 Session, the Board:

• Presented pending administrative rules to 1) require demonstrated continued professional development as a condition of LPN and RN licensure renewal beginning with the 2018 LPN and 2019 RN renewals; and 2) revised requirements for RNs practicing in nursing specialties. NOTE: both rule docket numbers received legislative approval and became final on adjournment of the 2016 Legislature.

• Introduced legislation to adopt the revised Nurse Licensure Compact (NLC) which, when implemented, will replace the current NLC. The “new” NLC incorporates ‘uniform licensure requirements’ for all member states (an authority in place in Idaho); identifies the governing body of the NLC as a Commission and clarifies the role and responsibilities of the Commission; articulates the diversity of settings in which nurses practice and the variety of roles in which they engage. In addition, the new definition affirms the practice of nursing occurs where the recipient of nursing services is located; clarity is essential in our current patient-focused healthcare delivery system that incorporates the practice of telehealth in which the nurse is at a physical location different from that of the recipient of the services being provided.

Once signed into law, it becomes effective July 1, 2016, for implementation consistent with the threshold designated in the Compact.

• Introduced legislation to adopt the Advanced Practice Registered Nurse Compact, a compact complementary to the NLC, providing the same state-based solution for the regulation of APRNs as the NLC has done for RNs and LPNs for the past fifteen years. The APRN Compact will allow an APRN to have one multistate license issued by the declared state of residence, granting the APRN the privilege to practice in other Compact member states without the need for additional APRN licenses. The APRN Compact models the NLC in content and format, and becomes effective on adoption by ten states. NOTE: at the writing of this Update, Senate Bill 1251 was awaiting the Governor’s signature. Once signed into law, it becomes effective July 1, 2016, for implementation consistent with the threshold designated in the Compact.

• Introduced legislation to amend the statutory definition of “practice of nursing” to more clearly articulate the diversity of settings in which nurses practice and the variety of roles in which they engage. The new definition affirms the
Update from Idaho Board of Nursing continued from page 5

Regular Meeting Business and Actions

The Board of Nursing meets quarterly for the conduct of regular business. At their January 21-22, 2016, meeting, the nine-member, governor-appointed Board of Nursing addressed business related to their primary strategic goals of licensure, practice, discipline/alternatives to discipline, education, communication, and governance. At that meeting, Board members Susan Odom, RN, Moscow, Chair; Vicki Allen, RN, Pocatello, Vice Chair; Whitney Hunter, 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 Merrillie Stevenson, RN, Wendell:  

- Granted approval to Weiser Memorial Hospital to employ Board-approved nurse apprentices;  
- Granted continued approval to Stevens-Henager College/Boise to administer a nursing assistant program;  
- Appointed Jill Hubble, RN, Boise; Susie Bunt, RN, Lewiston; and Susan “Spooky” Taft, Ketchum; to continuing 3-year terms on the Board’s Program for Recovering Nurses (PRN) Advisory Committee;  
- Revoked the licenses of five RNs and two LPNs as a result of substantiated violations of the Idaho Nursing Practice Act;  
- Reinstated the license of one RN on condition that the license be temporarily surrendered and the nurse enroll in the Program for Recovering Nurses and agree to be monitored for a period of up to five years;  
- Denied two applications for RN licensure by examination including the request to take/retake the NCLEX-RN®; and denied one application for RN licensure by endorsement;  
- Amended conditions of an RN limited license and authorized staff to approve future changes consistent with policies of the Board;  
- Granted approval to Northwest Nazarene University, Nampa, to initiate plans to administer a graduate level family nurse practitioner program;  
- Received an update on the Nurse Leaders of Idaho (NLI) Workforce Development Project funded by the Idaho Health and Welfare (NIH) Workforce Development Project funded by the Robert Wood Johnson Foundation State Implementation Project (SIP) grant with matching funds by the Board. Use of these funds is consistent with the Board’s authority “to enter into contracts or agreements with others to evaluate and develop the education, distribution and availability of the nursing workforce for the purpose of improving the delivery of quality health care” (§54-1404, Idaho Code);  
- Received reports from the Board’s APRN and PRN advisory committees, and appointed a Board-member task force to finalize proposed guidelines related to use of “agony therapist” prior to their referral to the Board for adoption; and  
- Reviewed the National Council of State Boards of Nursing (NCSBN) Proposed 2017 NCLEX-PN® Test Plan and provided feedback to the NCSBN Examinations Committee.

New Vision Statement

After eight months of discussion and deliberation, the Board adopted their new Vision Statement (shown below) for the upcoming Strategic Planning period 2016-2020. The Vision complements the Board’s Mission “to regulate nursing practice and education for the purpose of safeguarding the public health, safety, and welfare.”

IDAHO BOARD OF NURSING  
FY2016-2020 VISION STATEMENT

Regulating nursing with collaboration, innovation, and strategic leadership to ensure the nursing workforce meets the changing healthcare needs of Idahoans

The Board extends thanks and best wishes to departing Board members Chris Jenkins, RN, Homedale, who served from May 2012 to February 2016; and Susan Odom, RN, Moscow, who served from June 2004 to April 2016 and as Board Chair from 2006 until her departure after three consecutive four-year terms.

Board Position Openings and Next Meetings

Individuals interested in appointment to the Board of Nursing should visit the Governor’s website at https://www.gov.idaho.gov or call the Board of Nursing at 208.577.2476.

The next meetings of the Board are tentatively scheduled for April 21-22, July 21-22, and October 20-21, 2016, in Boise at a location to be determined. For further information, visit the Board’s website at www.ibn.idaho.gov or call the Board of Nursing at 208.577.2476.

As always, the Board invites the public to attend scheduled Board meetings and participate in the Open Forum held the second day of each meeting. The Open Forum provides the opportunity to dialogue with the Board on issues of interest not necessarily included 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.

REMINDER TO LPNs…

2016 IS THE YEAR TO RENEW YOUR LICENSE!

The LPN renewal period begins June 1 and ends August 31, the final day to renew without penalty. Visit the Board’s website at www.ibn.idaho.gov for instructions on how to renew using the “IDAHO NURSE PORTAL.”

We are an Equal Opportunity Employer and do not discriminate against applicants due to race, color, religion, sex, sexual orientation, gender identity, national origin, age, pregnancy, veteran status, or on the basis of disability or any other federal, state or local protected class.

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

MAKE A DIFFERENCE.

Advise your patients to quit smoking.

Smokers advised to quit by health care providers are nearly two times as likely to stop smoking.

Refers patients directly during consultation at: projectfilter.org/hcp
Throughout the 2016 Idaho Legislative Session, Nurse Leaders of Idaho (NLI) and ANA Idaho have worked together to represent nursing on legislation and activities of interest to nurses, especially in the area of healthcare policy. Michael McGrane has served as the lobbyist for our organizations.

Michael McGrane earned a degree in economics from the University of Utah and a Bachelor's and Master's in Nursing degrees from Idaho State University. He served as Director of Emergency Services at Saint Alphonsus Medical Center in Boise and the Franciscan Health System in Washington. He originated the Trauma Program at Saint Alphonsus, the Tacoma Trauma System, Life Flight at Saint Alphonsus, and Air St. Luke's among many other services. Michael is a native of Idaho and retired in May, 2015, as Senior Director of Air St. Luke's.

Session Overview
The 2016 Legislative Session ended with the Senate adjourning on Thursday and the House on Friday, March 25th. This is a final legislative wrap-up.

During the session, 656 bills and resolutions were introduced. Of those, 405 have been signed into law, and 173 are awaiting signature by the governor. The governor has 10 days following the end of the session to either sign or veto bills. If the governor fails to take any action on a bill within the 10 days, it becomes law without the governor's signature. Laws become effective July 1, 2016, unless they have an emergency provision, then they become effective on "sine die," the end of the session. Agency rules become effective on adjournment of the legislature.

Board of Nursing Rules
Continued Competence Requirements for Renewal of an Active License
The rules add requirements for continuing education and/or clinical practice when renewing a nursing license. While the rule becomes enacted upon closure of the legislative session, the additional competency requirements will become effective with the 2018 licensure renewal cycle.

- A licensee must complete at least two learning activities within the two-year licensure renewal period.
  - Practice: Current nursing specialty certification or 100 hours of actual or simulated clinical practice
  - Continuing Education:
    - 15 contact hours
    - 1 semester hour credit from college or university
    - Board recognized refresher course
    - Participation in or presentation of a workshop, seminar, conference or course relevant to nursing practice by a recognized organization.

- The rule specifies requirements for documentation and the retention of records.

Licensed Registered Nurse Functioning in Specialty Areas
Previous Board of Nursing rules addressed additional requirements for specialty practice for Flight/Transport Nurses and Nurse First Assistants. The changes accommodate nursing specialties in general and aligns rule with national standards for additional education, continuing competence and standards for specialty practice.

Nursing Bills
S1251 Nursing Interstate Licensure Compact: Updates and renews the interstate licensure compact for registered nurses and licensed practical nurses. It is effective July 1, 2016.

S1250 Advanced Practice Nurse Licensure Compact: A new interstate licensure compact agreement for advanced practice nurses. Although the law becomes effective July 1st, the agreement specifies that 10 states must adopt the compact before it is activated.

S1382 Revised Definition of Nursing Practice: Updates the Nurse Practice Act to better reflect the practice of nursing across the many areas of current practice.

Definition of Nursing Practice: the performance by licensed practical nurses, registered nurses and advanced practice registered nurses of acts and services that require formal nursing education and specialized knowledge, judgment and skill, which acts and services assist individuals, groups, communities and populations in order to promote, maintain or restore optimal health and well-being throughout the life process. Nursing practice encompasses a broad continuum of services delivered in healthcare and non-health care environments for remuneration or as volunteer service. Nursing practice may be clinical as well as nonclinical in a variety of areas including, but not limited to, education, administration, research, and public service. Nursing practice occurs at the physical location of the recipient.

Reference to the physical location of the recipient addresses telehealth services. This gives authority to the Idaho Board of Nursing to oversee practice of telehealth or other remote nursing services that are located outside Idaho but delivered to Idaho residents.

EMS Rules
Nurses participating with an Ambulance Service
The EMS Bureau clarified in rule that an ambulance agency utilizing nurses or physician assistants, acting as ‘Ambulance Based Clinicians,’ do not require the
addition of a paramedic to conduct interfacility transports. However, prehospital responses continue to require licensed EMS personnel, EMT, or paramedic. Other minimal ambulance staffing requirements must also be met.

Critical Care Paramedics
Addressing concerns related to the qualification of paramedics conducting interhospital transports of complex, critical patients, the EMS Physicians Commission adopted rules that change the paramedic scope practice, require additional training for Critical Care Paramedics and certification by one of two nationally recognized certification bodies for critical care paramedics.

Medical and Nursing Education
Budget approval for $25M to expand research, workforce development, and educational opportunities at Colleges and Universities including expansion of Idaho State University Health Sciences program.

Funding for four additional WWAMI Medical Education seats for Idaho bringing the total to 40 positions.

Announcement of the creation of the Idaho College of Osteopathic Medicine through public-private partnerships.

The school will be located with the Meridian Campus of Idaho State University and plans to accept 150 students in 2018.

Behavioral Health
Approved funding for two new community crisis centers in Southern Idaho, one in the Magic Valley and another in the Treasure Valley, to compliment success with another in the Treasure Valley, to compliment success with one of the Twin Falls.

Success of outpatient behavioral health contract with Optima, provided services to more patients at lower cost, resulting in savings.

The legislature adopted the Idaho Suicide Prevention Plan

Success of outpatient behavioral health contract with Optima, provided services to more patients at lower cost, and returned $5.1M to community behavioral health services.

Adopted the Idaho Suicide Prevention Plan

• Creates the Office of Suicide Prevention
• Youth training for Suicide Prevention
• Funding for the Idaho Suicide Hotline – 60% state, 40% private contributions
• Focused public awareness campaign

Medicaid Supported Living Services
Corrects Medicaid underfunding for suppliers of community living services.

Catastrophic Healthcare Program (CAT Fund)
Returns back to the general fund $29M in savings, created by shifting uninsured costs away from the CAT fund to coverage under the Healthcare Exchange.

Healthcare Coverage for the Gap
In spite of recommendations by two Medicaid Workgroups and several proposals to provide health insurance coverage for those beyond Medicaid qualification but not able to receive subsidy for private healthcare coverage, the legislature failed to take action to close the gap. The governor has said he will not act without the legislature to begin the required federal waiver process, and he will not convene a special session of the legislature to address this issue.

Bill Summary
H341 Patient Freedom of Information Act – Signed by the Governor
Makes the IDACARE database the sole reporting repository for healthcare licensing including nursing.

H374 Controlled Substance Prescription Database – Passed – Signed by Governor
Allows physicians and other providers to designate up to four substitutes, including RNs, to check the required Controlled Substance Database before prescribing.

H421 Health Insurance Exchange – No Hearing - Held in Committee

H480 Board Executive Directors, Licensure – Passed - Signed by Governor
Removes a requirement that the Executive Director of the licensing Board be licensed in that profession. This removes any requirement that the Executive Director of the Board of Nursing hold a nursing license. However, it does not preclude the executive director from holding a nursing license. This is the result of a U.S. Supreme Court decision "North Carolina Board of Dental Examiners vs. Federal Trade Commission."

H481 Right to Try Act – Passed – Signed by Governor
Allows terminally ill patients to try investigational drugs that have passed Phase 1 FDA safety trials.

H482 Board Member Qualifications – Passed – Signed by Governor
Removes requirements that members of Professional Boards hold licenses in their profession to avoid conflicts of interest.

H484 Primary Care Access Program (PCAP) – No Hearing – Held in Committee
The Governor’s limited proposal for providing managed primary care to gap population.

H494 Alcohol Infractions – Sent to the Governor
Reduces first time offense by minors to an infraction rather than a misdemeanor.

H528 Sexual Assault Evidence Kits – Passed – Signed by Governor
Requires the use of standardized sexual assault kits for the collection of physical evidence.

H557 Youth Athletics Concussion Monitoring – Passed – Sent to Governor
Requires written parental consent to participate in youth athletic activities. Requires monitoring of students suspected of suffering a concussion injury prior to returning to school or any athletic activity.

H583 Telehealth – Died in Committee
Would have authorized the payment for telehealth services by Medicaid and other health insurers.

H644aa – Affordable Care Waiver Act – Failed
Would have authorized the Department of Health and Welfare to pursue federal waiver for coverage of those within 100% of federal poverty.

S1204 Medicaid Expansion – No Hearing – Held in Committee
A bill to expand Medicaid coverage to those earning less than 158% of federal poverty, the limit for private health insurance subsidy under the Exchange.

S1205 Medical Assistance Eligibility “Healthy Idaho Plan” – No Hearing – Held in Committee
Would have extended Managed Medicaid coverage to those earning less than 100% of the federal poverty line and allow those between 100% and 138% to qualify for subsidy under the Exchange.

S1250 Advanced Practice Registered Nurse Compact – Passed – Signed by Governor
An interstate compact for EMS personnel licensure similar to the Nursing compact.

S1251 Nursing Licensure Compact – Passed – Signed by Governor
A new interstate compact for EMS personnel licensure similar to the Nursing compact.

S1281 EMS Personnel Licensure Compact (REPLICA) – Passed – Signed by Governor
Protects the record of first time offenses by minors.

S1322aaH Epinephrine Auto-Injectors – Passed – Signed by Governor
Authorizes the sale of epinephrine auto-injectors by pharmacists without prescription to individuals or groups for the emergency treatment of anaphylactic reactions.

S1326 Suicide Prevention/Director Authority – Passed – Signed by Governor
Authorizes the sale of epinephrine auto-injectors by pharmacists without prescription to individuals or groups for the emergency treatment of anaphylactic reactions.

S1322aaH Epinephrine Auto-Injectors – Passed – Signed by Governor
Authorizes the sale of epinephrine auto-injectors by pharmacists without prescription to individuals or groups for the emergency treatment of anaphylactic reactions.

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S1322aaH Epinephrine Auto-Injectors – Passed – Signed by Governor
Authorizes the sale of epinephrine auto-injectors by pharmacists without prescription to individuals or groups for the emergency treatment of anaphylactic reactions.
The purpose of this article is to inform and update Idaho nurses on the status of the Idaho State Implementation Program (SSIP) grant that is managed through the Idaho Nursing Action Coalition (INAC). This grant is awarded by the Robert Wood Johnson Foundation (RWJF) in cooperation with the American Association of Retired Persons (AARP) and has matching funds granted by the Idaho Board of Nursing (IBON) for two years (2015-2017). It targets academic progression towards an 80% Bachelor of Science in Nursing (BSN) degree prepared workforce by 2020, impacts lifelong learning opportunities for nurses beyond academic courses, and promotes attaining a more diverse nursing workforce.

In the past nine months, our work has focused on:

- Data collection
- Gaining information on statewide issues by holding regional meetings
- Discussing nursing education program opportunities with faculty from Idaho's community colleges and universities
- Providing information on INAC activities to academic provosts and the Idaho Board of Education (IBOE) staff
- Working with the Idaho Department of Labor (IDOL) to plan for workforce analysis.

Additionally, we have been fortunate to participate in four RWJF funded national meetings where we learned from the experiences of other states that are on the same journey.

What Was Learned from Idaho Regional Meetings
INAC held regional discussion meetings in Idaho Falls, Pocatello, Twin Falls, Boise, Grangeville, Moscow, and Coeur d'Alene. Each meeting was attended by a combination of chief nurses, nursing education program directors/deans, nurse managers, faculty, staff RNs, and student nurses from the region.

Each region had different issues in terms of workforce supply, student mobility, job vacancies, student applications, program availability, and the recruitment and retention of nurses. For example, the age demographic of new graduates from past years still require an individual transcript assessment prior to acceptance into a BSN program, and that is seen as a barrier to their academic progression.

We learned ADN RNs in Idaho want to seek a BSN and want to stay in their communities. Two programs are viewed as accommodating: Boise State University's (BSU) RN to BSN completion program and Western Governor's BSN. This is supported by the evidence that BSU has graduated nearly 800 BSN completion nurses.

BSN Academic Progression Models
Five models of academic progression for RNs are seen nationally; Idaho is fortunate to have active programs providing four of them, which include:

1. (Generic pre-licence BSN is evidenced at Idaho State University (ISU), BSU, Lewis Clark State College (LCSC), Brigham Young University-Idaho (BYU-I)
2. Post-licence RN to BSN is evidenced at ISU, BSU, and LCSC
3. Post-licence RN to MSN is planned at NNU
4. Community college and BSN program partnership is an emerging trend nationally and in Idaho we see this between North Idaho College and LCSC
5. BSN degree offered at a community college is not currently available in Idaho, although it is legal to provide this in Idaho, and it is an emerging trend in other states like California.

Future Work Towards the 80% BSN in Idaho
Idaho nurses endorsed this national goal in June 2015. To achieve it requires the efforts of three groups: (1) educators, (2) employers, and (3) individual nurses.

Educators
Education programs in Idaho are doing their part to achieve this goal. Not every model will be evident on every campus, nor does it need to be. Individual schools have successful programs in place and are positively impacting Idaho's BSN numbers. There is cooperation between Idaho schools in terms of articulation and student referrals. This collaboration is leading towards discussion and evaluation regarding pre-requisite course consistency and nursing curricular changes to further ease academic progression, remove barriers, and decrease costs.

Employees
Employers continue to have wide variability in hiring practices and promoting BSN attainment. The value is often placed more heavily on the license, experience, and professional certification of the nurse rather than on attainment of the baccalaureate degree. Pay differential for a BSN degree is often minimal, and sometimes a certification differential is greater than a degree differential. Tuition reimbursement is inconsistent; some employers acknowledge that hiring a BSN minimizes the risk of tuition reimbursements and scheduling issues to facilitate course work. Employers can be a primary driver of academic progression if the expectation of staff is a BSN degree, if employers utilize emerging evidence of patient outcome differences in care provided by a BSN nurse, and if they set an expectation at the time of hire that a BSN will be mandatory to maintain employment.

Individual Nurses
Individual nurses need to see a return on their investment of money and time to be motivated to attain a BSN. Realistically, a nurse in the last years of his/her career cannot be expected to return to school easily. A nurse who expects to work in the profession for 10 years or more could benefit by having a BSN degree, especially if a BSN will open a door to a job that might be less physically demanding.

Where is Idaho on the 80% BSN Journey?
This is the burning question. INAC is working closely with the IDOL to evaluate three datasets: the IBON license database, the IBOE school report, and the IDOL workplace report. The IBON implemented a new nurse license database with the 2015 RN re-license cycle. Many of us remember the new forms to complete on-line and a more thorough process than we had experienced in prior years. These new data are being merged with the old database to yield a more detailed and informative dataset. Today, we do not yet have all of the data points sorted, such as determining how many ADN RNs have attained a BSN, was the BSN earned in-state or elsewhere, where do the nurses live and work, and what is their age range. New data are being merged and new database to yield a more detailed and informative dataset.

What we do know is that by taking the total number of nurses and removing those that do not live in Idaho, and evaluating the numbers who have reported a BSN, we can determine a preliminary number of approximately 69% BSN workforce in our state.

Congratulations Idaho, we are well on the journey to 80%!”

Join us today!
www.volunteерidaho.org

May, June, July 2016

Idaho Nursing Action Coalition: Our Statewide Progress with Academic Progression and Achieving the 80% BSN Goal by 2020

by Margaret Wainwright Henbest1, MSN, RN, CPNP and Randall Hudspeth2, PhD, MS, APRN-CNS/CNP, FPRE, FAAAP, NEA-BC

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2 Idaho Nursing Action Coalition SIP-3 Grant Manager

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Editor’s note: This is the first part of a DNP project paper that identifies the local and national factors contributing to the clinical preceptor shortage in Idaho. Part II of this paper will be published in a subsequent issue of RN Idaho. The author will discuss factors within the policy and political stream, and will propose a plan to address the clinical preceptor shortage.

Problem Stream: Factors Contributing to Idaho’s Advanced Practice Registered Nurse (APRN) Clinical Preceptor Shortage

The Need for Change

With the implementation of the Patient Protection and Affordable Care Act (PPACA), a greater number of people have acquired health insurance; however, not all are able to access care. The demand for primary care providers (PCPs) continues to grow nationally as well as locally. This paper will examine factors contributing to the clinical preceptor shortage and apply a framework (Figure 1) to assess Idaho’s clinical preceptor shortage.

Idaho’s healthcare growth

The State of Idaho is unique. The population and workforce are “aging faster than the nation” and the state is “attracting increasing numbers of older residents from elsewhere” (Idaho Department of Labor Communications & Research, 2015, p. 1). Idaho’s health care sector is projected to grow faster than all other sectors over the next decade. According to the Idaho Department of Labor Communications & Research (2015), surprisingly, healthcare in Idaho is expected to grow faster (2.5%), than that of the economy (1.5%).

APRN utilization

On both national and local levels, the PCP shortage is fueled by increased demand and poor compensation for services. The 2011 Institute of Medicine’s, Future of Nursing Report called for APRNs to practice at the “full extent of education and training” and “achieve higher levels of education through an improved education system that promotes seamless academic progression” (Institute of Medicine, 2010, p. 1). The APRN’s growing role in the delivery of primary care has been felt to be a potential solution to this issue. APRNs licensed in the United States have almost doubled over the last decade, rising from approximately 106,000 in 2004 to 205,000 as of January 1, 2015 (American Association of Nurse Practitioners, 2015).

APRN education in Idaho

In Idaho, nurses have answered the IOM’s call as they continue to seek graduate education and training. National dialogue and ongoing individual state adoption of The Consensus Model has sought to improve the quality of APRN education and ensure all new graduates meet minimum competency to provide quality care that is safe.

Dictated by the APRN Consensus Model, graduate nursing programs are required to use The Criteria for Evaluation of Nurse Practitioner Programs along with Master’s and DNP Essentials documents as frameworks to guide curricular education (The APRN Consensus Work Group & the National Council of State Boards of Nursing APRN Advisory Committee, 2008). Despite this progress, APRN education programs are experiencing challenges related to an increased number of students and a national faculty shortage. Particularly, programs have been challenged to offer quality clinical site placements and preceptors (AACN, 2015). To further assess and improve APRN clinical placements in the State of Idaho, this author proposes a stepwise approach through agenda setting, identifying local incentives and barriers to precepting, and creating academic-practice partnerships to enhance the availability and clinical quality of APRN education.

Existing Local Barriers and Incentives to Precepting

Competition for clinical sites

Competition among nursing schools as well as competition from other medical trainees is intensifying. The 2013 Multi-Discipline Clerkship Clinical Training Site Survey reported 60% of APRN schools conveyed concern regarding the limited number of clinical sites while 59% communicated an insufficient supply of qualified preceptors (AAMC, 2014, p. 8). As enrollments and demand for clinical sites continue to grow, the Inter-Professional care of care at sites recommends continual monitoring of clinical site availability and endorses the development of new inter-professional care delivery models to support a dynamic health care environment (AACN, 2014). The goal of education should be an increasingly inter-professional setting as proposed to a competitive one.

Regulatory issues

Regulatory issues for in-state and distance-learning APRN students are growing. Clinical preceptors are governed by regulations from state boards of nursing and ongoing adoption of The APRN Consensus Model. Incorporated into the model are education standards established by The National Task Force on Quality Nurse Practitioner Education (NTF), which delineate student-preceptor ratios, clinical hour requirements, hours spent with direct patient care, faculty requirements, and student evaluations (American Association of Colleges of Nursing - American Organization of Nurse Executives Task Force on Academic-Practice Partnerships, 2012). Idaho’s healthcare system is facing complex and extensive administrative barriers to student clearances and affiliation agreements (AACN, 2015). Students are being screened by office managers who quickly decline acceptance of clinical rotations based on the assumption of this cumbersome processes (D. Smith, DNP-C, personal communication, November 2015).

APRN variability

APRN students have varying educational and clinical backgrounds. Additionally, curriculum varies from school to school and among degree programs. Graduate schools offer BSN to MSN, BSN to DNP, MSN to DNP, and accelerated RN to DNP programs. In 2014, APRN enrollment in graduate schools increased by 6.6% in master’s programs, by 5.9% in post-master’s programs, by 3.2% in research-focused doctoral programs, and 26.2% in practice-focused doctoral programs (AACN, 2015). With the expansion of programs, additional clinical hour requirements have been issued and varied clinical competencies, expectations, and evaluation processes exist.

Models of clinical education

The one-to-one preceptor-student model, the apprenticeship model, has been in use in APRN clinical training for more than 45 years (AACN, 2015). APRNs at the recent Nurse Practitioners of Idaho (NPI) Conference were hesitant with the idea of precepting more than one student at a time. As clinical resources are scarce, the apprenticeship model is not sustainable. Preceptor perceptions should be further studied and new clinical education models adopted.

Preceptor participation

Preceptors are vital to nursing education as they provide the mentoring, role modeling, and an arena for application of theoretical knowledge. A national 64-item survey, taken by 453 self-identified APRN student preceptors, identified time factors and productivity demands as the greatest barriers to precepting (C. Smith, DNP, personal communication, 2015). Highly ranked incentives were identified as recertification credits and access to clinical references. Interestingly, preceptors were influenced by professional obligation, personal learning, and prior relationship with faculty or students. The lowest ranked incentives were recognition and gifts (Webb, Lopez, & Guarino, 2015, p. 782). Among the 2015 Nurse Practitioners of Idaho (NPI) Conference, APRNs collectively expressed trepidation about the cost and time burden associated with the supervision of students. Anecdotally, it appears that preceptors in Idaho feel many students are ill prepared for clinical rotations (T. Carles, APRN, personal communication, October 7, 2015). More research is required to understand the incentives and barriers to precepting from the local preceptor perspective. Limiting barriers and providing valued incentives may improve preceptor interest.

Focusing Events and Indicators

Idaho’s uninsured

Multiple factors impact the need to address the preceptor shortage. Nationally, healthcare reform is the largest ever in history. Since the passage of the PPACA, 16.4 million previously uninsured people now have health coverage. In Idaho, 97,079 consumers now have affordable health insurance coverage through the Marketplace as of Feb. 22, 2015. Idaho has yet to expand Medicaid; however, if expanded, an additional 55,000 uninsured people would gain coverage (United States Department of Health and Human Services, 2015). The uninsured rate in Idaho in 2014 was 15.2 percent, down from 19.9 percent in 2013; however, Idaho ranks 15th nationally among states with the highest uninsured rate.

Physician shortage

A current and projected physician shortage supports the notion for APRN education from logical and economical stances. The Association of American Medical Colleges (AAMC) released a report in March 2015 projecting a national physician shortage of between 46,000 and 90,000 physicians over by 2022 (AAMC, 2015). The AAMC noted, “The average direct cost per resident is about $152,000, of which Medicare pays about $40,000” (AAMC, 2015, p. 2). Beginning with a landmark study conducted by Mundinger et al (2000), evidence continues to support the idea that APRNs deliver care above the level of physicians and has created momentum to support APRN autonomy and educational growth. The expert opinions from the IOM, the NTF, and the Inter-Professional Task Force are supportive of APRN role expansion as an instrumental avenue to improve the primary care provider shortage.
Graduate nurse student enrollments. On a national scale, the 2014-2015 academic year saw more than 15,288 qualified applications to master’s and doctoral programs turned away (AACN, 2015). The top reasons reported by nursing schools include an insufficient number of clinical teaching sites, a lack of qualified faculty, limited classroom space, insufficient numbers of preceptors, and budget cuts” (AACN, 2015, para.17).

In Idaho, graduate nursing program capacity is limited due to classroom space, insufficient numbers of preceptors, and limited clinical teaching sites, a lack of qualified faculty, limited clinical teaching sites, and the gravity of the issue. Additionally, Idaho’s healthcare organizations and student burden. St. Luke’s Regional Medical Center (SLRMC) in Idaho has an increasingly large and well-established medical centers in Idaho. St. Luke’s subscribes to the Triple Aim for a value-based health care system. Their partnership and network among 34 hospitals and health systems in Idaho and Oregon. The organization created the Saint Alphonsus Health System. (n.d.). Retrieved from http://members.aacn.org/eweb/upload/13-225%20WC%20Report%20FINAL.pdf


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FIGURE 1. Framework for Assessing Idaho’s Clinical Preceptor Shortage


Uniformed APRN workforce. In the State of Idaho, APRN students, faculty, and the Idaho State Board of Nursing are fully aware of the preceptor shortage; however, it is uncertain if practicing APRNs understand the gravity of the issue. At the October NPI Conference, multiple speakers addressed the topic of APRN clinical education. Additionally, the NPI organizational website and APRN locator with preceptor portal were introduced. The preceptor portal can be accessed by APRN students to identify Idaho APRNs who are willing to teach in the clinical setting. Attendees were encouraged to subscribe to become preceptors, participate in designated websites, and join local placement organizations to receive regular updates on the current issues facing APRNs in Idaho. These important avenues are significant for disseminating information, recruiting new preceptors and providing a unified voice for policy advocacy for APRNs practicing in Idaho.

References


When it comes to achieving quality care, better patient outcomes and financial stability, optimal staffing should be viewed as a necessity and not a nice, but impossible, dream — particularly as health care reforms and new regulations take hold.

That is a key message reflected in a new, comprehensive document commissioned by the American Nurses Association and developed by Avalere Health, LLC, in collaboration with nurse and policy experts.

Although the white paper, “Optimal Nurse Staffing to Improve Quality of Care and Patient Outcomes,” focuses more on acute care hospitals, nurses in all settings and at all levels can use this resource to advocate for and implement sound, evidence-based staffing plans. It is the first in a series of papers aimed at addressing the value of nursing care and services.

“The evidence from hundreds of studies — and the white paper — make it clear that there is a relationship between staffing and patient outcomes,” said Matthew McHugh, PhD, JD, MPH, RN, FAAN, a nursing outcomes and policy researcher and associate professor at the University of Pennsylvania School of Nursing. “If there are not enough nurses at the bedside, bad things are likely to happen.”

The white paper highlights published studies that demonstrate how appropriate nurse staffing helps to achieve both clinical and economic improvements, from reducing medication and other errors to shortening patients’ length of stay.

Yet there continues to be significant variations in staffing from one hospital to the next, because there are not enough budgeted positions, according to McHugh, a Pennsylvania State Nurses Association member who helped develop the paper. And members of the public generally are unaware of these variations.

“Sometimes it’s not that you didn’t think you could get lots of attention, and then go to another [in their community] and not get an equal level of care,” he said.

To ensure optimal staffing and equitable, quality care throughout the nation, RNs must continue to build the business case for optimal nurse staffing. “It’s a good investment in terms of the bottom line that pays dividends with regard to positive patient outcomes, better overall care, and in avoiding penalties, such as those associated with preventable readmissions,” McHugh said.

A closer look

“I, like many other nursing professionals, view safe staffing like air and water; it has to be there,” said Kathy Baker, PhD, RN, NE-BC, Virginia Nurses Association (VNA) member and nursing director of patient care support and emergency services at Virginia Commonwealth University Medical Center and Health System. “But because of the complexity of the environment in which health care is delivered today, we need to be more sophisticated in how we look at staffing. In the ‘90s, it was a matter of getting more bodies at the bedside. Now, it’s not just about the numbers, but rather linking it to all the variables.” Those variables include patient acuity, experience of staff, staffing mix and the changing needs of patients over time.

Further, while she said every organization is interested in staffing and scheduling, no one really has “owned” it. “The white paper fuels this dialogue and offers a very positive staffing framework,” said Baker, a Virginia Nurses Association member who lent her expertise to ANA’s 2014 Staffing Summit discussion and review of the document. (The framework is built on ANA’s Principles for Nurse Staffing.)

The white paper, in part, examines the various forces that have impacted discussions about staffing and health care, from Affordable Care Act (ACA) provisions and Institute of Medicine reports to changing demographics. It specifically notes that existing staffing systems are often antiquated and lack flexibility to adjust to factors, such as patient complexity, a rise in admissions, discharges and transfers, and the physical layout of the unit. It further addresses efforts by ANA and other organizations to promote federal regulation and legislation promoting flexible staffing plans, as well as ANA activities to support transparency and public reporting of staffing data.

Making it work

Flexible staffing models, forecasting technology and routine discussions about staffing levels are three key factors that can bolster care at health care facilities. Two hospitals that have engaged in these strategies, and are featured in the white paper, are Midland Memorial Hospital in Texas and Mayo Clinic Hospital in Phoenix, AZ.

In 2008, Midland Memorial Hospital created a Nurse Staffing Advisory Council to help improve staffing and address concerns that the hospital might fall short of meeting its mission to provide quality care, according to Bob Dent, DNP, MBA, RN, NEA-BC, CENP, FACHE, senior vice president and chief operating officer at Midland.

The advisory council, made up of 60 percent frontline nurses, nursing leadership and executive staff subsequently worked together to implement several strategies to address staffing and positively influence patient care.

One important change involved implementing a comprehensive, electronic patient-classification acuity system that could more accurately forecast staffing needs, said Dent, an ANA and Texas Nurses Association member. Previously, staffing decisions were being made with data that did not necessarily reflect up-to-date changes in patients’ conditions, for example. So managers were constantly reacting to short-staffing situations.

The new system further was validated by nurses on the units to ensure that it did reflect staffing needs based on the ability to meet patients’ needs on every shift. And nurses and leadership set the budgeted positions for nurse staffing at the 50th percentile of the National Database of Nursing Quality Indicators® benchmark. Using the 50th percentile in the all-hospital database for nursing hours per patient day is only used to procure positions needed in the budget. These resources are then assigned to patients based on their acuity level.

Midland also decided to eliminate the use of outside nurse staffing agencies, and instead created a roughly 100-member resource team/float pool to fill in for staff vacations, sick calls and when the patient census or acuity rises. The hospital still uses some travelers to meet patient needs, and nurse managers can hire ahead of the turnover curve.

Another vital factor in strengthening staffing and care is Midland’s shared governance system. “We have unit-based councils, and nurses can make decisions on staffing for what works for them, such as bringing in a nurse who only handles admissions and discharges, or staggering shifts in the ER so staffing is higher when more patients tend to come in for emergency care,” Dent said. “That’s the power of unit-based councils.”

“Midland also implemented fatigue management guidelines, and leaders conduct spot checks to ensure they are being followed,” Dent said. The guidelines, for example, specify that nurses cannot work more than 12.5 hours a day, no more than three 12-hour shifts in a row and no more than 60 hours in any seven-day period. Nurses and
administrators also routinely meet to address nursing retention and turnover, as well as other staffing-related issues formally and informally.

Lessons learned in Arizona

Like other hospitals across the nation, the Mayo Clinic Hospital in Arizona was expecting a greater shift from inpatient to outpatient care in 2012 based on the implementation of ACA provisions.

But our census didn’t drop as we anticipated,” said Kathleen Matson, MSN, MHA, RN, NE-BC, nursing administrator of nursing resources at Mayo. “So nurses and other employees were working more overtime. But it came at a cost, because we had an uptick in injuries and nurses felt burnt out. We also noticed that some of the drivers affecting patient satisfaction — like the length of time it took for someone to answer their call light — were affected. “We realized we needed to right-size our workforce.”

Mayo brought in several nurses to bridge the gap and then immediately hired staff for an additional 20 FTEs, according to Matson.

Mayo leaders also made improvements to their patient classification-acuity system to ensure it would more accurately forecast staffing needs based on patient needs. The system has 21 indicators that determine patients’ level of care, including looking at the number of medications they receive, their ability to perform ADLs, and need for 1:1 monitoring.

“We have the ability to run our classification system and then flex our staffing by the hour,” said Matson, an Arizona Nurses Association member. For example, Mayo can bring in more staff mid-shift if a unit that was staffed for 30 patients suddenly admits four more patients.

Additionally, Mayo nurse managers, supervisors and team leaders meet at least three times a day to address staffing concerns, and there is a built-in ability to share staff.

“Every nurse must meet core competencies, and processes are standardized from unit to unit,” Matson said.

“We also have an inpatient float pool to help us manage just-in-time and scheduled absences, and we engage in targeted recruiting for those areas of nursing — such as ICU and oncology — where we may have ongoing needs.”

Parting words

Nurse experts understand that financial resources are not limitless, and that staffing mix and experience are crucial considerations.

“At VCU Medical Center, we want all our nurses and allied health staff to safely and effectively care for patients, and we want to allow them to practice at the top of their scope of practice,” Baker said. “To optimally staff, we need to look at patients’ needs over time on a unit, and have the ability to align staff to the right places in the right times. And sometimes that means reorganizing, and not adding, staff.”

Dent emphasized that having not only the appropriate number of nurses, but also well-rested nurses, is a moral and ethical responsibility shared by all within health care.

“And we in nurse leadership have to be able to defend our budgets [for optimal staffing],” Dent said. “We need to be able to tell our boards of trustees and other administrators: “If we want to be able to deliver quality care to our community, then here is the staffing we need and here is the evidence [that supports that decision].”

To learn more or obtain the white paper, go to http://www.nursingworld.org/Avalere-White-Paper-on-Nurse-and here is the evidence [that supports that decision].”

Care to our community, then here is the staffing we need

This year, did your financial behavior add to your tax bill? Consider the following facts and strategies when examining your tax bill and trying to reduce your future tax bill.

- Mutual funds are stocks and/or bonds. Clients often will ask, “I didn’t withdraw from my mutual fund investments any dividends or interest, so they aren’t taxable, right?” NO! WRONG! In a non-retirement account, all activity in the account has a tax consequence. You need to choose wisely about what goes into that account.
- Fund managers may be generating taxable income. Mutual funds are required by law to distribute 90% of the interest dividends and capital gains to the shareholder each year. Even if you reinvest these distributions, they are still taxable.
- Retirement accounts offer an umbrella that defers taxes on your investments. This is a good place for investments that pay interest and dividends.
- Be wary of mutual funds that are frequent traders or have a high turnover in the fund. These activities lead to capital gains that are taxable. Short-term capital gains are from transactions where the stock was held for less than 1 year. These gains are taxed at regular tax rates. If the stock was sold and was held for longer than 1 year, it is a long-term capital gain and currently has a preferred tax rate of 0%, 10%, or 20%, depending on your tax bracket.
- High turnover in an account will also have more expenses due to active trading.

Suggested Strategies to Minimize Tax Consequences From Investments

Place growth funds with a low turnover in a taxable account. These are often index funds. Alternatively, you may use Exchange-Traded Funds (ETFs). These look like mutual funds in that they are a pool of various stocks or bonds. They are structured a little differently—instead of buying and selling stocks, they are “exchanged.” (This is using 1031 exchange tax (also called a “like-kind” exchange) law used also in real estate.)

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An easy way to reduce your tax picture is to contribute to retirement plans. If your employer matches your contributions, at least contribute enough to receive the full match. If you have earned income but no employer sponsored retirement plan, you may be able to contribute to an individual retirement account.

Use of a Roth IRA is another good option for minimizing your tax consequences from investing. As a retirement account, it defers the income from taxation. It is not tax-free when you make the contribution, but it IS TAX-FREE when you take it out. Frequently, it is suggested to use funds in a Roth if the expected tax rate will be higher in your retirement years. Roth accounts are especially useful when a large sum of money is needed to replace a roof or buy a new car. The money comes out tax-free; it does not increase the amount of social security that is taxable like other sources of money may.

You do have some control over your yearly tax bill. Understanding what is taxable and ways to lower tax liability will ensure you are tax savvy when investing.

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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 idahornurses.org.

Berg, Elizabeth Elinor. February 6, 2016. A farm wife and mother of six, Elizabeth went to Practical Nurses Training at Mercy Hospital in Nampa when she was in her 40’s and worked for many years at St. Alphonsus as an LPN. She will be missed by all who knew her.

Children, Lorraine Lynclama. December 21, 2015. Lorraine graduated from the Kaiser School of Nursing in Oakland, CA in 1951. She had an adventurous spirit and worked at Kaiser, General Electric Nuclear Lab in Livermore, and at hospitals in Sun Valley, the U.S. Virgin Islands, and in Boise.

Crow, Margarette Marie Halseth. February 5, 2016. Margarette graduated from the St. Joseph School of Nursing in Lewiston in 1940 and enlisted in the U.S. Army, where she was assigned to Bakersfield Hospital in Pasadena, CA. She later became supervisor at the Alexandria Hospital in Alexandria, VA, where she became a pro-activist for non-smoking and succeeded in creating an employee health program made up of all nonsmokers. Margarette enjoyed people, had a love of singing, and a heart that would help anyone who needed help. Her loving spirit and dedication to her family and friends will be missed.

Craft, Mary M. December 30, 2015. A 1939 graduate of St. Alphonsus School of Nursing, Mary spent the majority of her nursing career working as an RN at Holy Rosary Hospital in Ontario. She loved working on the maternity floor because “she would rather work where people were coming into the world than where they were leaving.” She helped deliver over 3,000 babies into this world.

Crow, Ruth Inez. March 5, 2016. Ruth was a member of the last graduating class of St. Alphonsus School of Nursing in 1948. She enlisted in the United States Cadet Nurse Corps, later working in the polio ward at Elks Rehab and then at Boise Veteran’s Hospital. Ruth and her husband Bill were active in the racing world, and in 1991 Ruth was the first and only woman to be inducted in the Western Idaho Racing Association Hall of Fame. Ruth traveled to every continent, including Antarctica in 2004. Her motto was “Never Give Up.”

Culver, Edna R. January 17, 2016. A graduate of Boise High and then St. Luke’s Nursing program as an RN, Edna’s family was very proud of her because she was the first to graduate from high school and beyond. She worked for the Red Cross on the Bloodmobile, having many adventures and making many friends. After she retired, she volunteered over 3,000 hours at St. Luke’s Hospital.

Farrington, Amy R. February 27, 2016. Amy received her nursing degree at the Lewis-Clark Normal School through the U.S. Army’s nursing program in 1949. She was deeply loved and will be greatly missed.

Fosberg, Margaret. March 17, 2016. Margaret was a standout basketball player and the starting point guard for two years at West Georgia College. She graduated from Emory School of Nursing in 1944, completing internships at Bellevue Hospital in New York City and in Public Health Nursing at Peabody College, Nashville. Margaret graduated at Gritman Hospital in Moscow for 17 years, then became the head nurse at the University of Idaho Student Health Center for 31 years. She will be fondly remembered for her sex education talks to the fraternities, sororities, and dorms on the U of I campus.

Glass, Carol Beth Powell. March 2, 2016. Carol studied at Whitworth College in Spokane and graduated from the Deaconess Hospital School of Nursing in 1953. After marrying her husband to Moscow, she worked in the office of Dr. Joe Wilson. Carol had numerous activities and interests, which her husband of 61 years fully supported. She had a virtual factory in her basement with knitting machines, sewing machines, and an abundance of material and yarn. She leaves a void in the hearts of many.

Groom, Lillian Edith Sandahl. February 3, 2016. Lillian lived hard work from an early age, having moved on the family farm when she was 14 and supporting herself working at Wootworth’s and cafes. She successfully completed her schooling and graduated from high school in 1948. Later, as the mother of six children, she earned her license as a practical nurse at Lewis-Clark State College. She worked at St. Joseph Regional Medical Center in Lewiston, Tri-State Memorial Hospital in Clarkston, and Syringa General Hospital in Grangeville. Lillian had a way of making an impact on the lives of those around her. She was so much to so many and her loving kindness, great sense of humor, and beautiful smile will be missed.

Marshall, Margaret Louise. December 20, 2015. Margaret enrolled in the nurse cadre program at Lewis-Clark Normal School during World War II and graduated in 1947. She worked at Tri-State Hospital as a new housewife and, after raising her two sons, continued her career at St. Joseph Hospital until her retirement in 1980. Her life was one of hard work and adventure, and she was known for her witty humor and bleacher umpiring. She is greatly missed.

Matthews, Sue Ellen Wormell. January 20, 2016. Sue was a registered nurse for nearly 40 years and was exceptional at her job. She worked in correctional facilities, trauma/ER, and spent the last 10 years of her career in the field of hospice care before she retired. Sue was deeply loved by her family and will be sorely missed. She was quiet and caring but had the perfect combination of humor, funny sarcasm, and wit. We never quite knew what was coming.

Outlaw, Rita Whipple. February 14, 2016. A single mother of three sons, Rita became the office manager for Dr. Ralph Nishitani in Boise. She later earned her nursing degree and became an RN, serving as both office manager and staff nurse for Dr. Nishitani before retiring 25 years later. Rita was an outstanding nurse, but an even more outstanding mother, grandmother, and wife. Her family was her first concern and she never hesitated to undertake any task necessary to make their lives better.

Pack, Helen Mae. February 16, 2016. Helen graduated from St. Alphonsus School of Nursing and loved her work as a nurse. She also loved being a wife, mom, and grandma, and was the rock of her family. Her love and caring will be missed by all who knew her.

Poesy, Brittany Incz. January 28, 2016. Brittany graduated from Potlatch High School in 2013 and moved to Coeur d’Alene to attend nursing school at North Idaho College. She was in her third year of school. She loved music, her friends, and her family. She died far too young.

See, Helen Myrtle. January 21, 2016. Following her graduation as a licensed practical nurse in 1965, Helen worked at State Hospital North in Orofino for a number of years before joining the nursing staff for the crews building Dworshak Dam in Alusaka. She later worked at Clearwater General Hospital, then joined Dr. Cruz’s Kamiah Clinic until her retirement. Helen never met a stranger and was always there to lend a hand.

Swinehart, Ann Ledgerwood. January 29, 2016. Ann earned her nursing degree at Lewis-Clark State College in 1971 and enjoyed a 23-year career as a registered nurse at Tri-State Memorial Hospital in Clarkston. She was a very loving and compassionate nurse. She later taught for five years in the nursing skills lab at Walla-Walla Community College, where she was honored three times as outstanding teacher of the year.

Young, Carol Margaret. March 11, 2016. Carol graduated from Kather School of Nursing in Rochester, MN in 1946. She started her career by moving to Idaho and working at Clearwater Valley Hospital in Orofino. She later worked at the Kamiah Medical Clinic, and retired from State Hospital North in Orofino after dedicating 20 years to working there. Carol played basketball on the Kamiah Women’s Town Team and was an avid sports fan. She was a great community supporter and never missed a Kamiah boy’s or girl’s sporting event. She loved greatly and was greatly loved.
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