The Nursing Voice

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AMERICAN NURSES ASSOCIATION CALIFORNIA

Special Points of Interest:

AMERICAN NURSES ASSOCIATION CALIFORNIA

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President's Perspective

Elissa Brown
President, ANA\California

Elissa Brown

Greetings,

Spring is coming…new beginnings… The hope is that we will continue to help others, and renew ourselves.

And, Happy Nurses Week—coming in May. The 2012 theme is "Nurses—Advocating, Leading, Caring." In today's political and healthcare climate, we face many challenges while trying to advocate, lead, and care; some ongoing, some new.

In keeping with that theme, here we are in the midst of a major election year. How wonderful that we live in a country where we have the right to vote; to participate in elections and decision making on local, state and national levels. Moreover, consider that it is a duty, an obligation, as well, and whatever your political leanings, do exercise that right to vote. Learn about the topics of concern, the varying sides of discussions, the candidates and their views, and the possible issues and outcomes at stake. These are exciting times, with so many avenues for communication—TV, radio, social media—that we cannot miss being informed. Liken it to evidence-based practice; base your thinking and decisions on the evidence, the knowledge you gain. We need to respect one another and differing viewpoints and to agree to disagree.

We also have the ability to be involved in decision making at our places of work. The same principles should be at play. With the focus on self-governance at all levels, everyone may have a role in deciding how to provide the best environment for staff to provide the best care for patients and families. Encourage your colleagues to get involved in constructive activities. Ask to be on those committees that are of interest to you, and will afford an opportunity to play a role in improving the quality of care. Become familiar with strategic planning, and how the goals of your workplace relate to everyday practice. Know and feel that you can make a positive difference—in the care you deliver, in the caring you convey, in teaching and sharing information, and in the improving the overall picture.

Being involved strengthens our nursing voice. As I have noted before: with over 360,000 nurses in California—Nurses are a strong and caring force in healthcare and in the local, state, national and international communities… get involved, bring your caring as a Nurse to the work place, to the community, to the capitol, and to your professional association.

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We Almost Lost the Board of Registered Nursing!!!

Honorable Tricia Hunter, RN, MN

At regular intervals, every Board, Bureau, and Commission has to go through a sunset review process to establish that they still are relevant and meeting their mission. Over the years, the process has been used to force boards to make changes that the Associations may not have supported. Because the bills required to sunrise the Board had to be passed, issues were frequently pushed in the legislation that were controversial.

The sunset review is the process of re-establishing a Board, Bureau, or Commission. The process takes two years. In the first year, a report is written based on questions asked by the Assembly and Senate Business and Professions Committees and then a hearing is held to review the report and allow the committee members to ask questions. The Assembly and Senate Business and Professions Committees alter the responsibility of the Sunset Review process. If everything goes correctly, the Committee will recommend the Board, Bureau, or Commission continue functioning and a bill is introduced in the following year from the Business and Professions Committee Chairperson.

Sunrise is the process of establishing a new Board, Commission or Bureau. It is a very detailed report required by the Business and Professions Committee that describes the public need and purpose for the Board, Bureau, or Commission. Each entity must also be financially independent of the state budget.

Governor Brown had several Sunset Bills sent to his desk this year. A number of these bills had language in them that had nothing to do with the Board being "sunrised" or had new requirements for the Board. Governor Brown does not believe policy bills should be in the same bill that determines whether or not a Board, Bureau, or Commission should continue. If the Governor doesn't like the language, his only option is to sunset a board that he may believe should continue. Before 2011, a Board would have become a Bureau if the Governor vetoed the bill. The Bureau would have all the authority of the Board. The Director of Consumer Affairs would have the authority to enforce the laws of the Board. In 2011, legislation was passed that eliminated the creation of the Bureau. Now, if the Governor sunsets a Board, the laws stay on the book, but nobody can enforce them!

The Governor had discussions with the Legislative Leadership about his vision for the sunset of a Board, Bureau, or Commission. When the BRN Sunset Bill was going through the process, the Governor's office notified the author and the Senate Business Profession's Committee that they had concerns about language in the bill and wanted it removed. The language had to do with allowing six boards, under Title 16, to hire sworn and non-sworn officers. The Board of Registered Nursing has the

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ANA\C Wants To See You....
IN THE NEWS

Have you or one of your colleagues been recognized for an accomplishment, elected to office, won an award, received a grant or scholarship, launched a new venture? Tell us about it! Send name, address, phone number, and accomplishment—

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1121 L Street, Suite 409
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Article Submittal to 'The *Nursing Voice*'

ANA\California accepts and encourages manuscripts and editorials be submitted for publication in the association's quarterly newsletter, The *Nursing Voice*. We will determine which letters and articles are printed by the availability of publication space and appropriateness of the material. When there is space available, ANA\C members will be given first consideration for publication. We welcome signed letters of 300 words or less, typed and double spaced and articles of 1,500 words or less. Articles printed in The *Nursing Voice* do not necessarily reflect the views of ANA\C, its membership, the board of directors or its staff.

ANA\California's official publication, 'The *Nursing Voice'* editorial guidelines and due dates for article submittal is as follows.

1. Manuscripts should be word processed and double-spaced on one side of 8 ½ x 11 inch white paper. Manuscripts should be emailed to Editor at TheNursingVoice@yahoo.com

   a. Manuscripts should include a cover page with the author's name, credentials, present position, address and telephone number. In case of multiple authors, list the names in order in which they should appear.

   b. The *Nursing Voice* reserves one-time publication rights. Articles for reprint will be accepted if accompanied with written permission.

   c. The *Nursing Voice* reserves the right to edit manuscripts to meet style and space limitations.

   d. Manuscripts may be reviewed by the Editorial Staff.

   e. Articles submitted by members' of ANA\C will be given first consideration when there is an availability of space in the newsletter.

2. Photographs should be of clear quality. Write the correct name(s) on the back of each photo. Photographs will be returned if accompanied by a self-addressed, stamped envelope. Mail photographs to: Samantha Hunter, Editor, The Nursing Voice c/o ANA\California, 1121 L Street Suite 409, Sacramento CA 95814. Or email photographs in jpeg format to thenursingvoice@yahoo.com

3. E-mail all narrative to TheNursingVoice@yahoo.com

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The *Nursing Voice* is published quarterly every January, April, July and October and is complimentary to ANA\C members, schools of nursing and their nursing students, affiliates of the association and their memberships. If you would like to submit an article for publication, please see 'Article Submission for The Nursing Voice' in this issue for deadlines and submission details.

If you would like to ***receive this publication*** or you would like to ***stop receiving this publication*** please write or call the ANA\C at (916) 447-0225 or fax to (916) 442-4394. Please leave your full name, complete address or address correction and a phone number should we need to contact you. Or, fill out and mail in the Update Request Form found in this newsletter.

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In June of this year, the American Nurses Association House of Delegates and convention will be in the Washington, D.C. area. Our elected delegates from California will be there, and will bring knowledge from our members and other Nurses as we address the issues at hand, and engage in the business of the association. After we return, we shall include reports and articles about the happenings at the ANA House, to keep California Nurses informed.

Issues: Health Care Reform: continues to be in the news; check the American Nurses Association\California website and the American Nurses Association website: www.nursingworld.org, for the latest information about healthcare reform, health care issues and nursing issues; also a video link to: 'Nurses Have Power: Let's Use It for Change.' Also see on the nursingworld.org link to the "Key Provisions Related to Nursing and Health Care Reform." Nurses continue to be a significant "caring" force in healthcare reform, through their work, community and political involvement at local, state and national levels.

Thank you to our ANA\California Board members who continue to work hard, to promote quality healthcare for the public, participate in healthcare reform and support the Nursing profession.

ANA\California wants to hear from our members about what you more would like to see in the way of programs, outreach, and opportunities for involvement.

Please keep your membership in ANA\C or join if you have not done so. ANA\C is the professional nurses association in California open for all RNs. I encourage you as always to join your professional nursing associations; to join at least two associations: your professional general organization, ANA\California, and your specialty organization; the networking opportunities alone are worth it.

Reminder: ANA\C has 4 officers with clear responsibilities, and four Board Directors, each with a specific focus, i.e., Practice, Education, Legislation and Membership. Board members work together, making for a strong association dedicated to nursing. Nurses can be involved either on committees with the Directors or at least on their mail groups. Some groups have only ANA\C members, others include nonmember nurses; however those who vote must be ANA\C members.

Contact us at ANA\C, about how you would like to be involved in ANA\C activities.

A Future of Nursing Update: Members of ANA\C and other nurses are involved with the California Action Coalition—the Statewide CAC and local groups, continue working together to address nursing's future in California. As mentioned before in the *Nursing Voice,* ANA\California is quite involved on committees and coalitions, and has strong representative leadership in the CACs, regionally and statewide. As the regional Co-Leader for the Los Angeles area, along with Dr. Rosie Curtis, we are working on activities in the L.A. area. Please check our website for updated information, links and opportunities to become active participants. *{Reference: The Future of Nursing: Leading Change, Advancing Health, by the Committee on the Robert Wood Johnson Foundation Initiative on the Future of Nursing, at the Institute of Medicine; (2011)}.*

Other issues: BRN updates; ongoing issues, state and national, continue with Health Care Reform; with bills related to nursing practice, and more. See our website for more information. ANA\C will keep you updated.

Visit the American Nurses Association website: www.nursingworld.org for the latest information about health care issues, healthcare reform and professional nursing issues on a national level. Registered Nurses are a trusted "caring" power in healthcare. Please take advantage of the opportunities to get more involved through work, professional associations and the community—at local, state, national and international levels.

Ongoing national: many healthcare reform issues continue being discussed; including the future of nursing initiatives. I continue vice Chairperson of the Executive Committee of the ANA Constituent Assembly (CA; the group of the Presidents and Executive Directors of all of the states plus a number of other constituents)). I shall share with you any updates on the issues. We have regular calls with the ANA President, and with regional groups.

My continuing appreciation to our current and future members, to our reliable, diligent ANA\California Board members, who give their volunteer time and to staff—who all promote quality healthcare for the public, participate in future of nursing programs, support the nursing profession, ANA\California and ANA.

And thank you to all nurses for what you do. Be kind to each other!

Comments, questions and suggestions are welcome.

"When you learn, teach, when you get, give."
Maya Angelou

***Celebrate National Nurses Week with the ANA**
Every year from May 6 to 12, the ANA celebrates National Nurses Week. The 2012 theme is "Nurses—Advocating, Leading, Caring." ANA offers a full line of products with the new theme and logo that can be purchased throughout the year. Celebrate your nurses by purchasing the official National Nurses Week products at www.nursesweekgifts.com.

Nurses
Advocating, Leading, Caring

25th HIV/AIDS
On the Front Line
April 25, 2012
UC Irvine Student Center (Doheny Room)
Irvine, California 92697
6.5 AMA PRA Category 1 Credit(s)
For more information or to register online, please visit our website at
www.hivconference.org

New Report on the Distribution of APRN Practice Location Zip Codes

The American Nurses Association and the Rural Health Research Center (RHRC) at the University of Washington have issued a report, "Understanding Advanced Practice Registered Nurse Distribution in Urban and Rural Areas of the United States Using National Provider Identifier Data." The study focused on NPs and CRNAs (because there were relatively few CNM and CNS observations.) The study found that in States that granted more practice autonomy, NPs and CRNAs were more likely to practice in rural locations. In addition, male NPs and CRNAs were more likely than females to be in rural locations. Efforts to encourage more men to choose careers as NPs or CRNAs would likely benefit rural communities.

The analysis was conducted using data distilled by ANA from the CMS National Practitioner Identifier (NPI) data to identify the universe of individual APRNs who had been issued an NPI as of March 2010. There were 152,185 individual APRNs in these data. Under contract to ANA the RHRC matched the zip code recorded for the APRN's practice location with a code from the set of rural urban commuting area (RUCA) codes, a location taxonomy that breaks urban-rural distinctions into 33 different categories ranging from urban core areas to isolated rural ones. For both NPs and CRNAs, 15.2% of APRNs had a practice location that was in a rural area. For CRNAs, 7.3% of the rural practices were in isolated rural areas; for NPs the comparable statistic was 16.4%.

The national ratio of rural NPs was 2.8 per 10,000 population compared to the urban ratio of 3.6 NPs per 10,000. At the state level, those states with the highest rural NP per capita ratios were generally found in New England, the Northwest, and the South Central portions of the United States and the lowest ratios in the Southwest, Southeast, and Midwest. The states with the lowest rural NP ratios were Nevada, Utah, and Texas. Those having the highest ratios were New Hampshire and Alaska. Three states (New Hampshire, New Jersey, and Illinois) had the same or greater rural than urban per capita NPs with NPIs.

The national ratio of rural CRNAs was 0.9 per 10,000 population while the urban ratio was 1.2 CRNAs per 10,000. More states with high rural population ratios were found in the Midwest than other regions of the country, and more states in the West and Northeast had low ratios. At the state level, the highest CRNA ratios were in Kansas and New Hampshire. The states with the lowest rural CRNA ratios were California and Indiana.

The study examined the relationship between state and individual-level characteristics and the probability of rural practice location (expressed statistically as "relative risk.") These factors included APRN gender—the only personal characteristic included in the NPI data—and the degree of practice autonomy in the State. For NPs, the autonomy categories were (1) fully autonomous or autonomous with condition, (2) collaboration, and (3) delegation or supervision. For CRNAs, the categories were (1) fully autonomous, (2) collaboration or supervision, and (3) no prescriptive authority. The odds of rural practice were higher for males than females for both roles. With respect to autonomy, rural practice was more likely in States with either of the more autonomous scopes of practice for both roles. This result was statistically significant only for the CRNAs located in the fully autonomous States.

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authority to hire non-sworn officers. The Dental Board has the authority to hire sworn officers. The Business and Professions Committee believed that the authority to hire either should exist for the six boards that can hire investigators. The Board would still have to seek authority from the Department of Personnel and the Department of Finance to hire the positions. The Policy is a good one but the Administration wanted policy issues in a separate bill and to have a hearing on their merits. This language was not part of the BRN and was new policy. The Administration wanted it removed.

The debate over this language was never shared with the Board of Registered Nursing or with the advocates for the bill. Three separate warnings were sent to the author's office that was forwarded to the Department of Consumer Affairs. The first warning was sent in May, the second two weeks before the end of session and the last warning 10 days before the Governor Vetoed the bill. It has been said that no one believed the Administration would Veto a Sunset bill reinstating the BRN because it affected so many nurses.

The Sunset of the Board caused major turmoil in the nursing community. There were a lot of misconceptions about what could happen with Boards when they are sunset. Some of the legislative staff thought the Board would become a Bureau and the role of the Board would be done by the Department of Consumer Affairs. This was not true. On January 1, 2012 the Board went away as technically did the staff. The staff of the BRN was told that their jobs would no longer exist as of January 1, 2012. The Governor intercepted immediately and through his administrative authority, placed the staff under the Department and kept them in place.

At the October, November and December meetings of the Board of Nursing discussed the process and impact of the Board being sunset on January 1, 2012. The Governor's office wanted an MOU in place with the outgoing board that allowed the staff to do the tasks that did not require Board action. This included actions such as minor curriculum changes and continuing the probation and diversion programs. During the transition to the new board, no nurse could be disciplined, no school could be approved, no application with issues could be resolved. California was looking at a year without disciplining a nurse. The MOU was signed in December, 2011.

The Governor's office was committed to re-establishing the Board of Registered Nursing. ANA\C was in constant communication. A major glitch was discovered in the process of writing a bill. The Governor had suggested in his veto message that an urgency bill could be passed in January and the Board could be reinstated. It was discovered that a new department could not be created with an urgency bill. To recreate the board a policy bill would have to be introduced and would not take effect until January 1, 2013.

The Administration's legal department came up with a unique process to reinstate the Board. Since the Board was established in the 2011 – 2012 budget, a trailer bill was introduced to reinstate the Board. The Administration meet with the "Big Five" (leadership from the Assembly and Senate and the Governor) and agreed to language. The language was in print on January 26th and referred to the Assembly Committee on Budget. The language was amended into a Senate Bill that had passed through the Assembly, in 2011, and been held in an Assembly Committee. By doing this, the bill could move faster through the process.

January 31, 2012, a hearing was held. There was a lot of confusion. Members on both sides expressed that they believed the Board functions could be done by the staff. Members on both sides wanted the bill to go to a policy committee (there was no new policy in the bill, it was a pure sunrise bill). There was a great deal of concern expressed by the Republican's about the process. Some questioned whether this was constitutional. The bill was a budget trailer bill long after the budget had been passed and the bill was designed for a majority vote under the new Proposition that had passed. The bill passed out on a partisan vote. SB 98 went to the Assembly Floor.

February 2, 2012, the Assembly floor vote was held on There was a lot of debate about the process listing the constitution concerns and the policy concerns. One member expressed that there was no urgency in passing the Board because a Bureau would exist! Despite the controversy, the bill passed with Democrat and Republican votes.

When the legislature wants to, they can move fast! The bill was sent immediately to the Senate; the Senate enrolled the bill and sent it to the Senate Budget Committee. Immediately, a hearing was held in the Senate Budget Committee. The same issues were raised and ANA\C testified about the Board and the authority that existed without this bill! There was still a lot of confusion. ANA\C had the opportunity to talk with individuals after the Senate Budget Committee and we were able to address the problems that would exist without the bill. Our efforts resulted in no one speaking against the bill on the Senate floor. The bill was sent from the Senate Budget Committee to the floor for an immediate vote and passed out with bipartisan votes!

The bill was immediately sent to the Governor and signed into law on the 14th of February. We are waiting for appointments to the Board to be made. All members must be reappointed and then a Board Meeting held to establish Board officers and committees.

Personal Practice Analysis of DNP

In order to understand the future of nursing, specifically the Doctorate of Nursing Practice (DNP) study, ANA/CA decided to interview someone who is currently in the midst of this study. We chose our ANA/Advocacy Institute grant winner, Candace (Candy) Campbell, MSN-HCSM, RN, who is currently enrolled at the University of San Francisco DNP program in the Clinical Nurse Leadership (CNL) track. Here's what we learned:

ANA/CA: "What in your prior professional life inspired you to take on yet another degree?"

CC: My passion is nursing has been twofold: to advance nursing as a profession, and to improve nursing practice in the areas of maternal-child health.

As a student nurse, I already had earned a B.A. in Speech Communication/Theatre, which was a great help personally and professionally. I served as President of my local chapter of CSNA (then known as SNAC), and on the State Board as Editor of the bi-monthly newspaper, *Range of Motion* for a two-year term. That experience helped establish an interest in nursing public policy, and how it relates to the field of Communication on the local and state level. (Hopefully, nursing students who read this will make it their business to think outside the school, and get involved in statewide nursing issues!)

Scroll ahead several years (after three children were nearly grown), when concerns about the problems nurses face (specifically HMOs. burnout, single parenting, and moral distress) became two one-person shows around the themes of nursing and healthcare. Both creative pieces were attempts to facilitate change by heightening awareness, through art. The first, *Whatever Happened to My Paradigm?* was commissioned by a national nursing association, in 1996. The second, *Full Frontal Nursing: A Comedy With Dark Spots,* was performed for a total of three months in San Francisco, in 1998. This show generated media attention and added to the public debate, which led to several speaking engagements and media appearances to discuss healthcare problems.

Meanwhile, in the mid-90s, on the clinical side, new studies emerged on the behavioral and developmental health of the premature infants we cared for in the NICU. My curiosity was piqued. That curiosity became a five-year qualitative research project around the question: How does a very premature birth impact the family? In 2003, the film *Micropremature Babies: How Low Can You Go?* (based on the research), won an award from the prestigious International Medical Media. The award helped garner educational distribution, and the film found it's way to universities, libraries and individuals on four continents.

Some valuable learning took place during this time, which impacted my nursing philosophy and practice. I realized that, (a) one determined person can actually complete research without a PhD, and (b) achievement within the nursing community is rarely recognized without at least three letters following one's name. With an eye towards more effective implementation of change, I determined to continue my education with a master's in nursing.

In the interim, my practice work led to an administrative post as Program Nurse for the Northern California Region of the state Newborn Hearing Screening Program. I was fortunate to share the experience of building the program from the ground up (literally, as we functioned without furniture for three weeks) with two Audiologists. This was a great experience utilizing the nursing process in a non-clinical environment. I was responsible for the education and certification of 120 hospitals, tracking NICU in-patients in all of Northern CA, and case-managing a portion of the out-patient population. Communication skills proved helpful during these times.

My MSN in Healthcare Systems Management culminated in four months spent under the watchful wings of Myrna Allen, MSN, RN and the Honorable Tricia Hunter, MN, RN, our ANA/CA advocates, in Sacramento. You two helped me learn so much about the political process, healthcare coalitions, and how to advocate for the nursing profession. It was a life-changing experience, and I recommend it to anyone who wants to learn more about healthcare advocacy!

ANA/CA: "Tell us which part of the fundamentals of the DNP caused you to continue your studies?"

CC: Two of the DNP Essential Practice Goals (AACN, 2006), seem particularly relevant to our ANA vision of future practice. They include: *Healthcare Policy for Advocacy in Healthcare,* and *Clinical Prevention and Population Health for Improving the Nation's Health.*

ANA/CA: Would you elaborate on that?

CC: When you think of healthcare policy in general, it sounds like a pretty dry subject. But when you tack on the bit about how healthcare relates to nursing advocacy, it really lit a fire under me.

Our modern world is so complex. In terms of health-related issues, the US budget strains with the weight of carrying an ineffectual national public health policy. There are so many looming socio-behavioral problems, including: infectious diseases, unhealthy behaviors (smoking, obesity, risky sexual practices, etc.), human trafficking, to name a few. Add to the list the elderly population surge (that's many of us!), and we understand that, according to the Government Accounting Office (GAO), increased fiscal requirements "will increase in coming decades as more members of the baby-boom generation retire and become eligible for federal health programs" (GAO, 2011,p.1).

By nature of our training and experience, the DNP prepared nurse already possesses useful skills to help solve problems in the public arena. DNP prepared nurses don't focus on conducting scientific research, but the application of it. We have the ability to analyze health policies from the view of nurses, healthcare stakeholders, and consumer groups (AACN, 2006). We are able to educate, advocate for, and influence decision-makers from the local to the national level. We are also trained to evaluate the efficacy of existing systems of healthcare, and to recognize and work to resolve ethical and legal issues that arise (AACN, 2006.)

Ask yourself: Who already enjoys the highest public trust? *Nurses.* Which has been voted the most ethical of all professions for nine consecutive years? *Nursing* (Gallop polls, 2011). In fact, since legislators and lobbyists once tied for last place position in the most ethical category (along with used car salesmen), nurses are in a superior position to be actively involved in political endeavors at every level. The DNP educated nurse possesses a "commitment to political activism and public policy development" (Ehrenreich, 2002, p. xxxiii). That sounds like just what so many of us are looking for. We need to utilize these same key ingredients of professional nursing practice within the political sector for the public good, and the DNP study helps us obtain the skills to achieve those goals.

ANA/CA: And the second point?

CC: In the public arena, DNP graduates are trained to unpack problems and analyze trends, and utilize information from epidemiology, biostatistics, occupational, environmental health, you name it (AACN, 2006). We bring value by communicating closely with the common person, as well as the bigger players. This ability to bridge two worlds qualifies us to develop programs, and to evaluate the results. Our unique positioning allows us an integrated view of possible solutions within the arena of public health that focuses on preventative teaching, and holistic management of chronic illness here, and abroad. The opportunities are limitless.

We've all heard of the studies which indicate that patient outcomes and satisfaction with DNP nurses is statistically the same as the satisfaction with care given by medical doctors (Elwell & White, 2011; Kuehn, 2009). This is really a green-light for nurses. Doctorally prepared nurses are well-suited to open their own businesses, including clinics, and provide a level of primary health service. Our advanced practice status is applicable to remote/isolated settings (Kuehn, 2009) where medical doctors are scarce, as well as in urban areas, where client needs overwhelm the supply of medical doctors (Elwell & White, 2011).

ANA/CA: So where do you see yourself in 5 years?

CC: Of course, I'm not sure about that, but as a probationary doctoral student, I have already received offers for advancement. The first was the opportunity to teach master's level students at USF, to which I gladly agreed. (I love teaching. For me, it seems like the perfect combination of Theatre and Nursing.) Another was the grant given me by the ANA/Advocacy Institute, to be under the tutelage of nurse-policy experts in Washington D.C. for a year. This has been such fun and so invigorating! What a responsibility, to advocate on the national level for nurses. I am honored and humbled by this ongoing experience.

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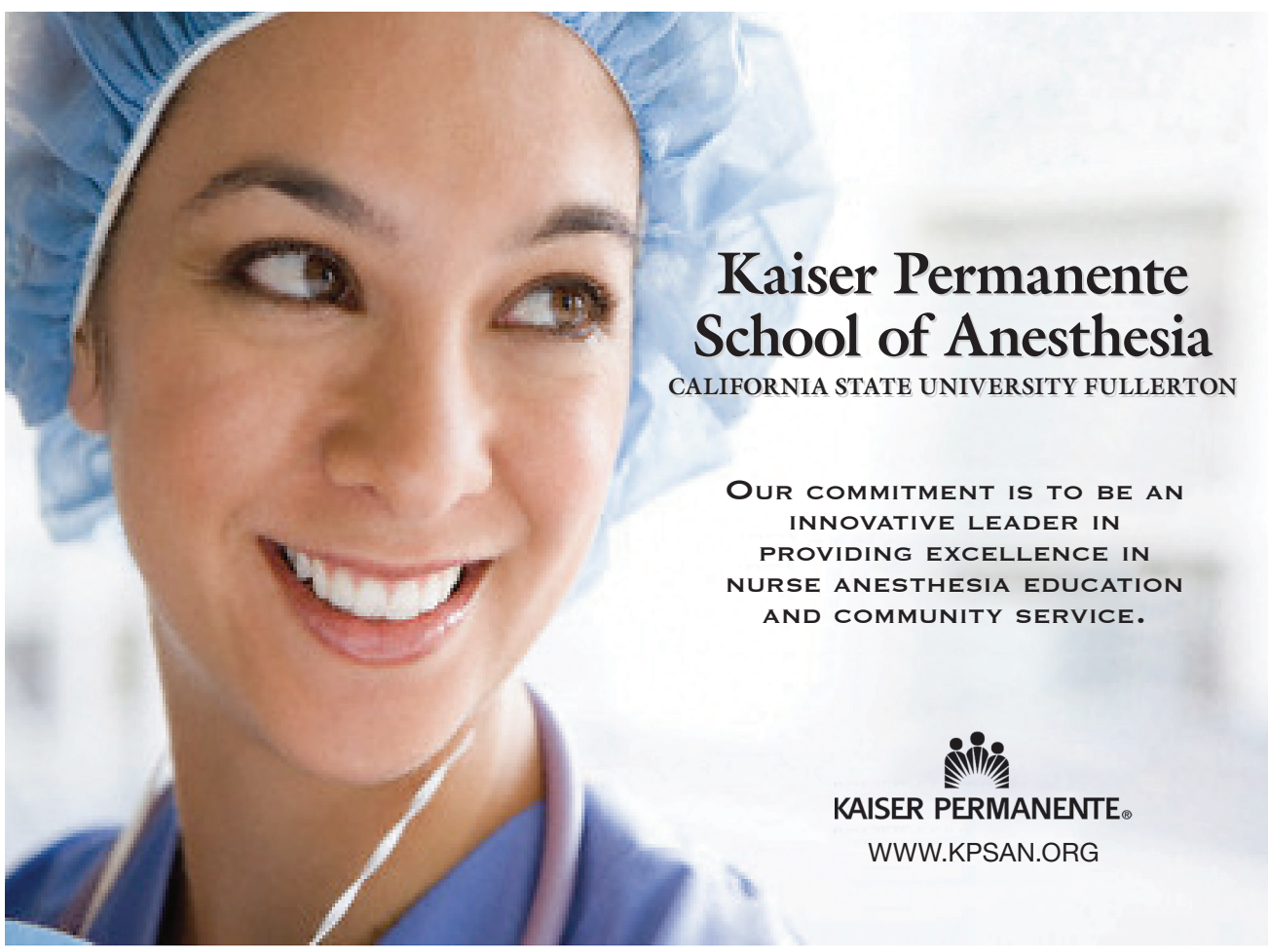

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In less than five years, I may apply for a gubernatorial appointment. And there's also the possibly of running for public office. We'll see. Although advanced education is not a pre-requisite for those positions, I want to complete the degree first. One thing is for sure: There are so many opportunities for nurses to help mold public policy, (It is worth mentioning that presently, we have a CA legislature with elected representatives, which includes no nurses. Considering California registered nurses number > 300,000, we could easily elect nurse-candidates, if more nurses would run for office!)

Clinically, my dream of opening a women and children's health clinic was the catalyst for my entrance into a doctoral program. In five years, I hope to be helping other nurses open similar clinics.

All in all, despite the grueling work/study schedule, I feel blessed beyond measure to be in the DNP program, and am eager to absorb as much as possible. I want to encourage other nurses who are also over age 50 to consider the DNP, because they understand the concept of *finishing well by making a difference.* This has become very important to me. I feel guided by the spiritual concept of serving humanity in every possible endeavor. This was the mission to which Florence Nightingale called nurses (Christian Heroes, 2011).

Simply put, the DNP will help us help more people.

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Reliving the Legacy of Margaret Sanger, RN

Angela Schwab, BSN, PHN, RN

Presidential election years are extremely crucial to our democratic form of government. They are an opportunity for Americans to speak their voice about the direction the country should move regarding the most important topics. Stump speeches shape our discourse as individuals begin to align themselves with candidate views. Our political system occasionally leads to division, yet the change all parties call for requires compromise. For example, the healthcare debate has become increasingly corrosive to the relationships between policy makers, health care providers, and patients. Nurses, who make up over seventy percent of the healthcare workforce, should feel compelled to keep current with government platforms and pitched policies. Navigating this political time of change leaves nurses watchful of how government officials will implement change, in healthcare, while upholding the integrity of nursing.

Nurses have been at the forefront of political change since Margaret Sanger's fight for women's health occurred a century ago. She was a nurse who stepped up in an era of paternalism and fought for the public health of the world by making sure women had reproductive and personal health choices. Her impact led to political change and gave women the right to take control over their own healthcare through the commencement of Planned Parenthood. She brought about education and changed the ways nurses counseled patients on what some deemed controversial women's health issues such as birth control, pregnancy, abortion, and sexually transmitted diseases. She had an enormous impact on women's ability to control their own healthcare. Thanks to Sanger's defining actions, nurses today know that it would be extremely negligent to recommend the rhythm method of birth control to a breastfeeding mother, or any woman for that matter. It is hard to imagine a day when nurses had to contemplate potential legal ramifications if they distributed educational materials or contraceptives. Planned Parenthood gave nurses and women an opportunity to seek counsel, educational materials, contraceptives, and sensitive procedures that previously carried the treat of the law.

As someone who has been on both sides of the nurse patient relationship, I am extremely thankful that as a nurse I can educate my patients and assist them with the implementation of their healthcare decisions. As a patient, I am beyond appreciative that at the end of the day I have the ability to make the decisions about my body autonomously.

Undeniably, Margaret Sanger's legacy inspires the nurses of today to stay strong in their battles to protect the integrity of healthcare. It is truly unfortunate that healthcare and patient's rights remain in debate. I believe that nurses have an important opportunity this year to make sure our voices are heard. More people are watching and participating in the discourse, and we need to be part of the conversation. The dedicated nursing community has worked too hard educating our patients to take responsibility for their health to allow Planned Parenthood to come under attack. Defunding an organization like Planned Parenthood is more than a political statement it is a direct attack on the autonomy of women, and the importance of listening to nurses not the least of which is Sanger. Every day nurses hold the hands of women suffering through heart disease, breast cancer, gynecologic issues, fertility issues, to name a few. Nurses understand that women's health requires different assessment skills. Sadly, this truth gets lost in the current political debate.

Instead of putting the protection of healthcare at the center of the table, money has become the driving force of politics. It is unfortunate that power and money from a few are impacting legislation in an unproportionate way. Lobbying does not need to be a scandalous affair. It can impact change that greatly affects nurses at the bedside. In order for nurses to make this kind of impact we must join together and make sure our voice is not ignored. ANA\C is working hard and fighting to make sure the knowledge of nursing is not disregarded. We are not "just nurses," we are the men and women that (among other things) educate the public on health and wellness. We are fighting to make sure patient's rights are upheld. There is a reason we are the most trusted profession, and have been for quite some time. That is because the voices of our profession speak the truth.

Important changes should be about numbers and knowledge, not money that comes from few large donors. Representing seventy percent of the healthcare workforce, nurses as a group are united, knowledgeable, and are becoming a voice in this political time. We urge nurses to join ANA\C so that in unity we can protect what Margaret Sanger put in place. Now is the time to make sure that as change begins nurses are at the table with a voice. Together, we can assure that the future of health care is based on policy not politics. Heath care is changing and nurses should be guiding the discussion.

How Value-Based Purchasing is Changing Nursing

Rebecca Hendren, for HealthLeaders Media, June 14, 2011

The advent of value-based purchasing has thrown everyone into a mad scramble. You can't stand in a group of nurse executives without hearing someone ask about how others are improving their patient satisfaction or sharing notes about HCAHPS scores.

"Value-based purchasing is a game changer," says Lillee Gelinas, MSN, RN, FAAN, vice president and chief nursing officer at VHA Inc.

On a long-term scale, it has everyone wondering how on earth they will achieve so much—from improved patient experience to sustainable quality outcomes—in such a short time. As hospitals plan how to best operate in this new world, it's worthwhile taking the time to reevaluate who should be working on what.

Gelinas recently presided over a meeting of 100 VHA CNOs and says it was one of the most successful CNO meetings VHA has ever held because rather than focusing on a specific topic, such as value-based purchasing, the group focused on innovation and how to develop strategies that will help organizations achieve transformation.

One of the meeting's "A-ha!" moments came when speaker Tim Porter-O'Grady shared a conversation he had with a CEO. The CEO was talking about his passion for patient care and how he was working on improving it. Porter-O'Grady responded that CEOs should not be concerned with things with which they have no competency.

The importance of organizations ensuring proper role delineation struck a chord with the CNOs. Gelinas says it's important that people who are competent to do so are responsible for the right things. The c-suite should be responsible for the context of care, whereas direct caregivers must be responsible for the content of care. Confusion over these two things only results in inertia and everyone trying to do everything.

"The context of the organization is owned by the c-suite. You (CNO) are responsible for the context of care, meaning the environment, the culture, the behavioral standards, the organizational values," says Gelinas. "The content of care is owned by the caregivers. When it comes to transforming care at the bedside, taking waste out of work, that's what caregivers have to do and that's the content of care."

Gelinas equates c-suite involvement in provision of care decisions as akin to a radiologist trying to do heart surgery. What is far more important is that leaders devote their energies to leadership, cultural transformation, ensuring the organization enforces standards of behavior and codes of conduct, and that the values of the organization are in alignment with its mission.

"The hammer has fallen," says Gelinas. "First we had the tsunami of value-based purchasing and the realization we have to have whole-scale transformation to be successful. After that comes awareness. Now, what is the work that has to be done and where do we start?"

In the old days, if a nursing unit noted its rate of ventilator-associated pneumonia (VAP) was above average, it would start a quality improvement project. The traditional process would involve convening a team, figuring out a strategy, and implementing some tests of the changes. As rates improved, the hospital would celebrate, figure out how to maintain the improvements, and then move on to the next quality improvement project.

"It used to be that we could focus on quality improvement and if we got to a point where we had a 3% reduction in VAP we would be so happy," says Gelinas. "Now with value-based purchasing that's not good enough. Now it's about whole-scale transformation, not incremental improvement, and this difference is what has everyone's attention. Where do we start when we know the game's changed?"

As hospitals scramble to improve HCAHPS and quality outcomes all areas of the hospital are involved. Determining who should be responsible for what is a good first step.

Rebecca Hendren is an editor with HealthLeaders Media. She can be reached at rhendren@hcpro.com.

In the News....

Pathway to Excellence
ANA/C wishes to congratulate Anaheim Memorial Hospital, Anaheim California has been awarded the Pathway to Excellence Designation.

ANA/C wishes to congratulate Tahoe Forest Hospital, Lake Tahoe, California has been awarded the Pathway to Excellence Designation.

Magnet Status
ANA/C wishes to congratulate Washington Hospital, Fremont, California has received Magnet Status

ANA/C wishes to congratulate St Joseph Hospital of Orange, California has received Magnet Status

ANA/C wishes to congratulate Torrance Medical Center, Torrance California

WASC Accreditation
ANA/C wishes to congratulate West Coast University for achieving regional accreditation from the Accrediting Commission for Senior Colleges and Universities of the Western Association of Schools and Colleges (ACSCU/WASC).

Members
IOM committee member Linda Burnes Bolton, RN, DrPH, FAAN, vice president for nursing, CNO and director of nursing research at Cedars-Sinai Medical Center in Los Angeles, has been elected to the Robert Wood Johnson Foundation's board of trustees. She joins a diverse group of 13 other board members in leading the nation's largest philanthropy devoted exclusively to improving the health and health care of all Americans. Since serving as Vice Chair of the IOM committee that issued *The Future of Nursing: Leading Change, Advancing Health,* Dr. Burnes Bolton has continued as a *Campaign for Action* leader, serving on the campaign's Strategic Advisory Committee, actively engaging in the work of the California Action Coalition, and continuously speaking on behalf of the campaign to state and national leaders across the country.

Dr. Elizabeth Dietz, ANA\C Vice President and ANA Board Member announced that she is running for the Board of ANA this June at the ANA House of Delegates in Washington, D.C.

ANA and NCSBN Unite to Provide Guidelines on Social Media and Networking for Nurses

Chicago—The American Nurses Association (ANA) and the National Council of State Boards of Nursing (NCSBN®) have mutually endorsed each organization's guidelines for upholding professional boundaries in a social networking environment.

The use of social media and other electronic communication is expanding exponentially; the latest statistics indicate that there are 150 million U.S. Facebook accounts and Twitter processes more than 250 million tweets worldwide on a daily basis. Social networking can be a positive tool that fosters professional connections, enriches a nurse's knowledge base, and promotes timely communication with patients and family members. ANA and NCSBN caution nurses that they need to be aware of the potential consequences of disclosing patient-related information via social media and mindful of employer policies, relevant state and federal laws, and professional standards regarding patient privacy and confidentiality.

"Nurses must recognize that it is paramount that they maintain patient privacy and confidentiality at all times, regardless of the mechanism that is being used to transmit the message, be it social networking or a simple conversation. As licensed professionals they are legally bound to maintain the appropriate boundaries and treat patients with dignity and respect," comments NCSBN Board of Directors President Myra A. Broadway, JD, MS, RN, executive director, Maine State Board of Nursing.

ANA is conducting a social media webinar, **"Nursing Guidelines for Using Social Media,"** on Oct. 25 featuring Nancy Spector, PhD, RN, director, Regulatory Innovations, NCSBN and Jennifer Mensik, PhD, RN, NEA-BC, ANA board member and administrator for Nursing and Patient Care Services at St. Luke's Health System in Boise, Idaho.

"Social Media can be a powerful tool, one with the potential to enhance or undermine not only the individual nurse's career, but also the nursing profession," said ANA President Karen A. Daley, PhD, MPH, RN, FAAN. "ANA hopes these principles provide a framework for all nurses to maintain professional standards in a world where communication is ever changing."

ANA's e-publication, "ANA's Principles for Social Networking and the Nurse," provides guidance to registered nurses on using social networking media in a way that protects patients' privacy, confidentiality and inherent dignity. This publication is available as a downloadable, searchable PDF, which is compatible with most e-readers. It is free to ANA members on the Members-Only Section of www.nursingworld.org; non-members may order the publication at www.nursesbooks.org. ANA also provides additional resources at its **Social Networking Principles Toolkit page**.

NCSBN's white paper "A Nurse's Guide to the Use of Social Media" can be downloaded free of charge at https://www.ncsbn.org/Social_Media.pdf. NCSBN is also developing electronic and hard copy versions of a brochure for nurses and nursing students that details professional standards regarding patient privacy and confidentiality in social networking. A YouTube video on social media is also being produced. Both products will be available in late November 2011 and will be accessible via www.ncsbn.org free of charge.

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

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Silver Spring, MD 20910-3492
301.628.5000
www.nursingworld.org

The National Council of State Boards of Nursing (NCSBN) is a not-for-profit organization whose members include the boards of nursing in the 50 states, the District of Columbia and four U.S. territories—American Samoa, Guam, Northern Mariana Islands and the Virgin Islands. There are also nine associate members. Mission: NCSBN provides education, service and research through collaborative leadership to promote evidence-based regulatory excellence for patient safety and public protection.

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111 E. Wacker Drive, Suite 2900
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National Health Expenditures 2010

On January 9, 2012, the journal *Health Affairs* published the CMS annual report on national health expenditures: *"Growth In US Health Spending Remained Slow In 2010; Health Share Of Gross Domestic Product Was Unchanged From 2009,"* by A.B. Martin, D. Lassman, B. Washington, A. Catlan, and the National Health Expenditure Accounts Team.

http://content.healthaffairs.org/content/31/1/208.full

"U.S. health care spending grew 3.9 percent in 2010 following record slow growth of 3.8 percent in 2009; the two slowest rates of growth in the fifty-one year history of the National Health Expenditure Accounts. Total health expenditures reached $2.6 trillion, which translates to $8,402 per person or 17.9 percent of the nation's Gross Domestic Product (GDP)."

The report, as always, goes into a great deal of detail with respect to different types of health care services, sources of funds, differences in spending between government programs and privately insured health coverage, etc. However, the data with respect to 2010 for the most part were unremarkable compared to the prior year and the year before that. Growth continued; expenditures increased. In some cases growth had accelerated from the prior year; other cases exhibited deceleration. In no case reported in the CMS highlights did any expenditure category exhibit absolutely lower expenditures.

The U.S. from 2007-2010 appears to be in somewhat of a steady state. On average national, health expenditures have increased by roughly $100 million per year. Per capita national health expenditures increased by $258 per year. The initial part of this century's first decade exhibited somewhat higher increases: $134 million per year and approximately $400 per year, respectively.

Of potential interest to RNs and APRNs, hospital expenditures continued to increase although at a lower rate than observed in 2009. This was also the case with physician offices, home health care, and nursing facilities—all areas with high numbers of employed RNs. Independent APRN services are not separately identified in the report. APRN services are included in a category called "Other Professional Services." The CMS quick definition of that category lists "private-duty nurses," but it also includes the North American Industry Classification System group, 6213 Offices of Other Health Practitioners. That's where any expenditures for APRNs would be, but the Commerce Department doesn't disaggregate the myriad separate "other" health practitioners operating in this country. The grand total for 2010 in this category was $68,357,400,000. On Medicare Part B approved charges alone, APRNs contributed $2,173,641,846, or three percent of the that total. Private insurance and Medicaid reimbursements to APRNs would increase that percentage but the actual amounts are unknown.

Membership and Communication

American Nurses Association \ California
Membership Application

Last Name/First Name/Middle Initial | Credentials | Date of Application

Mailing Address | Apt. / Unit Number | Home Phone Number

City / State | Postal Code 'Zip' | Home Fax Number

Basic School of Nursing | Year Graduated | License Number / State

Employer Name | Business Phone

Title/Building/Department | Business Fax

Address | Postal Code

Employer City / State | E-mail Address

Referred By:

MEMBERSHIP DUES VARY BY STATE

Membership Category (Check one)

M Full Membership Dues–$255
- ❍ **Employed–Full Time**
- ❍ **Employed–Part Time**

R Reduced Membership Dues–$127.50
- ❍ Not Employed
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- ❍ New graduate from basic nursing education program, within six months after graduation (first membership year only)
  Grad. Date _____
- ❍ 62 years of age or over and not earning more than Social Security allows

S Special Membership Dues–$63.75
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Note:
$7.50 of the SNA member dues is for subscription to *The American Nurse*. A percentage of your dues may or may not be applied to an SNA/DNA subscription. State nurses association dues are not deductible as charitable contributions for tax purposes, but may be deductible as a business expense. However, that percentage of dues used for lobbying by the SNA is not deductible as a business expense. Please check with your SNA for the correct amount.

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This is to authorize ANA to withdraw 1/12 of my annual dues and any additional service fees from my checking account designated by the enclosed check for the first month's payment. ANA is authorized to change the amount by giving the undersigned thirty (30) days written notice. The undersigned may cancel this authorization upon receipt by ANA of written notification of termination twenty (20) days prior to the deduction date as designated above. ANA will charge a $5.00 fee for any return drafts.

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