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ASNA Alabama State Nurses Association

Alabama Nurse

ANF Alabama Nurses' Foundation

June, July, August 2018 • Volume 45 • Issue 2

Provided to Alabama's Nursing Community and Funded by the Alabama State Nurses Association.

Quarterly publication direct mailed to more than 87,000 Registered Nurses and Licensed Practical Nurses in Alabama
Alabama State Nurses Association • 360 North Hull Street • Montgomery, AL 36104

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ASNA'S 2018 ANNUAL CONVENTION

NURSES: CARING FOR OTHERS, CARING FOR SELF

October 4- 6, 2018
Grand National Hotel and Conference Center, Opelika, Alabama

Facing Lake Saugahatchee, the hotel offers walking trails and easy access to nearby attractions. There is something for everyone in the family.

Football fans will find the close proximity to Auburn University and Jordan-Hare Stadium a touchdown moment. And what trip to the Auburn area is complete without a stop at historic Toomer's Corner?

Those of you wanting to get a jump on Christmas **Shopping** have a wide variety of local stores, specialty shops and antique malls to choose from to find that perfectly unique gift.

Nature lovers may enjoy Chewacla State Park, and The Louise Kreher Forest Ecology Preserve & Nature Center.

Art enthusiasts are close enough to make a quick trip to the Jule Collins Smith Museum of Fine Art and Pebble Hill College of Liberal Arts.

The Grand National offers 3 three courses with 54 holes, scenic views, driving ranges, putting greens and golf lessons.

Amenities include, resort-style indoor and outdoor pools with a bar, as well as eight tennis courts, and private balconies sure to provide a view of local wildlife, beautiful sunsets, and panoramic views to calm the soul.

For those of you who just don't want to let go of the outside world, Complimentary Wi-Fi and spacious work desks are also included.

Allow extra time before and after Convention to enjoy the area and make this a **Family Fall Getaway!**

Governor Kay Ivey will be the Awards Celebration Speaker

Interested in Becoming a Delegate?

Look for information in the *Convention News* section on page 11.

Online Convention Registration is available at alabamanurses.org.

If you find online registration challenging, feel free to contact the ASNA office at 334-262-8321 or 800-270-2762.

SAVE THE DATE:
***Elizabeth A. Morris Clinical Education Sessions* – FACES '19**
Tuesday, April 16, 2019 | Eastmont Baptist Church, Montgomery, AL

President's Message

Year of Advocacy - Inspire, Innovate, and Influence

Rebecca Huie
DNP, RN, ACNP
ASNA President

Hello Alabama Nurses! Our national affiliate, The American Nurses Association (ANA) has deemed 2018 as the "Year of Advocacy." ***Advocacy has been defined as the act or process of pleading for, supporting, or recommending a cause or course of action. Advocacy may be for persons (whether as an individual, group, population, or society) or for an issue, such as potable water or global health. (ANA Code of Ethics, www.ana.org)*** This is an excellent theme, because that is just what ASNA is about. As the professional organization for ALL Alabama nurses, we advocate for you. Plus, as an ASNA member, YOU HAVE INPUT into shaping ASNA advocacy efforts! ASNA was started by nurses 105 years ago and has been entirely governed by nurses to this day. Your current scope of practice is the result of decades of nurse advocates participating. Are you a participator?

The ASNA Board held the annual Strategic Planning Summit in February, and we realized that ADVOCACY was not included as one of our pillars for our 2017-2018 Vision! We quickly added Advocacy as the first pillar, because that is one of our main strategies (see image on page 3)! Dr. John Ziegler, ASNA Executive Director, serves as a full-time lobbyist to advocate for our nursing profession and monitor pending legislation that may positively or negatively impact our profession or healthcare delivery. Dr. Ziegler provides legislative updates throughout the legislative session and informs ASNA members about issues that need immediate attention.

Did you know that YOU can actually be part of developing or altering policies as they are being created? This is FRONT END ADVOCACY. Unfortunately, we nurses often are the first to see the impact of a good or bad policy at the bedside after it has been instituted. Then we complain and try to make things better...after the "cow is out of the barn!" (BACK END ADVOCACY) As nurses and nurse leaders, we advocate almost daily for our patients, employees, safe practice, quality care, etc. Great! Wouldn't it be better if you were participating in developing these rules ON THE FRONT END of the process?

A recent example of ASNA's advocacy efforts, in collaboration with the Nurse Practitioner Alliance of Alabama (NPAA), happened during this legislative session and resulted in the passing of House Bill 429. NPAA introduced this bill into legislation that would allow Certified Registered Nurse Practitioners (CRNPs) and Certified Nurse Midwives (CNMs) to have signature authority for medical forms within their scope of practice to improve access to services for the patient. Many of you that are reading this may be thinking that as a nurse, politics/legislation is not for you or doesn't interest you, but as nurses we must be involved, even if in a minor capacity, in the process of policy formation and stay informed of the issues impacting healthcare reform and of legislation that may impact our nursing profession. Nurse's Week has just passed and the ANA theme was **'Inspire, Innovate, and Influence.'** There are over 95,000 nurses in Alabama, but less than 2,000 are members of ASNA. Just think of the INFLUENCE that your professional nursing organization would have, if all 95,000 nurses were members. There is power in numbers, and the larger the membership of ASNA, the louder our voice becomes when we are advocating for the nursing profession. ASNA would love to hear personal stories from you on advocacy. Please share your story on Twitter using **#BedsideAndBeyond** or on our ASNA Facebook page.

As you are reading this, many ASNA and nursing events have already taken place this year. ASNA kicked off the year with our annual Board of Director's retreat in February to review the progress of our strategic plan and generate new strategies for 2018. We updated our resolution list for the remainder of this year. The topics that ASNA will continue to follow and provide information on are as follows:

2017:

1. The Opioid Epidemic: How Can Nurses Play a Role in Addressing the Issue?
2. Diversity & Inclusion
3. Domestic Violence
4. Mental Health Break the Silence

2016 Carryover Resolutions:

1. Banning Electronic Cigarette Advertisements in Public Places and Media
2. Strengthening Volunteer Driver Protections for Non-Profit or Faith Based Organizations
3. The Alabama State Nurses Association Mentorship Program
4. Health Literacy – ASNA will partner with the Alabama Health Action Coalition (AL-HAC) on this resolution

If there are other topics that you would like for ASNA to advocate for or raise awareness on, please contact your local ASNA District President. This information can be found on our website at www.alabamanurses.org.

The annual "Nurses Day at the Capitol" was held February 28, 2018, with the largest number of nurses and nursing student participants ever. There were over 750 in attendance! The Capitol lawn was covered with nurses and future nurses! It was an exciting and energetic event. Continuing Education topics included; "Social Media and Nursing Practice," "Transitioning from Student to Practicing Nurse," "Mental Health Access to Care," and "Bullying, Violence and Incivility in the Workplace." Following the C.E. events, nurses gathered on the Capitol steps for the Legislative Rally with a robust speaker lineup that included Representatives April Weaver, Laura Hall and Tom Whatley. Other speakers included Carl Henderson, Student Representative, Peggy Benson, Executive Officer of the Alabama Board of Nursing, Michael Humber, Alabama Association of Nurse Anesthetists, and me. Tedra Smith, Chair of the Alabama Coalition of Nursing Organizations served as the EMCEE for the event. If you missed it, we hope to see you there next year.

During the month of March, ASNA sponsored the Alabama Association of Nursing Students (AANS) annual Leadership Conference that was held at the University of Alabama in Huntsville. Speakers for the event included ASNA's previous president, Mr. Brian Buchman, and me. Jeanette Atkinson, Student Liaison, also spoke to students about the importance of joining ASNA after graduation and gathered ideas on how ASNA could better support our future nurses as they transition into the profession.

ASNA participated in the 1st Annual Women Veterans Health Expo that was held at Samford University in Birmingham, Alabama on March 15, 2018. Dr. Kanini Rodney, MPH, MBA, MD, FACP, Women's Health Medical Director and Amy Southern, RN, MSN, Women's Health Program Manager from the Birmingham VA Medical Center coordinated the huge initiative in conjunction with the Alabama Departments of Mental Health and Public Health. This was an excellent event with approximately 170 participants from the local community including professionals and women Veterans themselves. Program speakers and panelists shared experiences, offered insight and engaged participants in dialogue

President's Message continued on page 3

Alabama nurse

The Alabama Nurse is published quarterly every March, June, September and December for the Alabama State Nurses Association, 360 North Hull Street, Montgomery, AL 36104

President's Message

continued from page 2

about the challenges/issues that are unique to our women Veterans and the services that are available to help them with re-integration, violence, suicide prevention, chronic pain and stress management. ASNA was proud to be in attendance and support this admirable event.

ASNA spent several months in preparation for the annual C.E. event, FACES'18, with over 400 nurses and nursing student participants from across the state. There were robust speakers, presentations, and posters. A special "Thank You" to our Plenary Speakers: Dr. Arlene Morris, past ASNA President, Anne Gibbons, JD, and Lynn Beshear, RN, Alabama Department of Mental Health Commissioner. The 2018 Leadership Academy participants held their first meeting and planning session during FACES'18. This year there are 17 participants from all over the state of Alabama enrolled in the ASNA Leadership Academy. I had the pleasure of listening to their project ideas, and I was so impressed with their concepts. I feel privileged to serve as a mentor for one of the participants. Thank you to all ASNA members that are serving as mentors, to Dr. Ellen Buckner, Founder of the Leadership Academy, and to the dedicated nurses that assist with the curriculum, coordination and planning. If you are an ASNA member, please consider participation in the 2019 Leadership Academy to **inspire, innovate, and influence** change in your workplace or community. It is a wonderful opportunity for networking, learning, and collaborating with other nurses and nurse leaders across the state.

ASNA participated in various Nurses Week events across the state, some of which included the Birmingham VA Medical Center, UAB Hospital, UAB Highlands, Huntsville Hospital, Baptist South, UAB Nurses Night Out and many more. If you have pictures from your local Nurses Week activities, please share them with us on Twitter using **#ASNALovesNurses** on our ASNA Facebook page. We would love to see how you celebrated Nurses Week. ASNA celebrates all nurses! Thank you for what you do!

The state of Alabama will be represented at the annual American Nurses Association Membership Assembly June 22-23, 2018 in Washington D.C. We are looking forward to meeting with all of the state Representatives during

Lobby Day on Capitol Hill, June 21, 2018. ASNA is the voice for your profession, so if there are ideas or issues that you would like for us to address, please message us on Facebook. We want to hear from you!

We hope that you will join us for our annual ASNA Convention October 4-6, 2018. ASNA is well underway with preparing for this huge event. The activities will be held at the Marriott in Opelika, AL. There will be fun activities, networking, music, awards ceremony, and much more. There will be opportunities for poster submissions and a call for abstracts. This is a wonderful opportunity for you to share your projects, success stories, or research! Please check out our website for more information and updates. Be there to **inspire, innovate, and influence**…… and be an advocate for your profession!

Finally, I would like to take a moment to reflect on the tragic shooting that occurred at UAB Highlands in March taking the life of a longtime nursing supervisor, Nancy Swift. Tim Isley, Supervisor in surgical instruments sterilization was also critically wounded in the shooting. ASNA extends condolences to the families, staff, and medical community impacted by this tragedy.

ED's Notes

Summer is a Great Time to be a Nurse

John C. Ziegler
MA. D. MIN
ASNA Executive Director

What is your passion away from work? What do you do to relax? For most people, summer presents more opportunities to chill out! A recurring theme in professional seminars, conferences and nurse gatherings is "take care of yourself." That is a central theme promoted by ASNA as well. This is no accident. The majority of nurses are stressed to the max. In fact, a recent national survey revealed that a disturbing percentage of nurses (more than 60%) would choose another profession…if they had it to do over again! A follow-up survey indicated that this dissatisfaction was not profession specific…but workplace specific. In other words, nurses were happy with their profession – but not so much with issues related to their workplace environment. Pile those workplace issues on top of our 2018 fast-pace culture and bam… stress.

I am often asked, what does the staff do at the Alabama State Nurses Association? It seems like we get past one event or large project and before you know it, we're facing another. People say that is the nature of a non-profit association. Members expect (and deserve) attention to issues that concern them the most. Much of our time is spent helping people. I am constantly amazed and grateful for our ASNA staff. They are here to help your summer and work be a little less stressful.

Condolences:

ASNA extends it's deepest sympathy to:

To the family and friends of Nancy Turnage Swift, RN – UAB Highlands, killed while on duty.

To the family and friends of Dr. Jean Kelley, long-time ASNA Member.

Terrel H. Smith, brother of ASNA District 5 member, Dr. Constance Smith Hendricks.

LPN Corner

Are You a Downer?

Gregory Howard
LPN

What is meant by a downer…

Someone dis-spiriting or depressing. "Someone who brings the mood down."

In a time when customer service is so important to our profession, are you doing your part to hold up the banner?

Whether you realize it or not, we all can, and will, react to negative episodes in our lives in the work place. It is up to us, to not be a victim to what happens negatively at home or in the work place. It is up to us to not let the negative situation affect our customer service.

If you have a disagreement with someone in your personal life…

You could be a Downer at work.

If your car is suddenly not operating and you must report for work in an hour…

You could be a Downer at work.

If there is a family tragedy…

You could be a Downer at work.

If you constantly greet people with personal problems and negative conversations…

You are a Downer!

We should be a "Ray of Sunshine." Refreshing in a time when our clients are at a low point in their lives or most of the time.

The people we serve deserve and pay for the best possible care we can give.

Do not let them down and do not cast a shadow on our profession.

"Let's Always Strive for Excellence"

Legal Corner

Don Eddins
JD

Estate planning is important, since we never know what the future holds. At a minimum, the estate plan should include a will, a durable power of attorney and an advance directive for health care, which includes a living will.

A will, or "last will and testament," allows an individual to decide the disposition of his estate, rather than the government. The maker of the will, also known as a "testator," can determine how his property is divided after death, rather than having a probate court divide belongings under a division plan established in the law. Ultimately, the probate court might divide the property same as the testator (perhaps equally among all children) but someone would have to ask the court to be named administrator. But in order to divide the property, that person would have to post bond, which can cost hundreds or even thousands of dollars, depending upon the size of the estate. A will can include a clause excusing the posting of a bond.

In my opinion, equally important even to a will is a power of attorney (POA), to be used if the maker of the document becomes incapacitated.

If you are in an accident or for some other reason become unable to tend to your affairs, the person you have designated for power of attorney is able to go to the bank and Social Security Administration or wherever needed and sign for you. If you don't have such a document and become incapacitated, someone would have to go to court to obtain the authority.

A word of caution on a POA – don't give it to someone you don't trust fully. As the old saying goes, don't send a hungry man for your sandwich because he will eat it on the way back. Entrust with your POA only a person who would act in your best interest.

Alabama has a very good law on advance directives for health care. Basically such documents include two parts. One is a living will that allows the individual to decide whether he/she wishes to be connected to life-sustaining devices in case of terminal illness. The second part allows you as the maker of the living will to select your health care proxy to make decisions about treatment when you are unable to do so or to ensure that your wishes of no treatment are carried out.

Whether a person chooses to adopt a living will is very much a personal decision. As an attorney, I do not encourage or discourage it. My wife and I have a living will because we do not want to put the burden upon our children of deciding whether to disconnect life sustaining devices.

Under the law, only those persons deemed incapable of being cured of a terminal illness and incapable of regaining consciousness would be disconnected from life sustaining devices. The prognosis must be made by two doctors, including the individual's personal physician. In addition, even if life-sustaining measures were discontinued, the terminally ill individual would be given comfort medications.

You may make a living will without naming a health care proxy. However, the selection of a health care proxy, in writing, gives health care professionals someone to consult with on critical issues related to your treatment, if you are incapacitated.

In today's society, estate planning is essential to avoid taxes and ensure that our preferences are met. It is something that none of us wants to take the time to do, but is nonetheless very important. Your legal professional can help.

PUBLICATION

The Alabama Nurse Publication Schedule for 2018

Issue	Material Due to ASNA Office
Sep/Oct/Nov	July 16, 2018
Dec/Jan/Feb. 19	Oct 16, 2018

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

ASNA reserves the right to not publish submissions.

Alabama Nurses Foundation

The mission of the Alabama Nurses Foundation is to increase public knowledge about the nursing profession and help nurses grow in advancing their education. Most nurses think about the foundation only in terms of academic scholarships and yes we did award a number of academic scholarships at FACES on April 17, 2018. However, in this issue we would like to focus on the Community Grants. At least four Community Grants are awarded each year for community-based projects. Past recipients have been involved in environmental issues in the Uniontown and nutritional issues in northern Alabama. We are seeking more grant recipients.

ANF
Alabama Nurses' Foundation

Alabama Nurses Foundation
360 North Hull St.
Montgomery, AL 36104
PH: 334-262-8321
FX: 334-262-8578

Alabama Nurses Foundation Community Grants Application

Purpose

The purpose of the Alabama Nurses Foundation Community Grants is to help Alabama nurses working in the community settings to contribute to the health and welfare of the Alabama Citizens. Grant recipients are encouraged to participate in community-based projects that can impact a positive change in a current health issue.

Application Deadline and Award

The Alabama Nurses Foundation will award the Community Grants on an ongoing basis throughout the year. Up to four different grants will be awarded each fiscal year. Each Community Grant is awarded for $500. Funds may not be used for influencing legislation or to lobby government officials.

Eligibility Criteria

1. Must address a current Alabama health issue.
2. At least one grantee must be a current ASNA member.
3. Preferable to leverage resources with other community organizations and/or other 501c3 agencies.
4. Funds may not be earmarked to complete academic work.
5. Priority will be given for projects that support the ASNA Strategic Plan and/or resolutions adopted by the ASNA House of Delegates.
6. The project may be based in either a nurse's work or volunteer setting.

For more information:

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Director of Leadership Services, ASNA
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Montgomery, AL 36104
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charlenerasna@alabamanurses.org

Alabama Board of Nursing Applications

Interested applicants should complete the application on-line at https://alabamanurses.org

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http://www.nursingald.com/publications

Alabama Nurses Foundation

Alabama Nurses Foundation Scholarship Recipients

Courtney Morgan Cox, Auburn University

My goals are to complete the dual MSN program as a Nurse Educator and Nurse Practitioner and work in a rural community as a FNP and finally complete a PhD program in nursing to be a tenured-tract university professor and concurrently working as a nurse practitioner.

Emily Markwell, University of Alabama in Birmingham

My goals are to graduate from the Neonatal Nurse Practitioner and become involved with the local nurse practitioner association. And in long run help establish a follow-up clinic for the Huntsville Hospital NICU as the closest follow up clinic is 90 minutes away.

Tracie Collins Hughey, Auburn University

My goals are to remain with Air Methods as a master prepared nurse educator and to become certified CAMTS Certification for North Flight Air Medical in Tuscaloosa. In addition become a Certified Flight Registered Nurse (CFRN) and certified in critical care (CCRN) and work as adjunct faculty in local colleges and universities.

Frederic Jay Prosser, University of North Alabama

My goals include maximizing my leadership potential as a clinical coordinator in the Intensive Care Unit. My goal is to educate, train and mentor the next generation of nurses. I will focus on unit based education. In addition I want to be a fierce advocate for the profession of nursing.

Emma Nichols, University of South Alabama

My goals are to pass NCLEX on the first try and work for a few years to determine which area of nursing to specialize in for becoming a Nurse Practitioner.

Jeffery Wade Forehand, University of Alabama

My goals are multiple - the continued pursuit of lifelong learning, continued leader and supporter of District 5, and use of mobile learning (M-learning) in nursing. The long term goal is to provide Alabama and the Southeast with highly educated nurse leaders.

Tyler Sturdivant, University of Alabama in Huntsville

My goals are to complete the DNP degree and continue to grow membership in the Alabama Association of Clinical Nurse Specialists. The long term goal is to growth in faculty role and obtain a leadership position at the University of South Alabama College of Nursing.

Holly J. Fowler, University of North Alabama

My goal after graduation with a 4.0 GPA is to become a Certified Diabetic Educator (CDE). This will be followed by obtaining a PhD in Nursing and ultimately teaching in an academic institution. Leaders and educators have complementary roles and by being a positive role model for peers and the community at large will contribute to expand the discipline.

Rachel Duncan Wells, University of Alabama in Birmingham

My goals include to successfully defend my dissertation, publish 3-disseration related manuscripts, graduate in the summer 2019 with a 4.0 GPA. And after graduation I hope to obtain a post-doctoral fellowship to expand my knowledge of adaptive intervention design and methodology while developing adaptive palliative care intervention for advanced heart failure patients.

Samantha Fetner Baggett, Auburn University

My goals since being accepted into the first cohort of Auburn DNP program in the summer of 2018 is to continue to practice as a nurse practitioner in rural Alabama. I dream one day to be part of the Auburn faculty to give back to the future of nursing like so many faculty and staff have done for me.

Leadership Academy 2018

The ASNA Leadership Academy cultivates nurse leaders to ▶Motivate ▶Inspire ▶Create ▶Influence ▶Lead

A LEADERSHIP ACADEMY PROJECT EXAMPLE

Establishing the Alabama Association of Clinical Nurse Specialists

Tyler Sturdivant
MSN, RN, AGCNS-BC, SCRN
2017 ASNA Leadership Academy Participant

In Alabama, the clinical nurse specialist (CNS) faces many challenges related to practice authority and role clarity. Although title protected, the CNS has no true advanced-practice privileges in the state with no option to gain prescriptive authority independently or with a collaborating physician. At the start of my Leadership Academy project, there was no state-wide CNS organization in Alabama, making the CNS the only recognized advanced-practice nurse without a representing professional organization. To make matters worse, only one CNS educational program remains in the state, with programs closing at an alarming rate nationwide. These closings, limited practice, and lack of a professional organization in Alabama has led to underutilization and lack of recognition of the CNS role. Please refer to the featured article in this edition for further information on the CNS role in Alabama.

To address the need for a professional voice in Alabama, I collaborated with the CNS program coordinator at the University of South Alabama, Dr. Chondra Butler, to gain assistance and insight on forming a state-wide organization for the CNS. To assess interest in forming the organization, interest letters were sent to all licensed CNSs in the state with responses collected via an organizational email address. With overwhelming support, an initial virtual meeting was held with 23 CNS participants from around the state.

Ideas were exchanged in this initial meeting where the Bylaw and Finance committees were formed with chairs appointed. At the next virtual meeting, the Bylaws were approved with the proposed organizational dues. Also in this meeting, officers of the organization were elected with a detailed discussion on the mission of the organization. On August 31, 2017, the Alabama Association of Clinical Nurse Specialists (AACNS) was created! AACNS aims to serve as a local and national networking hub for the CNS while promoting, clarifying, and establishing a professional voice for the role. All current, retired, or student CNSs are invited to join. National certification is not required for membership. For a membership application, email aacns2017@gmail.com. You can also like us on Facebook @AlabamaAssociationofCNSs.

To date, AACNS has held two virtual meetings since creation with plans to have a face-to-face meeting in Montgomery in the Fall. There are currently 15 paid members around the state with a state-wide membership drive in action now. The creation of AACNS has been presented nationally at the annual National Association of Clinical Nurse Specialists Conference with an affiliation agreement with the national organization pending. Members of the AACNS Board of Directors were appointed to the Alabama Board of Nursing's CNS Taskforce to help communicate the role around the state and to impact legislation that will improve practice authority for the CNS in Alabama. With future increased membership, AACNS will take the lead in promoting the role of the CNS in Alabama and nationwide.

L.A. Sponsors

Huntsville Hospital

UAB Hospital

Leadership Academy Class of 2018 and Mentors

Leadership Academy Class of 2018:
Row 1- L to R: Barbara Neill, Tara Eslick, Sasha Harris, Cynthia Dale, Thutrang Nguyen, Cynthia Cleveland
Row 2 – L to R: Linda Gibson-Young, Christina Baughn, Christy Palmer, Andrew Haiflich, Jennifer Humphries
Row 3 – L to R: Cynthia Ward, Frederick Richardson, Partricia "Morgan" Webb, Shericia Hardy

The Clinical Nurse Specialist: Under the Magnifying Glass

Tyler Sturdivant
MSN, RN, AGCNS-BC, SCRN

Chondra Butler
DNP, RN, AGCNS-BC

The clinical nurse specialist (CNS) is an advanced practice nurse (APN) who serves as a clinical expert within a specialty population. Like other APNs, (nurse practitioner, nurse midwife, and certified registered nurse anesthetist) the CNS is educationally prepared with either a master's or doctoral degree. While the other APNs function primarily as providers, the CNS role encompasses a multitude of healthcare practices. The CNS focuses on treating and managing health concerns of patients and populations through practice in three spheres of influence which include the patient, the nurse, and the system spheres. Within these spheres, the CNS functions as a direct care provider for patients and families, as an educator, mentor, and coach to nursing personnel, and as a change agent to impact outcomes within the healthcare system. Serving as a direct care provider is a distinguishing role of the CNS; however, performing actions within the nursing and system spheres indirectly impacts the quality of care provided to patients as well. Though each sphere encompasses separate and specific practice interventions, the CNS often engages within each sphere simultaneously and moves fluidly between each sphere seamlessly, offering a unique and global view to improving patient outcomes that cannot be performed solely through the direct care provider roles of other APNs.

CNSs have been named the APN leader in preventing hospital-acquired conditions (HACs) that include pressure injuries, falls, central line associated blood stream infections, and catheter-associated urinary tract infections in the United States. This reduction in HACs not only improves the quality of care provided to patients, but also saves institutions on average $45,500 per case that would otherwise not be reimbursable by the Centers for Medicare and Medicaid Services. Not only have CNSs shown significant impact on the number of HACs, CNSs often serve on interdisciplinary teams that drastically reduce readmission rates, lengths of stay, and psychiatric patient events that have direct care and fiscal implications for the patient, nurse, and system alike.

Traditionally, the CNS only practiced within the acute care setting; however, CNSs are now being utilized in outpatient primary care settings to treat patients and impact outcomes that are focused on disease prevention, health promotion, and wellness care. National CNS certifications are based on a specialty population area and include adult-gerontology, pediatric, and neonatal. These certifications are offered through either the American Association of Critical-Care Nurses or the American Nurses Credentialing Center. Within the specialty population, CNSs can narrow their focus based on practice setting, such as the emergency department or critical care unit, or based on specific disease processes such as psychiatric, cardiovascular, or oncology.

The Consensus Model for APRN Regulation: Licensure, Accreditation, Certification and Education aimed to create uniformity between states regarding all APN roles and the requirements necessary to practice by the year 2015. All except three states recognize the CNS as an APN. Today, many states have adopted portions of the model, but there are still wide variations from state-to-state regarding APN scope of practice and licensure requirements, especially for the CNS. Some states allow CNS licensure and practice without national certification while others require national certification to obtain licensure. Practice and prescriptive authority for the CNS varies greatly among states. Many states allow the CNS to practice and prescribe with oversight from a collaborating physician, while some states allow the CNS to practice and prescribe independently without the use of a collaborating physician. Unfortunately, some states do not grant prescriptive authority to the CNS at all. Prescriptive authority is not exclusively related to medications, but more so, the ability to write orders for laboratory studies, diagnostic tests, durable medical equipment, and even discharge instructions. The lack of prescriptive authority in this regard can greatly limit the CNS's scope of practice and prevent them from practicing to the full extent of their educational training. With the versatility of CNS practice and the variability of each state's practice requirements, CNSs face an uphill battle with role confusion, fiscal reimbursement allowances, and justification of employment positions. In fact, the CNS is the only APN role decreasing in numbers nationally with direct relation to lack of understanding and utilization of the unique role.

In Alabama, the CNS is considered an APN and must submit proof of national certification to be licensed. The CNS technically has independent practice authority as no collaborating physician is required to practice, and the role is title protected. However, this practice authority is not as it seems. The CNS in Alabama does not hold prescriptive authority, even for durable medical equipment or laboratory studies, and "may not perform any of the functions" of the other APNs according to Article 5 of the Nurse Practice Act. Essentially, the CNS can be used in specific areas as an expert clinician but cannot use the APN skills and education obtained to practice in a direct care provider role. Because of this restricted practice authority, many CNSs fail to license in Alabama as they cannot practice to the full extent of training; to date, there are only approximately 80 licensed CNSs in the state with far more educationally prepared in the role of the CNS.

To add insult to injury, CNS educational programs are closing at an alarming rate with only one remaining in Alabama, and until recently, there was no professional organization for the CNS in the state. In addition, the four APN roles lack cohesion and true understanding of each other's scope of practice, creating a conflicting and competitive environment regarding advocacy for full practice authority. Program closings, lack of a professional voice, and other APN competition aids to promote lack of necessity of the CNS role in the state and nationwide.

As of February 2018, a total of 18 states and Washington, D.C. allow the CNS to prescribe without the oversight of a collaborating physician, and a total of 20 states allow prescriptive authority with a collaboration agreement. Of the states that recognize the CNS as an APN, Alabama is one of only 10 states that does not allow the CNS to prescribe at all. In stark contrast to Alabama, Oregon allows CNSs to practice and prescribe non-pharmacological and pharmacological treatments without a collaborating physician and does not require national certification to be eligible for CNS licensure. With this authority, the CNS practices to the full extent of training and scope, enabling superior healthcare outcomes known to be produced by a CNS professional. Although not in full compliance with the Consensus Model related to licensure, the Oregon Association of CNSs is investigating possible ways to mitigate this issue.

To assist in creating a professional CNS voice in Alabama, the Alabama Association of Clinical Nurse Specialists (AACNS) was established in August 2017. AACNS serves to promote the CNS role, provide a network for CNSs within the state, and to provide organizational support for any policy initiatives that will impact healthcare and CNS practice authority in Alabama. Membership of AACNS is open to any individual educationally prepared as a CNS; licensure and certification are not required.

AACNS is currently applying as an affiliate of the National Association of Clinical Nurse Specialists to gain national support for CNS role promotion and resources for policy initiatives. Many AACNS members serve on the Alabama Board of Nursing (ABN) in either leadership roles or on special APN taskforces designed specifically to examine current APN practice and develop plans to allow each APN role to practice to the full extent of training. For the CNS role, the taskforce aims to improve practice authority through development of ABN-approved standardized procedures, communication of the CNS role throughout the state, addition of pharmacology educational requirements similar to other APNs, exploration of billing restrictions, and collaboration with other APNs to improve nursing practice in Alabama. With state-level and national organizational support, the CNSs in Alabama will have assistance in overcoming the hindrances that stagnate role promotion, employment, and scope of practice of the CNS.

The first step of role promotion starts with true understanding and outreach. Whether a bedside nurse, APN, or nurse executive, there is knowledge to gain regarding healthcare and the roles of nursing professionals. As an APN, CNSs should be privy to the same educational-based practice standards and role recognition as the other APNs. With the availability of full practice and prescriptive authority for the CNS, superior outcomes for the patient, nurse, and system can be achieved. As an overarching nursing goal to provide the highest quality of care to patients, all nurses should strive to promote nursing practice to the full extent of educational training. With the help of all, education on the role and value of the CNS can be disseminated and promoted throughout the state and nation.

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AANS News

Technology Connects Alabama Students to Achieve Success in Organizational Project

Marissa Walker
Director North, Alabama Association of Nursing Students

The Alabama Association of Nursing Students (AANS) is a student-led organization composed of Associate Degree (AND) and Baccalaureate Degree (BSN) students from across the state of Alabama. The Executive Board is composed of 10 members from several schools located in varying areas of the state. Since the Executive Board members are located across the state and several hours away from one another, there are a few ways they communicate with each other and plan their many upcoming events. Technology has been such an incredible communication tool in which the AANS board uses frequently and almost every day. One of the most common ways the board communicates with their members is using an app called GroupMe. GroupMe is a form of messaging within the app that allows the AANS members to communicate by sending messages either to the group for all members or to an individual member – for communication that needs to only be sent to one person. Within the app you can do several things which can make planning or creating events more effective and time-efficient; you can send pictures and videos, create polls and events, and attach links to outside information such as documents. This app is great for communicating on the go or in between classes and clinicals versus setting a time and date to meet up, especially since members can live as far away as four hours from one another. The app can also be used from a computer, which comes in handy if you are not as tech savvy. Another app that is heavily utilized is called ZOOM. This app allows the AANS board to speak to each other all at once, but it also allows them to video chat as well. If you would prefer to not be seen on video there is an option to turn the video chat off, so you are not seen by the other people in the call – just in case you are in your pajamas! As many nursing students know to be true, it is extremely difficult to schedule events and meetings around busy class and clinical schedules, but it is also difficult for teachers to do this as well. Dr. Donna Guerra, the AANS Faculty Advisor can use both the GroupMe app and ZOOM to stay updated and connect with the Executive Board. Jeanette Atkinson, the ASNA Liaison for the AANS can also join in on the calls and messaging to stay updated on upcoming events as well as relay information between organizations. Both apps have been extremely helpful to the Executive Board and those who communicate with the AANS board. Another helpful program that is utilized by the AANS board members is Google Drive and Google Docs. These programs allow information and documents to be accessed by those who they are shared by email. The AANS President can upload the meeting minutes or schedules to Google Drive and all members are able to access them on their own devices at any time. Some documents, such as collaborative efforts can be accessed and edited by other members. This allows everyone to get their ideas and suggestions into one document that can be edited and accessed at any time and in any location. Technology has become an essential element to our success as a student-led organization and with improvements in technology constantly occurring, the AANS intends to explore and harness it to reach their goals.

ASNA CITATIONS OF EXCELLENCE

*You can nominate any outstanding nurse**

The following individuals were nominated by their fellow nurses

Dr. Norma Cuellar, The University of Alabama, Capstone College of Nursing

Dr. Cuellar is a distinguished member of the nursing community at The University of Alabama's Capstone College of Nursing. She chairs The CCN Committee on Inclusiveness, which strives to make the college a welcoming and inclusive environment for all students, faculty, and staff. Dr. Cuellar is a nationally recognized speaker, scholar, and nurse professional largely due to her work with NAHN, her program of research with the Bama-L Project, and her dedication to the promotion of cultural diversity and inclusion.

Lisa Bentley, Northport Medical Center

Lisa is a great asset to our NICU. She is a great leader and mentor to the nurses. She is always willing to help and has a positive attitude that shows in how she presents herself.

Dr. Shirna Gullo, Oakwood University

Dr. Shirna Gullo is the Director of Healthy Campus 20/20. She has revitalized the concept of healthy living by promoting and educating students at Oakwood University and the community on the best practices on healthy living by maintaining a healthy mind and body. Dr. Gullo is an organizational leader who thrives on sharing information with the community and OU. She has coordinated a dozen of health fairs at OU and in the community.

"Healthy Campus 2020 (HC2020) is Oakwood University's organized initiative to empower students to make healthy choices. This program is a response to the problem of preventable diseases, which affect our students. Healthy Campus 2020 will help to educate the campus regarding healthy lifestyle decisions utilizing the eight laws of health in order to foster a holistic approach to a healthy mind, body, and soul. The goal of Healthy Campus 2020 is to make Oakwood University the healthiest campus in America." Oakwood University (n.d.)

Dr. Gullo uses time and resources to ensure that every student is successful. Recently, the former ITT Technical Institute students discovered they will be eligible to take the NCLEX. Shirna collaborated with healthcare professionals to develop a team to help the students prepare for the NCLEX. She deserves to be recognized for her unselfish and dedication to the nursing profession.

ASNA District 4 Nominations

- Dr. Tochie J. Lofton
- Mrs. Suzanne McGill
- Dr. Margaret Moore-Nadler
- Mrs. Loletha Reeves
- Mr. Timothy Wiggins
- Mrs. Bobbie Wilson

*For more information go to alabamanurses.org and click on your district and "Nominate Someone."

ASNA'S 2018 ANNUAL CONVENTION

NURSES: CARING FOR OTHERS, CARING FOR SELF

October 4- 6, 2018 | Grand National Hotel and Conference Center, Opelika, Alabama

Awards Criteria & Procedure

- Awards are for ASNA members, unless otherwise stated.
- Any ASNA member, group, or staff may submit nominations.
- All ASNA awards must be submitted on the ASNA Nominations Form.
- Award recipients will be selected by the ASNA Awards Committee.
- Awards will be presented at the ASNA Convention.

1. Lillian B. Smith Award

Lillian B. Smith was the Executive Director of the Alabama State Nurses Association from 1940-1968. She always gave above and beyond the call of duty for nurses and the profession in Alabama. She was recognized and respected for her commitment to improving health care in Alabama by other healthcare providers.

To be awarded to a member who has demonstrated long-term commitment to ASNA and the nursing profession. This commitment demonstrates activities above and beyond usual responsibilities at the local level.

A. Evidence of long-term commitment to ASNA:
   - Years of membership
   - ASNA activities
   - District, county, and/or state-level activities

B. Other professional activities
C. Community involvement
D. Other supporting documentation and comments

2. D.O. McClusky Award

D.O. McClusky was the Administrator of Druid City Hospital from 1946-1976. Mr. McClusky was always a leader in assuring that nurses had good working conditions. He believed if nurses had good working conditions, they could give better nursing care. He was also very supportive of the Alabama State Nurses Association.

To be awarded to a healthcare administrator who has demonstrated outstanding support of nurses and the profession. ASNA membership is not required.

A. Evidence that the nominee is the chief executive officer, chief nursing officer, or other administrator of the healthcare agency
B. Evidence of involvement with or on behalf of nursing
C. Evidence of involvement with or for:
   - Specific hospital or agency
   - Local nursing organization
   - State nursing organization
   - Nursing or healthcare in general

D. Other supporting documentation and comments

3. Outstanding Non-Member Award

To be awarded to a person who is not a member of ASNA but has demonstrated significant contributions to and/or support of nursing, healthcare, and/or ASNA during the past year.

A. Evidence of involvement with or on behalf of nursing and/or healthcare:
   - Specific hospital or agency
   - Local nursing organization
   - State organization
   - Nursing or healthcare in general

B. Other supporting documentation and comments

4. Outstanding New Member Award

To be awarded to a new member, defined as a person who has been an ASNA member for two years or less.

A. Evidence of significant contributions to ASNA, district, and county
B. Other supporting documentation and comments

5. Lillian Holland Harvey Award

Lillian Holland Harvey was a dynamic professional who promoted transcultural relations by leading all of nursing forward. She started the first baccalaureate school of nursing in Alabama.

To be awarded to an ASNA member who has made significant contributions in one or more of the following areas: fostering transcultural relations, promoting advancement of minority groups, and upgrading healthcare services to those who are culturally and economically underserved.

A. Evidence of contributions to:
   - Fostering transcultural relations
   - Promoting advancement of minority groups
   - Upgrading healthcare services to those who are culturally and economically underserved
   - Professional involvement
   - Community involvement

B. Other supporting documentation and comments

6. Louise Barksdale Outstanding Nursing Practice Award

Louise Barksdale gave her entire nursing career being a staff nurse. She not only committed her vast energies to her patients and community, but also to her professional association, being active on the local, state, and national level.

To be awarded to an ASNA member who:

A. Assists patients in functioning at and maintaining optimum levels of health and activities as persons, members of families, and members of their communities through application of nursing knowledge
B. Demonstrates excellence in nursing and contributes to improving the quality of care
C. Evidence of contributions to ASNA, county, district, and/or state and to the community
D. Other supporting documentation and comments

7. Health Policy Award

To be awarded to an active party in the legislature or in an organization that promotes health policy in Alabama. ASNA membership is not required.

A. Evidence of involvement with or on behalf of nursing and/or healthcare in general
B. Other supporting documentation or comments

8. Cindajo Overton Outstanding Nurse Educator Award

Cindajo Overton made a tremendous contribution to nursing education. Her career consisted of 10 years of bedside nursing and 26 years of nursing instruction at Wallace Community College. Cindajo chose nursing education as she believed this was the best way to have the greatest impact on nursing. Cindajo was a member of ASNA for 38 years and was active at the local, state, and national level.

To be awarded to an ASNA member who is an outstanding nurse educator in an academic or service setting.

A. Evidence of excellence in teaching or service
B. Advances the science of nursing through clarifying, refining, and/or expanding the knowledge base of nursing
C. Promotes a theory base for nursing curricula
D. Influences scholarly development in nursing education and/or research
E. Innovative in assisting and encouraging student nurses in professional development
F. Contributes to the improvement of quality healthcare through the teaching process
G. Professional and community involvement
H. Publications and presentations
I. Other supporting documentation and comments

9. Outstanding Nursing Administrator Award – Academe or Service

To be awarded to an ASNA member who is/has been employed in administration of a healthcare organization or school/college of nursing and demonstrates outstanding performance.

A. Demonstrates and encourages excellence in teaching or nursing care delivery
B. Advances the science of nursing through clarifying, refining, and/or expanding the knowledge base of nursing
C. Promotes a theory base for nursing practice and/or curricula
D. Supports the professional development of faculty/staff
E. Professional and community involvement
F. Provides innovative leadership to fulfill the mission of the organization
G. Other supporting documentation and comments.

10. Outstanding Retired Nurse Award

To be awarded to an ASNA member who is retired from employment as a nurse and has made significant contributions to nursing and healthcare following retirement.

A. Evidence of:
   - Contributions to nursing and ASNA
   - Contributions to politics in relationship to nursing
   - Community involvement

B. Other supporting documentation and comments

11. Outstanding Healthcare Organization Award

To be awarded to an organization that provides extraordinary direct healthcare to patients.

A. Recognized for provision of quality care to patients
B. Promotes a positive image of nursing
C. Provides desirable working conditions for nurses
D. Promotes ethical and professional nursing practice
E. Recognizes nurses for their contributions to the organization and quality of patient care
F. Community involvement
G. Other supporting documentation and comments

12. Outstanding Advocate of the Year Award

To be awarded to an individual who actively supports ASNA and is directly involved in promoting nursing and healthcare issues in Alabama.

A. Evidence of involvement with or on behalf of nursing and/or healthcare
B. Other supporting documentation or comments

13. Charlene Roberson Mentorship Award

Charlene Roberson has been involved in ASNA since 1985 and currently serves as the Director of Leadership Services. Charlene possesses expert knowledge on all things ASNA, and has touched the lives of all ASNA's membership through advertisement, questioning, fellowship, and mentorship.

To be awarded to a registered nurse who has demonstrated attributes of mentorship. ASNA membership is not required.

A. Encourages peers in their practice of professional nursing
B. Acts as a role model to other healthcare professionals
C. Innovative in assisting/encouraging nurses in personal and professional development

ASNA'S 2018 ANNUAL CONVENTION

NURSES: CARING FOR OTHERS, CARING FOR SELF

October 4- 6, 2018 | Grand National Hotel and Conference Center, Opelika, Alabama

ASNA Delegate Responsibilities

Contact your District President

All Delegates are elected by the district. Being a Delegate can be an exciting experience but one that also has some inherent responsibility. As you may know, the House of Delegates (HOD) is the governing and official voting body of the Alabama State Nurses Association (ASNA). The House meets annually. Members of the HOD have a crucial role in providing direction and support of the work of the Alabama State Nurses Association. Delegates are elected to the HOD to work for the betterment of ASNA and the nursing profession. Each delegate is expected to study the issues thoroughly, attend each session of the HOD (including the Open Forums), and engage in active listening and debate. Also, delegates are encouraged to use the extensive resources and collective knowledge available at each meeting to provide direction and support for the work of the organization. Such a commitment benefits the individual delegate, the association, and the nursing profession.

If a delegate in unable to attend the House of Delegates, the district president must be notified at once. When alternate delegates are substituted for delegates, it is the responsibility of the District President to notify ASNA of the change immediately.

All Delegate information will be located on the website (www.alabamanurses.org) under the District tab and that tab will be labeled Delegates.

Delegates should discuss potential issues with District members before the convention. An example would be resolutions.

Important information for ASNA Delegate Registration

- Delegates are encouraged to register for the convention in advance in order to expedite the on-site credentialing process and to receive a lower registration fee.
- A block of rooms has been reserved at the Auburn Marriott Opelika Hotel & Conference Center at Grand National. NOTE: the cutoff date for the reduced conference registration fee and hotel discount will be September 13, 2018. ASNA has blocked a certain amount of rooms for this convention. Please consider that off-site hotel registration of delegates causes a financial hardship to the organization if the room block is not met.
- To ensure eligibility for the credentialing process, delegates are required to present their **current ANA membership card and one picture ID** at the Delegate Registration desk. If you do not have a current membership card please contact April Bishop, Programs Coordinator for assistance. Each delegate will be issued a name badge, a delegate ribbon, and informational materials upon proof of identification. The name badge and delegate ribbon must be worn in order to be admitted to the floor of the House of Delegates.

Please call the ASNA office at 1-800-270-2762 or 334-262-8321 if you have questions or concerns.

ASNA's Official Call for Resolutions All You Need To Know

What Is a Resolution?

It is a formal written call to action on a subject of great importance to members of ASNA. In other words this is an action members would like ASNA to pursue. Resolutions are often the source of action in developing positions on issues affecting nurses, nursing, and the needs of the public. Once the resolution is voted on and passed by the House of Delegates ASNA will try to implement in order to meet the needs of the association. Resolutions may be sent to other organizations, governmental agencies, or other individuals. The resolution process is one of the most important functions of the House of Delegates.

Call for Resolutions

Any ASNA member may research, write, and/or submit a resolution for consideration by the ASNA House of Delegates. Resolutions should be submitted to the Governance Committee through the ASNA office at 360 N. Hull St., Montgomery, AL 36104 by **JULY 1, 2018**. Only an emergency resolution will be accepted after the designated date, and is contingent on the ASNA President's approval.

Types of Resolutions

Resolution are classified according to the following:

- **Substantive Resolution,** which deal with basic principles and policies of ASNA, or issues of statewide or national concerns of nurses as practitioners and citizens.
- **Courtesy Resolutions,** which give recognition to outstanding persons who have made especially valuable contributions to ASNA or the nursing profession.
- **Commemorative resolutions,** which deal with commemoration of important events or developments in nursing, allied professions, or government.
- **Emergency Resolutions,** which have significance for the association and require immediate action.

How is a Resolution written?

A resolution has two parts – the "whereas" section and the "resolved" section. The "whereas" section is a series of single item, factual statements which present documentation of the need for the resolution. The "resolved" section is a series (or single) item action statement(s) of position by ASNA and is the actions by which the intended result will be obtained.

Procedure for Registration of a Delegate

1. The most current membership roster available from ANA will be available either in online or printed version.
2. The duties of the ASNA Delegates Credentials Committee (DCC) include all phases of delegate registration. ASNA Staff will be on hand to assist and answer questions.
3. All delegates must provide a current membership card and 1 (one) photo ID.
   a. If the delegate's name and membership card match the current roster, a member of the DCC will proceed to register the delegate.
   b. If the delegate's name and membership number do not match the current roster, the DCC will check the Master Delegate List (the original information supplied by the district president). If the name appears on this list, the procedure for registering an alternate delegate as a delegate will be followed.
4. Each delegate will be provided a name badge identifying them as a delegate.
5. The delegate is to be instructed to retain the House of Delegates name badge. This name badge and some form of photo ID must be available during all sessions of the House of Delegates, should the presiding officer call for a check of delegate credentials.
6. The delegate's name will be marked on the control listing to develop a running tally of those delegates who have completed delegate registration.

Nominations and Election of Officers

Alabama State Nurses Association's (ASNA) nomination and election of Officers shall be conducted in accordance with the current issue of *Robert's Rules of Order* during the official meeting of the ASNA House of Delegates (HOD).

1. NOMINATIONS
   A. Nominations Committee
      a. Nominations from the Nominations Committee shall be accomplished according to ASNA Bylaws.
   B. Nominations from the floor of the HOD shall be accomplished according to the current issue of *Robert's Rules of Order.*

2. ELECTION OF OFFICERS
   A. Elections will be by secret ballot.
   B. Only credentialed delegates will be allowed to vote at the ASNA Convention. See ASNA website (alabamanurses.org) under members only section for convention information.

Available Positions on the ASNA Ballot for 2018-2020

*President-Elect/Delegate

Treasurer

Commission on Professional Issues (Vote for 4)

Nominating Committee (Vote for 3)
(Districts 1, 2, and 3)

**must be joint member of ASNA/ANA*

Look for nomination information and procedures on alabamanurses.org.

FACES '18 HIGHLIG

Elizabeth Morris Clinical Education Sessions - ***FACES '18***
POSTER WINNERS

Each year ASNA awards a first place recipient for the best scientific-based Poster. The winners are:

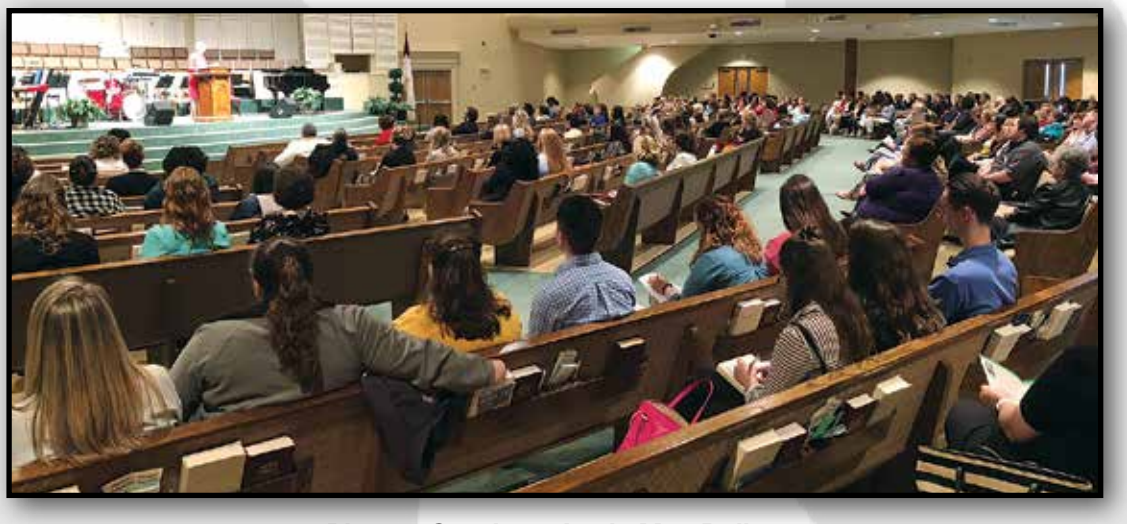
First Place

Dr. Marsha Cannon – *An Exploration of Formal Mentoring Experience of Junior Faculty in Associate Degree Programs*

Honorable Mention

Dr. Tomeka Mechell Royster – *The Impact of a Computer-Based Digital Platform on Health Assessment Skills of Online Master of Science in Nursing*

Congratulations to both recipients!



Plenary Session - Annie Mae Bellow

Comfort Care at AS

ASNA Membership Table

Jackson Hospital at ASNA FACES

HURST at ASNA F

Alabama Organ Center at ASNA FACES

ALLKids at ASNA FACES

Middle Tennessee School of An

GHTS

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Why Your Nursing Networks Matter

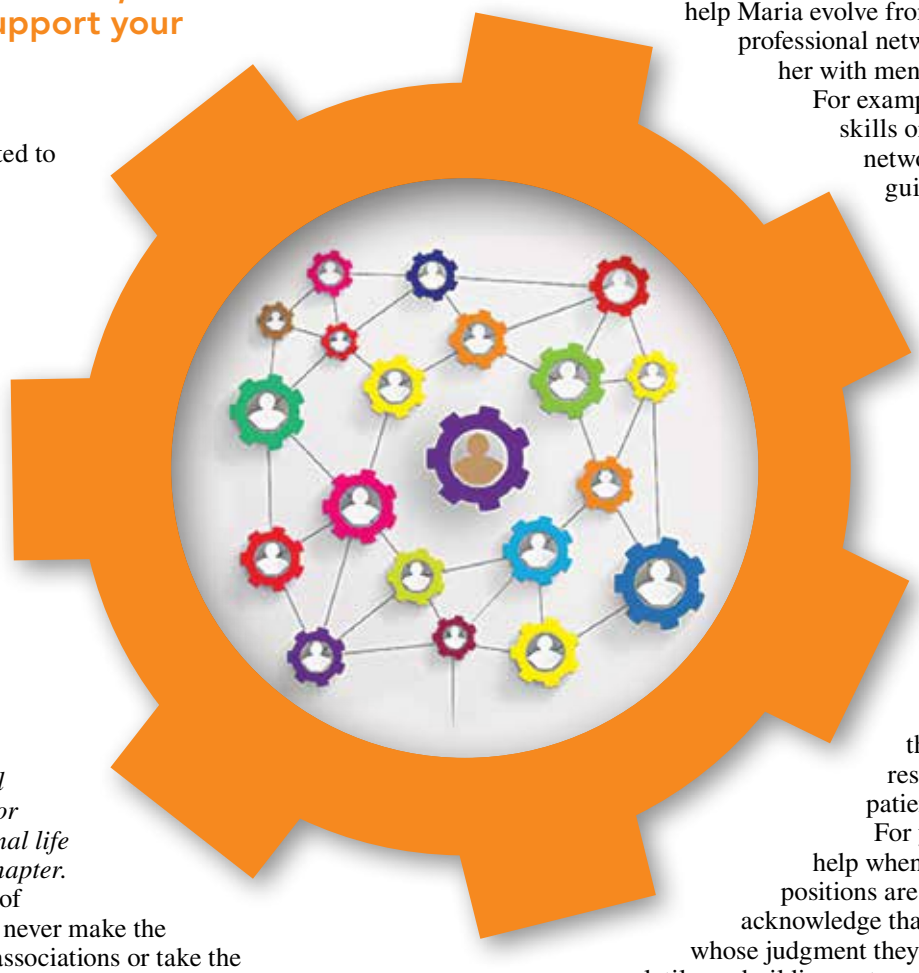
Retrieved from American Nurse Today
March 2018 Vol. 13 No. 3

Networks help you advance your career, provide high-quality care, and support your colleagues.

Takeaways:

- Professional networks are crucially connected to quality patient care.
- Building a professional network can take two paths: a network in your immediate clinical environment or one created through an organization.
- Professional networking has rules, such as adding value to others, building a professional image, and being prepared and positive.

By Rose O. Sherman, EdD, RN, NEA-BC, FAAN, and Tanya M. Cohn, PhD, MEd, RN



Maria is a direct-care nurse working on a medical/surgical unit in an acute-care hospital. She recently achieved certification and became a member of a national nursing organization for her specialty, both of which are needed to advance through the clinical ladder at work. However, Maria isn't sure why her hospital values membership in the national organization or how it will help her career. She has a busy personal life and doesn't have time to volunteer in her local chapter.

Maria's lack of understanding about the value of professional networks isn't unusual. Many nurses never make the investment of getting involved with professional associations or take the time to ensure that they have a strong network of colleagues within and outside their own organization. They wonder why they should spend what free time they have on an activity that seems so indirectly related to their work, and they fail to see how a network can enhance their professional growth or be a wise career investment.

The value of professional networks

Maria, like all direct-care nurses, is part of the profession of nursing. As a member of the profession, she has the opportunity to develop through continuing education, certification, and membership in nursing organizations. These activities will help Maria evolve from a novice to an expert nurse and open doors to professional networks. Professional networks also will provide her with mentorship, support, and teamwork opportunities. For example, if Maria's interested in developing specific skills or advancing her education, she can use her network to identify a mentor for skill development or guidance on educational opportunities.

Professional networks are crucially connected to quality patient care. Specifically, healthcare demands evidence-based practice, but nurses across the nation frequently are faced with variations in patient care and deep-rooted sacred cows of practice that are neither evidence-based nor current. Working in silos of individual clinical settings, nurses are left with less-than-optimal patient care and the need to develop evidence-based solutions from scratch. This is where professional networks can promote evidence-based practice through collaboration. For example, as a member of a national organization, Maria has access to networking with other medical/surgical nurses. Together they can compare and share best practices or research findings from their clinical practice, reducing the need to re-create the wheel individually. The result is consistent evidence-based, high-quality patient care.

For young nurses like Maria, a strong network can help when looking for new career opportunities. Many positions are never advertised, and workforce recruiters acknowledge that their best referrals come from professionals whose judgment they trust. Today's healthcare environment is volatile, so building a strong network should be part of a professional insurance policy.

Steps to building a network

Building a professional network can take two paths: a network in your immediate clinical environment or one created through an organization. Both require common steps.

First, establish an understanding of your goals and who can help you achieve them. For Maria, this could include using her knowledge and experience as a certified medical/surgical nurse to establish a unit-based education program or to take part in a unit-based council to work collectively with other nurses through evidence-based practice and nurse competencies. Maria also might be interested in tapping into the nursing organization she's joined to seek out up-to-date practice alerts. Regardless of the professional network, after goals are set and the right people are identified, you can interact, share knowledge, and receive plans to help you achieve your goals.

If you don't have a specific goal in mind, building a professional network might seem daunting or unclear. Start by putting yourself out there in the nursing profession. For Maria, who may not be able to commit to joining a committee within the nursing organization, she can plan to attend the organization's annual conference. While there, she can take steps to maximize the networking experience. First, she should think about some conversational topics and introductory questions to use when interacting with other attendees. Depending on Maria's professional goals, the topics and questions could revolve around clinical practice, leadership development, or advancing education. In addition, Maria should be professionally prepared for the conference, including wearing professional attire and taking business cards. She also should plan to attend all social events and interact with the conference vendors, who could be potential future employment opportunities or offer cutting-edge evidence-based products she can share with her clinical colleagues.

The golden rules of networking

Networking opportunities exist everywhere, including online with sites such as Facebook, LinkedIn, and Twitter. Many nursing organizations have Facebook and Twitter accounts that nurses can follow to support networking about clinical practice and professional development. LinkedIn, on the other hand, helps nurses identify mentors and colleagues with similar interests. Regardless of whether you're networking at a conference, within an organization, or online, you'll need to follow some rules. (See *Expert* advice.)

Networking for introverts

If you're naturally introverted, networking may not come easily. You may even avoid networking events because they're exhausting and force you outside your

Expert advice

Put these best practices from networking experts at Essential Communications into action.

1. **Networking is about planting, not hunting.** Professional relationships are built over time. Never reach out to network and then abruptly ask for a job.
2. **Effective networkers add value to others.** When networking, adopt a mindset of abundance not scarcity. Think about what you can do for the other person first. Perhaps you can connect him or her with a colleague or share an interesting article. The best networkers are givers not takers.
3. **Build a professional image.** Make a positive professional impression by having an up-to-date LinkedIn page, a professional email address and outgoing phone message, and business cards.
4. **Be prepared.** Networking opportunities can occur in the most unlikely settings. Always carry business cards and be ready to build a relationship.
5. **Craft your elevator speech.** When you're asked, "What do you do" or "What are you looking for," have a short, coherent answer that easily rolls off your tongue.
6. **Be positive.** Don't complain about anything to people you network with – you're building a relationship, not seeking therapy.
7. **Share the airtime.** The best way to begin building a relationship is to ask other people about themselves and their careers. Spend as much time listening as you do talking.
8. **Follow up consistently.** If you've been helped by another, send a thank-you note. If you've been given some homework, get it done and provide follow-up.
9. **Dig your well before you're thirsty.** By the time you need to build relationships, it may be too late; they take time to cultivate. Networking should be an ongoing professional investment.

Source: Essential Communications. essentialcomm.com

comfort zone. The hardest part can be walking through the door into a room. Fortunately, most people would rather talk than listen, so let others do the talking. You can never go wrong asking questions and establishing common ground. (See *Get the conversation started.*) Chances are that once you start asking questions, the conversation will flow easily. Most nurses like to be asked about their opinions and sought out for advice. You'll be seen as a great networker because you take the time to listen.

Get the conversation started

Use these questions to jumpstart conversations at networking events.

- How did you get started in your role?
- What are your challenges?
- What significant changes are you seeing in your environment?
- What's the most innovative thing that's happening in your organization?
- What do you think will happen with healthcare reform?
- What trends do you see happening in nursing today?
- What advice would you give to an emerging nurse leader?
- How can I help you?
- Who else at this meeting would be helpful for me to speak with?

Join the networked world

Over the course of her career, Maria will learn that building a network is one of the most powerful opportunities that membership in a professional association can provide. A good network outside her clinical setting will help her gain access to and act on new information quickly. She'll also save time and energy by accessing other professionals who've overcome some of the same challenges she's facing. Many young nurses have fast-tracked their careers by getting involved with association committees or running for office.

We live in a networked world, so developing your networking skill set is important to your career success. You never know what new opportunities you'll encounter or who you'll meet until you extend your hand, introduce yourself, and start asking questions.

Rose O. Sherman is a professor of nursing and director of the Nursing Leadership Institute at Christine E. Lynn College of Nursing, Florida Atlantic University in Boca Raton. You can read her blog at www.emergingrnleader.com. Tanya M. Cohn is a nurse scientist at West Kendall Baptist Hospital Nursing and Health Sciences Research in Miami, Florida.

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Membership News

Dr. Jean Kelley (1930 - 2018)

Dr. Jean Kelley passed away peacefully at her home on April 8, 2018. She was born in Vintondale, Pennsylvania to Mary Kanich and John Jacobs. She graduated as Valedictorian from Harrisville High School (MI) and then earned a Diploma in Nursing from Mercy Central School of Nursing before being called to active duty with the Army Nurse Corps. While serving in the Korean War as a Lieutenant nurse, she met and married the love of her life Clarence Breck Kelley Sr. at Fort Benning, GA. Dr. Kelley was Professor Emeritus at the University of Alabama at Birmingham School of Nursing (UABSON), where she dedicated her entire academic career to the growth and development of nurse leaders. During her tenure with the UABSON she served as Assistant and then Associate Dean for the Graduate Program. Dr. Kelley pioneered the advancement of graduate nursing education throughout the South and the nation and helped found the first doctoral nursing program at UAB, in the Southeast, and one of twelve nationwide. Dr. Kelley was an inductee into the Alabama Healthcare Hall of Fame as well as the Alabama Nursing Hall of Fame and a Fellow in the American Academy of Nursing. Because of her lifelong commitment to nursing education, the University of Alabama Board of Trustees established the Jean A. Kelley Endowed Lectureship at the UABSON in 1989. She received the Distinguished Faculty Award by UAB and the UABSON Distinguished Alumni Award also. In 2010 she was recognized as one of the UAB School of Nursing's Sixty Visionary Leaders for her dedication to the growth and development of tomorrow's nurse leaders. Dr. Kelley was preceded in death by her husband Clarence Breck Kelley Sr. and is survived by her daughter Mary Vaughn (Michael); and two sons C. Breck Kelley Jr. (Paula) and Mike Kelley (Pascha); and eight grandchildren Kelley and David Vaughn; Cole (Stephanie), Kimberly and Chase Kelley; Stephen Litchfield, Kristin and Sean Kelley. A Funeral Mass was held Thursday, April 12, 2018 at Our Lady Of the Valley Catholic Church, Monsignor Rohling presided. Memorial gifts can be made to UAB School of Nursing Building Fund, 1720 2nd Ave S, NB 1010, Birmingham, Alabama 35294. Gifts will be used to name a special tribute wall for Dr. Kelley in the School's building expansion, opening in Fall 2018.

Membership News

Welcome New and Returning Members (January 1, 2018 - March 31, 2018)

Debra Abernathy
Danielle Anderson
Colleen Anusiewicz
Amy Baker
Daniel Bankson
Christina Baughn
Carol Bell
Tisha Bell
Iris Bessiouni
Chastity Billups
Catherine Blache
Rachel Bloodworth
Cheryl Booth
Fannie Boswell
Alesha Boykin
Arvenia Bradley
Tiffany Bumpus

Teresa Burke
Sharon Carroll
Katherine Cassidy
Sasha Catchings Walker
Monica Chamblin
Teresa Clark
Angelia Clayton
Charlene Cleveland
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Jennifer Coman
Donna Cordes
Shawn Cosper
Courtney Cox
Sherry Cox
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Viviam Dante
Kelli Davis
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Donna Dunn
Sara Michelle Eaton
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Denise Elliott
Laura English
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Penny Ewing
Tracy Faniel
Mirlene Francisque
Paula Fullwood
Patricia Gilliam

Carol Gilmer
Mary Glover
Jaenelle Grace
Darcy Grandchamp
Jennifer Grap
Bettye Guy
Amanda Haigler
Stephanie Hall
Patricia Hannon
Linda Hanson
Sue Hardy
Angela Harris
Jeffery Harris
Karen Harris
Ashley Hawkins
Rachel Haynes
Jill Hiers

Margaret Hill
Lauren Hornbuckle
Erin Hornsby
Eleanor Howell
Cynthia Huckabee
Brittany Hughes
Alethea Ivey
Cindy Jessett
Carolyn Johnson
Stevie Lee Johnson
Cherie Keahey
Tara Kelly
Janie King
Renee King
Sarah Krause
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June Lassiter
Kimbrell Lee
Cynthia Lehman
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Georgeanne Lose
Martha Lowe
Caroline Luckie
Shea Ludgood
Aretha Mahan
Deanna Markris
Joseph Marks
Cheryl Marrero
Christine Marsch-Albert
Lisa Martin
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Kelly McClure
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Bonnie McMath
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Tracy Merry
Marthalyn Meyer
Maisha Moore
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Traci Morrow
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Celestia Slater
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Evangeline Snider
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Jonarius Stallworth
Jordan Stephens
Victoria Stewart
Clint Stinson
Laura Stone
Delphanie Stovall
Karen Sullivan
Carolyn Swain
Valarie Swain
Devin Talley
Judy Taylor
Michael Taylor
Shanise Thomas
Nicole Timbes
Karli Todd
Pamela Trammel
Ngoc Thao Tran
Courtney Tritt
Melissa Turner
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Amber Uptain
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Laura Wright
Sandy Wright Leonard
Stephanie Wynn
Amanda Yarbrough
Tamara Yeldell

ASNA/ANA Membership Activation Form

ASNA Alabama State Nurses Association | ANA American Nurses Association

Essential Information

First Name/MI/Last Name

Date of Birth

Gender: Male/Female

Mailing Address Line 1

Credentials

Mailing Address Line 2

Phone Number *Check preference:* ☐ Home ☐ Work

City/State/Zip

Email address

County

Current Employment Status: (eg: full-time nurse)

Professional Information

Current Position Title: (eg: staff nurse)

Employer

Required: What is your primary role in nursing (position description)?

☐ Clinical Nurse/Staff Nurse
☐ Nurse Manager/Nurse Executive (including Director/CNO)
☐ Nurse Educator or Professor
☐ Not currently working in nursing
☐ Advanced Practice Registered Nurse (NP, CNS, CRNA)
☐ Other nursing position

Type of Work Setting: (eg: hospital)

Practice Area: (eg: pediatrics)

Ways to Pay

Monthly Payment $15.00

☐ Checking Account *Attach check for first month's payment.*

Checking: I authorize monthly recurring electronic payments to the American Nurses Association ("ANA") from my checking account, which will be drafted on or after the 15th day of each month according to the terms and conditions below. Please enclose a check for the first month's payment. The account designated by the enclosed check will be used for the recurring payments.

☐ Credit Card

Credit Card: I authorize monthly recurring electronic payments to the American Nurses Association ("ANA") be charged to my credit or debit card on or after the first of each month according to the terms and conditions below.

Monthly Electronic Deduction | Payment Authorization Signature

I understand that I may cancel this authorization by providing ANA written notice twenty (20) days prior to deduction. I understand that ANA will provide thirty (30) days written notice of any dues rate changes. I understand that my dues deductions will continue and my membership will auto-renew annually unless I cancel.

Annual Payment $174.00

☐ Check ☐ Credit Card

Membership Dues (Joint ASNA/ANA only $15 monthly/$174 annually)

Dues: .....$

ANA-PAC Contribution (optional).....$

American Nurses Foundation Contribution (optional).....$

Total Dues and Contributions.....$

Credit Card Information ☐ Visa ☐ Mastercard ☐ AMEX ☐ Discover

Credit Card Number

Expiration Date (MM/YY)

Authorization Signature

Printed Name

Please note: $49 of your membership dues is for a subscription to *American Nurse Today*. American Nurses Association (ANA) membership dues are not deductible as charitable contributions for tax purposes, but may be deductible as a business expense. However, the percentage of dues used for lobbying by the ANA is not deductible as a business expense and changes each year. Please check with your State Nurses Association for the correct amount.

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ASNA Alabama State Nurses Association

Continuing Education

Promoting Quality Through Transitions of Care for Older Adults

Authored by: *Julie Savage Jones, EdD, MSN, RN, CNE and Arlene H. Morris, EdD, MSN, RN, CNE*

Disclosures: Neither the author or planning committee have any conflict of interest.

Target audience: All health care workers

Learning Outcome: The nurse will be able to explore the issues surrounding difficulties of promoting quality care during the transitions of care for older adults and state how to formulate best care for older adults during these transitions.

Contact Hours: 3.6 (ABN). Contact Hours are valid May 1, 2018 – April 30, 2020.

Fees: ASNA Member $ free Non Member $36.00 (Fees must be paid on line and the same time as the completing the evaluation.)

Accreditation: The Alabama Board of Nursing (Provider Number ABNP0002 – *Expires April 6, 2021)*

Instructions for Credit: Participants should read the learning outcome on line or printed out. After reading complete the post test at the end of the activity and compare your responses to the answers provided and review any incorrect response(s). Participants must complete the evaluation on line and submit the appropriate fee to receive continuing nursing education credit. The Certificate of Attendance will be generated after the evaluation has been completed. ASNA will report the contact hours to the Alabama Board of Nursing within 2 weeks of completion.

Introduction

Nurses are paid for their astute observations, skills and ability to identify and intervene to promote positive outcomes for patients in their care. The risk for negative outcomes is intensified with every transition to a different care provider or setting. This problem potentiates suffering of older adults and their families, while also dramatically increasing cost of care due to inaccurate or incomplete treatment.

Older adults comprise an increasing percent of the population in the United States as well as globally (World Health Organization, 2015; Center for Disease Control, 2013). Older adults are at risk for functional decline during both acute illness and progression of one or more chronic conditions. Many older adults live independently, with family members or friends, or in an assisted living facility (ALF). If supportive care is needed following hospitalization for an illness or injury, Medicare recipients can qualify for payment for rehabilitation in a skilled nursing facility (SNF) or in a long-term care (LTC) facility for 20 days post hospitalization without a copay and additional days with a copay (CMS, 2013). However, an older adult may prefer to receive rehabilitation nursing services and other therapies at home with family members or friends as partners in the recovery process. During every transition into and across any of these care settings, including home to the acute care facility, potential for problems increases without thorough communication and accurate assessments as foundation for meeting care needs.

Transitions of care (TOC) issues have been noted to be a problem impacting patient outcomes. According to the Centers for Medicare and Medicaid Services (CMS), improving transitions of care impacts quality of life and quality of care for older adults. The CMS (2018) noted many areas needing intervention, including:

> Preventing medical errors, identifying issues for early intervention, preventing unnecessary hospitalizations and readmissions, supporting consumers preferences and choices, and avoiding duplication of processes and efforts to more effectively utilize resources. (Para one)

Preventing 30-day readmissions is a quality measure associated with TOC. The Joint Commission (TJC, 2013) has addressed the issue of transitions of care, citing factors that may increase the risk of readmission, including

> diagnoses associated with high readmissions, co-morbidities, the need for numerous medications, a history of readmissions, psychosocial and emotional factors, such as issues relating to mental health, interpersonal relationships, or family matters, the lack of a family member, friend or other caregiver who could provide support or assist with care, older age, financial distress, and deficient living environment. (Page 3)

One of the areas TJC (2013) cited that could have a profound impact on TOC is:

> Two-way patient and family education – teaching the patient and family about their role and responsibility in managing a condition, while gaining an understanding of psychosocial issues affecting the patient and family. (Page 3)

The American Nurses Association (ANA) has identified several issues that could impact these problem-prone areas. The ANA initiatives, recommendations from the Agency for Healthcare Quality and Research (AHRQ), and from the Hartford Institute for Geriatric Nursing (HIGN) will be discussed in this paper.

Discharge Planning and Transitions of Care

Ideally, discharge planning should begin on the day of admission. Likewise, a patient being discharged from an acute care facility to a skilled care facility should have family present and involved in this stage of care for goals to be developed throughout care with the client and family an integral part of the process.

Consider the following scenario regarding transitions of care: Mr. Jones is an 86-year-old male with a history of mid-stage dementia and hypertension (treated with an antihypertensive). He was employed for decades as a popular math and history teacher, and was involved in his community through his church, school, and other volunteer organizations; currently his community involvement is limited to church attendance, eating at restaurants with family, and going for drives in the country. He infrequently initiates conversation, but responds to questions and requests, although answers may at times refer to a different situation than the one under discussion. He is usually pleasant and able to provide his self-care if prompted verbally and with needed objects in a slow, calm manner. Occasionally, he verbally recalls his military experiences, including combat episodes. He enjoys attending worship services and listening to music of various genres, including music from the 1950s.

He was recently admitted to an acute care facility from home, where he was cared for by his son and daughter-in-law. His daughter-in-law brought a notebook of his healthcare information, including an Allow Natural Death (AND) order signed by his attorney. His admitting diagnosis was dehydration and urinary tract infection. His family stated they had noticed some progressive weakening and slowing of his activities. Mr. Jones had limited verbal responses when questioned by the admitting registered nurse (RN) who was unfamiliar to him. The family was not with the patient on transfer from the hospital to the skilled nursing facility (SNF). The patient was transferred at 9 a.m. and the day shift hospital RN, who had just met him that day, called report to the day shift Licensed Practical Nurse (LPN) at the skilled care facility. The physician's discharge summary was sent to the admitting office.

The nursing report noted that the patient needs assistance with meals. No further information was provided. Family members spoke with the SNF admitting RN via phone. They informed the nurse that Mr. Jones had lost ten pounds in the last month. They said that he has always fed himself, but lately seems disinterested in his meals. Both of Mr. Jones caregivers work outside of the home. A private duty sitter cares for him during the day while they work. Mr. Jones was placed on a regular, no added salt diet with liquid nutritional supplements with meals. Additionally, Mr. Jones continued Bactrim DS for treatment of his urinary tract infection for seven more days. At the end of the first week at the SNF, when treatment team convened, Mr. Jones was noted to have lost seven additional pounds. When questioned about his food intake, the RN contacted the nursing assistant on day shift, who reported that he usually only drinks some of his liquid nutritional supplement at meal time.

This scenario includes preventable issues that, had they been addressed, could have had a positive impact on this client. From this case, it is apparent that Mr. Jones has a commonly occurring issue of forgetting how to carry out tasks. He appears to have forgotten how to use his eating utensils and this resulted in his weight loss and dehydration, causing further weakening and withdrawal. The potential for error was high in this case. Let's look at some of the issues involved in these transitions, including some methods to prevent or address them. Clearly, the family members caring for Mr. Jones did not have a clear understanding of the trajectory of dementia. There was also a breakdown in communication from home to hospital to SNF regarding the functional status of this resident. The following scenario shows how the same staff could have incorporated evidence-based assessment tools and interventions to improve the quality of care and outcomes to enable this older gentleman to return home to his family rather than rapidly decline.

During the transition of care scenario, the hospital RN, who just met the client on the day of discharge, called report to the SNF LPN. The family was not present for the transition at 9 a.m. to the SNF due to lack of being informed of the time the transfer would occur to enable taking a break from their work. Limited information regarding the patient's functional status was included in the transfer report. The hospital care team had not performed or included any kind of functional assessment on admission or during the client's stay. Had the hospital care team done these assessments on admission and every three days, this objective information could have been used to better structure care and could have been included in the discharge report. The Agency for Healthcare Research and Quality (AHRQ, 2017) provides an evidence-based system to improve quality and efficiency of healthcare through the TeamSTEPPS® communication tools (https://www.ahrq.gov/teamstepps). The hospital RN transferring care to the admitting RN at the SNF could have used the I-PASS-the BATON acronym to relay: **I**dentity of the nurse, **P**atient identifiers, **A**ssessment of the chief complaint, vital signs, symptoms and diagnosis, and the **S**ituation including current status and circumstances, and **S**afety needs such as critical lab values/reports, socioeconomic factors, allergies and alerts such as falls or isolation status. Further information includes **B**ackground of comorbidities, previous episodes, current medications and family history; **A**ctions that have been taken and are required (with rationale), **T**iming of urgency and prioritization of actions; **O**wnership of who is responsible (including family members); and anticipated **N**ext steps such as the plan or contingency plans for any anticipated changes.

The staff of this SNF had recently adopted the GITT 2.0 toolkit, "a template and resources that can be adapted by any organization across the healthcare continuum interested in enhancing interprofessional education surrounding quality initiatives" for care to older adults, provided by the Hartford Institute for Geriatric Nursing, New York University (https://www.consultgeri.org). The admitting RN assessed Mr. Jones using the "Try This" series, available as an application for iPad,

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iPhones, or tablets. Assessment and intervention guides from this series had been downloaded to iPads for the interprofessional healthcare team. Furthermore, all staff in this facility had completed the eight-item competency checklist for care of adults 65 years+ (Hartford Institute for Geriatric Nursing, 2002).

Initially, the admitting nurse wished to differentiate changes of aging from dementia by asking the patient and family eight items from the AD8: The Washington University Dementia Screening Test (Galvin and Zweig, 2013). Mr. Jones scored six out of eight, indicating a significant impairment of cognition. The Katz Index of Activity of Daily Living (ADL) (Shelkey and Wallace, 2012) revealed three of the six areas needing assistance were feeding, bathing and dressing. The Lawton Instrumental Activities of Daily Living (IADL) scale (Graf, 2013) revealed that all eight areas needed assistance. The Fulmer SPICES overall assessment tool for older adults (Wallace and Fulmer, 2007) revealed there were no noted **S**leep disorders, some **P**roblems with eating and feeding, no **I**ncontinence, some **C**onfusion, no **E**vidence of falls, and no **S**kin breakdown.

Although several fall risk assessment scales exist, the RN used the Heinrich II Fall Risk Model (Heinrich, 2016) to evaluate Mr. Jones. Findings revealed that he was at risk of falling due to his increased weakness since being hospitalized. The LPN reported a near fall occurred when assisting him to the bathroom following lunch. This information prompted the RN to further evaluate for orthostatic hypotension at various times throughout the following day in order to promptly assess for potential etiology (Esstman, 2016). The LPN reported that Mr. Jones' standing blood pressure significantly dropped following each meal. The RN explained that blood diversion to the gastro-intestinal system for digestion could preclude sufficient flow to the brain upon standing. The care team used these findings to plan for post-prandial hypotensive episodes by encouraging toileting prior to each meal and sitting or reclining in a chair for at least 30 minutes after eating (Saccomano, 2017).

The admitting nurse used the seven-item Mini Nutritional Assessment (DiMaria-Ghalili and Amella, 2012) to obtain Mr. Jones' baseline status and make appropriate plans for Mr. Jones to have assistance with meals. This was communicated to the nursing assistants participating in his care. The treatment team RN used the Family Preference Index (Boltz, 2012) to ask the son and daughter-in-law their desires regarding participating in supportive care of Mr. Jones. They decided that in addition to the evening meal they would alternate coming at breakfast and lunch meals each day to be a familiar presence and to assist with intake. They were hopeful that Mr. Jones would return to the home they shared at completion of his rehabilitation stay. Following use of the Eating and Feeding Issues in Older Adults with Dementia: PART II Interventions (Amella and Lawrence, 2007), the plan of care was revised to include staff offering, and remaining to encourage intake of, water and various juices through the day, and liquid nutritional supplements and small finger-food snacks at mid-morning and mid-afternoon (rather than providing liquid nutritional supplements with meals), turning off the television (a potential distraction to eating), providing oral hygiene morning and evening, and assessing for pain.

The RN used the five-item observational tool Assessing Pain in Persons with Dementia (Horgas, 2012) to determine that Mr. Jones had a frightened expression, and occasional short periods of hyperventilation. The RN used the Geriatric Depression Scale: Short Form (Greenberg, 2012) to determine that Mr. Jones was depressed. In addition to nursing interventions such as more frequent position changes and appropriate medication administration for pain, the family was consulted regarding measures to increase comfort in the unfamiliar environment. They brought a small audio player loaded with music that Mr. Jones had enjoyed, and a photo album which included pictures of family and friends throughout several decades.

Potential Barriers to Effective Transitions of Care

The fact has been established that rebound back into the hospital within 30 days of discharge is a negative outcome. This has implications for planning across transitions of care. Although nurses have knowledge, skills, and attitudes that can be used to identify transition of care issues and prevent negative patient outcomes, barriers impact their ability to function as change agents that promote such outcomes.

Safe Staffing

Unsafe staffing ratios potentially impact nurses' ability to have time to complete the assessment and planning necessary to promote positive outcomes. Nurses working in medical-surgical units in some hospitals are asked to care for up to six to seven patients, including older adults with multiple comorbid conditions. Nurses working in these facilities need to advocate for safer staffing ratios to facilitate better patient care outcomes. The American Nurses Association (ANA) is taking a lead role on this issue. The ANA (2015) collaborated with Avalere Health, LLC to develop a white paper, *Optimal Nurse Staffing to Improve Quality of Care and Patient Outcomes,* to address the growing problem of unsafe staffing and quality of patient care. This paper can be accessed at http://info.nursingworld.org/staffingwp/.

Nursing Process

Promoting better outcomes, such as decreased readmission rates, requires careful planning. Consider a geriatric client with dementia transitioning from care at home to care in the hospital setting for surgery or acute illness, and then to the skilled nursing facility. To plan effective care, the nurse must include detailed assessments that identify potential problems common for older adults. Due to the widespread problem of functional decline for older adults acutely ill, the nurse needs to assess the client's current functional status. The Katz Index of Activity of Daily Living (ADL) (Shelkey and Wallace, 2012) mentioned earlier is a tool that can be utilized in hospital and outpatient settings. Additionally, the older, acutely ill adult is at risk for delirium, particularly problematic with urinary tract and other infections. Specialized assessment tools can address common issues. The Mini-Cog™ (Doerflinger, 2013) or the Confusion Assessment Method (CAM, Inouye et al, 1990) can be used in inpatient, acute care settings to identify clients with delirium. There is also a CAM version for the intensive care unit. Nurses can make a positive impact on the outcomes for geriatric patients transitioning through various levels of care by routinely using evidence-based assessment tools to guide planning the client care. Licensed practical nurses can help facilitate the process by helping to collect data and reporting it promptly to the RN.

Nurses do not always feel empowered to complete assessments in addition to basic head to toe physical assessment taught in nursing school. However, nurses should integrate assessment tools to provide further objective assessment of geriatric clients and to facilitate communication in transitions of care. Utilizing specialized assessments tools can help identify issues that often impact geriatric clients and result in planning interventions to address common problems. Additionally, making the provider and other team members aware of such issues can be the start to promoting better outcomes for geriatric clients. Routine use of evidence-based assessment tools from the series *Try This: Best Practices in Nursing Care to Older Adults* (htpps://www.consultgeri.org) can be supported through narrative and video instructions on the website.

Family Involvement

Frail, vulnerable older adults need a family advocate with them during times of illness, and during transitions of care. Nurses need to involve family members in the care of patients, when this is possible. In American culture, children are considered vulnerable and require caregivers, especially when they are ill. However, when vulnerable, aging parents are hospitalized due to illness, the expectation that a family member will remain with them is not always a consideration. Nurses can do a better job of encouraging families to be involved, especially during transitions of care. Nurses have been designated as the most trusted profession by a Gallup poll for over a decade and are assumed to act in the best interest of patients and families. Knowing that involvement of patient and family in the process of transitions of care improves outcomes, nurses must incorporate and involve the patient and family in the plan of care throughout all stages.

Continuity of Care

In this case, the hospital RN called report to the RN at the SNF. The hospital nurse had never cared for the client before the day of discharge. This reflects several issues encountered in nursing related to continuity of care. Healthcare risks increase fragmentation and reduce quality without continuity of care. Ideally, a tentative plan for the approximate day of discharge should be determined at admission to acute care facilities. This information can be obtained from InterQual® (Change Healthcare, 2018) criteria, an evidenced-based clinical decision support system used for utilization review, and includes information such as average length of stay, based on diagnosis. Hospital case managers use these criteria to justify admission to an acute care facility. With proper planning and care coordination, discharge could be planned to allow a nurse with more complete knowledge regarding a client to call report to the admitting RN in a SNF. In addition to more familiarity with the patient, use of evidence-based communication tools for transfer of care increase both speed and quality of information communicated.

Regulations

In Alabama, LPNs can perform focused assessments, whereas comprehensive assessments are completed by an RN. However, SNFs are required to have a RN present for only 8 hours during the day shift. Therefore, most discharges to these facilities are carried out during the day shift hours. Individuals who transition from the acute care facility to the SNF often have multiple comorbid conditions. By the very nature of their general health condition, these clients are at risk for decline. Adding acute illness to this situation results in clients at elevated risk for rebound back to the hospital. Nevertheless, these clients are in an unfamiliar environment and potentially without family present. During the evening and night hours, care of these clients is overseen by LPNs, who are not allowed by state law to carry out a comprehensive health assessment. This presents a problem for less experienced LPNs. Ideally, an RN available within the facility at all hours of the day, every day of the week would provide a thorough assessment during changes in client condition, and address issues that would otherwise result in rebound back into the hospital. Readmissions within 30 days of discharge have implications for hospital reimbursements, possibly indicating quality of care issues.

Staffing Issues

According to Jones' (2016) research, new graduate LPNs encountered issues when transitioning to work in long term care environments. Two of the most stressful issues were managing death and dying of residents and intimidating and disruptive behaviors. In this study, LPNs did not feel prepared to deal with the difficulties associated these problems. Death is not usually an expectation in SNF, as people transition to these environments with the expectation to improve. However, clients in SNFs are often fragile and their health status is at risk for rapid or unexpected decline. Management of situations where the client's health status declines should be included in all levels of nursing education curriculum and as a competency evaluation during job orientation. A supportive environment, including availability of RN or advance practice nurse (APN) for more complex issues can help increase staff retention, thus reducing costs for the facility.

Another problem exists in healthcare environments that has a negative impact on client care. The Joint Commission (2008) referred to the problem as intimidating and disruptive behaviors. Jones (2016) found that new graduate LPNs transitioning to work in a LTC and SNF settings encountered these behavior from several disciplines of staff within the facilities or from client family members. This impacted their job satisfaction and could have resulted in negative client outcomes. These behaviors also negatively impact the teamwork needed to result in better client outcomes. The American Nurses Association (2015b) has a position statement and toolkit to help facilities address these behaviors in the workplace. Addressing incivility in healthcare will ultimately promote better outcomes for the clients, as well as satisfaction and retention of nurses. This is also an ethical issue that can be addressed by the ANA Code of Ethics.

The ANA (2015a) Code of Ethics speaks to the issue of incivility, indicating that the registered nurse is to "create an ethical environment and culture of civility and kindness, treating colleagues, coworkers, employees, students, and others with dignity and respect" (ANA, 2015a, p. 4). Although this code applies to registered nurses, the ANA asserts that this issue is applicable to all healthcare workers and stakeholders, stating that "stakeholders who have a relationship with the worksite

also have a responsibility to address incivility, bullying, and workplace violence" (p. 1). In their position statement, *Incivility, Bullying, and Workplace Violence,* the ANA (2015b) asserted that nursing professionals will no longer tolerate these behaviors in nursing practice. Guidance is offered to identify and build a culture where this problem is not tolerated. The Center for American Nurses (CAN, 2008) also asserted that all healthcare organizations should adopt a zero-tolerance for lateral violence and bullying, emphasizing that organizations should adopt educational and behavioral interventions to help nurses deal with these behaviors.

The Agency for Healthcare Research and Quality (2018) also developed TeamSTEPPS® 2.0 for Long-Term Care. This evidence-based teamwork system is designed to improve quality, safety, and efficiency of healthcare, including a curriculum guide with videos to facilitate better communication and teamwork. Additionally, a slide presentation provides an overview of the program for leaders. The framework for this model of care provides key principles of teamwork, communication, leadership, situation monitoring, and mutual support (AHRQ, 2018).

As nurses and other healthcare providers on the team age themselves, we must consider what type of care will be provided when we are the recipients and how will that influence quality of life for each of us. By providing standardized objective information, nurses' assessments can prompt action by other healthcare team members. These best practices can help reduce length of stay and hospital readmissions that impact us all as citizens and healthcare providers. Further indications may also be implicated for staff patient ratio. Additionally, creating a culture that supports collaboration and teamwork and does not tolerate intimidating and disruptive behaviors will result in better client outcomes. If this is not being done in the current environment, nurses must help change the paradigm.

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Continuing Education Questions:

Compare your response(s) to the correct answers following the questions:

1. The Joint Commission specified which of the following risks for readmission? (select all that apply)
   a. Family or other caregiver support
   b. Financial distress
   c. Older age
   d. Psychosocial and emotional factors

2. Which of the following does The Joint Commission recommend to reduce errors associated with Transfer of Care (TOC)?
   a. Care maps that specify assessments and interventions for each day of hospitalization
   b. Rapid discharge from acute care facilities to rehabilitation settings of care
   c. Two–way patient and family education that allows healthcare team members to gain understanding of related issues.
   d. Written discharge instructions

3. What communication tool is suggested by the Agency for Healthcare Research and Quality (AHRQ) to promote communication at transitions of care?
   a. ADESCC
   b. CUS
   c. I-PASS-the-BATON
   d. SBAR

4. In this scenario, which assessment tool revealed problems with eating and feeding and some confusion?
   a. Fulmer SPICES
   b. Heinrich II Fall Risk
   c. Katz Index of Activity of Daily Living
   d. Lawton Instrumental Activities of Daily Living

5. In this scenario, which assessment tool was used to assess pain?
   a. Assessing Pain in Persons with Dementia
   b. Mini-Cog
   c. Mini-mental Status Exam
   d. Numeric pain rating scale

6. In this scenario, which assessment tool was used to determine family involvement in care?
   a. Family Preference Index
   b. No assessment of family involvement was made
   c. Observation of who was present
   d. Question and answer session

7. Which nurse licensure is required for comprehensive patient assessments in Alabama?
   a. Patient care technician certification
   b. Licensed practical nurse
   c. Registered nurse
   d. Advance Practice Nurse

8. Which barriers to quality care was identified by Jones' (2016) research of new graduate LPNs in Alabama? (select all that apply)
   a. High patient to nurse staffing ratios
   b. Intense and strenuous work required for patient care
   c. Intimidating and disruptive behaviors (incivility)
   d. Managing situations of death and dying of patients

9. Which professional organization has developed a toolkit to address behaviors such as bullying and incivility in the workplace?
   a. Agency for Healthcare Quality and Research (2018)
   b. American Nurses Association (2015)
   c. Centers for Medicare and Medicaid Services (2018)
   d. Hartford Institute for Geriatric Nursing at New York University College of Nursing

10. Which of the following has been found to improve quality outcomes and reduce rates of health decline or readmission of older adults? (select all that apply)
    a. Creating a workplace culture that supports collaboration and teamwork
    b. Including management of issues related to death and dying in all nursing curricula
    c. Use of evidence-based assessment tools to provide care for all patients
    d. Zero-tolerance of bullying, intimidating and disruptive behaviors

Correct Responses

1. B, C, D
2. C
3. C
4. A
5. A
6. A
7. C
8. C, D
9. B
10. A, B, C, D

Clinical Corner

CMS Fast Facts

CMS Program Data - Populations[1]

Medicare (avg monthly)	CY 2015	CY 2016	CY 2017[2]
Parts A and/or B	55.5	57.0	58.5
Aged	46.6	48.1	49.8
Disabled	8.9	8.8	8.8
Original Medicare Enrollment	38.0	38.6	38.3
MA & Other Health Plan Enrollment	17.5	18.4	20.2
MA Enrollment	16.5	17.3	18.7
Part D (MA PD+PDP)	39.5	41.2	42.8
Medicaid (avg monthly)[3]	**FY 2015**	**FY 2016**	**FY 2017**
Total	68.5	70.9	72.3
Aged	5.5	5.7	5.8
Blind/Disabled	10.5	10.6	10.6
Children	28.0	28.0	28.2
Adults	15.4	15.5	15.7
Expansion Adult	9.1	11.2	12.0
CHIP (avg monthly)[3]	**5.9**	**6.5**	**6.7**

[1] Populations are in millions and may not add due to rounding.
[2] Preliminary and Subject to change
[3] Projected estimates

MA - Medicare Advantage, MA PD - Medicare Advantage Prescription Drug Plan, PDP - Prescription Drug Plan, CHIP - Children's Health Insurance Program

SOURCES: CMS/Office of Enterprise Data & Analytics/Office of the Actuary

Original Medicare Persons Served & Payments by Type of Service, Calendar Year 2015

	Persons Served (in millions)	Program Payments (in billions)
Total	**34.4**	**$359.9**
Part A	**7.7**	**$181.9**
Inpatient Hospital	6.6	$130.0
Skilled Nursing Facility	1.8	$29.1
Home Health Agency	1.7	$6.9
Hospice	1.4	$15.9
Part B	**33.8**	**$178.0**
Physician/DME	33.3	$102.2
Outpatient	25.3	$64.4
Home Health Agency	2.0	$11.3

Total = Parts A and/or B

DME - Durable Medical Equipment

SOURCE: CMS/Office of Enterprise Data & Analytics

Medicare Deductibles, Coinsurance, Premiums

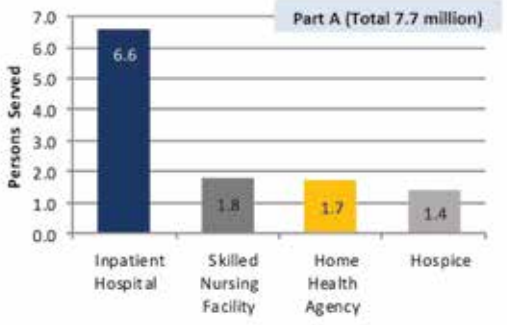
	CY 2017	CY 2018
Part A		
Inpatient Hospital Deductible	$1,316.00	$1,340.00
Coinsurance/Day	$329.00	$335.00
Coinsurance/LTR Day	$658.00	$670.00
Coinsurance/SNF Day	$164.50	$167.50
Part B		
Deductible	$183.00	$183.00
Part D		
Maximum Deductible	$400.00	$405.00
Initial Coverage Limit	$3,700.00	$3,750.00
Out-of-Pocket Threshold	$4,950.00	$5,000.00
Premiums		
Part A	$413.00	$422.00
Part B	$134.00-$428.60	$134.00-$428.60

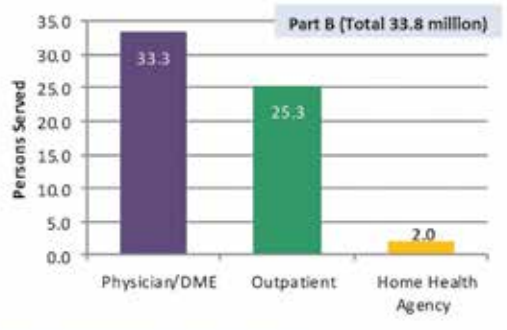
NOTE: The inpatient hospital deductible applies per benefit period.

LTR - Life Time Reserve
SNF - Skilled Nursing Facility

SOURCE: CMS/Office of the Actuary

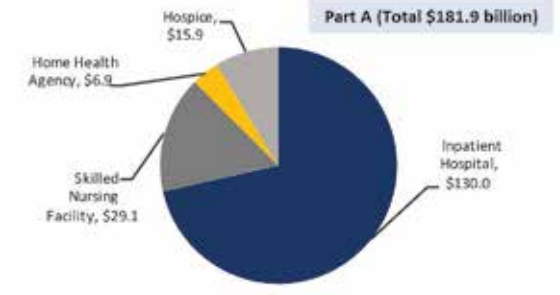
Original Medicare Persons Served (in Millions) by Type of Service, Calendar Year 2015

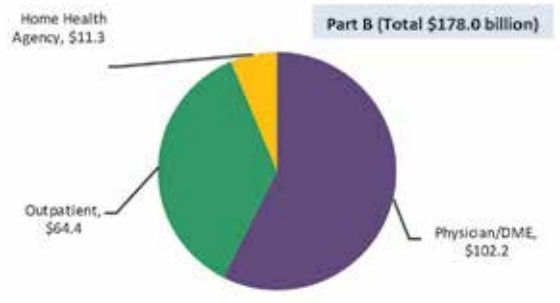




Total Persons Served, 34.4 million

Original Medicare Program Payments (in Billions) by Type of Service, Calendar Year 2015





Total Program Payments, $359.9 billion

Medicare Institutional Providers Calendar Year 2016

Type of Provider	Count
Total Hospitals	6,146
Short Stay	3,419
Psychiatric	570
Rehabilitation	277
Children's	99
Long Term	420
Critical Access	1,343
Religious Non-Medical	18
Home Health Agencies	11,956
Skilled Nursing Facilities	15,274
Labs	254,133
Outpatient PT/Speech Pathology	2,080
Rural Health Clinics	4,153
Federally Qualified Health Centers	7,723
Ambulatory Surgical Centers	5,529
Comprehensive Outpatient Rehab Facilities	193
Hospices	4,473

PT - Physical Therapy

SOURCE: CMS/Office of Enterprise Data & Analytics

Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Providers by Specialty Calendar Year 2016[5]

Specialty Type	Count
Total DMEPOS Providers	85,297
Pharmacy	50,077
Medical Supply Company	10,138
Optometry	5,485
Podiatry	5,232
Individual Certified Prosthetist/Orthotist	2,444
Optician	2,033
Orthopedic Surgery	1,929
Ophthalmology	1,477
General Practice	1,395
All Other DMEPOS Providers	5,351

[5] Providers utilized by Original Medicare beneficiaries for all Part B non-institutional DMEPOS services. Providers may be counted in more than one specialty classification but are reported as a single provider in the "Total DMEPOS Providers" count.

SOURCE: CMS/Office of Enterprise Data & Analytics

National Health Expenditures Calendar Year 2016

Total	$3,337.2
% of GDP	17.9%
Per Capita	$10,348
Health Insurance	$2,486.8
Private Health Insurance	$1,123.4
Medicare	$672.1
Medicaid (Title XIX)	$565.5
CHIP (Title XIX & XXI)	$16.9
Department of Defense	$41.5
Department of Veterans Affairs	$67.4

Dollars in billions except for Per Capita.

SOURCE: CMS/Office of Actuary

CMS Financial Data Fiscal Year 2016[6]

Total Federal Program Spending ($ in billions)	$1,067.2
Medicare Benefits[7]	$683.6
Total Medicaid	$368.3
CHIP	$14.8
Other Spending	$0.5
Total Program Management ($ in millions)	$6,387.7
Total Appropriation	$4,279.9
Other Sources	$2,107.8
Total Health Care Fraud & Abuse Control Funding ($ in millions)	$1,959.9
FTE Employment	6,238

[6] Program Management figures in FY 2016 are preliminary and subject to change.
[7] Medicare Benefits, including Health Information Technology Incentive Payments.

SOURCE: CMS/Office of Financial Management

Clinical Corner

Medicare Part D Utilization and Expenditures Calendar Year 2015

Utilizing Beneficiaries, in millions	**38.9**
Prescription Drug Events, in billions	1.4
Total Part D Expenditures, in billions	**$89.8**
Part D Benefit Payments	$89.5
Part D Administrative Expenses	$0.3

SOURCE: CMS/Office of Enterprise Data & Analytics/Office of the Actuary

Medicare Prepaid Contracts (01/2018)

	Count
Total Prepaid Plans (MA and others)	701
Total Prescription Drug Plans	63

SOURCE: CMS/Center for Medicare

Medicaid Beneficiaries and Payments by Selected Type of Service, Fiscal Year 2013

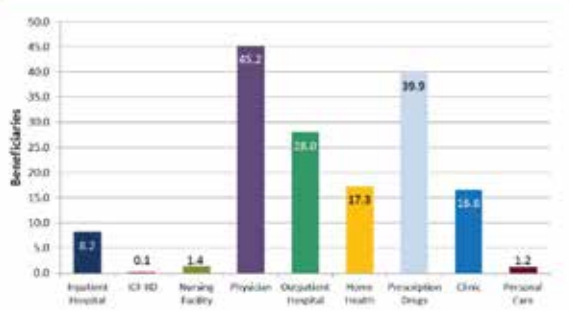
	Beneficiaries (in millions)	Payments (in billions)
All Services	**64.5**	**$361.3**
Inpatient Hospital	8.2	$30.6
ICF-IID	0.1	$11.6
Nursing Facility	1.4	$46.5
Physician	45.2	$10.0
Outpatient Hospital	28.0	$12.1
Home Health	17.3	$6.3
Prescription Drugs	39.9	$18.6
Capitation	--	$251.0
Clinic	16.6	$12.1
Personal Care	1.2	$11.5
Other Services	--	$61.8

NOTES: Beneficiaries represent unique individuals on whose behalf Medicaid payments for the indicated services were made during the fiscal year. Excludes enrollees in separate Title XXI Children's Health Insurance Programs. Excludes data for Colorado, Idaho, and Rhode Island and contains partial data for Kansas and North Carolina.

ICF-IID - Intermediate Care Facility for Individuals with Intellectual Disabilities

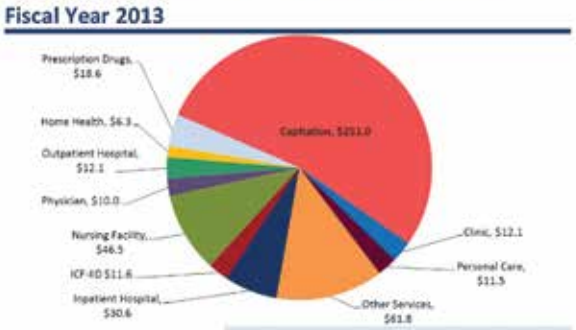
SOURCE: CMS/Center for Medicaid and CHIP Services

Medicaid Beneficiaries (in Millions) by Type of Service Fiscal Year 2013



Total Beneficiaries , 64.5 million

Medicaid Payments (in Billions) by Type of Service Fiscal Year 2013



Total Medicaid Payments, $361.3 billion

Medicare Non-Institutional Providers by Specialty[4] Calendar Year 2016

Specialty Type	Count
Total Providers	1,249,691
Primary Care	226,310
Surgical Specialties	109,234
Medical Specialties	147,866
Anesthesiology	41,732
Obstetrics/Gynecology	34,889
Pathology	12,354
Psychiatry	28,031
Radiology	37,560
Emergency Medicine	46,816
Non-Physician Practitioners	391,605
Limited Licensed Practitioners	104,318
Ambulance Service Supplier	10,334
All Other Providers	80,815

[4] Providers utilized by Original Medicare beneficiaries for all Part B non-institutional provider services. Providers may be counted in more than one specialty classification but are reported as a single provider in the "Total Providers" count.

SOURCE: CMS/Office of Enterprise Data & Analytics

Clinical Corner

Suicide Warning Signs

The following signs may mean someone is at risk for suicide. Risk is greater if a behavior is new or has increased and if it seems related to a painful event, loss, or change.

- Talking about wanting to die or to kill oneself
- Looking for a way to kill oneself, such as searching online or buying a gun
- Talking about feeling hopeless or having no reason to live
- Talking about feeling trapped or in unbearable pain
- Talking about being a burden to others
- Increasing the use of alcohol or drugs
- Acting anxious or agitated; behaving recklessly
- Sleeping too much or too little
- Withdrawing for feeling isolated
- Showing rage or talking about seeking revenge
- Displaying extreme mood swings

REMEMBER: Suicide is Preventable
Call the National Suicide Prevention Lifeline
1-800-273-TALK (8255)
or
suicidepreventionlifeline.org

Provided by the US Department of Health and Human Services
Substance Abuse and Mental Health Services Administration (www.samhsa.gov)

Helpful web-based resources for caring for older adults

- This website has a plethora of information related to aging, chronic conditions, elderly, end-of-life issues: Agency for Healthcare Research and Quality (AHRQ) https://www.ahrq.gov
- Agency for Healthcare Research and Quality (AHRQ) Healthcare Quality: How Does Your State Compare? https://www.ahrq.gov/research/data/data-infographics/.../qdr-state-snapshots.html
- Agency for Healthcare Research and Quality (AHRQ) The SHARE Approach—Using the Teach-Back Technique: A Reference Guide for Healthcare Providers from the Agency for Healthcare Research and Quality (AHRQ), Rockville, MD. https://www.ahrq.gov/professionals/education/curriculum-tools/.../tools/.../index.html
- Alabama Ageline (Alabama Department of Senior Services) www.alabamaageline.gov
- Alzheimer's Association https://www.alz.org/
- American Association for Retired People (AARP) Caregiving Guides for Families Providing Care at Home https://www.aarp.org/caregiving/care-guides/at-home/
- American Nurse Credentialing Center Certification www.nursingworld.org/ANCC/
- Assisted Living Disclosure Collaborative (ALDC) from the Agency for Healthcare Research and Quality, (AHRQ) in Rockville, MD. http://www.ahrq.gov/research/findings/factsheets/aging/index.html
- ****Excellent website with many nursing assessment tools and intervention guidelines:* Hartford Institute for Geriatric Nursing (HGIN) Try This: ® Series https://consultgeri.org/tools/try-this-series
- John A. Hartford Foundation (JAHF) Patient Priorities for Care www.patientprioritiescare.org
- National Hartford Center of Gerontological Nursing Excellence https://www.nhcgne.org/
- National Institutes of Health's Alzheimers and Related Dementias https://www.nia.nih.gov/health/alzheimers
- National Institutes of Health's National Institute on Aging https://www.nia.nih.gov
- The Joint Commission Transitions of Care Portal https://www.jointcommission.org/toc.aspx

Clinical Corner

Medicare

What is Medicare and what does it cover?

Medicare pays for health care for:

- People age 65 years and older
- People under age 65 with receiving Social Security Disability benefits
- People of all ages diagnosed with Amyotrophic Lateral Sclerosis (ALS or Lou Gehrig's disease) or end-stage renal disease (permanent kidney failure that requires dialysis or a kidney transplant).

Medicare covers **medically necessary care** for acute care, such as doctor visits, drugs, and hospital stays.

Except for the specific circumstances described below, Medicare **does not pay** for most long-term care services or personal care — such as help with bathing or for supervision (often referred to as custodial care).

When Does Medicare Pay for Long-term Care Services?

Following Hospitalization

Medicare will help pay for a short stay in a skilled nursing facility if you meet all of the following conditions:

- You have had a **hospital admission** with an inpatient stay of at least **three days**
- You are admitted to a **Medicare-certified nursing facility within 30 days** of that inpatient hospital stay
- You need **skilled care,** such as skilled nursing services, physical therapy, or other types of therapy

If you meet all these conditions, Original Medicare will pay a portion of the costs for up to 100 days for each benefit period as follows:

- For **the first 20 days, Medicare pays 100 percent** of the cost.
- For **days 21 through 100, you pay a daily copayment, which was $164.50** as of November 2017), and Medicare pays any balance.
- Medicare does not pay costs for days you stay in a skilled nursing facility after day 100.

(Medicare Advantage plans must cover the same services, but the cost sharing may vary.)

To treat medical conditions

Medicare pays for the following services when your doctor prescribes them as medically necessary to treat an illness or injury:

- Part-time or intermittent skilled nursing care
- Physical therapy, occupational therapy, and speech-language pathology provided by a Medicare-certified home health agency.
- Medical social services to help cope with the social, psychological, cultural, and medical issues that result from an illness. This may include help accessing services and follow-up care, explaining how to use health care and other resources, and help understanding your disease
- Medical supplies and durable medical equipment such as wheelchairs, hospital beds, oxygen, and walkers. For durable medical equipment, Medicare pays 80 percent of approved amount and you pay 20 percent.

There is **no limit** on how long you can receive any of these services as long as they **remain medically necessary** and a doctor reorders them every 60 days. There also is no requirement for your condition to improve, or for improvement to be expected.

To prevent further decline due to medical conditions

In some cases, Medicare also covers ongoing long-term care services to prevent further decline for people with medical conditions that may not improve. This can include conditions like stroke, Parkinson's disease, ALS, Multiple Sclerosis, or Alzheimer's disease.

Hospice care

Medicare covers hospice care if you have a terminal illness, are no longer seeking a cure, and you are not expected to live more than six months. With hospice care, Medicare covers drugs to control symptoms of the illness and pain relief, medical and support services from a Medicare-approved hospice provider, limited respite care, and other services that Medicare does not otherwise cover, such as grief counseling. You may receive hospice care in your home, in a nursing home, or in a hospice care facility.

LTC
PATHFINDER

Planning Ahead
Planning considerations and options associated with your age:

- Less than 50
- Between 51 and 64
- Age 65 and older

Receiving LTC
Resources for people already receiving long- term care services.

- Already receiving LTC

Medicare also pays for some short-term hospital stays and inpatient care for caregiver respite.

Resources for additional Medicare information or help:

- medicare.gov to download or order the Medicare & You 2018 Handbook (PDF)
- 1-800-Medicare (1-800-633-4227) for specific billing and coverage questions
- State Health Insurance Assistance Program (SHIP) for personalized information and assistance, find state contact information at shiptacenter.org

Last modified: 11/14/2017

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Springhill Medical Center is a family-owned hospital that's been around for more than four decades. We offer our nurses the most advanced tools for patient charting and bedside care.

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Bradford Health Services

About

Bradford Health Services has been helping Alabama nurses heal for decades. Bradford's Healthcare Professional's program is designed to help nurses and other medical professionals resolve issues surrounding their chemical dependency and the unique difficulties faced when reentering practice.

Approach

Bradford's innovative approach includes these key program components

- Multi-disciplinary Evaluation
- Relapse Prevention Therapy
- Desensitization Group
- Trauma Recovery Group
- Grief and Loss Group
- Adventure-Based Therapy

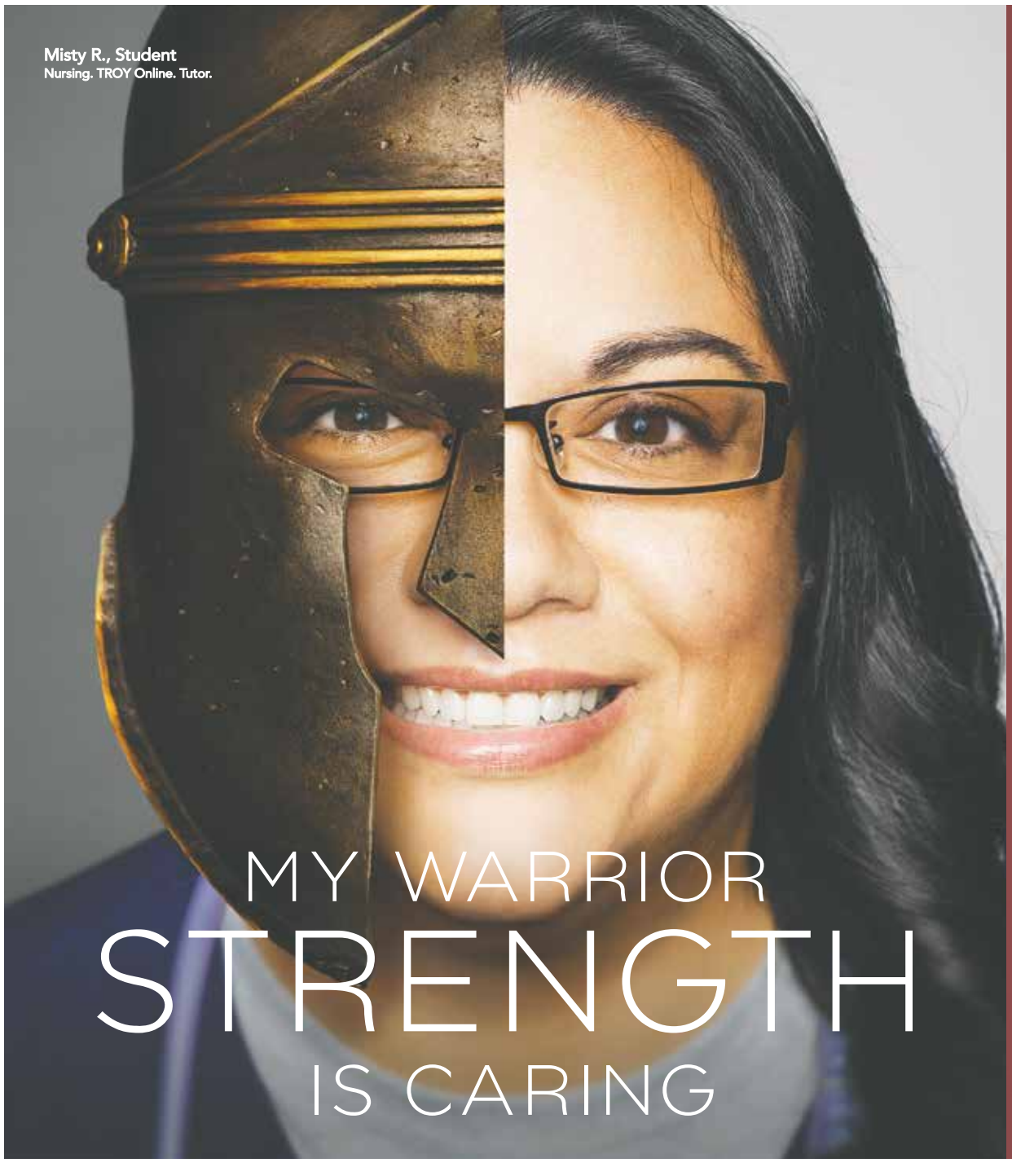
The program addresses

- realities of the work place
- demands and pressures that contribute to stress
- burn out
- depression
- alcohol and drug abuse

The goal is patient recovery and the successful return to professional practice.

For confidential help call us at 1-800-333-1865 or visit us at www.bradfordhealth.com

BRADFORD HEALTH SERVICES



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