We are really excited about this year's convention. We want this convention to be fun as well as educational. The Convention is October 5th through the 7th at the Embassy Suites Hotel, Hoover, Alabama. This year’s theme is “Nurses: Critical to the Future of Healthcare.”

Convention activities will begin on Thursday with the Mable Lamb (Pre-Convention) Continuing Education Sessions. Thursday evening the opening ceremony will begin with ASNA President, Dr. Rebecca Huie presiding and The National Guard Medical Unit, Birmingham will be Trooping of Colors. Followed by greetings from local Mayors, Dr. Mark Wilson, Health Officer, Jefferson County Department of Health, and John Beard, President, Alacare Home Health and Hospice. The Keynote speaker will be Dr. Nina Sanders, Vice Provost, College of Health Sciences, Samford University. Dinner will follow with comedy by Joy “the Queen of Comedy.”

The House of Delegates (HOD) will open on Friday morning. The ASNA CE Provider Unit has done a great job of securing some dynamic CNE speakers. There will be several dynamic poster presentations and vendors on hand in the exhibition hall. Later that evening we will have a live auction of a host of items that any nurse would be proud to have. You don’t want to miss this! Please know that the funds raised by the auction will support nursing scholarships so please come ready to bid. Later on, we will crank up the night with music and Karaoke by “Aqua Productions.” This is truly going to be a fun time.

This year’s Service Project is the YWCA, victims of domestic violence. (A list of items needed is on page 8.) We applaud the YWCA for its “End Domestic Violence” Program. We will have former Police Chief, Annetta Nunn and others speaking on this subject.

On Saturday, we will have Awards and Scholarship Presentations. This is a time to acknowledge nurses who are making a mark in the nursing profession to improve healthcare within our state and country. Our city has so much to see and experience. We hope that you get out and explore the Birmingham’s Civil Rights District, Railroad Park, Uptown Food District, Barons Baseball Field, The Birmingham Zoo, Pepper Place, The Galleria Mall and local night life.

This year’s convention is truly going to be an enriching experience. To all the nurses across the state, presenters, vendors, student nurses and sponsors we look forward to seeing you here!
The President’s message

Be Involved, Informed, and Influential

Rebecca Huie, DNP, ACNP

Hello fellow Alabama nurses! As we move into the Fall season, I want to remind you that the ASNA Annual Convention and House of Delegates is just around the corner! We hope that you will join us October 5-7 at the Embassy Suites in Hoover. Please, join us for networking, fun, education, and more. Each year, ASNA supports a community service project at the annual convention. This year we will provide education regarding domestic violence and receive donations to support the women and children of the Young Women’s Christian Association (YWCA). Domestic violence (DV) is a crime that is more prevalent than many may realize. That is why it is so important that nurses are educated to recognize the signs of DV, know how to communicate with the victim, and how to get the victim help. If you are unable to attend the entire convention, you can attend the Mable Lamb Rehabilitation & HealthCare Centers we strive to keep our focus on what is most important….Our Residents! We are confident that you will find the professional, caring atmosphere at our

President's Message continued on page 8

ASNA Board of Directors

President: Rebecca Huie, DNP, ACNP
President-Elect: Sarah Wilkinson, DNP, RN
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Continuing Education Coordinator, Katie Drake-Speer, MSN, RN

Our Mission

Promoting excellence in nursing.

Our Vision

ASNA is the professional voice of all registered nurses in Alabama.

Our Values

• Modeling professional nursing practices to other nurses
• Adhering to the Code of Ethics for Nurses
• Becoming more influential as an association
• Advocating for nurses of all specialties
• Promoting diversity and inclusion
• Promoting health parity
• Advancing professional competence
• Respecting the human dignity of every person

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PUBLICATION

The Alabama Nurse Publication Schedule for 2017

Issue Material Due to ASNA Office

Guidelines for Article Development

The ASNA welcomes articles for publication. There is no payment for articles published in The Alabama Nurse.

1. Articles should be Microsoft Word using a 12 point font.
2. Article length should not exceed five (5) pages 8 x 11.
3. All references should be cited at the end of the article.
4. Articles should be submitted electronically.

Submissions should be sent to: edasna@alabamanurses.org

Editor, The Alabama Nurse
Alabama State Nurses Association
360 North Hull Street
Montgomery, AL 36104

ASNA reserves the right not to publish submissions.
I Didn’t Sign-up to Be a Psych Nurse!

John C. Ziegler, MA, D. MIN

Although psychiatric nursing is a distinct discipline, all nurses need to have a fundamental knowledge of mental illnesses and their impact on overall health. As the mental health system has continued its evolution from institutional to community-based care, more and more nurses have expanded their skills to include assessment and care of the mentally ill. In spite of system transformation efforts to integrate mental health into the mainstream healthcare system, there remains a distinct “mental health system” dedicated to that patient population. Nurses who are not mental health specialists can benefit greatly by knowing more about this distinct system. After all, the patient in the exam room, hospital bed or emergency room may have a history of receiving services through the mental health system. You may wonder how your ASNA ED has any knowledge about the mental health system and what can he say that will help me as a nurse...

Bryce Hospital

Before becoming Executive Director of ASNA, I served as the Public Information Officer for the Alabama Department of Mental Health from 2001 to 2012. As PIO, I worked with the commissioners, executive staff and the directors of 14 mental health hospitals/facilities across the state. Our hospitals were JCAHO certified and at that time, the department had over 3,000 employees serving over 125,000 Alabama citizens with mental illnesses per year. The state has now closed a number of its facilities over 125,000 Alabama citizens with mental illnesses per year. The state has now closed a number of its facilities. The state has now closed a number of its facilities. States have saved millions by transferring the financial burden from state hospitals to federally qualified community services. Now, the good thing about serving mental health patients through community services is that people can be closer to family and avoid possible stigma of residing in a state institution. This presents however a dilemma for community providers because of compliance issues. Some patients who do not comply (take their meds)...decompensate, leave home (or a group home), possibly use substances to offset symptoms, decompensate more and COME SEE THEIR LOCAL NURSE IN THE EMERGENCY ROOM...

Alabama’s Mental Health System - Challenges:
A. To be fair, mental illnesses are complicated. Assessments and diagnoses may vary between practitioners. Many patients have comorbidities with other disorders/illnesses and treatments vary in effectiveness between patients and practitioners.
B. The subjects of “barriers” and “access to care” always come up when talking about the mental health systems. Ironically, fear and the unwarranted stigma associated with some mental illnesses keep many people from seeking treatment until symptoms are in crisis stage. Even for people who are willing to seek help, the lack of resources may be a barrier.
C. There is a huge shortage of providers. For example, there are less than 20 board certified child and adolescent psychiatrists in Alabama and 90% practice in large cities. Regarding adult services - one of our largest community mental health centers reportedly had a four-month waiting list for new patients to see a doctor! For mental health patients to have to wait months for an appointment is a prescription for a crisis.
D. Money. State hospitals like Bryce Hospital in Tuscaloosa were funded 100% by state dollars. When services are contracted to the community, patients often can qualify for federal assistance…and federal dollars. The federal dollars are passed through the state via bloc grant or healthcare entitlements and do not drain the Alabama general fund. States have saved millions by transferring the financial burden from state hospitals to federally qualified community services. The federal dollars are passed through the state via bloc grant or healthcare entitlements and do not drain the Alabama general fund. States have saved millions by transferring the financial burden from state hospitals to federally qualified community services. Now, the good thing about serving mental health patients through community services is that people can be closer to family and avoid possible stigma of residing in a state institution. This presents however a dilemma for community providers because of compliance issues. Some patients who do not comply (take their meds)...decompensate, leave home (or a group home), possibly use substances to offset symptoms, decompensate more and COME SEE THEIR LOCAL NURSE IN THE EMERGENCY ROOM...
E. Public/Private System. When people seek and can afford access to private mental health care and do so voluntarily...they are indeed fortunate. If an individual has a psychiatric crisis that poses a danger to themselves or others they may be adjudicated for mandatory care, pending stabilization. Most patients who are committed can be stabilized and discharged from the hospital in a matter of weeks. Most simply go home. Other people are discharged with the recommendation of community-based care through a local provider. Once a patient is discharged, their compliance with treatment is voluntary.

As stated above in item D, compliance issues may occur and the client may decompensate into a crisis stage again. In severe cases, this creates what some call the “revolving door.”
F. The Revolving Door. One Probate Judge told me that he just committed the same person for the 17th time! Even after a commitment order, many patients may wait in jails or crisis stabilization units for days waiting for a bed to open in a hospital. Because of the crowded “front door” there is enormous pressure on hospital staff to discharge patients (out the back door). Administrators in state hospitals may feel pressure to “get them stabilized” and out of the “state funded” beds…into the “federal dollar” services system. To complicate matters even more, patients not under a court order can walk at any time. That is their civil right. For patients who choose non-compliance with treatment, going through the revolving door again (recidivism), SEEING A NURSE IN THE EMERGENCY ROOM or homelessness may be next.
G. Treatment Compliance. The Mental Health System has an inherent dilemma. Like a storm, the present system is a product of winds blowing in one direction and colliding with winds blowing in the opposite direction. Nurses have studied ethics. The mental health system is a product of winds blowing in one direction and colliding with winds blowing in the opposite direction. Nurses have studied ethics. Nurses have learned that the decision made in disease control. With personal health issues, people have the right to decide to comply or not with recommended treatment. However, when there is a disease outbreak (like Ebola) the public good takes precedent and public officials can mandate quarantine for contagious individuals. People with mental illness have a brain disease that is NOT contagious. In rare cases (less than 2%), some people may become a danger to others. In these rare cases, the public safety takes precedence and patients may be placed in mandatory care until they are stabilized. When they are no longer considered a danger...
Legal Corner

ASNA's Legal Program: A Prime Benefit for Members

Don Eddins, JD

Registered nurses often ask me about the Alabama State Nurses Association legal program. Really, it should be classified as two programs.

As an ASNA member is entitled to a free one-hour consultation per year on any subject that the ASNA attorney—myself—feels qualified to discuss. Probate matters, domestic relations, accidents, job issues—whatever legal issue the nurse wants to discuss. FREE!

Often just a talk with an attorney on an important matter can lead to resolution and peace of mind. If you are an ASNA member and need such a consultation, call the ASNA office in Montgomery, my office in Auburn at (334) 821-9981 or, better still, email me at doneddins@asnaalabama.us

It is important to note, however, that often nurses think because they receive the Alabama Nurse, they are entitled to ASNA benefits. Those membership advantages are only available to nurses who sign up for membership and pay dues each month (or year).

The second part of the legal program provides that if a nurse receives a letter from the Alabama Board of Nursing indicating that the nurse’s license is under investigation, the ASNA lawyer will represent the nurse on the matter without charge.

The stipulation is that the nurse must be an ASNA member when the act that led to the investigation occurred. It’s sort of like automobile insurance. You can’t wait until the accident occurs and then purchase insurance to cover it.

Frequently, I discuss licensure matters with non-members, but if I represent them, that representation is not free. So sign up before you get that dreaded letter from the BON.

Sitting across from the desk of me, nurses have told me that they never thought their license would be on the line in connection with a BON investigation. But the truth is anyone can make a mistake.

And often the investigation is not really related to an error or omission by the nurse. I’ve done cases in which a patient’s family did not get the outcome that they desired, so they blamed in on the physician, the medication, facility and/or the attending registered nurse.

The legal program is just one of so many ways ASNA advocates for registered nurses in Alabama. ASNA monitors to support or oppose BON rules changes, for instance. ASNA fights for you at the Alabama Legislature. Other nursing groups may be for a certain subset of nursing, but ASNA is for all registered nurses.

The legal program is an important benefit in spectrum of advocacy activities the Association is involved in. ASNA is, after all, the state’s oldest and most influential nursing organization.
Happy Veteran's Day!

On this 70th celebration in recognition of America’s veterans, ASNA would like to send out a special salute to our nurses who have served in the military. You took up the call to defend freedom. It is our great privilege to say, “Thank You For Your Service!”

Mark Armes
Mary Ann Austin, Colonel, US Army Nurse Corps, 1968 -
Angela Bell, Sergeant, US Army National Guard, 2000 - 2011
Midje Blandamer, Captain, US Army
John W., Butler, Captain, US Army, 1987 - present
Janie Lowery Chatman, Captain (Retired), US Army, 1978 - 1998
Virginia A. Collum, Lieutenant Colonel (Retired), US Army Guard, 1982 - 2005
Kathy Cunningham, Sergeant, US Army, 1972 - 1976
Kevyn B. Curnier, US Navy, Hospital Corpsman 2nd Class, 2001 - 2009
Jan Hambel Evans
Daniel Frain
Eric Gonzalez, Captain, US Army, 1997 - present
Dalton W. Gregory, Senior Airman, US Air Force National Guard, presently serving
Jennifer Groff, Major (Retired), US Air Force
Deborah Isaac, Lieutenant Colonel (Retired), US Air Force, Air National Guard, & Air Force Reserve 1982 - 2010
Joyce Jeter, Captain, US Army Nurse Corps, 1989 - 1996
Rita Ferguson, Lieutenant Colonel (Retired), US Army Nurse Corps, 1977
Richard Foote, Lieutenant Colonel, US Air Force
Carolyn (Call) Gilbert, SPC E-4, 1992 - 1998
Icy Moton-Hale, US Navy, 8 years
Pam Fagon Gray, Major, US Air Force (Retired)
Dalton W. Gregory, Senior Airman, US Air Force National Guard, presently serving
Jennifer Groff, Major (Retired), US Air Force
Icy Moton-Hale, US Navy
Charlotte Junkins, Major, US Army Reserve, 1999 - present
Jean B. Kelley
Rupert B. Laco, Captain, US Air Force, 2007 - present
Active Reserve Duty
Timothy Coggleshall Landers, Jr., E4, US Army
Jonathan Langford
Beckie McSpadden Leath
Mary J. Lee, 1st Lieutenant, US Army Reserve, 2007 - present
Crowell A. (Tony) Lisenby, E6, ANG, Navy 1958 - 1978
David A. Lowe, Sergeant (Retired), US Army, 2003 - 2010
Patricia A. Lyons, Commander (Retired), US Navy, 1976 - 2000
Regina R. McCre, HM1, US Navy, 84 - 96
Randy Moore, Lieutenant Commander, US Navy Nurse Corps, 1988 - 2008
Wynsay Morris
Heather Simecheck Mullins
DeShone Nance, Staff Sergeant, US Army Reserve, 1999 - present
Charlotte Narmore, Major, US Army Reserves, 1999 - present
James Nolan, Lieutenant Colonel, US Army, presently serving
Debra Parker, Colonel, USAF, 1973 - 2007
Jimmy Paulk, Colonel (Retired), US Army Reserves
Mary (Candy) Ross, Colonel (Retired), US Army Nurse Corps, 1984 - 1990
Wanda B. Spillers, Major (Retired), US Air Force Nurse Corps, 1986 - 2006
Bennie A. Stallworth, Lieutenant Colonel (Retired), US Army
Kimberly Taylor, 1st Lieutenant, US Army Nurse Corps, presently serving
Gerald Thomas, US Navy
Abeba Vester, Sergeant 1st Class, US Army, 1992 - present
Tiffany Watts
Lavonne Williams, Major, US Air Force, 1997 - present

We Have a Reputation to Uphold!

Gregory Howard, LPN

Nurses...for decades we have been known for our compassion, dedication and service to the sick. We have a legacy, as well as a reputation to safeguard. The question is… Are We / Are You Upholding the Legacy?

The training and nursing education you receive prepares you for the challenges you will face on the clinical side. Your life experiences will prepare you for the rest of your work in healthcare. They say it takes a special person to undertake the duties and challenges of this profession, as well as other disciplines in the healthcare arena. You need to enter the profession with “a little salt and pepper” to help ensure the end product is “well-seasoned.” But, also remember to clothe it in compassion and respect. Example: Be an advocate for the clients you serve! The education and clinical training one receives, prepares you for the challenges you will face as you practice nursing. As Kenny Rogers would say, “You got to know when to hold it and when to fold it.” The outcome we get is the result of the choices we make. Just remember our heritage and ask “What Would Florence Nightingale Do?” Team work and collaboration is the spice to a successful outcome. Your most valuable weapon/tool is the bond you share with your colleagues. You must have a bond and it must work both ways to be effective. The wellbeing of the clients we serve depends on it.

Alabama Nurses Foundation

The mission of the Alabama Nurses Foundation (ANF) is to increase public knowledge about the nursing profession and helps nurses grow in advancing their education. All proceeds from the Alabama Nurses license tag purchases and renewals benefit the ANF. See www.alabamanurses.org web site for additional information about obtaining a license tag.

The Alabama Nurses Foundation (ANF) awards educational and community grant scholarships throughout the year. Refer to the Foundation web site located at www.alabamanurses.org for applications and any associated deadlines. The scholarships are selected based on academic performance and professional leadership. One of the scholarships is directed to pre-licensure candidates who have completed at least 12 hours of academic study. Scholarships are limited to students enrolled in an Alabama institution and are for $1000 (pre-licensure) and $2000 licensed nurses.

In addition the ANF awards $500 community service grants on an ongoing basis through the year. These grants must address a current Alabama health care issue and priority will be given to projects that support the ASNA Strategic Plan and/or resolutions adopted by the ASNA House of Delegates.

GOT YOURS?

AT YOUR LOCAL TAG OFFICE

LPN Corner

ASK FOR A "NURSE TAG"

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GOT YOURS?

AT YOUR LOCAL TAG OFFICE

LPN Corner
ASNA LEADERS AT ANA NURSES DAY IN WASH. D.C.

U.S. Representative Martha Roby 2nd Congressional District

Visiting with U.S. Representative Terri Sewell, 7th Congressional District

U.S Representative Robert Aderholt 4th Congressional District

U.S Senator Richard Shelby’s Legislative Assistant Clay Armentrout

U. S. Representative Mo Brooks, 5th Congressional District

ASNA Leaders, The Alabama Coalition visit with U.S Senator Luther Strange

Stopping to visit with U.S. Representative Gary Palmer, 6th Congressional District

ASNA Executive Director Dr. John Ziegler addresses the ANA Membership Assembly

ASNA President-Elect Sarah Wilkinson Address ANA Membership Assembly

U.S. Representative Bradley Byrne Congressional District 1
Recognizing VA Nurses!

Belinda Cagle, RN is a two time recipient of the “House Staff Appreciation Award” presented by the Department of Medicine at the University of Alabama, Birmingham (UAB). The Birmingham VA Medical Center (BVAMC) has a residency program for UAB internal medicine residents for their primary care residency track. This award is in appreciation of exemplary support of the Medicine House Staff and their patients. The recipient is nominated by the 1st, 2nd and 3rd year Residents. This exemplary award was presented to Ms. Cagle during the 2017 annual resident’s dinner. Ms. Cagle began her career at the BVAMC in 2012 on an inpatient unit and she transferred to the Primary Care Red Clinic in 2014. She has always had a passion for nursing and volunteered as a Candy Stripper at a local hospital when she was 18 years old. She then participated in one of the first classes for Certified Nursing Assistants (CNA) in 1981. Ms. Cagle has served in the US Army, receiving the Army Commendation Medal, Good Conduct Medical and Expert Marksmanship Ribbon. She received her Licensed Practical Nurse degree in 1990, Associate Degree in Nursing (ADN) in 2011 at Wallace Community College, and graduated from UAB with honors with a Bachelors of Science in Nursing (BSN) in December 2013. Ms. Cagle is currently enrolled at Walden University pursuing her Master’s Degree in Leadership and Management Program with expected graduation date of May 2018. Ms. Cagle states, “What is great about working at the VA Medical Center is not only am I a service connected disabled Veteran, but I have the opportunity to assist other Veterans or direct them to where they can receive assistance.” She says that two of her favorite quotes are: “Anything worth doing is worth doing right” ~ Hunter S. Thompson and “doing is worth doing right” ~ Hunter S. Thompson and that two of her favorite quotes are: “Anything worth doing is worth doing right” ~ Hunter S. Thompson and “We are currently seeking full and part-time RNs, LPNs and CNAs to join our team of compassionate and caring employees at our Network of Alabama facilities, Generations of Vernon and Generations of Red Bay. If you are interested in working in an environment where generations of residents and employees are family contact Jennifer Robinson at Generations of Vernon at 205-695-9113 or Tammi Cottie at Generations of Red Bay at 256-356-4982. Competitive Salaries Sign on bonuses for Licensed Nurses Uniform Allowance Upon Hire and Annually to the VA system. Veterans Health Administration (VHA) health professions education mission enables VA to enhance clinical learning and practice environment, recruit and retain high quality professional staff, and provide excellent care to Veterans. Residency programs ensure a supervised transition to competent clinical practice. Accredited residencies at VA have historically included Medicine, Dentistry, Psychology, Pharmacy, and other clinical professions but not nursing. Since 2009 accreditation for PNBR programs has been available through the Commission on Collegiate Nurse Education (CCNE).

“Development of this PNBR is the perfect next step for the partnership between the UAB School of Nursing and the BVAMC,” said Assistant Professor, Dr. Randy Moore, Program Director for the new residency. “Residency programs ensure a supervised transition to competent clinical practice. We are thrilled to have even more opportunities to use this innovative model of nursing education as one of the building blocks for our future nursing workforce.”

The new PNBR is one of three awarded for 2017 and one of 17 nationwide. Enrollment to the program will be competitively open to all accredited baccalaureate nursing programs.

Humphrey Takes Great Care of VA Patients

Our patient care spotlight shines on VA Red Clinic nurse Tawanda Humphrey as she provides world-class care in the incredible way she managed a clinically unstable patient. When she recognized the veteran’s dangerously high blood pressure, Tawanda immediately called attention to the problem, triaged the patient quickly, and had him seen by one of the residents. We are deeply grateful to work along such professional and dedicated nurses!

The Birmingham VA Medical Center along with its multiple-site home care offices of administering, managing, or supervising a home care program or multiple-site home care offices. Possession of a license to practice professional nursing as issued by the Alabama Board of Nursing required. Applicants must include their license number on their application. If your application states you have a college degree, the Alabama Department of Public Health requires documentation verifying possession of the degree prior to hire or employment. Overnight travel is required for some positions. Contact: Sheila Dawson at (334) 206-5677.

New Salary Program

To apply, interested applicants should complete an Application for Examination Form available at http://www.personnel.alabama.gov, or at any Alabama Career Center Office.

The Alabama Department of Public Health is an equal opportunity employer.
The year 2017 has been designated by ANA as the “Year of the Healthy Nurse.” As nurses, we are caretakers. We care for our patients and our families. We are dedicated to our careers and put so much time and energy into everything else that we sometimes forget to take care of ourselves. Many nurses work in an extremely stressful environment that requires mental, physical, emotional, and spiritual energy. We work various hours and shifts that cause sleep disturbances or lack of sleep. Some nurses work in an environment that requires heavy lifting or moving of patients that could lead to musculoskeletal injuries. Others may work in a stressful, but sedentary, role that can lead to ergonomic injuries as well as weight gain. Whatever position that you work in, we all need to be role models for our patients, families, and staff and lead a healthier lifestyle. But most importantly, we need to strive to be healthier for our own quality of life. ASNA signed up to accept the challenge and we encourage all nurses to take small steps toward a healthier lifestyle. Visit this link http://www.nursingworld.org/HealthyNurse-HealthyNation to set up your own personal profile and take the survey. This will provide you with a personalized dashboard to track your progress toward a healthier lifestyle and connect you with others that have the same goals. Listed below are the monthly topical focuses for a healthier lifestyle:

<table>
<thead>
<tr>
<th>Month</th>
<th>Topic</th>
</tr>
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<tbody>
<tr>
<td>January</td>
<td>Worksite Wellness and Worker Well-Being</td>
</tr>
<tr>
<td>February</td>
<td>Cardiovascular Health</td>
</tr>
<tr>
<td>March</td>
<td>Nutrition</td>
</tr>
<tr>
<td>April</td>
<td>Combating Stress</td>
</tr>
<tr>
<td>May</td>
<td>Women’s Health National Fitness and Sports Month</td>
</tr>
<tr>
<td>June</td>
<td>Men’s Health Cancer Awareness Skin Health</td>
</tr>
<tr>
<td>July</td>
<td>Healthy Sleep</td>
</tr>
<tr>
<td>August</td>
<td>Happiness</td>
</tr>
<tr>
<td>September</td>
<td>Recovery Work-Life Balance</td>
</tr>
<tr>
<td>October</td>
<td>Infusion Control Immunizations Mental Resilience/Moral Distress</td>
</tr>
<tr>
<td>November</td>
<td>Mental Health Wellness</td>
</tr>
<tr>
<td>December</td>
<td>Healthy Eating/Healthy Holidays</td>
</tr>
</tbody>
</table>

As you all are aware, this year has been filled with uncertainty, concern, skepticism, disappointment and triumph regarding health care reform. Regardless of your point of view, the Senate rejected the final repeal amendment on July 28, 2017. That does not mean the debate for reforming health care in the United States is over. As a nurse professional, your voice matters in regards to the health care reform and legislative issues that impact our nursing profession and healthcare delivery. I encourage each of you to stay informed and let your voice be heard. Write your legislators and senators and let them know what you think about these issues. We are at the frontline of providing care for our patients every day. We spend more time with the patient than any other healthcare discipline and we are the MOST TRUSTED PROFESSION! Our voices matter and we have the power to influence change. Thank you for all that you do each and every day. Hope to see you at convention this year!

Rebecca Huie

<table>
<thead>
<tr>
<th>CDC Vaccine Schedules App for Clinicians and Other Immunization Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Download the App</td>
</tr>
<tr>
<td>Note: If you previously downloaded the tool, check that you have version 4.0.1 with 2017 schedules and footnotes.</td>
</tr>
<tr>
<td>Download “CDC Vaccine Schedules” free for iOS and Android devices.</td>
</tr>
</tbody>
</table>

Product Specs
Version: 4.0.1
Requirements: Requires iOS 6.0 or later and Android 4.0 or later; optimized for tablets and useful on smartphones.
Updates: Changes in the app are released through app updates.

Figure 1 and 2 should be read with the footnotes that contain important general information and considerations for specific populations.

Figure 1. Recommended immunization schedule for adults aged 19 years or older by age group, United States, 2017

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>18-24 years</th>
<th>25-49 years</th>
<th>50-64 years</th>
<th>≥ 65 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tet/HPV*</td>
<td>1 dose annually</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HPV®</td>
<td>1 or 2 doses depending on indication</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Var*</td>
<td>3 doses</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HCV</td>
<td></td>
<td>1 dose</td>
<td></td>
<td></td>
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<tr>
<td>IPV (adult dose)</td>
<td>3 doses</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Td, tetanus, diphtheria, and pertussis (Whooping cough)</td>
<td>3 doses</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PCV13*</td>
<td>3 doses</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PPSV23*</td>
<td>1 or 2 doses depending on indication</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Haemophilus b meningitis (Haemophilus b conjugate vaccine)</td>
<td>2 or 3 doses depending on vaccine</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tdap</td>
<td>2 or 3 doses depending on vaccine</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Var®</td>
<td>2 or 3 doses depending on vaccine</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Measles/Mumps/Rubella (MMR)</td>
<td>1 or 2 doses depending on indication</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Var®</td>
<td>3 doses</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Measles**</td>
<td>2 or 3 doses depending on vaccine</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HBV</td>
<td>3 doses</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Figure 2. Recommended immunization schedule for adults aged 19 years or older by medical condition and other indications, United States, 2017

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>18-24 years</th>
<th>25-49 years</th>
<th>50-64 years</th>
<th>≥ 65 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tet/HPV*</td>
<td>1 dose annually</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HPV®</td>
<td>1 or 2 doses depending on indication</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Var*</td>
<td>3 doses</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>HCV</td>
<td></td>
<td>1 dose</td>
<td></td>
<td></td>
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<tr>
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<td></td>
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<tr>
<td>HBV</td>
<td>3 doses</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

List of donation items needed for the YWCA (http://www.ywcabham.org/)
Women’s underwear, clothes, and shoes – all sizes
Boys and girls underwear – all sizes
Boys and girls shoes – all sizes
Baby items: bibs, pacifiers, onesies, etc.
Diapers
Strollers
Diaper wipes
Clothes
Household Items: Pots Pans Umbrellas Dish Towels Dishes Drinking glasses Towels

September, October, November 2017
President’s Message continued from page 2

As you all are aware, this year has been filled with uncertainty, concern, skepticism, disappointment and triumph regarding health care reform. Regardless of your point of view, the Senate rejected the final repeal amendment on July 28, 2017. That does not mean the debate for reforming health care in the United States is over. As a nurse professional, your voice matters in regards to the health care reform and legislative issues that impact our nursing profession and healthcare delivery. I encourage each of you to stay informed and let your voice be heard. Write your legislators and senators and let them know what you think about these issues. We are at the forefront of providing care for our patients every day. We spend more time with the patient than any other healthcare discipline and we are the MOST TRUSTED PROFESSION! Our voices matter and we have the power to influence change. Thank you for all that you do each and every day. Hope to see you at convention this year!

Rebecca Huie
Alabama’s Hispanic population grew 158% between 2000 and 2011, more than any other state. Nursing literature has addressed the need for ethnic/racial diversity, citing diversification as a means of providing culturally competent care (Taxis, C.J., 2002). Yet, Hispanic nurses represent a mere 1.2% of the nursing workforce in Alabama.

To address the aforementioned and other needs, the Alabama chapter of the National Association of Hispanic Nurses (NAHN) was formed August 31, 2017. Currently we have 18 members (4 PhD, 2 DNP, 2 MSN, 2 BSN, 1 ADN, 1 LPN, 6 Students).

The purpose of this Association is to foster the development and improvement of health care for all people residing in the state of Alabama and, in particular Hispanic ethnic groups, through the concerted efforts of Hispanic Nurses.

Since the inception, the chapter has elected officers, participated in one community service event, and completed two fundraising events.

It has taken over five years to finally bring to fruition what started as discussions between three nurses—Yaricet Matos Ramos, MSN, CRNP, Martha Dawson, PhD and Grace Grau, DNP, CRNP. We are thankful to our supporters, the Alabama Health Action Coalition (ALHAC), UAB School of Nursing, HICA.

Alabama’s chapter of the National Association of Hispanic Nurses, immediate goals are:

• to promote leadership, professional and educational advancement of chapter members, particularly the ability of nurse members to meet the healthcare needs of the Hispanic population;
• to promote scholarly activities, including research activities and seek financial support for 2 nursing scholarship/year;
• to be recognized and utilized as a resource by community leaders when considering matters that affect the Hispanic population.

Visit our website to join or learn more https://alnahn.nursingnetwork.com/ or Contact Grace Grau at nursegg@uab.edu.

Through the donation of a booth by the Hispanic Interest Coalition of Alabama (HICA), members provided cardiovascular risk assessments at Fiesta Birmingham on Saturday, October 1. Pictured here are members—Yolanda Harris, Grace Grau and Reyna Silva.

Pictured here are the newly elected officers: Tatiana Powell - Treasurer; Jacqueline Godber - Secretary; National President Elect & Member - Norma Cuellar in yellow; Aimee Duthil - President-Elect, and Grace Grau, President.

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About Student Members Aracely Alvarez, Ana Gonzalez and Grace Grau attended the 2016 National Conference in Chicago (Sponsored by University of Alabama at Birmingham (UAB) School of Nursing).

Chapter Members L-R: Back row – Dr. Vanessa Gaioso; Dr. Norma Cuellar, National President Elect; Student Members - Aracely Alvarez, Karen Nunez, Shelly Roman, Ana Gonzalez, Lisette Ornelas, Erika Alvarez. Front row – Tatiana Powell- Treasurer, Jacqueline Godber-Secretary, Aimee Duthil-Chapter President Elect. Not Pictured: Dr. Grace Grau - Chapter President, Brian Dickson, Dr. Martha Dawson, Dr. Linda Moneyham, Yolanda Harris and Dr. D’Ann Somerall, Reyna Silva.

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## Registration Form

2017 Annual Convention | Nurses: Critical to the Future of Healthcare | October 5-7, 2017

Register online at alabamanurses.org OR mail this form.

**Name & Credentials:** ________________________________

**Street Address:** ________________________________

**City/State/Zip:** ________________________________

**Daytime phone:** (__________) E-mail: ________________________________

**Credit Card #:** ________________________________ **Exp:** __________ **CVV #**

### Fees

1. **Mabel Lamb Continuing Education Day Workshops (Thurs., Oct. 5, 2017)**
   - Select your tract and registration type. Add $10 to fees if received after Sep. 22, 2017
   - **Tracts**
     - 9:00 AM – 3:00 PM (Tract I)
     - 9:00 AM – 3:00 PM (Tract II)
   - **Registration Type**
     - ASNA member $45
     - Non-member $65
     - Optional box lunch $20

2. **Convention (Thurs. night, Oct. 5; Fri., Oct. 6; Sat., Oct. 7, 2017)**
   - Select one registration type below. Includes tickets to all meal functions listed in this application. Add $20 to fees if received after Sep. 22, 2017. Meals may not be available if registration received after Sep. 22, 2017.
   - **ASNA Delegates Only**
     - $250 (must register for entire convention)
   - **Fee paid by district**
     - (check with your district president before selecting)
   - **Non Delegates – Full Convention**
     - ASNA Member $275
     - Non-member $340
   - **Daily Registration**
     - (if not attending full convention)*
     - ASNA Member $125/day
     - Non-member $150/day
     - Poster Presenter $99/day
   - **Select your day(s)**
     - Thursday
     - Friday
     - Saturday

**Friday Tracts (pick one):**
- Domestic Violence
- Leadership Academy

3. **Additional Meal/Function Tickets**
   - For guests or those meals not included in your registration.
   - $20 Thursday, October 5, 2017 – President’s Reception
   - $50 Thursday, October 5, 2017 – Opening Celebration ( Meal & Entertainment)
   - $70 Friday, October 6, 2017 – All Day Break & Lunch
   - $50 Friday, October 6, 2017 – Dinner & Entertainment
   - $35 Saturday, October 7, 2017 – Awards Luncheon**

4. **Total Enclosed: $_________**

**Indicate Award Luncheon Choice**
- Saturday, October 7, 2017
- Chicken Piccata
- Pepper Crusted Pork Loin

---

*ASNA Special Dues members (65+y/Retired or Completely Disabled) receive an additional 10% discount on registration.

---

**How to Register for Convention:**
Register online at alabamanurses.org/convention or send registration form and payment to (check made payable to ASNA) ASNA, 360 North Hurt Street, Montgomery, AL 36104-3644. Fax to 334-262-8678 (do not mail if faxing or registering online).

**For hotel reservations:** Contact the Embassy contacts Birmingham Convention center at 1-800-EMBASSY. Request the room rate for the “Alabama Nurses Association” (Code NRU) to receive the special rate of $130.00 plus tax. Cut off for discounts is Sept. 15, 2017. Reservations made after this date will be based on space and availability.

**Continuing Nursing Education (CNE):** The Alabama State Nurses Association is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center’s Commission on Accreditation.

**Alabama Board of Nursing (Valid through April 16, 2021):**
- “A maximum of 1.0 (ANCC)/1.0 (ABN) contact hours may be earned.
- An additional 5.5 (ANCC)/6.4 (ABN) contact hours may be earned by attending the Mabel Lamb CNE Sessions (including an optional 1.0 (ANCC)/1.2 (ABN) program Thursday afternoon).

**Registration:** The Mabel Lamb CNE Day registration includes continuing nursing educational sessions only and an optional CNE presentation.

**Single-day Convention registration includes meal functions and CNEs. Individuals registering the day of the Convention will be issued food tickets ONLY if available. Additional guest tickets may be purchased for food functions only.

**Payment:** Amount of registration is determined by postmark if mailed or date received in case of phone, fax, or online. Payment or Purchase Orders must accompany registration in order to be processed. All registrations received after September 22, 2017 will be considered “at door” and processed on site. Before September 22, 2017 will be considered early registration.

**Confirmations:** Confirmations are available to print immediately following your online registration. Registrations received via mail will receive an email confirmation within two weeks of receipt.

**Cancellations:** A written request must be received prior to September 22, 2017. A refund minus a $20 processing fee will be given. No refund will be given after September 22, 2017. We reserve the right to cancel the activity if necessary. In that case a full refund will be given.

**Returned Check Fee:** $30 returned check fee for any returned checks or dishonored payments.

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alabamanurses.org/convention
Thursday, October 5

Mable Lamb Nursing Continuing Education Day
Pre-Convention Continuing Nursing Education (CNE)

8:30 AM Registration

9:00 AM – 3:00 PM Tract I – Transplants
(Sponsored by Children’s of Alabama)
Reproductive Health for the Transplant Patient, Dr. Bates
Current Issues in Organ & Tissue Donation, Ann Rayburn, COA
Transplant Ethics, Gwen Gardner, MS, RN
Quality is No Accident, Page Turner
Bridging the Gap: Transitioning Adolescent Transplant Recipients, Sally Smith, RN

9:00 AM – 3:00 PM Tract II – Addiction and Professionals
(Sponsored by the Ethics and Human Rights Committee, ASNA)
What is Addiction?, Bronwyn McInturff, MSW, LICSW
Treating Addiction: The Challenges, Bronwyn McInturff, MSW, LICSW
The Alabama Board of Nursing Voluntary Disciplinary Alternative Program (VDAP), Speaker TBA
Alternative Pain Management, Cathy Russell, PhD, RN

12:00 PM – 1:00 PM Lunch

1:00 PM – 3:00 PM ASNA Board of Directors Meeting

3:15 PM – 4:15 PM Lagniappe (Special CNE presentation open to all Preconvention and Convention Attendees)
Professional Nursing Ethics: Avoiding Ethical Drifts, Katie-Drake-Speer, MSN, RN

5:00 PM Opening of ASNA House of Delegates
Call to Order, Rebecca Huie, DNP, RN, President
Opening Ceremony
• Trooping of Colors and Pledge of Allegiance, sponsored by National Guard Medical Unit
• National Anthem, Dr. Bobbie Holt Ragler
• Official Greetings
Dr. Mark Wilson, Jefferson County Department of Health,
Dr. Terri Poe, UAB Medical Center
Emily Walters, President Alabama Association of Nursing Students
Report of the Credentials Committee
President’s Report
Executive Director Report
Introduction of Candidates

6:30 PM President’s Reception

7:00 PM + Supper and Special Entertainment

Friday, October 6

7:15 AM – 8:00 AM Breakfast Pre-function Area

7:15 AM – 8:00 AM Registration

8:00 AM – 10:00 AM View Auction Items

8:00 AM – 2:00 PM Exhibits and Posters Pre-function Area

10:00 – 11:30 AM Tract I – ASNA Leadership Academy Presentations

10:00 AM – 11:30 AM Tract II – Domestic Violence
Original Play Presentation and Discussion, Pam Whitt and Annetta Nunn

11:30 AM – 12:15 PM Lunch Pre-function Area

12:15 PM – 1:30 PM Keynote Address, Dr. Nina Sanders, Provost Sanford University

1:30 PM – 2:30 PM Alabama Board of Nursing Update, Peggy Benson, MSN, RN

2:45 PM – 5:45 PM HOD resumes
Chair aerobics led by Dr. Bobbie Holt-Ragler, Community Health Advocate
Call to Order: President Huie
Report of the Credential Committee
• Reports (only if in addition to written report in Convention Book)
• Officers
• District Presidents
• Commission on Professional Issues
Standing Committee (only if in addition to report in Convention Book)
• Continuing Education, Ethics and Human Rights, Finance, Legislative, Membership, and Nominations
• Task Force Reports

6:00 PM Supper

6:45 PM Live Auction

8:00 PM + Special Entertainment (DJ and Karaoke)

Saturday, October 7

7:30 AM + Breakfast on your own or provided by hotel for hotel guests

8:00 AM – 8:30 AM Registration

8:15 AM – 9:00 AM Voting

9:00 AM Biosafety and Infectious Diseases, Speaker TBA

10:00 AM House of Delegates reconvenes
Chair Aerobics led by Dr. Bobbie Holt-Ragler
Call to Order: President Huie
Report of the Delegate Credentials Committee
Memorial Service, Deborah Theiford Zimmerman
Report of Tellers
Adoption of 2017 Resolutions
New Business
• Strategic Plan
• 206 Resolutions Evaluated
Convention Invitation 2018 Announcements
Installation of New Officers

12:00 PM – 1:30 PM Awards Luncheon

Available Positions for the 2017 Ballot

If you are willing to have your name placed on the ballot for any of the offices listed below, please fill out this form and leave it at the Convention Registration Desk, or mail to: Alabama State Nurses Association, 360 North Hull Street, Montgomery, ALA 36104-3658. Also, see consent to serve form on the next page.

[ ] Vice President
[ ] Secretary
[ ] Commission on Professional Issues (4 needed)
[ ] Nominations Committee (2 needed, Districts 4 and 5)

Name _____________________________________________ District # _________
Address _________________________________________________________________
Phone: (w) ___________________________ Phone: (h) __________________________
E-mail __________________________________________________________________

[ ] Officers
[ ] District Presidents
[ ] Commission on Professional Issues
Standing Committee (only if in addition to report in Convention Book)
[ ] Continuing Education, Ethics and Human Rights, Finance, Legislative, Membership, and Nominations
[ ] Task Force Reports

2017 Annual Convention continued on page 12
NURSES: CRITICAL TO THE FUTURE OF HEALTHCARE

Become a Delegate!

To be a delegate at the annual ASNA House of Delegates you must:

- Be an ASNA member in good standing (90 days or more is preferred, but newer members are also encouraged to participate)
- Be selected by your district and added by the district president to the official delegate list
- Register as a delegate for all three sessions (entire convention) of the House of Delegates
- As stated above, register for all three sessions, but if you cannot attend a session make sure your district president has an alternate for you

If you would like to be a delegate for our 2017 convention, please contact your district president.

ASNA Leadership Opportunities: 2017-2019
Consent to Serve Form for Alabama State Nurses Association Office

- Vice President
- Secretary
- Commission on Professional Issues
- Nominating Committee

The Commission on Professional Issues has openings for 4 positions this year.

Nominating Committee

The Nominating Committee has openings for 2 positions this year (Districts 4 and 5).

All criteria for eligibility must be met before your name will appear on the ballot.

Are you able to get time off to attend meetings necessary to fulfill the duties of the office for which you are submitting this Consent to Serve Form?  [ ] Yes  [ ] No

If you would like to be a delegate at the annual ASNA House of Delegates you must:

1. Be a current member of ASNA.
2. Have sufficient education and experience within the organization that will demonstrate his/her understanding of the requirements of the office as evidenced by being active at the local and/or state level.
3. Have commitment for time involved with the position compatible with employment.
4. Have ASNA District Board of Directors verify participation and attendance in the local board and chapter level and willingness to give time and effort to accomplish tasks.

If you are able to serve the professional organization, we assume that you have cleared time with your employer to attend meetings. Applicants should be willing to absorb own expenses.

Registered Nurse – ER
7 pm-7 am or 3 pm–3 am shift (14% differential, as applicable)
Monroe County Hospital
2016 South Alabama Avenue, Monroeville, AL
(251) 743-7453
www.mchcare.com
EOE

Book Review

Dr. Karen Walton, DNP, RN, CHSE
Stop Nurse Burnout: What to do when working harder isn’t working

Now find your dream job at nursingALD.com
FREE to Nurses!
Personal Items

Beverages

Ready to Eat Food Items

- Canned meat, poultry, or fish (6)
- Jerky, Beef, Turkey (2 packs)
- Canned or Dried Fruits & Vegetables (10)
- Canned soups, Chili, Stew, or Broth (6)
- Crackers – low salt (2 packs)
- Peanut Butter & Jelly or Jam (2 each)
- Dry Cereal/Granola – keep fresh & dry in resealable bag or container (2 packs)
- Nuts & Trail mix – keep fresh & dry in resealable bag or container (2 packs)
- Protein Bars or Fruit Bars (6 packs)
- Storable Treats – healthy, no salty chips (as needed)
- Comfort Foods & Beverages (as needed)

Beverages

- Fruit Juice – ready-to-drink containers (10)
- Powdered Mix (4 boxes)
- Bottled water – 1 gallon per person per day

Separate water supplies for
- Each Pet
- Plants
- Washing Dishes
- Washing Laundry – bedding, clothing, etc.
- Bathing & Showering

Personal Items

- Toilet Paper & Facial Tissue
- Hand Soap & Lotion
- Toothbrush & Toothpaste
- Denture Care
- Feminine Hygiene Products
- Sunscreen & Bug Repellant

Miscellaneous

- Manual Can Opener
- Pet Food
- Paper Towels & Disinfectant Wipes
- Garbage Bags
- Flashlight & Batteries
- Battery Operated Radio
- Extra Batteries
- Spare set of House Keys & Car Keys
- Household Bleach & Medicine Dropper
- First Aid Kit & Personal Medicines
- Candles & Matches in Water-Proof Bag
- All important papers together in Water-Proof Bag

Helpful Hints from someone who has lived through several Gulf Coast hurricanes.

- Pick beverages carefully as ice may not be readily available.
- Have Fondues Pot & with fuel or camp stove & appropriate cookware available for food preparation.
- Select appropriate can sizes as open food cans will probably not be saved.
- Have plenty of first aid supplies as individuals will be injured during the clean-up.
- Fill a bathtub with water (if you have notice of the impending disaster) for dishes, laundry, bathing, & flushing the commode.

Disasters have the potential to cause emotional distress and as nurses our role is to be cognizant of the most vulnerable which are:
- youth and adults working in the impacted area
- loved ones of victims
- first responders, rescue and recovery workers

Stress, Anxiety, and Depression are common reactions following the disaster. Nurses volunteering in disaster areas need alertness to the following warning symptoms of the survivors affected by the disaster:
- sleeping too much or too little
- stomach aches or headaches
- anger, feeling edgy, or lashing out at others
- overwhelming sadness
- a feeling of needing to be busy all the time
- worrying much of time but not sure why
- lethargy
- increased consumption of alcohol, tobacco, & illicit drugs
- anorexia or overeating
- a continuum of not connecting to others to social isolation
- feelings that you will never be happy again

Concepts Nurses can employ to help disaster victims cope with the stress:
- self-care – encourage healthy eating, limiting alcohol, tobacco, & drugs. Get outside if possible – even walking around the block.
- reach out to family and friends – talk to them about how you feel

- talk to your children – remember the children will probably feel angry, confused, sad, and scared. Let them know it is OK to have these feelings and encourage the children to talk about what is on their mind. Try to limit TV news reports and social media about the disaster. Help the children and teens maintain as normal as a schedule to the extent possible. The adults should model healthy eating.
- encourage sleep hygiene as some will have trouble falling asleep whereas others will keep waking up during the night. Suggestions include to go to bed when ready to sleep and don’t watch TV, use cell phone or lap top in bed. Limit food intake (especially sugar), alcohol, and caffeine at least an hour before bed. If the person wakes up and cannot return to sleep suggest journaling about feelings. 
- take care of pets or get out into nature as both of these tend to make you feel better. Suggest volunteering at an animal shelter or in the disaster area when appropriate to own area.

Encourage Self Help for Appropriate Individuals. Disaster Distress Helpline answered by trained crisis counselors:
Call 1-800-985.5990
Text “TalkWithUs” to 66746
These lines are available 24 hours/day; 7 days a week
TTY for Deaf or Hearing Impaired 1-800-846-8517
Spanish Speakers Text “Hablanos” to 66746

The following suggestions are in part derived from SAMHSA (Substance Abuse and Mental Health Services Administration of the US Department of Health and Human Services)

The Healthy Nurse, Health Nation™ (HNHN) Grand Challenge is a nationwide movement designed to transform the health of the nation by improving the health of its 3.6 million registered nurses.

The biggest issue nurses face today
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Disaster Preparedness

Get Ready for Emergencies
Pet Disaster – Preparedness Kit

This information is gleaned from the Alabama Department of Public Health and The Humane Society of the United States

Disasters are not only traumatic for your family but also your pets. Just as a Disaster Preparedness Kit is developed for the family an associated kit should be planned for your animals. Some basic items to consider for pets include the following:

**Essential Items**

- **Food** (in a water proof container) and water for at least 3-5 days for each pet. If taking canned food include a manual can opener if the cans do not have flip tops. In addition to drinking water have an additional gallon of water set aside for the pets in case the pet is exposed to chemicals or flood waters and needs to be rinsed.
- Medications and medical records stored in a water proof container. Records should include vaccinations, medical records, veterinarian contact information. This information is essential if animal is to be boarded.
- **Collar or harness with ID tag and leash.** Animal should wear collar/harness with tag (identification & rabies) at all times – even if they do not wear at home.
- **First Aid Kit including cotton bandage rolls, tape, bandage scissors, antibiotic ointment, flea & tick protection, latex gloves, isopropyl alcohol and saline solution.**
- **Crate or Pet Carrier which should be large enough for the animal to stand up comfortably, turn around, & lie down.** The animal may need to stay in carrier for hours at a time. Make sure the crate or carrier is secure with no loose items inside to accommodate smaller animals.
- **Include a picture of you and your pet together which can be used to document ownership if you become separated from the pet. It is helpful to also have description of the pets along with the photographs.**
- **Familiar items such toys, treats, blankets or towels may be needed for warmth or bedding depending on species of animal.**
- Sanitation needs include newspapers, paper towels, plastic trash bags, shampoo, grooming items, and if appropriate litter box and litter.

**Arrange a Safe Haven**

- **Contact your veterinarian for a list of preferred boarding kennels in the event of an emergence.**
- **Ascertain in advance if the local animal shelter will provide emergency shelter.**
- **Choose a designated caregiver outside your immediate area to take care of your pets.**

**Evacuation Preparation**

- **Store the emergency kit as close to an exit as possible.**
- **Make sure all pets are wearing collars with current identification.**
- **Always bring pets inside with the first warning of a storm.**
- **Consider your evacuation route and call ahead to make arrangement for boarding your pet outside the disaster area.**
- **Remember most hotels have at least one designated hall for individuals with pets.**

Remember if it is not safe for you, it is not safe for your pets!
Supporting Children and Adolescents in Disaster

In Alabama when the word disaster comes to mind we tend to think about just hurricanes and tornados; however, there are many other types of disasters impacting children and adolescents. Some are caused by human intervention related to political issues or hate related interventions. Examples include bombings, mass shootings, and/or riots. Other disasters are sourced from climate changes and a train derailment or interstate accidents. Depending on rain fall, areas of a state may be involved in wildfires or in some cases house fires. Following a disaster of such magnitude that the President declares the area eligible for Federal Assistance, the community is usually in a state of shock and disorientation. Parents and other responders need to take the time to process and accommodate their reactions to the disaster. Humans develop from an infant responding to their environment. They will assimilate the experience into the context of their current developmental stage and develop their responses to the situation differently depending on their current stage of cognitive development.

Most children when surrounded by supportive adults and peers can adjust to the traumatic events of the disaster. Children will receive the support needed to create the context and assimilation of their own individual development with time. The children experiencing childhood in a negative environment (loss of home and family members, pets, etc.) and if they are adapting to losing their home. Some of the children, in an attempt to regulate the experience, will engage in pre-disaster functioning more rapidly. Adolescents are more prone to be isolated and withdraw from others. Teenagers demonstrate regressive behavior associated with a younger developmental stage. All age groups return to pre-disaster functioning in families can share their experience with one another. The degree of exposure to frightening events has a direct correlation to return to pre-disaster functioning. An example would be losing a home to a hurricane after you have had to evacuate as compared to leaving a burning home in the middle of the night. Age specific anticipated behaviors These behaviors are normal and abate over time, usually no more than a month:

Preschool (Fears because their secure world has been disrupted)
• Crying on a continuum from whimpering to screaming
• Trembling or becoming immobile
• Run away from adults or running aimlessly
• Regression (specific behaviors that had been overcome) – bed-wetting, loss of bowel control, thumb sucking, fears of dark or animals or being alone, inability to dress self or to feed self

6-12 years old (Fears related to dangers to self and loved ones as well as a fear of damage to the environment. They have difficulty with the loss of prized possessions and pets)
• Regressive behaviors – bed-wetting, nightmares, sleep issues, irrational fears (such as building safety)
• Trembling or becoming immobile
• Regression (specific behaviors that had been overcome) – bed-wetting, loss of bowel control, thumb sucking, fears of dark or animals or being alone, inability to dress self or to feed self

12 – 17 Year old (The teenager will react to the degree that the event disrupts their family and the community. It may cause them to isolate from their family, peers, school life and even intactness of their own bodies. They may regress to earlier stages of cognitive development)
• Withdrawal, isolation, depression, and/or sadness
• Regression (specific behaviors that had been overcome) – bed-wetting, nightmares, sleep issues, irrational fears (such as building safety)
• Risk taking behaviors – alcohol, drugs, driving too fast
• Sleep disturbances
• Avoidance of developmentally appropriate behaviors such as going to camp or college

Learning Outcome:
 Nurses to provide appropriate supportive care based on best practices which can be individualized to the needs of children and adolescents in times of a disaster.

Instruction for credit:
 Participants should read the Learning Outcome online or printed out. After reading complete the posttest and compare answers to ones provided and review any incorrect responses by reviewing content in the monograph. Participants must complete the evaluation online and submit the appropriate fee to receive continuing nursing education credit.

What are the role of the Basic Principles for Mental Health Nursing that apply to a disaster?
 Nurses are usually among the first volunteers in stricken areas. Special mental health disaster training is valuable but not essential. Concepts for nurses to keep in mind include the following: assistance needs to be tailored to the community involved using cultural competence as a guide. Remember that all will experience some type of a disaster. The response to a disaster is an immediate one; however, a minority of survivors will experience long-term psychological issues such as PTSD. Be prepared that the large number of people involved may increase the intensity of the response. It is essential to collaborate and consult with trusted organizations and community leaders to make sure all members of the community are served. This means adjusting the tail of the biologic response as needed. The term parents will only be used throughout this monograph.

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CE Corner

CE Corner

CE Corner
time watching the storm depicted as a big red ball on the screen. Their eyes were glazed over. They could not follow a conversation, could not make eye contact. After a quick assessment of the situation the first action by the volunteer was to turn off the televisions and organize age appropriate groups and play therapy. In time the survivor’s behavior reflected improvement. The lesson is that television and social media dwelling on negative aspects of a disaster can impede the recovery process.

What are the Factors that Influence the Development of PTSD?

PTSD sometimes develops several years after the event. Many children normally exhibit stressors 1-2 years following the event but most adapt without developing this. The severity of the event in association with the strains of everyday life has an impact on the children normal adapting reactions. Strains of ongoing life include a parent’s loss of employment or divorce; both of which may limit availability of a supportive environment. Other factors associated with the development of PTSD include loss of essential support in the community and especially the schools.

It is normal for children to have fears and anxieties following a disaster. And at times they are unconnected to anything specific in their life. The child is best helped by accepting them as real and helping parents to also accept at face value. This may be difficult with a dysfunctional family and even more so if the family was dysfunctional prior to the disaster. The intensity and duration of the anxieties and fears will decrease more rapidly when families exhibit understanding. A normal reaction of children in families who are not supportive is shame, rejection, and not being loved. Teach parents to expect regressive behavior in younger children and remind them that it is usually temporary. In words that parents understand, teach them that this is a cognitive mechanism to allow children to redevelop coping patterns that had been functioning prior to the disaster. One way to facilitate is offer praise for positive behaviors. Another coping mechanism parents may employ is to relax routine rules. Younger children express separation anxiety by clinging and refusing to let parents out of their sight – even if they have not expressed this behavior before. As the danger resolves the clinging behavior improves. Children exhibit the most fear when they do not understand what is occurring around them or if they are provided erroneous information. Remind parents that children can absorb factual information and will cope with the situation better if they are accurately informed. When families can remain together healing is enhanced. The adults modeling positive behavior can be growth enhancing for the children.

Sleep issues are problematic after a disaster. In fact, sleep issues are probably the number one problem following a disaster. It takes many forms – resistance to bedtime, inability to sleep, unwilling to sleep in own room, or refusal to sleep alone. The children often want to sleep in the parent’s bed, insist that the parent remains in room until they fall asleep, or sleep with the lights on. Perhaps the most problematic is excessively early awakening. These are detrimental to the child’s wellbeing as well as increasing stress for the parents. The before mentioned behaviors will resolve in time. Encourage parents to accept temporary changes such as child sleeping with you for a brief time but to aim for return of normal pre-disaster routines. Teenagers may need special consideration for bedtime privacy. If the parents do not already, encourage calming pre-bedtime activities to reduce chaos in the evening. However, some sleep behaviors may need professional intervention. Teach parents to be observant for continued sleep terrors, nightmares, and refusal to fall asleep. These behaviors point to deep-seated fears and anxieties.

How Can I Help?

There are some basic concepts that non psychiatric nurses (or other volunteers) may employ to help with the healing process. The first is to establish rapport. A few simple actions will enable this process. Show interest and respect, make sure your communication is appropriate for the child’s current cognitive level (in case of regression). Communicate trust and promise only what you can deliver. Let them know that you are an informed authority.

The second important action is to identify, define, and focus on problems. Once identified, focus on solving the issue and achieve a resolution. Inherent in this is to evaluate the capacity of the family to deal with the problems or the resolutions identified. Another important action is to convey understanding. Display patience, listen to stories over and over, and reaffirm their feelings by providing a nurturing environment. Listen carefully and interpret the disaster from the child’s point of view. Be aware that you will hear the same story over and over. Each time support the storyteller’s feelings.

Communicate clearly in words the children understand and if possible in their native tongue. Seek family members input to interpret code words if used by the children. An example would be a strange name for an object they treasure. It is often helpful to talk in groups of family members as the role of the family is to learn and sort out the crisis together. Provide support and a nurturing environment to facilitate healing. One fact to keep in mind is the role of the child as an interpreter for the family members not fluent in English. Some of the information given to the families may be beyond to cognitive level of the child at the time. Be alert and use non-family interpreters as needed.

Determining when a volunteer needs rest

Nurses and other volunteers are at risk for burnout during the process. Look for potential symptoms in self or in others. Specifically, be alert to physical and emotional exhaustion, fatigue that will not go away despite adequate rest, and noticeable increased irritability in the volunteer situation and/or at home. And most of all a decrease in the ability to work effectively or a relentless nagging feeling of a desire not to work. If any of these or any combination occurs the volunteer should take a break from the situation and return when fully rested. Volunteering can be a rewarding experience but not when your body is mentally and physically drained.

References:


3. Post Test – Score your test using the provided key.

If any question is answered incorrect review monograph to determine the correct response. Select the one (1) best response

1. Special Mental Health Training is necessary to volunteer in a disaster situation.
   A. True
   B. False

2. Teenagers should be encouraged not to ruminate over and over the same about the loss of a best friend.
   A. True
   B. False

3. The most frequently noted complaint in children following a disaster is
   A. Sleep issues
   B. Bed-wetting

4. In facilitating the healing process the first thing a volunteer nurse should do is
   A. Establish rapport
   B. Define the problem to seek solutions
   C. Both are equal in importance

5. Parents need to understand that regressive behavior is
   A. To be expected
   B. Warning sign of potential development of PTSD

Answers:

1(B) 2(B) 3(A) 4(A) 5(A)

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September, October, November 2017

C.E. Corner continued on page 16
Cardiovascular Disease and Education in Men

Mark J. Caldwell II graduated from Delaware Technical and Community College-Terry Campus in December 2012 with his ADN. After graduating from Del Tech, Mark accepted a position in the Critical Care Nurse Residency at Christiana Hospital. When the nurse residency completed, Mark then accepted a position in the Cardiovascular Critical Care Complex as a staff nurse. He is currently working towards a MSN in Executive Nursing at Wilmington University. Ryan can be contacted at Rymiller@christianacare.org.

Ryan Miller is an Assistant Nurse Manager in the Cardiovascular Critical Care Complex at Christiana Care Health System. He is a 2010 graduate of the University of Delaware simulation lab at the University of Delaware and enjoys sharing his clinical experiences with the nursing students. Ryan can be contacted at Rmiller@christianacare.org.

According to the Centers of Disease Control (CDC) (2017), cardiovascular disease is the leading cause of death for men in the United States. In 2013, one in every four men died as a result of heart disease. That is over 320,000 deaths. Potentially even more concerning is the fact that more than half of the men who died of coronary heart disease had no previous symptoms or diagnoses. In 2010, according to the American Heart Association (AHA) (2017), 74.9% of coronary bypass graft surgery patients and 61.7% of percutaneous coronary intervention patients were diagnosed with vascular disease. With more men being diagnosed with cardiovascular disease, it is important for healthcare providers to ensure there is adequate education and community based resources to ensure men across the country can be made more aware of the disease and their potential to die due to heart disease.

The information needs to be provided to both you and your patients and the amount of resistance to blood flow in your arteries” (2016, para 1). Hypertension is diagnosed in men in cardiology clinics and primary care offices everyday across the country. Uncontrolled hypertension is a known risk factor for heart disease. The AHA (Hyde et al., 2016) identified that men, as a group, have an increased prevalence of hypertension, in particular, of cardiovascular events, complicated by the significant risk reduction in hospital admissions. The American Heart Association stated that normal blood pressure is a systolic reading less than 120 millimeters of mercury and a diastolic reading less than 80 millimeters of mercury. More than 80 million Americans suffer from hypertension, a condition that can be managed with medication. In addition, arterial pressure and increasing stress levels can contribute to the risk of developing hypertension. It is also critical to note that hypertension often runs in families and can be passed down through generations and go undiagnosed. It is vitally important for patients to have access to care in order to initially be diagnosed and to adequately manage their disease.

Hypertension is defined by the Mayo Clinic as, “a common condition in which the long-term force of the blood against your artery walls is high enough that it may eventually cause health problems, such as heart disease. Blood pressure is determined both by the amount of blood your heart pumps and the amount of resistance to blood flow in your arteries” (2016 para 1). Hypertension is diagnosed in men in cardiology clinics and primary care offices everyday across the country. Uncontrolled hypertension is a known risk factor for heart disease. The AHA (Hyde et al., 2016) identified that men, as a group, have an increased prevalence of hypertension, in particular, of cardiovascular events, complicated by the significant risk reduction in hospital admissions. The American Heart Association stated that normal blood pressure is a systolic reading less than 120 millimeters of mercury and a diastolic reading less than 80 millimeters of mercury. More than 80 million Americans suffer from hypertension, a condition that can be managed with medication. In addition, arterial pressure and increasing stress levels can contribute to the risk of developing hypertension. It is also critical to note that hypertension often runs in families and can be passed down through generations and go undiagnosed. It is vitally important for patients to have access to care in order to initially be diagnosed and to adequately manage their disease.

According to the American Heart Association (2017), elevated cholesterol contributes to the development of atherosclerosis or plaque and can lead to the development of heart disease, high blood pressure and stroke. High Density Lipoproteins (HDL) help remove cholesterol in arteries. Low Density Lipoproteins (LDL) result in the main buildup of cholesterol that increases for risk for a narrowed and clogged arteries (2017). A lack of education and community resources play a significant role in the knowledge deficit and the reason so many men lose their lives to a disease they are at risk for developing due to lack of knowledge. More community outreach needs to occur with a focus on prevention and who primary care. Elevated cholesterol is a modifiable risk factor for heart disease that can be reversed with proper diet, exercise, and medication regimen. It is vital that as healthcare shifts from inpatient care to population health that community outreach efforts targeted the male population in providing early education towards prevention of heart disease.

Smoking is difficult to stop but is a modifiable risk factor to heart disease that many individuals are not aware of. It is common for anti-smoking advertisements to focus on the risk of lung cancer, but rarely do these advertisements focus on the risks to the cardiovascular system. In a recent study that looked at coronary artery disease in smokers, it was noted that in the United States “…approximately 4 to 10 million adults with coronary heart disease were former smokers” (Shahoumian, 2016). It is overwhelming to consider so many smokers whether they quit or continued smoking eventually developed heart disease. Again, this is another modifiable risk factor that needs be highlighted so that education can be provided to the community.

The risk factors of cardiovascular disease as outlined above are more commonly known risk factors, but it is important to also note some of the lesser-known risk factors of cardiovascular disease in men. Hypogonadism is a condition where the male body does not make enough of testosterone, the male sex hormone. Testosterone plays an important role in the male body such as in metabolism, bone density, vasculature, and brain function. In men, testosterone peaks in early adulthood and decreases by 1-2% per year for the remainder of life (Hyde et al., 2012). The gradual decline of testosterone in men is a part of the normal aging process and with that comes the effects of the aging process. Low testosterone is associated with risk factors for cardiovascular disease, including insulin resistance, metabolic syndrome and type 2 diabetes, and predicts the development of atherosclerosis and cardiovascular events (Hyde et al., 2012).

Whether it is one of the main risk factors or even some of the more minor risk factors associated with cardiovascular disease in men, it is obvious that more information needs to be provided to decrease the prevalence of this disease process with men in our communities. It is vital that as healthcare shifts from inpatient care to population health and preventative medicine that nurses take the lead in bringing healthcare education to our communities. More needs to be done to promote healthy lifestyles in our communities and neighborhoods. Cardiovascular disease in men is a significant disease process where there is clearly a knowledge deficit regarding the disease, its treatment, and more importantly, its modifiable risk factors. Nurses need to take the lead and forge a path to ensure adequate education in place outside of the health system about disease processes like cardiovascular disease.

References
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Contact CPT Karla Sanchez (251) 471-2990 or karla.j.sanchez.mil@mail.mil for more information.
When thinking of human papillomavirus (HPV), we usually associate this virus with women and cervical cancer. However, HPV linked cancer in men is occurring with increasing frequency in certain head and neck cancers.

What is HPV?
HPV is a DNA virus that affects the skin of the mouth, vagina, cervix, and anus and can be spread through skin to skin contact or anal, vaginal, or oral sexual activity. The Centers for Disease Control and Prevention (CDC) states that “nearly all sexually-active people” will contract HPV at some point but most infections will clear without causing symptoms (Prevention, 2017). While there are more than 100 different types of HPV, more than 40 types affect the genitals and are classified as “low risk” and “high risk.” For example, low risk HPV types 6 and 11 cause genital warts, but high risk HPV types 16 and 18 are associated with cervical cancer and some oropharyngeal cancers (“Icahn School of Medicine at Mount Sinai,” 2016; “Institute,” 2015). Since we are discussing men’s health in this DNA Reporter issue, I will focus on HPV and head and neck cancer in men.

Are all head and neck cancers linked to HPV?
When high risk HPV 16 enters the epithelial cells that line our mouth and throat, the oncoprotein E6 and E7 are produced. These proteins cause mutation of two squamous cell carcinoma and are classified further by the area from which they originate. The area classified as “oral cavity” includes lips (inner lining and outer), front portion of the tongue, gums, cheeks, floor of mouth, and hard palate. The area classified as the “pharynx” includes 3 sections: the nasopharynx, which is behind the nose or upper pharynx which is the middle/soft palate area including base of tongue and tonsils; and the hypopharynx which is the lower part of the pharynx and includes the larynx/voice cords and epiglottis which sits above the larynx. Cancers of the head and neck can also affect the parasinus sinuses, nasal cavity, and salivary glands.

Alcohol and tobacco use has been shown to be contributing factors to cancers of the head and neck. The good news to report is that as tobacco use has declined, head and neck cancers associated with tobacco are also declining. The bad news is the incidence of oropharyngeal cancer (those involving the tongue and tonsils) has escalated. It is estimated that the prevalence of HPV driven oropharyngeal tumors has risen from approximately 16% in the mid to late 1980s to nearly 75% in the early 2000s (McKieran, 2016). These HPV driven cancers are shifting the patient demographic to younger men who may not have any tobacco history. The prevalence is increasing fastest in Caucasian men, but is also seen in non-Caucasians as well (D’Souza et al., 2016).

What does a diagnosis with HPV driven head and neck cancer mean to my patient?
When high risk HPV 16 enters the epithelial cells that line our mouth and throat, the oncoprotein E6 and E7 are produced. These proteins cause mutation of two squamous cell carcinoma cells and are classified further by the area from which they originate. The area classified as “oral cavity” includes lips (inner lining and outer), front portion of the tongue, gums, cheeks, floor of mouth, and hard palate. The area classified as the “pharynx” includes 3 sections: the nasopharynx, which is behind the nose or upper pharynx which is the middle/soft palate area including base of tongue and tonsils; and the hypopharynx which is the lower part of the pharynx and includes the larynx/voice cords and epiglottis which sits above the larynx. Cancers of the head and neck can also affect the parasinus sinuses, nasal cavity, and salivary glands.

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First Steps in Improving Blood Pressure Control Among Primary Care Hypertensive Veterans Utilizing Quality Improvement Tools

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Abstract
Background
Uncontrolled hypertension (HTN) is associated with poor clinical outcomes. Most people can obtain controlled blood pressure (BP) with two or less medications regardless of lifestyle modifications, such as following the Dietary Approaches to Stop HTN (DASH) diet and regular exercise. Quality improvement tools were used to identify first steps in improving BP control in one Patient Aligned Care Team (PACT) at a Veterans Administration (VA) Medical Center in Southeastern United States.

Methods
A team charter was developed and several quality improvement tools were used to identify the first steps to improve BP control. A process map and a SWOT (Strengths, Weaknesses, Opportunities, and Threats) analysis were conducted. Opportunities were targeted using a literature search and brainstormed ideas. The Chronic Care Model conceptual framework guided the brainstorming session, which derived our HTN bundle intervention. An evidence based HTN bundle was designed, which included meaningful use of the Electronic Medical Record (EMR), non-traditional clinical visits (including face-to-face visits with a Registered Nurse [RN], a Doctor of Pharmacy [Pharm. D.], or telemedicine visits), medication adherence assessment and reminder by the RN or Medical Support Assistant (MSA) via

Improving Blood Pressure Control continued on page 20
phone visit prior to clinic visits, home BP monitoring with logging, and a BP protocol. Two Plan Do Study Act (PDSA) cycles were conducted over 6 months, and check sheets were used to track progress of the HTN bundle.

Results
Among one PACT with 847 veterans, 547 (65%) were diagnosed with HTN or HTN including diabetes (DM). The PACT’s medical doctor (MD) selected 172 (33%) veterans with uncontrolled BP from the EMR to be scheduled for a follow up clinic visit in the near future. For various reasons, these veterans failed to return for their follow up clinic visit and were listed on the EMR inactive list. This list was easily generated in the EMR by the MD; however, the list was not currently being used for this purpose. The MD selected 32 veterans from the 172 to be scheduled first for a follow up visit based on their acidity and duration of lapse appointment. Over the course of 6 months, these veterans were added to the existing PACT clinic schedule. The MD recommended fourteen of the 32 veterans to the Pharm. D. or RN. More than half of the 32 veterans (56%) had controlled BP at the initial follow up visit. The HTN bundle was used to improve and sustain BP control in veterans who belong to this PACT. BP metric goals improved 7% for veterans with HTN and 9% for veterans with HTN and DM over 6 months. We met the hospital metric target goals of 68% and 76%, respectively, within 6 months.

Conclusion
We used an interprofessional team to complete a quality improvement project in a selected primary care clinic. The Model for Improvement PDSA cycles, process map, SWOT analysis, and check sheets appeared to be useful quality improvement tools in combination with an evidence based HTN bundle to improve BP metrics, approach to stop HTN (DASH) diet and regular exercise. However, the lack of medication adherence has been estimated as high as $300 billion (Osterberg & Blaschke, 2005). Medication adherence is essential for improved quality of care and better health at a reduced medical cost (PhRMA, 2011). Frequent BP monitoring is necessary to obtain a BP target goal. According to the World Health Organization (2003), HTN was the number one reason patients visit their primary care doctor; however, a study done by the Mayo Clinic classified HTN eighth among the top ten reasons, with skin disorders being the number one reason patients seek clinic visits (St. Sauver et al., 2013). Nevertheless, HTN continues to be a major driver of healthcare utilization. Unfortunately, primary care has been insufficient in controlling HTN in some populations, in part, due to lack of access (Bosworth et al., 2008). Home BP measurement is often needed to accurately assess HTN (Stergiou & Bliziotis, 2011), and it has been used to successfully control BP among veterans (Powers et al., 2011). Access to care has been improved by some clinics using telemedicine, RNs, pharmacists, and phone visits (Marrgol et al., 2013). Phone visits have been shown to be effective, in specific situations, as a substitute for primary care clinic visits for veterans (Sperber et al., 2014).

Based on the VA Primary Care BP Internal Report for the 4th quarter of fiscal year 2013, 20% (8) of the primary care providers did not meet VA Medical Center BP metric goals. This equates to approximately 30-32% of the veterans with uncontrolled BPs. In 2013, VA Medical Center BP control metric goals were 68% for veterans with HTN and 70% for veterans with a comorbidity of HTN and Diabetes (DM); stretch goals were 75% and 79%, respectively. A quality improvement project was created and facilitated by a VA Quality Scholar fellow to improve BP control among veterans. VA Quality Scholar fellows are trained in health care quality and metrics to lead continuous improvement in health care services in the VA system and nationally. The purpose of this quality improvement project was to within 6 months improve BP control rates for a selected Patient Aligned Care Team (PACT) from 62.3% to 75% for veterans diagnosed with HTN and DM. The medical home in the VA system is the newly developed PACT model designed to take care of veterans using a consistent team of healthcare professionals for patient driven care.

Methods
Our interprofessional team constructed a project charter to identify the quality improvement project’s duration, scope, and resources. We held weekly meetings to conduct the project’s activities. A process map of the primary

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The Chronic Care Model was used to guide the HTN Bundle. Below is a modified Chronic Care Model for our quality care project: HBPM = Home BP monitoring, Levels of care = nontraditional care, EMR = electronic medical record. The model for improvement constructs are: (1) community resources and policies (free or discounted medication from outside pharmacies, and logistical needs), (2) self-management support (nurse visits, telemedicine, phone visits, home BP monitors and logs), (3) delivery system design (nontraditional clinic visits including RN, Pharm. D., phone visits, and face to face), (4) decision support (BP management protocol, and 5) clinical information systems (EMR). All constructs are needed for an effective primary care clinic. This model acknowledges and enhances the role of the patient in the management of a chronic disease such as hypertension. In this model, the informed empowered patient and the prepared proactive team are partners.

http://www.improvingchroniccare.org/index.php?p=The_Chronic_CareModel&L=2

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care clinic visit workflow was constructed to determine clinic workflow issues, and the Strengths, Weaknesses, Opportunities, Threats (SWOT) analysis was conducted to assess these aspects, which helped us to focus our efforts. Several opportunities were noted, such as: (1) the prospective arrival of new BP equipment, (2) the need for BP measurement training for the nursing staff and pharmacist (Pharm. D.), (3) the need for meaningful use of the EMR, (4) the need for optimizing the newly developed PACT, (5) the need for maximizing the non-traditional clinic visits (RN and Pharm. D.), and (6) the potential need for standardizing medication regimens using a BP protocol (including VA HTN guidelines and an algorithm for initiating and allocating non-traditional clinic visits). The high-level process map displayed the process of the HTN bundle. This process map assisted the PACT team with identifying: (1) the scope of the process, (2) delays, (3) improvement opportunities, (4) where to focus our improvement efforts, and (5) how to work with HTN. This provider and his PACT were selected for this quality improvement project to improve BP control rate from 62.3% to 75% for veterans diagnosed with HTN and from 63.7% to 79% BP control rate for veterans diagnosed with HTN and DM within 6 months. A VA Quality Scholar joined the VA Quality Improvement Department in July 2013 and began the project in November 2013. The VA Medical Center target goal for HTN treatment was set at 74% (Cobb, 2006). This was similar to the current national HTN guidelines (Chobanian et al., 2003).

Hypertension Bundle

The HTN bundle consisted of: (1) meaningful use of the EMR, (2) non-traditional clinic visits (RN or Pharm. D.), (3) medication adherence assessment using the Morisky Scale, (4) medication adherence reminder via phone prior to their clinic visits, (5) home BP measurement, (6) telemedicine phone visits, and (7) nurse phone visits. We offered a refreshed BP measurement training for the professional staff to retrain them to use the RN License Practical Nurse (LPN) and Pharm. D. staff to accurately measure BP using American Association of Cardiovascular and Pulmonary Rehabilitation (ACCP) guidelines for a calculation of the mean of two BP measurements.

We performed a literature search and adopted Wagner’s Chronic Care Model (Wagner, 1998; Bodenheimer et al., 2002) as our conceptual framework to identify the project’s interventions. Targeting our opportunities, the model revealed several interventions to include in our HTN bundle. We used data from the EMR to identify eligible veterans and removed veterans from the list. Using the Wagner’s Chronic Care Model and information from the SWOT analysis, we brainstormed to develop our HTN bundle to test in the PDSA cycles. We used the SWOT analysis to capitalize on our strengths, minimize our weaknesses and to identify possible opportunities. We were able to identify four key areas: (1) meaningful use of the EMR, (2) telemedicine and home BP monitoring, (3) medication adherence and (4) telemedicine phone visits.

The first PDSA cycle revealed that utilizing quality improvement tools appeared to be useful in the first steps to improving BP control. The Institute of Medicine (IOM) identified and suggested 6 dimensions of quality care: (1) safe, (2) effective, (3) efficient, (4) timely, (5) equitable, and (6) patient-centered. The IOM identified six dimensions of care: (1) safe, (2) effective, (3) efficient, (4) timely, (5) equitable, and (6) patient-centered.

Discussion

Our quality improvement project revealed that utilizing quality improvement tools appeared to be useful in the first steps to improving BP control. The Institute of Medicine (IOM) identified and suggested 6 dimensions of quality care: (1) safe, (2) effective, (3) efficient, (4) timely, (5) equitable, and (6) patient-centered. The IOM identified six dimensions of care: (1) safe, (2) effective, (3) efficient, (4) timely, (5) equitable, and (6) patient-centered.

We learned several lessons from the SWOT analysis. In particular, we realized that targeting our opportunities could be bundled into an intervention to maximize our strengths, minimize our weaknesses and monitor our threats. Next, we learned that the EMR inactive list was used in re-establishing care for veterans who missed clinic visits improved BP control rates upon the first follow up visit due to the effectiveness of the medication intensification. For some, BP control was not accomplished at the follow up visit and, consequently, harm was potentially prevented by re-establishing care and further treatment and follow up. Of note, there were few veterans on three or more medications suggesting a low percentage of veterans in the PACT with resistant HTN (Egan et al., 2015). Constructing a process map allowed us to identify steps to focus our efforts, and it highlighted the fact that the scope of the process began before the clinic visit with the phone reminder. Therefore, we focus our efforts on...

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The PACT Team had 847 veterans, and 171 (31%) of them with and without DM had uncontrolled BP. Of the 172 veterans with uncontrolled BP, 71 (41%) were on the EMR inactive list. The EMR inactive list included veterans who were diagnosed with HTN and from 63.7% to 69.1% for veterans with HTN and DM. From 3 months to 6 months, BP control rates increased from 67.3% to 71.8% for veterans diagnosed with HTN and from 69.1% to 74% for veterans diagnosed with HTN and DM. Our 6-month target goal for HTN veterans and HTN veterans with DM was 75% and 79%, respectively.

Setting

One VA Medical Center provider who was below the expected VA Medical Center BP protocol goals had a 62.3% control rate for veterans diagnosed with HTN and a 63.7% control rate for veterans diagnosed with HTN and DM. Overall, 62% of this provider’s veterans were diagnosed with HTN and 63.7% with DM. This provider and his PACT were selected for this quality improvement project to improve BP control rate from 62.3% to 75% for veterans diagnosed with HTN and from 63.7% to 79% for veterans diagnosed with HTN and DM. A VA Quality Scholar joined the VA Quality Improvement Department in July 2013 and began the project in November 2013. The VA Medical Center target goal for HTN treatment was set at 74% (Cobb, 2006). This was similar to the current national HTN guidelines (Chobanian et al., 2003).

Data Collection

Baseline BP control rates and BPs were extracted from the EMR inactive list. With PDSA cycle #2, PACT team members used check sheets to collect the data during the veterans’ clinical visit. The check sheets were used to keep track of the HTN bundle data. The VAQCs followed meeting with the PACT team regularly to gather the data and implement the PDSA cycles.
medication adherence, home BP monitoring, and non-traditional clinic visits including telemedicine. Similar to the HTN literature, poor medication adherence was a major issue in BP control, including telemedicine. DiMatteo et al., 2001; DiMatteo et al., 2005; Osterberg, & Blaschke, 2005, and home BP monitoring and logging improved medication adherence (Stenger et al., 2011). At the start of the quality improvement project, we found that many veterans had home BP monitors but were not monitoring their BP. Some of us in monitoring their BP were not bringing their logs to their clinic visit. After initiating the HTN bundle, more veterans self-monitored their BP, reported elevations, and brought their logs with them, taking a key role in their BP management. This could potentially avoid harm by tapering medications based on office BP using an accurate technique and considering home BP measurements. To provide effective treatment, we used our BP protocol to make medication adjustments to match science, avoiding overdose or under use of the optimal medication and dosage. A diuretic was considered for anyone who might benefit based on the HTN protocol. In addition, white coat HTN was identified with home BP monitoring and medication treatment was avoided for white coat HTN, as recommended by the HTN guidelines. We found that incorporating a routine reminder and assessment of medication adherence using the Morisky 8 item scale was easy to administer. For whatever reason, veterans omit taking their BP medications before their clinic visit. However, reminder phone calls were required an extensive amount of the RN’s time. It was difficult to ascertain the effectiveness of the HTN bundle because check sheets were used inconsistently on busy days. Yet, we notice that Pharm. D. and RNs were actively participating in BP self-monitoring and phone visits all increased gradually over the 6 months, but we needed more data to evaluate the impact of using non-traditional visits. Utilizing non-traditional staff but the follow up visits appeared to be safe (i.e., no apparent untoward effects or issues), effective (i.e., improved BP control), efficient (i.e., improved access to care and allowed the MD to see more high acuity veterans), and patient centered (i.e., utilized veterans' preferences for non-traditional staff allocation and BP self-monitoring).

According to our efforts, a HTN bundle looks promising: (1) control BP to prevent poor outcomes, (2) deliver care focused on the Institute of Medicine 6 dimensions, and (3) utilize technology to enable our health care team to function at their highest capacity. Future use of the HTN bundle should seek to determine a smoother integration of the HTN bundle into workflow patterns of the clinic.

Limitation

Examining the veterans from this provider, with the provider knowing, may have changed the veterans’ behavior; thus, our results might be due to a Hawthorne effect and not our HTN bundle. A large sample of physicians needs to be examined in order to make an asssessment that our HTN bundle contributed to the improvements. We are also aware that the initial results that we saw might be a regression to the mean; however, the follow up visits appeared to be safe (i.e., no apparent untoward effects or issues), effective (i.e., improved BP control), efficient (i.e., improved access to care and allowed the MD to see more high acuity veterans), and patient centered (i.e., utilized veterans’ preferences for non-traditional staff allocation and BP self-monitoring).

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Conclusion

Several opportunities existed to improve BP control in this one PACT team. Quality improvement tools such as the model for improvement, use of national guidelines, central database participation, and quarterly feedback reports.

References

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22. New 25 bed unit
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