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Nevada RNFORMATION

THE OFFICIAL PUBLICATION OF THE NEVADA NURSES ASSOCIATION
The Nevada Nurses Association is a constituent member of the American Nurses Association
Quarterly publication direct mailed to approximately 1,000 RNs and LPNs and delivered electronically via email to 40,000 RNs and LPNs in Nevada

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Inside

articles

regular features

The President's Message

Mary Bondmass, Ph.D., RN, CNE
President, Nevada Nurses Association
Mary.bondmass@unlv.edu

Happy New Year Colleagues, and welcome to 2020!! I hope everyone has sufficiently recouped from the fun but frequently hectic holiday season.

Rather than reflect on NNA's past year, which I briefly covered in the November issue, I would like to address the coming year and talk a bit about the process and upcoming plans for your NNA. As long as the weather cooperates, the entire Board of Directors will meet in Reno in February for a retreat to strategically chart the course for NNA in 2020. Since most Board members serve as the liaison to one or more of the various NNA committees, a report from each respective committee's 2019 activities and accomplishments will be given. Additionally, we collectively work on our budget for the coming year and brainstorm to set goals that we would like to see accomplished for and by the organization in 2020.

While I can't speak for my colleagues regarding their thoughts on the 2020 NNA goals, I can speak to mine. One goal that I would like to share with you and personally drive in 2020 is our educational endeavor for nurses in Nevada. Over the year, I would like to see the development of an entire online curriculum of continuing education (CE) offerings that would be free to NNA members as a member benefit and offered at a minimal fee for NV nurses who are not NNA members. The NNA already has the technology needed, and we have the expertise among NV nurses to achieve this goal relatively easily. Don't be surprised, Colleague, if I call upon some of you to contribute that expertise in the form of a CE offering. I envision a list of our CE offering to be easily accessible from the NNA website and to be in one-hour online segments – similar to what we have now, just expanded more broadly. If you have some ideas for CEs or you would like to present something in a CE format, I hope you will contact me; my email is mary.bondmass@unlv.edu.

In closing colleagues, I applaud all of you who have completed some form of professional progression in 2019, and I encourage others to think of your educational advancement, either through CEs, professional progression, and or certification in 2020. As nurses, I feel like we owe it to the citizens of Nevada to provide them with the most educated workforce possible.

Best regards to all for a happy and healthy new year!

Mary D Bondmass

Mark Your Calendars

- January is National Radon Action Month in Nevada
- February is National Heart Health Month
- Saturday, March 28, 2020 - 6th annual Wild West: Tea on the Comstock Big Hat High Tea at the Governor's Mansion.
- April is National Donate Life Month (visit NVDonor.org)

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Four Nevada Nurses were Inducted as Fellows in the American Academy of Nursing

On October 26, 2019 in Washington DC, four distinguished nurses from Nevada were inducted as Fellows in the prestigious American Academy of Nursing (Academy). These included:

June Cho, PhD, RN, FAAN
Faculty, University of Nevada Las Vegas

Elizabeth Fildes, EdD, RN, CNE, CARN-AP, PHNA-BC, FIAAN, FAAN
Faculty, Chamberlain University

Linda Anne Silvestri, PhD, RN, FAAN
Faculty, University of Nevada Las Vegas

Rhigel Alforque Tan, DNP, RN, APRN, GNP, ANP, PMHNP, FAAN
Faculty University of Nevada Las Vegas

The Academy serves the public and the nursing profession by advancing health policy, practice, and science through organizational excellence and effective nursing leadership. The Academy and its more than 2,700 members, known as Fellows, create and execute knowledge-driving and policy-related initiates to drive reform of America's health system.

Academy Fellows are nursing's most accomplished leaders in education, management, practice, and research. Fellows include association executives; university presidents, chancellors, and deans; state and federal political appointees; hospital chief executives and vice presidents for nursing; nurse consultants; researchers; and entrepreneurs.

Fellows have been recognized for their extraordinary nursing careers and are among the nation's most highly-educated citizens: more than 90% hold doctoral degrees and the rest have completed masters programs.

The above information about the Academy is verbatim from their website: https://www.aannet.org/about/about-the-academy

June Cho

Elizabeth Fildes

Linda Anne Silvestri

Rhigel Alforque (Jay) Tan

NNA Mission Statement

The Nevada Nurses Association promotes professional nursing practice through continuing education, community service, nursing leadership, and legislative activities to advocate for improved health and high quality health care for citizens of Nevada.

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APRNS AND HOME HEALTH ORDERS

There has been some confusion over the recently passed Nevada law regarding APRNs and Home Health Orders. The Nevada Division of Public and Behavioral Health's website includes the following information, *"A new Nevada law allows licensed physician assistants (PA) and licensed advanced practice registered nurses (APRN) to order home health care for a patient. This law took effect July 1, 2019. Although state law now allows a PA and APRN to order home health, if your home health agency is certified by the Centers for Medicare and Medicaid Services (CMS), it is important to be aware of the federal regulations governing home health agencies, including Code of Federal Regulation (CFR) 484.60(b)(1) which notes: "Drugs, services, and treatments are administered only as ordered by a physician."*

While Nevada passed a law giving APRNs this approval, federal regulations were not revised. (CFR as stated in the above paragraph, "… only as ordered by a physician.") Therefore, for home health agencies licensed by the state and certified by CMS, APRNs cannot order home health services.

However, for home health agencies licensed by the state, but not certified by CMS, APRNs can order home health services.

Additional information is located at http://dpbh.nv.gov/Reg/HealthFacilities/HCQC-Blog/, or you can contact Carol Eastburg, RN, at the Bureau of Health Care Quality and Compliance.

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over the nation in five main areas of health:

- Physical Activity
- Rest
- Nutrition
- Quality of Life
- Safety

HNHN provides an interactive web platform that allows participants to engage in conversation, inspire action, join challenges, find resources and education, take a free health-risk appraisal survey, and make a commitment to move toward a healthier life. Already in two short years, over 117,000 people have joined and are participating. On the physical activity domain, 46% of nurses completing the survey reported not participating in any type of weekly aerobic workout, while 47% reported no weekly muscle-strengthening exercise (American Nurse Today, 2019). The Move More, Move 4 a Cause, and Renew Mind and Body challenges, helped make physical activity the most popular domain. Quality of Life challenges included Get Your Gratitude On, Stress Less, and Bringing in the Joy. Organizations and hospitals can also get involved as was demonstrated when the Medical University of South Carolina tripled its nursing staff's consumption of fruits and vegetables through a Nutrition platform challenge. The Safety platform has a broad focus from safety issues in the workplace to no texting while driving, and the Rest platform focuses on assisting nurses in getting the sleep they need.

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American Nurse Today. (2019). Year in review. *American Nurse Today, 14*(9), 62-70.

Jones, J., & Saad, L. (Eds.). (2018). *American's Ratings of the Honesty and Ethical Standards of Professions, 2018* (Timberline: 937008). Retrieved from Gallup News website: https://news.gallup.com/poll/245612/americans-ratings-honesty-ethical-standards-professions-2018-trends.aspx

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June Cho *Elizabeth Fildes* *Linda Anne Silvestri* *Rhigel Alforque (Jay) Tan*

Please send it in a Word document to us at lbowman@nvnurses.org. Our Editorial Board will review the article and notify you whether it has been accepted for publication.

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Healthy Nurse Healthy Nation

Christa Secord, MSN, FNP-BC, Director at Large, Nevada Nurses Association

Once again, for the 17th year straight, nursing was ranked the most trusted profession by the annual Gallup Honesty and Ethical Standards poll (Jones & Saad, 2018). As nurses, we are known for putting our patients, families, and friend's needs at the top of the priority list and our own somewhere towards the bottom. In the 2018 HealthNurse survey, 70% of participants either agreed or strongly agreed with the statement, "I put my patient's health, safety, and wellness before my own" (American Nurse Today, 2019, p. 66). American Nurses Association (ANA) recognized the need for nurses to prioritize their own health, and by doing so, improving the health of our entire nation. In pursuit of this incredible goal, ANA Enterprise launched Healthy Nurse, Healthy Nation (HNHN) on May 1, 2017.

By improving the health, safety, and wellness of the over 4 million US nurses, CNAs, and nursing students, the initiative seeks improvement of nurses as health role models, advocates, and educators (American Nurse Today, 2019). HNHN aims to connect nurses from all over the nation in five main areas of health:

- Physical Activity
- Rest
- Nutrition
- Quality of Life
- Safety

HNHN provides an interactive web platform that allows participants to engage in conversation, inspire action, join challenges, find resources and education, take a free health-risk appraisal survey, and make a commitment to move toward a healthier life. Already in two short years, over 117,000 people have joined and are participating. On the physical activity domain, 46% of nurses completing the survey reported not participating in any type of weekly aerobic workout, while 47% reported no weekly muscle-strengthening exercise (American Nurse Today, 2019). The Move More, Move 4 a Cause, and Renew Mind and Body challenges, helped make physical activity the most popular domain. Quality of Life challenges included Get Your Gratitude On, Stress Less, and Bringing in the Joy. Organizations and hospitals can also get involved as was demonstrated when the Medical University of South Carolina tripled its nursing staff's consumption of fruits and vegetables through a Nutrition platform challenge. The Safety platform has a broad focus from safety issues in the workplace to no texting while driving, and the Rest platform focuses on assisting nurses in getting the sleep they need.

Although created with nurses in mind, the HNHN platform is open for anyone to join. Check it out at hnhn.org or text healthynurse to 52-886. Take the free health survey and start a new health journey in one or several areas of interest along with nurses from around the nation. HNHN can be accessed through social media platforms:

Twitter: @HeathlyNurseUSA
Instagram: HealthyNurse
Pinterest: HealthNurse
Facebook: Healthy Nurse, Healthy Nation

The Nevada Nurses Association (NNA), has initiated a Healthy Nurse, Healthy Nation committee with a primary objective to mirror the national challenge of improving the health of nurses across the state through education. We have started monthly health educational classes for anyone interested. Each class will last approximately 30 mins, followed by a short HNHN committee meeting, and FREE nursing CEUs for the educational portion will be provided. The classes are presented by fellow nurses and will be held on the second Tuesday of the month at 12 noon. Please plan to attend, and please join us and get involved with this important committee. If you have a health topic you would like to present, or if you have any questions, please contact Christa Secord at cjsecord@gmail.com or Linda Bowman at lbowman@nvnurses.org.

References
American Nurse Today. (2019). Year in review. *American Nurse Today, 14*(9), 62-70.
Jones, J., & Saad, L. (Eds.). (2018). *American's Ratings of the Honesty and Ethical Standards of Professions, 2018* (Timberline: 937008). Retrieved from Gallup News website: https://news.gallup.com/poll/245612/americans-ratings-honesty-ethical-standards-professions-2018-trends.aspx

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Sometimes you will inspire your patients; more often, they will inspire you.
– Florence Nightingale

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NNA Environmental Health Committee

Minerals used in Healthcare

Bernadette M. Longo, Ph.D., RN, APHN-BC, CNL, FAAN, Chair, NNA's Environmental Health Committee

Every day we depend upon the products of mining. Some of those products are familiar like the steel in vehicles that we ride in to get to the clinic or hospital, the lithium batteries in our cellular phones, or the cement and steel construction of the buildings where we practice, even the metal in our stethoscope. All are made from rock-based materials mostly in the form of minerals that are extracted from the Earth. Minerals form naturally and are solid inorganic compounds made from combining various elements. Minerals also have a consistent chemical composition, hardness, and a unique crystalline structure. In addition, some metals are also elements and are found in native form such as gold, silver and copper.

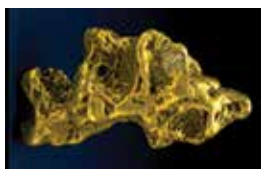
Many minerals are used in the delivery of healthcare. Halite is commonly used in healthcare and at the dinner table, but we don't think of it as a mineral. We know it as salt (sodium chloride) that is dissolved in the familiar IV fluid called *normal saline*, which is a solution at 0.9% concentration. Another is gypsum ($CaSO4 \bullet 2H2O$), a soft mineral mined in Nevada, and is commonly used in the material for orthopedic casts.

Mining is a major industry that contributes to our state's economy. The minerals mined in Nevada are classified into two main categories: (a) Metal Minerals such as native gold, silver, copper sulfides and molybdenite, and (b) Industrial Minerals such as barite, gypsum, limestone, quartz (silica sand), lithium compounds, and perlite. Many of these minerals are used in medical treatments and devices to delivery state-of-the-art healthcare (Table 1).

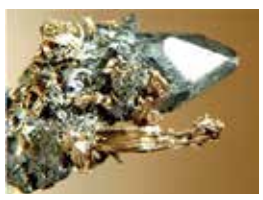
References & Resources
Minerals Education Coalition. Available at: https://mineralseducationcoalition.org/
Mining Matters Organization, the publication "Medicine from the Ground Up." Available at: https://miningmatters.ca/
Smithsonian National Museum of Natural History. Research and Collections' Geogallery. Available at: https://geogallery.si.edu/gems-minerals-meteorites-rocks
State of Nevada Division of Minerals. Resources available at: http://minerals.nv.gov/

Minerals & Elements used in Healthcare

I. Medical Treatments



Gold:
used in dental fillings, gold nanoparticles, cancer drugs & historically rheumatoid arthritis drugs



Silver:
anti-bacterial properties, added to bandages, wound dressings, catheters, and creams

Gypsum:
used in orthopedic casts

Lithium:
used as medication for treatment of bipolar disorder

Sulphur:
used in medications to treat various skin diseases, arthritis, and various infections

Platinum compounds:
used in medicines to target cancer cells

Bismuth:
the common ingredient in medicine to calm upset stomachs

Mercury:
used in dental amalgam, sphygmomanometers and thermometers

II. Diagnostics & Devices

Barium:
X-ray contrast used for screening gastrointestinal tract

Manganese:
an MRI contrasting agent

Iron:
an MRI contrasting agent

Cesium compounds:
Used to separate DNA in biomedical research

Copper:
Used in X-ray machines

Lead:
Used to shield workers from x-rays

Molybdenum:
Used in CAT scanners

Holmium:
A rare earth element used in solid-state lasers

Titanium:
used in orthopedic implants

Photo credits: The Smithsonian Institution, Minerals Education Coalition, and Mindat.org

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What was Your Inspiration to Become a Nurse?

What you see is what you get - Where do we go from here?

RNF is starting a new column, "What Was Your Inspiration to Become a Nurse?" It will include inspiring stories from nurses. Was there a person or an event that inspired you to become a nurse? Below is the first inspirational story in this series and I think you will really enjoy it. If you have a story you'd like to share, please contact Linda Bowman at Lbowman@nvnurses.org.

By Norman Wright, RN, BSN, MS

To **inspire** is to fill someone with confidence and desire to do something: As we enter a new decade, RNformation is adding a new column on inspiration that invites you, the readers, to write your stories of inspiration. Here is one of mine:

After graduating with my BSN in 1979 my first RN job was a public health nurse in New Jersey. My case load included a 22-year-old quadriplegic named Louie.

Louie got drunk and thought it would be a good idea to dive, head first, into a shallow brook. Even though Louie became a quadriplegic only a few years earlier he was severely depressed, which I tried to alleviate by talking with him while dressing decubiti. His three pressure ulcers went down to the bone, each the diameter of a large orange. While caring for Louie I vowed - if ever I met a quadriplegic who still had hope - I would do all in my power to prevent Louie's path to destruction. In a strange way Louie was the inspiration to what followed:

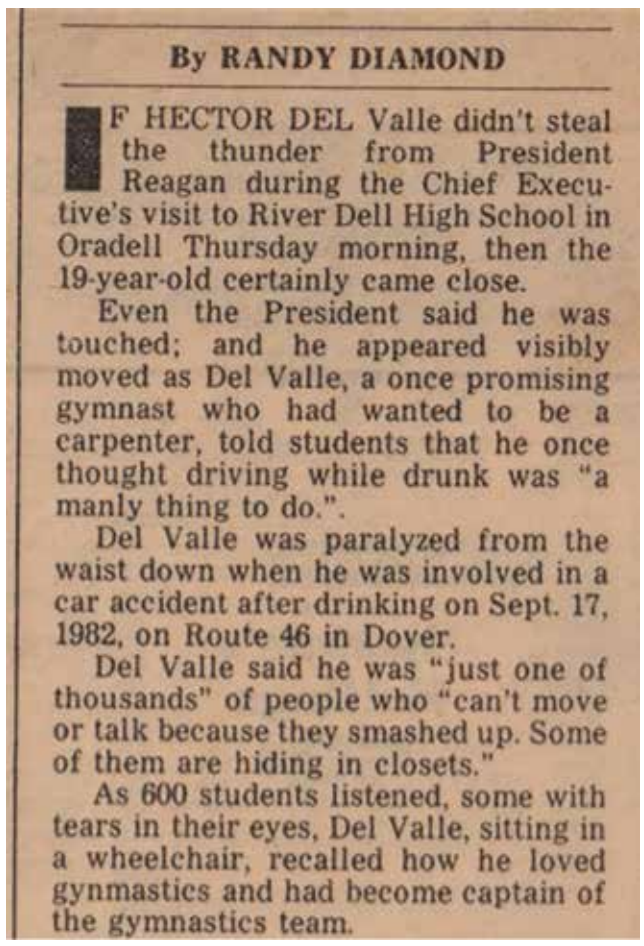
I left public health nursing, becoming a Rehabilitation Coordinator for auto insurance companies. In addition to advocating for the best medical treatment the job also involved vocational modification. In October 1982 I was assigned the case of Hector DelValle, a 17-year-old boy high school senior who became a C 6-7 quadriplegic six weeks earlier after drinking, driving and crashing into a brick wall.

During my initial interview Hector inspired me by saying, "*What you see is what you get – where do we go from here?*" His can-do attitude made me realize that Hector was what I asked for. He became a quadriplegic a few weeks before, was not depressed, had spirit and belief in the future.

I continued to coordinate Hector's care at the rehab hospital, visiting every few weeks to review his condition, the care he received, and chances of regaining use of his legs and arms. As 1983 approached it became apparent this was unlikely. Just before New Year's Eve while watching the evening news Hector appeared, speaking about his drinking, driving and becoming paralyzed. At that time Mothers Against Drunk Driving (MADD) was a growing movement . . . and at that moment it clicked! Hector could be a spokesman to prevent others from suffering his fate and he agreed. Hector was released from the rehab in April and returned to be a student at Dover High School.

Associated Press
President Reagan greets Hector Del Valle, 19, of Dover, paralyzed from injuries sustained in an accident he had while driving drunk.

Norman Wright (upper left) applauds as President Reagan shakes Hector's hands.



By RANDY DIAMOND

IF HECTOR DEL Valle didn't steal the thunder from President Reagan during the Chief Executive's visit to River Dell High School in Oradell Thursday morning, then the 19-year-old certainly came close.

Even the President said he was touched; and he appeared visibly moved as Del Valle, a once promising gymnast who had wanted to be a carpenter, told students that he once thought driving while drunk was "a manly thing to do.".

Del Valle was paralyzed from the waist down when he was involved in a car accident after drinking on Sept. 17, 1982, on Route 46 in Dover.

Del Valle said he was "just one of thousands" of people who "can't move or talk because they smashed up. Some of them are hiding in closets."

As 600 students listened, some with tears in their eyes, Del Valle, sitting in a wheelchair, recalled how he loved gynmastics and had become captain of the gymnastics team.

1984 newspaper clip

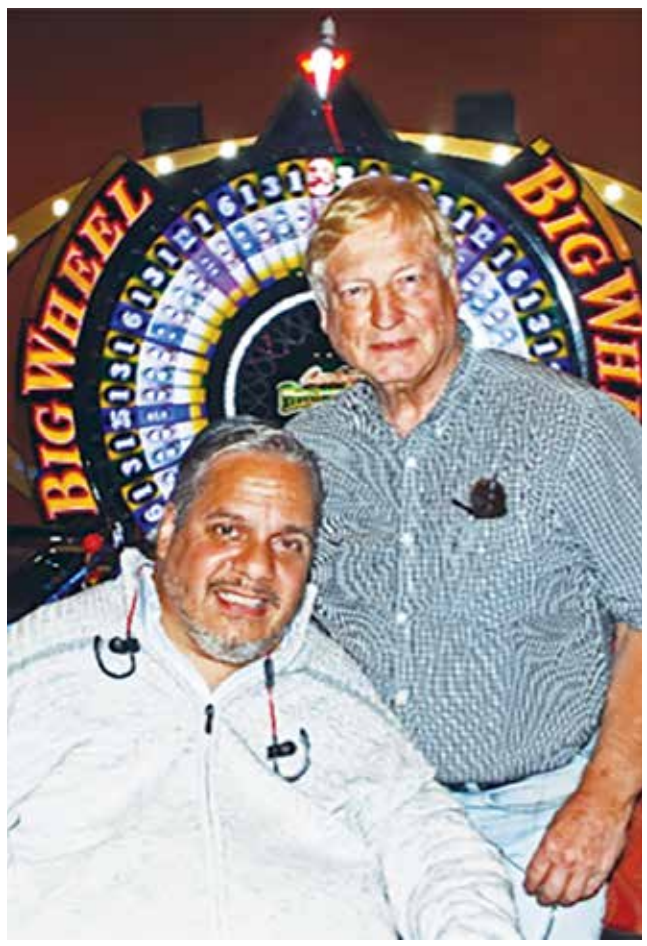
As graduation day approached the idea of giving a commencement speech materialized. Approval from Dover High School was obtained, I wrote a speech and hounded New York TV news reporters to cover it. This included "pushing" my way into WCBS and WABC TV studios. Long story short Hector's graduation speech made front page news of New York's newspapers and National coverage on CBS and ABC TV. The next morning Hector received a call from President Reagan.

Negotiations with his auto insurance company resulted in obtaining a modified van that, despite the fact he could only move his shoulders and had severe limitations of his elbows, Hector was able to drive independently. The Governor of New Jersey became involved and Hector was hired by the Bergen County Council on Alcoholism, driving throughout New Jersey speaking, and demonstrating, the dangers of drinking and driving to high school students.

Throughout this time many of my co-workers discouraged me from continuing to promote Hector, saying, "What happens in the future when he is no longer attracting audiences and the media?" I ignored their discouragement, persisted, and Hector's job speaking to high school students and media coverage continued.

At that time New Jersey's legal age to buy alcohol was 21 but it was 18 In New York and many teenagers were driving to New York, drinking, and getting into accidents while driving back to Jersey. The MADD initiative campaigned to create National laws to establish 21 as the legal drinking age. In June 1984 President Reagan came to a New Jersey High School to promote the uniform drinking age and shared the stage with Hector. Although Hector was smooth when he was speaking to high school audiences his Presidential speech needed to be polished. Another speech was written, practiced, and delivered masterfully.

Hector again made National News, this time the coverage was universal. The naysayers kept saying, "but what happens when the spotlight is no longer on him, when his '*15 minutes of fame*' ends?" I ignored them and continued to work with Hector until 1988 when my professional part in his rehabilitation ended. We maintained a friendship and kept in regular contact until the mid-nineteen nineties, when he moved to Florida and our contact became infrequent.



Hector visits Las Vegas in 2015

Long story short, Hector was a 17-year-old high school gymnast, with a "D" average, who planned to be a carpenter - went on to get his Master's Degree in Social Work. He is active and loves life.

Hector visited Las Vegas in 2015 to attend a spinal cord injury convention and our friendship renewed. Hector inspired me to be a better nurse and in return I played a part to inspire him to find a path that turned tragedy to triumph.

It has been 37 years since Hector paralyzed himself. Communicating even a portion of how Hector has inspired countless others since 1982 in this brief article is impossible - and Hector's story continues.

Which brings me to you. Don't be discouraged by the cynics, those who disparage your ideas. Find a path that feels right for you, believe in yourself, pursue it, and give it your fullest.

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Research & EBP Corner

Efficacy of Videoconferencing via Project ECHO in Improving Hemostasis Knowledge

Submitted by
Mary Bondmass, Ph.D., RN, CNE

This RNF feature presents abstracts of research and evidence-based practice (EBP) projects completed or spear-headed by nurses or student nurses in Nevada. The focus is on new evidence (i.e., research) or on the translation of evidence (i.e., EBP) in Practice, Education or Research. Submissions are welcome and will be reviewed by the RNF editorial board for publication; send your abstract submission in a similar format used below to mary.bondmass@unlv.edu.

Amber Federizo, DNP, APRN, FNP-BC

Dr. Federizo is the only Hemostasis board certified nurse in the state and her clinic covers the entire state of Nevada. She is the Director of Research at the Hemostasis and Thrombosis Center of Nevada and the first in her field to become a principal investigator on global clinical trials as a nurse practitioner. Dr. Federizo has presented research in the Philippines and Germany and has been asked to present this research in Malaysia next year. Her research and work to improve access to care for women with bleeding disorders globally led to recognition by the National Hemophilia Foundation in 2018 as humanitarian of the year. Currently, Dr. Federizo is researching the long-term remission patterns of Hepatitis C following therapy in hemophiliacs, the long-term natural history of hemophiliacs treated with monoclonal antibodies, and the efficacy of fc fusion in prolonging the half-life of FVIII in human subjects affected with severe hemophilia A. Below is Dr. Federizo's abstract and poster.

BACKGROUND

The Extension for Community Healthcare Outcomes (ECHO) video conferencing platform affords clinicians access to specialty and subspecialty education that may otherwise be unavailable due to geographic barriers. Experience with ECHO largely focuses on improving generalist clinician knowledge about the diagnosis and treatment of highly prevalent chronic conditions, however, little is known about ECHO's efficacy in improving competency in low prevalence chronic conditions found that primary care clinicians that utilized ECHO changed their behavioral health care plans 75% of the time. Given the subspecialty nature of hemostasis, the ECHO platform offered a possible avenue to reduce knowledge gaps in bleeding disorders.

Educating clinicians about hemostasis who practice in fields outside of hematology is critical for the early identification, referral, and treatment of individuals and families with bleeding disorders. The utilization of distance education and videoconferencing may be a viable avenue to reduce time to accurate diagnosis and treatment. Project ECHO initiatives seek to improve the education of generalist clinicians to improve care for complex patients with great geographic barriers to specialty care. In this format, the impact of access to care may be exponentiated.

METHODS

Project Site and Population

The project site was the Project ECHO campus in Reno, Nevada. Potential subjects include registered participants accessing Nevada ECHO programs. Stakeholders included Nevada's Project ECHO, faculty at the University of Nevada, Reno (UNR), clinicians across the state and the co-medical director of the Hemostasis and Thrombosis Center of Nevada (HTCNV), a federally recognized HTC. Nevada's Project ECHO approved three sessions in 2018. These were considered "special series" sessions. Faculty at UNR provided guidance over the project and ensured compliance with institutional requirements. The HTCNV co-medical director was responsible for program development, implementation, and evaluation.

Inclusion and Recruitment

All participants were recruited via electronic and paper flyers announcing the dates and times of the hemostasis sessions with Project ECHO. Demographic questions included: professional title, year of graduation, area of current practice, and prior exposure to hemostasis education in the last six months. Participants engaged voluntarily and were eligible to receive continuing medical education credits and a $10 Amazon gift card upon completion of the pre and post-survey questionnaires.

Design, Data Collection, and Materials

The same presenter was utilized for each ECHO session to ensure consistency. The project was designed as a prospective educational assessment. The same ten-item questionnaire (one additional open-ended question on the post-test) was utilized for both pre and post-assessment (Figure 1). The demographic assessment and pre-test questionnaire encompassed the first ten minutes and the post-assessment encompassed the last five minutes of the one hour presentation. The questionnaire asked multiple choice and true/false questions. It was reviewed and approved by three clinicians with experience in hemostasis.

RESULTS

A total of 20 clinicians participated with 17 completing both the pre and post-survey questionnaires. A paired t-test analysis was utilized to compare the groups. A statistically significant improvement was found between the overall pre and post-test scores of the two groups ($p < .001$). Average years of experience was 12. Open-ended responses emphasized key points such as the difficulty and necessity of identifying populations such as women

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with bleeding disorders early to avoid the current average of delayed diagnosis of 16 years in von Willebrand disorder.

Identification of von Willebrand Disorder as the most common bleeding disorder improved 59% (p <.001). Identification of the knowledge of hemophilia as a spontaneous mutation improved 52% (p <.001). The knowledge of the use of anti-fibrinolytics as first line therapy in women with menorrhagia improved 35% (p <.029). The appropriate use of desmopressin in the treatment of a patient with von Willebrand Disorder improved 58% (p <.001). Although confidence in the ability to diagnosis bleeding disorders moved closer to Agree in the post-assessment it was not statistically significant (p <.052). Prior to the session, 88% of participants were able to correctly identify the impact of a federally designated treatment center on the care of a male with hemophilia. On post-assessment 100% of respondents were able to identify the impact. Given the high percentage of respondents able to answer this question correctly prior to the session, a non-significant increase was found on post-assessment.

Critical improvements in knowledge gaps were identified which may guide future designs and sessions. The impact of the study was limited by its application and assessment of only one session. It is recommended that future designs follow the improvement and confidence of clinicians longitudinally across multiple sessions, especially in such complex conditions. Offering multiple repeat sessions at hours outside of 5pm could improve recruitment and participation.

CONCLUSION

This project suggests that the ECHO telementoring platform may be useful to non-hematologist clinicians in the prevalence, diagnosis, and treatment of patients with bleeding disorders. Participants found the opportunity valuable. This modality enhances the access to care for not only rural clinicians and patients but also clinicians and patients with less access to subspecialty consult in urban areas. Results suggest proof of concept that the Project ECHO platform can increase knowledge of complex condition diagnosis and management among non-specialists, which is vital to improving access to care for rural and frontier residents with bleeding disorders. Additional research is needed to analyze the need for potential integration of a direct telemedicine component, replicate results and study the impact of ECHO on care outcomes long-term.

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Efficacy of Videoconferencing via Project ECHO in Improving Hemostasis Knowledge

Amber Federizo, APRN, FNP-BC

University of Nevada, Reno

Co-Medical Director at the Hemostasis and Thrombosis Center of Nevada

Background

The Extension for Community Healthcare Outcomes (ECHO) video conferencing platform affords clinicians access to specialty and subspecialty education that may otherwise be unavailable due to geographic barriers. Experience with ECHO largely focuses on improving generalist clinician knowledge about the diagnosis and treatment of highly prevalent chronic conditions, however, little is known about ECHO's efficacy in improving competency in low prevalence chronic conditions (Zhou, Crawford, Serhal, Kurdyak, & Sockalingam, 2016). Komaromy, Bartlett, Manis, & Arora (2017) found that primary care clinicians that utilized ECHO changed their behavioral health care plans 75% of the time. Given the subspecialty nature of hemostasis, the ECHO platform offered a possible avenue to reduce knowledge gaps in bleeding disorders.

Educating clinicians about hemostasis who practice in fields outside of hematology is critical for the early identification, referral, and treatment of individuals and families with bleeding disorders. The utilization of distance education and videoconferencing may be a viable avenue to reduce time to accurate diagnosis and treatment. Project ECHO initiatives seek to improve the education of generalist clinicians to improve care for complex patients with great geographic barriers to specialty care. In this format, the impact of access to care may be exponentiated.

Federally Recognized Hemophilia Treatment Centers (HTC)

Since the 1970's, the federal government has supported a regional network of specialty comprehensive hemophilia diagnostic and treatment centers that today numbers over 130 nationwide centers (Baker, Crudder, Riske, Bias, & Forsberg, 2005). When thousands of hemophiliac patients became infected with Hepatitis C and HIV in the 1980s, it was HTCs that helped identify an etiology that HIV was bloodborne and not based on lifestyle behaviors alone (Evatt, 2006). HTCs provide coordinated and comprehensive team-based clinical and surveillance services in concert with the federal Human Resources Services Administration (HRSA) goals, Centers for Disease Control (CDC) objectives, and National Hemophilia Foundation recommendations.

Community clinician awareness of bleeding disorders, federally recognized HTCs, and how to proceed with an effective diagnostic work-up may be affected by distances to these centers. Due to inexperience with complex and costly laboratory diagnostics, partial panels often miss a diagnosis or must be repeated for completeness adding to overall health care costs. Clinicians inexperienced in referring or working up a female patient for a bleeding disorder may proceed with hormonal intervention or utilize cautery which may mask the underlying bleeding disorder. This delay in diagnosis may result in ineffective treatment during future emergencies, planned procedures, and needlessly prolong a poor quality of life. Tele-education and telementoring can provide an avenue of advanced education to community clinicians and build their professional network. Once educated, these community clinicians can proceed with an appropriate diagnostic work-up and treatment while awaiting referral to a federally recognized HTC and potentially successfully co-manage diagnosed patients with the HTC, reducing geographic barriers to expert care.

Objectives

- Improved awareness of the importance of federally recognized hemophilia treatment center referral and care.
- Improved recognition of factors affecting early identification of patients for testing, enhanced recognition of pre-analytic variables affecting laboratory diagnostics in hemostasis.
- Improved recognition of affected populations.
- Improved confidence in initiating early evaluation of patients prior to referral.

Methods

Project Site and Population

The project site was the Project ECHO campus in Reno, Nevada. Potential subjects include registered participants accessing Nevada ECHO programs. Stakeholders included Nevada's Project ECHO, faculty at the University of Nevada, Reno (UNR), clinicians across the state and the co-medical director of the Hemostasis and Thrombosis Center of Nevada (HTCNV), a federally recognized HTC. Nevada's Project ECHO approved 3 sessions in 2018. These were considered "special series" sessions. Faculty at UNR provided guidance over the project and ensured compliance with institutional requirements. The HTCNV co-medical director was responsible for program development, implementation, and evaluation.

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Design, Data Collection, and Materials

The same presenter was utilized for each ECHO session to ensure consistency. The project was designed as a prospective educational assessment. The same ten-item questionnaire (one additional open-ended question on the post-test) was utilized for both pre and post-assessment (Figure 1). The demographic assessment and pre-test questionnaire encompassed the first ten minutes and the post-assessment encompassed the last five minutes of the 1 hour presentation. The questionnaire asked multiple choice and true/false questions. It was reviewed and approved by three clinicians with experience in hemostasis.

1. Which of the following is the most common bleeding disorder? a. Factor VIII (8) Deficiency b. Factor IX (9) Deficiency c. Factor X (10) Deficiency d. Von Willebrand Disorder	6. A complete Von Willebrand panel includes the following: a. VWF antigen, VWF ristocetin cofactor b. VWF ristocetin cofactor c. VWF antigen, VWF ristocetin cofactor, FVIII (8) activity, multimeric analysis d. VWF antigen, VWF ristocetin cofactor, FVIII activity
2. What percentage of new cases of hemophilia are a result of spontaneous mutation? a. 20% b. 25% c. 30% d. 35%	7. Delays in diagnosis include: a. female gender b. Initiation of hormones prior to testing c. Cautery of nasal mucosa prior to testing d. All the above
3. Treatment of a male with hemophilia in a federally recognized HTC can reduce mortality and morbidity by 40%. a. true b. false	8. Anti-fibrinolytics are preferred over hormones to initially treat a female suspected of a bleeding disorder presenting for menorrhagia. a. true b. false
4. The most definitive tests to evaluate whether a female may suffer from bleeding complications resulting from hemophilia include: a. Factor VIII (8) or Factor IX (9) activity testing b. PT, PTT and Factor VIII (8) or Factor IX (9) activity testing c. PTT and Factor VIII (8) or Factor (9) activity testing. d. Genetic analysis and Factor VIII (8) or Factor (9) activity testing	9. When should a patient with von Willebrand disorder be treated with desmopressin? a. any patient with von Willebrand disorder may be treated with desmopressin b. after confirmation of an effective desmopressin trial c. if the patient has type 2B von Willebrand Disorder d. if the patient has type 3 von Willebrand Disorder
5. Pre-analytic variables that affect Von Willebrand testing and may result in a false negative include: a. anxiety b. prescribed hormones c. sample processing d. fear of needles e. all the above	10. I am confident in my ability to diagnose bleeding disorders. a. strongly disagree b. disagree c. neutral d. agree e. strongly agree
POST TEST Additional question 11. What was your biggest take away from today's presentation?	

Results

A total of 20 clinicians participated with 17 completing both the pre and post-survey questionnaires. A paired t-test analysis was utilized to compare the groups. A statistically significant improvement was found between the overall pre and post-test scores of the two groups ($p < .001$). Average years of experience was 12. Open-ended responses emphasized key points such as the difficulty and necessity of identifying populations such as women with bleeding disorders early to avoid the current average of delayed diagnosis of 16 years in von Willebrand disorder (Kirtava, Crudder, Dilley, Lally, & Evatt, 2004).

Identification of von Willebrand Disorder as the most common bleeding disorder improved 59% ($p < .001$). Identification of the knowledge of hemophilia as a spontaneous mutation improved 52% ($p < .001$). The knowledge of the use of anti-fibrinolytics as first line therapy in women with menorrhagia improved 35% ($p < .029$). The appropriate use of desmopressin in the treatment of a patient with von Willebrand Disorder improved 58% ($p < .001$). Although confidence in the ability to diagnosis bleeding disorders moved closer to Agree in the post-assessment it was not statistically significant ($p < .052$). Prior to the session, 88% of participants were able to correctly identify the impact of a federally designated treatment center on the care of a male with hemophilia. On post-assessment 100% of respondents were able to identify the impact. Given the high percentage of respondents able to answer this question correctly prior to the session, a non-significant increase was found on post-assessment.

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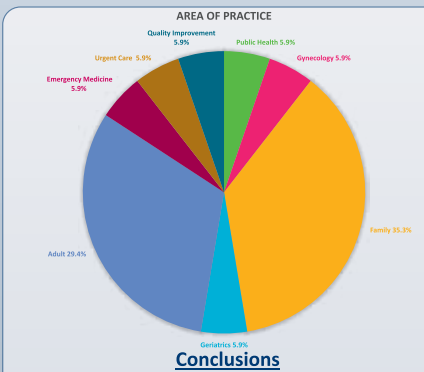
Take Away Responses
There is still work that needs to be done to ensure that patients are properly diagnosed and treated in a timely manner.
Test more often
Diagnostic testing and general overview.
It is more complicated and there is not an exact answer.
Testing women with heavy bleeding for bleeding disorders.
The constant referral from the ED to the OB or PMD for bleeding needs to be reconsidered. It seems that the bleeding disorder differential is often overlooked.
Need for awareness.
The screening tool and the information on signs in newborns, PEDS, and adults.
Testing for bleeding disorders.
Amber is extremely knowledgeable! Understanding the hormone factor in false negatives results with VWD.
Introduced to the program, exposed to more knowledge about clotting disorders. Issues with insurance reimbursement. Thank you for a great presentation.
To apply the knowledge to my practice
That bleeding disorders are more common in women with heavy periods than often thought.
No comment
Consider bleeding disorders the first time I see epistaxis in child or heavy menstruation in females
Females can have hemophilia especially when there is a paternal genetic factor passed on. Also, how to treat and diagnose the disorder.
The cause for false negative test results, to consider more than just PT/PTT for evaluation



Conclusions

This project suggests that the ECHO telementoring platform may be useful to non-hematologist clinicians in the prevalence, diagnosis, and treatment of patients with bleeding disorders. Participants found the opportunity valuable. This modality enhances the access to care for not only rural clinicians and patients but also clinicians and patients with less access to subspecialty consult in urban areas. Results suggest proof of concept that the Project ECHO platform can increase knowledge of complex condition diagnosis and management among non-specialists, which is vital to improving access to care for rural and frontier residents with bleeding disorders. Additional research is needed to analyze the need for potential integration of a direct telemedicine component, replicate results and study the impact of ECHO on care outcomes long-term.

Additional invitations to present further material was offered by Nevada ECHO at the conclusion of the project. This project was guided by Roger's Diffusion of Innovations theory and demonstrated competencies in 7 of the 8 American Association of Colleges of Nursing DNP prepared role essentials.

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Antimicrobial Stewardship

CDC Updates Antibiotic Resistance Threats Report

Norman Wright, RN, BSN, MS

On November 13, 2019 the CDC published its **ANTIBIOTIC RESISTANCE THREATS IN THE UNITED STATES 2019** report updating the previous 2013 report. The 2019 report shows improvements in some areas and concerns in others.

https://www.cdc.gov/drugresistance/pdf/threats-report/2019-ar-threats-report-508.pdf

The 2013 report stated, *"At least 23,000 people die each year as a direct result of these antibiotic-resistant infections."* The 2019 report increases this number to, "more than 35,000," and when adding in the number of deaths from Clostridioides difficile, (the new term for C-diff) the total increases to 48,700.

The 2019 CDC report lists resistance concerns as urgent, serious, concerning and those on a watch list. The pathogens listed as Urgent Threats are

- *Carbapenem-resistant Acinetobacter*
- *Candida auris (C. auris)*
- *Clostridioides difficile (C. difficile)*
- *Carbapenem-resistant Enterobacteriaceae (CRE)*
- *Drug-resistant Neisseria gonorrhoeae (N. gonorrhoeae)*

Serious threats include

- Drug-resistant Candida
- Extended-spectrum beta-lactamase (ESBL)-producing Enterobacteriaceae
- Vancomycin-resistant Enterococci (VRE)
- Multidrug-resistant Pseudomonas aeruginosa (P. aeruginosa)
- Methicillin-resistant Staphylococcus aureus (MRSA)
- Drug-resistant Streptococcus pneumoniae (S. pneumoniae)
- Drug-resistant Tuberculosis (TB) and others.

The 148 page report raises alarms and is divided into sections. The first section: **"THE THREAT OF ANTIBIOTIC RESISTANCE"** has subsections including: **"Everyone is at Risk, Antibiotic Resistance Spreads Easily Across the Globe and Stopping Spread of Antibiotic Resistance Saves Lives."** These address the **"Think Globally – Act Locally"** theme that this column has previously discussed. The next section: **"Antibiotic-Resistant Infections Threaten Modern Medicine"** reviews how resistance impedes sepsis treatment, surgery, organ transplants, dialysis, cancer therapy and more.

Robert R. Redfield, M.D. Director of the CDS states: *"Stop referring to a coming post-antibiotic era—it's already here. You and I are living in a time when some miracle drugs no longer perform miracles and families are being ripped apart by a microscopic enemy. The time for action is now and we can be part of the solution."*

Which brings us to progress and hope in the report. Efforts to combat resistance are having a positive impact and MRSA, VRE, and other pathogen rates are slowing but these positive trends must only be the beginning...as some threats are reducing, others are developing.

Anyone following this column will notice it is now titled **Antimicrobial Stewardship**. To quote the 2019 report: *"In this report, CDC uses "antibiotic" to describe antibacterial and antifungal drugs, which kill bacteria and fungi.* The report goes on to say, *"C. auris emerged after the 2013 report was published. It is a multidrug-resistant yeast that can cause invasive infection and death. It spreads easily between hospitalized patients and nursing home residents."* The May 2019 edition of RNformation reviewed Nevada's C. auris concerns and what Nevada is doing to combat this antimicrobial resistant fungus. The ANA republished the article, with modifications, in the November 2019 issue of **American Nurse Today**

https://www.americannursetoday.com/antibiotic-stewardship/

The CDC's 2019 report stresses the importance of hand hygiene, good EVS services, and that all health care providers work to prevent the transmission of pathogens.

The report gives *"strategies to decrease infection spread within healthcare settings (e.g., implementing hand hygiene) • Vaccinating"* and more.

Be a volunteer in the army of health care providers and enlist in the battle to prevent infections, join the Nevada Antimicrobial Stewardship Program (NVASP) and other organizations promoting Antimicrobial Stewardship.

The CDC's 2019 report is comprehensive and easy to read. Please take some time to review it.

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"Primary care centers, ERs, trauma centers, and community health settings provide opportunities for early intervention with at-risk substance users before more severe consequences occur."

SAMHSA, 2017

NEVADA STATE
Opioid Response - An STR/SOR Project

This publication was supported in whole or in part by the Nevada Division of Public and Behavioral Health Bureau of Behavioral Health, Prevention, and Wellness through funding provided by the Nevada State Targeted Response to the Opioid Crisis Grant (1H79TI080265-02) awarded by the Substance Abuse and Mental Health Services Administration (SAMSHA). The opinions, findings conclusions and recommendations expressed in this publication/program/exhibit are those of the author(s) and do not necessarily represent the official views of the United States Department of Health and Human Services, SAMSHA or the State of Nevada.

VHA Creates a Welcoming Environment for Transgender Veterans

Denise Rowe DNP, APRN, FNP-BC

Transgender is an umbrella term that includes a variety of identifications and expressions to describe individuals who do not fit into traditional gender expectations (e.g. male, female). For example, the term Gender Identity refers to a person's innate, deeply felt psychological identification as male or female, which may or may not correspond to the person's body or designated sex at birth. Transgender individuals may identify as male, female, or neither. They may also identify as heterosexual, bisexual, gay/lesbian or they may choose some other label that describes their sexual orientation.

Transgender individuals may experience psychological distress because their natal gender identity is not what it appears to be. For example, individuals with the male reproductive system and other physical traits attributable to men may identify as female and individuals with the female reproductive system and other physical traits attributable to female may identify as male.

The feelings of distress experienced by individuals whose gender is not congruent with the gender assigned at birth is currently defined as Gender Dysphoria (or Gender Identity Disorder) in the Diagnostic and Statistical Manual, fifth edition (DSM-5) (American Psychological Association, 2013)

Transgender persons face many social challenges. Compared to the general population, they experience more discrimination, stigma, and hostilities causing barriers to accessing care which result in higher rates of physical and mental health conditions and poorer health outcomes (Kauth, et al., 2014; Graham, et al., 2011).

Chronic stress from discrimination often leads to higher rates of depression, anxiety, post-traumatic stress disorder (PTSD), and increased rates of suicidal ideation (Blosnich et al., 2013). Between 2000 and 2011, Veterans Health Administration (VHA) data on veterans diagnosed with Gender Identity Disorder found that transgender veterans had a risk of suicidal behavior 20 times higher than that of the general veteran population. Transgender veterans were more likely to be homeless, incarcerated, and to have experienced military sexual trauma. (Kauth, et al., 2014). Black transgender veterans are at higher risk for several mental and physical health conditions with a three times higher rate of incarceration and double the rate of homelessness of the general veteran population (Kauth, et al., 2014).

Transgender persons experience higher rates of substance use (alcohol, tobacco, drugs), intimate partner violence (IPV), and sexually transmitted infections (STIs). Transgender women with male sex partners are at increased risk for HIV infection, human papilloma virus (HPV) and hepatitis. (Graham, et al., 2011; Makadon, Mayer, Goldhammer & Potter, 2007; Grant, Motter & Tanis, 2011; APA, 2019; Herek, Gillis & Cogan, 2009; Maguen & Shipherd, 2019; Shipherd, Green, & Abramovitz , 2010)

There are an estimated 15,450 transgender service members on active duty (Elders & Steinman, 2014) and at least 134,000 transgender veterans (Gates, & Herman, 2014). With an awareness of these alarming population statistics, the VHA is dedicating resources to improve health outcomes for transgender veterans by creating an environment in which transgender veterans can feel welcome, safe, and receive comprehensive patient-centered care.

VHA directive 1341(1) on providing health care for transgender and intersex veterans states that VA staff should "provide clinically appropriate, comprehensive, veteran-centered care with respect and dignity to enrolled or otherwise eligible transgender and intersex veterans, including but not limited to hormonal therapy, mental health care, preoperative evaluation, and medically necessary post-operative and long-term care following gender confirming/affirming surgery.

Veterans must be addressed based upon their self-identified gender identity; the use of veteran's preferred name and pronoun is required." (Department of Veterans Affairs, 2019a)

Creating a welcoming environment for transgender veterans is an important VHA priority. VHA facilitates this directive by supporting inclusive initiatives, increasing staff knowledge base, and educational awareness, and by providing more training for healthcare providers. Treating transgender veterans respectfully is promoted within the clinic setting through the use of inclusive and gender-neutral language (e.g. use of veteran's preferred name and gender, pronouns (e.g. he, she, him, her), use of posters, welcoming signage, and providing gender neutral bathrooms and use of gender neutral forms and educational materials (Department of Veterans Affairs, 2019b)

Cross sex hormone feminizing therapy (male to female) with estrogen and masculizing therapy (female to male) is available to treat transgender veterans experiencing gender dysphoria. While the VHA medical package does not provide funding for gender-conforming, reassignment surgeries, pre-operative evaluations for veteran desiring reassignment surgeries, and post-operative and long-term care following reassignment surgeries are offered. Cosmetic procedures related to reassignment surgeries such as breast, augmentation/reduction, facial reconstruction, and electrolysis are not covered in the VHA medical package.

The Healthcare Equality Index (HEI) is a national LGBTQ benchmarking tool used to evaluate healthcare facilities' policies and practices related to the equity and inclusion of their LGBTQ patients, visitors and employees. VA Southern Nevada Healthcare System (VASNHS) successfully achieved the coveted status of "Leader in LGBTQ Healthcare Equality" for 2019 and is the only healthcare facility in the State of Nevada with this standing. (Human Rights Campaign, 2019)

Since 2013 when the Office of Patient Care Services established the transgender directive, VHA has implemented transgender supportive directives, provider education programs, and clinical services that support personalized, pro-active, patient-driven healthcare for veterans with transgender-related identities. As the largest healthcare system in the United States, VHA continues its leadership in creating a more welcoming environment for this vulnerable veteran population.

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Healthcare Systems: Confusion, Cost and Calamity

John Malek, PhD, MSN, ARNP (ret.)

Whether you are employed, retired, or unemployed at some point, all of us will need to access healthcare. Receiving services, of course, is somewhat easier with the help of insurance. Trying to decipher insurance plans and coverage is a daunting task. Our state and federal leaders find it difficult to control health expenditures, laws and budgets. According to the National Conference of State Legislatures, "some health cost controls have medical consequences; some are obvious and some are unintended. During budget crises, for example, health programs may reduce coverage, shift costs to enrollees or phase out programs for special populations."

A couple of dilemmas contributing to the financial impact of insurance include the cost of premiums as well as healthcare taxes. It seems that every year, premiums and deductibles increase significantly, while covered services often decrease. Average premiums and deductibles nationwide for unsubsidized shoppers averaged $440 per month, while premiums for family plans averaged $1,168. The average annual deductible for individual plans was $4,578 and the average deductible for family plans was $8,803. Average annual premiums after employer contributions are $1,235. According to information retrieved from the Nevada Division of Insurance, there are vast differences in health insurance rates for 2019 between Northern and Southern Nevada. For instance, a 21 year old in Clark County pays an average of $304/month whereas in Carson County premiums range from a low of $331/month to a high of $550/month. The average premium in Carson County is approximately $437/month. On the other end of the age spectrum, a 60 year old in Clark County pays an average of $825/month, whereas in Carson County the average premium is $1186/month. These premiums do not reflect catastrophic coverage. Why do these differences exist? Part of the reason is population based. Typically, the lower the population of an area, the higher the premium, and not all plans are available in rural areas where populations are lower than in urban districts. Another reason is territorial. Insurance corporations have marked their terrain in an effort to secure coverage only to specific geographical locations. Your plan may cover your healthcare needs in Carson City but not in Reno. You may be covered in Reno, but not in Las Vegas. Most insurance plans incorporate preferred providers. This means if you see a provider on your plan, your out-of-pocket expense is much lower than if you see out-of-network providers. Be aware that if you seek service at an out-of-network hospital or physician, reimbursement for treatments will be drastically discounted and you will be responsible for any remaining balance. Physicians and hospitals sign contracts with insurance carriers that allow providers to take a discount on reimbursement with the assurance that patients on a particular plan will be directed to see particular providers on a certain insurance plan. In other words, providers are guaranteed continuous numbers of patients which offset decreased reimbursement rates.

Healthcare taxes are higher in the United States than they are worldwide. The taxes we pay covers Medicare, Medicaid, military programs like the VA, and private insurance that people receive through employment. Everyone suffers from the lack of transparency and inflated billing to a looming physician shortage. Significant resources and attention have been dedicated to researching and discussing various perceived problems in the current system, and the list of flaws is seemingly endless. Is it impossible to provide all services for all people? Many people can't get appointments with their providers within 24-48 hours. When primary care office visits finally do occur, often after a few weeks of waiting, they usually last under 10 minutes. That is why there is now a whole industry devoted to walk-in-clinics. It seems as if we are settling for a broken healthcare system.

The healthcare system is multi-faceted, perplexing and enormously intricate. Coverage plans include employer based, state and federal policies, Medicaid, Medicare and private plans. The health system is constantly evolving. The healthcare industry continues to grow and stake their claim on communities. Consumers are finding it more difficult to navigate their way to affordable care and providers. Patients must wait weeks to months to secure appointments. Physicians, Nurse Practitioners and Physician Assistants have limited time to evaluate patients and can do little more than generate referrals to various specialists. The resulting consequences to these approaches force patients to spend yet another day waiting at medical offices in addition to time spent acquiring the appointment. Rarely can a patient be seen by a specialist without a referral and proper authorization from an insurance entity. In addition, there is a total lack of transparency among providers and institutions regarding the cost of services. Trying to locate the best bang for your buck when diagnostic tests are required is next to impossible. At this point in time these entities are not required by law to disclose the cost of their services.

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A Superior System: Single Payer Legislation vs. Affordable Care Act

	Single-Payer Bill, H.R 676	Affordable Care Act
Universal Coverage	**Yes.** Everyone is covered automatically at birth.	**No.** About 30 million will still be uninsured in 2022 and tens of millions will remain underinsured.
Full Range of Benefits	**Yes.** Coverage for all medically necessary services.	**No.** Insurers continue to strip down policies and increase patients' co-payments and deductibles.
Savings	**Yes.** Redirects $400 billion in administrative waste to care; no net increase in health spending.	**No.** Increases health spending by about $1.1 trillion over 10 years. Adds further layers of administrative bloat to our health system through the introduction of state-based exchanges.
Cost Control/Sustainability	**Yes.** Large-scale cost controls (negotiated fee schedule with physicians, bulk purchasing of drugs, hospital budgeting, capital planning, etc.) ensure that benefits are sustainable over the long term.	**No.** Preserves a fragmented system incapable of controlling costs. Gains in coverage are erased by rising out-of-pocket expenses, bureaucratic waste and profiteering by private insurers and Big Pharma.
Choice of Doctor and Hospital	**Yes.** Patients will be allowed free choice of their doctor and hospital.	**No.** Insurance companies continue to deny and limit care and to maintain restrictive networks.
Progressive Financing	**Yes.** Premiums and out-of-pocket costs are replaced with progressive income and wealth taxes. 95 percent of Americans will pay less for care than they do now.	**No.** Continues the unfair financing of health care whereby costs are disproportionately paid by middle- and lower-income Americans and those families facing acute or chronic illness.

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This chart from the Physicians for a National Health Program outlines the comparison between Single-Payer Insurance and the Affordable Care Act.

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Throughout history, the deliverance of healthcare services has undergone tremendous changes. Not all of those changes have significantly benefitted patient services, especially within the primary care arena. Having spent my career working in rural areas of Nevada, it was quite apparent resources would be limited. Trauma patients were transferred to higher levels of care, most elderly with an acute illness were admitted to inpatient care, and the remainder of the community had the services of primary providers and a walk-in clinic. Consumers are on the receiving end of a constant battle to balance cost and services with quality. Providers have little time to do anything more than order labs, renew prescriptions, and make appropriate referrals. Providers don't have adequate time to spend with patients due to the overwhelming requirements to meet expected quotas for their organizations. Though many facilities of outpatient services utilize a "model" of healthcare delivery, this approach is typically based upon the organizations' policies and procedures. Research has indicated four healthcare models when providing treatment: medical, holistic, epidemiological, triangle, and social. However, what do these actually mean to the consumer? In addition, there are two broad approaches to financing healthcare: a market-based approach and a government-financed approach.

Many questions arise when dealing with financing: Who is provided access? How much coverage is provided? How are the services paid? How does reimbursement apply? Are there limitations to care? What guides care decisions for patients? What is the quality of services? Are there competitive options? How much is prevention and wellness emphasized? How are healthcare costs managed and controlled? How is healthcare reform established?

Knowing as much as possible about healthcare coverage, whether you pay for it yourself or partially contribute, will save a great deal of stress, anxiety, confusion and headaches. You cannot just arrive at any provider's office when you need one and assume they will accept your insurance, especially if they are not on your plan. Stay informed. While providers are implementing more and more preventive services such as screenings for colon cancer, breast cancer, diabetes and hypertension, we are still pretty much a disease-management healthcare system. Preventative services are helping to detect illness before something becomes serious, but how successful this approach is, remains to be seen. In an article written by Savage and Eyal (2019), the authors state that "despite billions of dollars spent by governments, insurance remains terribly expensive. Deductibles and premiums combined cost millions of families at least as much as a second mortgage or rent payment would. Deductibles of $7000 are now commonplace." Even after deductibles are met, many insurance plans pay only 60-80 percent of billed charges. You need to know your deductibles for various services. Deductibles are the amount of money paid out of pocket BEFORE your insurance plan will pay for provider visits/services. Many patients don't reach their deductible in a calendar year for outpatient services, and deductibles are reset every January 1 very often changing from year to year. For example, depending on your plan, a deductible for Radiology services based upon the test ordered could cost anywhere from $5.00-$200.00. The balance may be paid through negotiated discounts or payments to the provider of these services. Some plans may require you to pay 20% or more for provided diagnostic services.

Each year, employers, private insurance, and Medicare negotiate for improved premium rates to save money. These changes affect who your primary provider is, hospitals on the plan, cost of premiums, deductibles and co-pays. There may also be changes in drug formularies, preferred pharmacies and changes to covered services. We can no longer feel secure in the health plan or health system we are enrolled in. What is working for you this year may not be available to you next year.

According to the World Health Organization, "a good health system delivers quality services to all people, when and where they need them. In all cases, it requires a robust financing mechanism; a well-trained and adequately paid workforce; reliable information on which to base decisions and policies; well maintained facilities and logistics to deliver quality mechanisms and technologies."

Unlike most Western democracies, health insurance in the United States is provided by a haphazard mix of employer-based plans. Medicare is provided for those over age 65 years, on social security disability or with chronic renal failure. Medicaid is available under varying state-dependent rules for some low-income recipients, yet tens of millions are still without health insurance. Administrative costs, which include both the direct costs of the insurers and the indirect costs imposed on physicians and hospitals, make up nearly 25% of our bloated national healthcare expenditures. This high cost adds no proven value to healthcare outcomes. Our current system of covering healthcare expenditures is both inefficient and unfair. Changes must be made. Remember, you get what you pay for. As a dear colleague pointed out, why does health insurance need to be attached to employment anyway? What about single-payer health insurance and the Affordable Care Act? Let's explore the differences between them.

In an article written by Physicians for a National Health Program, "Single-Payer health insurance is a model that seeks to provide healthcare coverage so that all people have access to essential care throughout their lives, regardless of their ability to pay. Although the Affordable Care Act made it possible for millions of Americans to become insured, it is NOT single payer healthcare. Single payer health insurance is a health insurance system financed by taxes that is managed and run by one entity, such as a government. "It is referred to as single payer because it is the one entity (the government) that pays the costs (a "single payer)." A single payer health insurance system is financed by taxes so that individuals and citizens of the country do not pay extra costs when seeking out essential care. The United States does not currently have a single-payer health system. Many presidential candidates however have expressed their support of this system. Services would include Doctor Visits, Preventative Care, Long-term care, Mental health treatment, Reproductive healthcare, Dental, Vision, Prescription drug and medical supply costs. Depending on how the system is set up, certain coverage may not be included. As always, cost is a consideration. You may still have co-pays with a single-payer health system, or you may have certain coverage excluded.

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World Health Organization: https://www.who.int/topics/health_systems/en/

Nevada Nurses Foundation, Arthur L. Davis Publishing Scholarship Recipient

Ethics in Nursing Practice

Written by Maria Lauren Doyle
University of Nevada, Las Vegas MSN student

Witnessing ethical dilemmas are inevitable healthcare. For example, observing a homeless individual without any insurance provided substandard care by the healthcare team (Maville & Huerta, 2008). Nurses witness clinical situations in numerous perspectives that involve their patients, their families, and health care team members. Nurses provide care to any person to protect their patients' welfare, improve health status, and quality of life. The International Council of Nurses (2012) stated that it is inherent in nurses to be respectful for human rights, cultural rights, the rights to life and choice, to dignity, and to be treated with respect. Nurses advocate for equity and social justice in resource allocation, improved access, social, and economic services. Beneficence as one of the ethical principles is pivotal in nursing decision making the process. Nurses must know their morals, values, and beliefs to be ethical practitioners. The American Nurses Association (2015) Code of Ethics for Nurses with Interpretative Statements provision of 1.1 Respect for human dignity affects personal decision-making. As nurses play important roles in care delivery, they serve as patients' advocates and affect change. Nurses are key contributors to the resolution of ethical dilemmas present in clinical settings.

Beneficence as one of the ethical principles in the nursing practice influence clinical and personal decision-making. Epstein and Ward (2016) explained that beneficence calls health care providers to do good to patients, to prevent and remove harm. A homeless individual without healthcare coverage received substandard care infringes this principle. Being a bystander and doing nothing intensifies the encroachment of this principle. Nurses are key factors in conveying relevant information to other members in the healthcare delivery of safe and patient-centered care. This ethical dilemma prompts nurses to share the responsibility of initiating and supporting action to meet both health care and social needs of the homeless patient, member of a vulnerable population. As a result, Beneficence guides nursing decision-making process to act in a manner that will prevent and remove harm, and protect patient's safety.

The American Nurses Association (2015) described the Code of Ethics for Nurses with Interpretative Statements provision of 1.1 Respect for human dignity; a fundamental principle that motivates all nursing practice to respect for the intrinsic dignity, self-worth, unique characteristics, and human rights. The need for and right to health care is universal, transcending all individual characteristics and differences. This provision can also be used for personal decision-making guided by fundamental values and commitment in the nursing practice. A homeless individual is undoubtedly in need and has the right to health care. The financial status of the patient is not the main determination of how health care professionals should provide the treatment and care to any individual. Nursing practice is guided with fundamental values that are humane and ethical. Practicing in the realm of compassion and respect for human dignity, worth, uniqueness not influenced by the social or economic status, personalities and clinical diagnoses. Nurses are caregivers in nature with the mission of delivering care that is patient-centered unrestricted by considerations of social, health, and economic status.

Conclusion

Nurses are key players in providing ethical care to any person. Nurses are known to be patient advocates, and often encounter complex and ethically challenging clinical situations. Beneficence as one of the primary ethical principles is very useful for personal decision-making. It is essential in nursing professionals to identify potential harm and benefits of other options and serves as advocates for their patients, especially the vulnerable population. The American Nurses Association (2015) Code of Ethics for Nurses with Interpretative Statements provision of 1.1 Respect for human dignity is a fundamental principle in motivating and inspiring nursing practice. Nurses are respectful for all individuals' dignity, self-worth, attributes, and human rights. They recognize the need for and the right to health care is universal, and not subjective of the person's social and economic status. A homeless individual receiving substandard care due to a lack or absence of insurance coverage, it is the nurse to duty to advocate and convey relevant information in a constructive way. Nurses are contributors to obtaining positive outcomes in ethically-challenging situations.

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A Visit to the Border

Submitted by Linda Bowman, RN,
Managing Editor RNF

We have all heard media stories about "the wall." The physical boundary between the United States and Mexico. What is it really like at the border? Most of us in Nevada don't know.

October's issue of *American Nurse Today* included an article by Leah Curtin, RN, ScD(h), Executive Director, Professional Outreach, "Must nurses care for migrants?" Ms. Curtin referenced Article 25 of the Universal Declaration of Human Rights adopted by the General Assembly of the United Nations in 1948. Article 25 is *the right to a standard of living*. It states in part, "Everyone has the right to a standard of living adequate for the health and wellbeing of himself and of his family, including food, clothing, housing, and medical care and necessary social services…" The word "everyone" caught my attention. Article 25 didn't state, only legal immigrants or only those born in the U.S. but "everyone."

In October 2019, I interviewed seven individuals who made the trip from Reno, Nevada to Tucson, Arizona. The travelers I spoke with included Stan, Jackie, Lloyd, Pat, Billie Jean, Greg, and Kristin. For some, it was their first journey; for others, it was their third. These individuals ranged in age from mid-30s to early 70s. I wanted to know, given what I'd read in the media about the unsafe conditions, why they took this trip.

Pictured: Stan Dunford-Jackson, Billie Dunford-Jackson, Kristin Famula, Jackie Reilly, Bob Alto, Lloyd Rogers, Pat Purkey-Entwistle and Mark Glenn. Not pictured is Reverend Karen Foster.

What compelled them to go from comfort to courage and take a trip to a relatively unknown and unsafe area? According to Stan, the reason he wanted to visit the border was, in part due to conversations he had with undocumented citizens passing through Reno in 2017. He remembers how they described the terror they experienced when trying to flee Central America.

Lloyd described how he had close friends who had to relocate from northern Nevada to Baja, Mexico to live near family members. A family member had tried to obtain legal status but received poor legal advice, and once he crossed back into Mexico, he was not allowed to return to the United States.

Bob taught at a local community college. He taught Deferred Action for Childhood Arrivals (DACA) students and had friends who were deemed "illegal." They had fled to the United States from a violent society.

Pat belongs to Northern Nevada International Center located at University of Nevada Reno. Through this organization, she met families from Syria, Afghanistan, and the Congo. She recalls the stories of the terror experienced by the undocumented individuals and their families.

Some of the travelers remember when the Unitarian Universalist Fellowship of Northern Nevada (UUFNN) became a sanctuary for a family man who attempted to go through the proper channels to become a U.S. citizen, but couldn't obtain legal status. He lived in the UUFNN away from his family for weeks. Ultimately, even though he had a severe medical condition, had raised his family in the U.S., was gainfully employed and paying taxes, he was removed from his family and deported.

The group arrived in Tucson, Arizona, on October 5, 2019, around 2:00 pm. Once there, they set out to see the border wall in Nogales. The town of Nogales is split into two parts. One side is in Mexico, while the other side is in the United States. I asked them to describe the wall.

The wall with razor wire and individuals waiting to catch a glimpse of their loved ones.

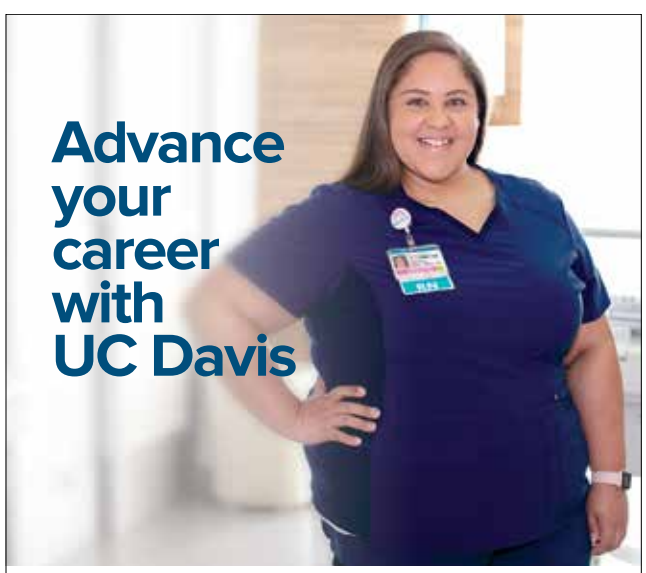
I learned that the land the wall is built on is sometimes six feet lower on the Mexico side, making it impossible for loved ones to see each other. When the land is level on both sides, and families should be able to see each other, small, tight mesh between the pillars prevents them from touching one another.

On one of the most impactful days, the travelers carried jugs of water into the desert for immigrants who reached the desert on the U.S. side. The travelers described the desert as hot, dangerous, gravely, steep, and rocky with a narrow path. The corridor they walked had been "groomed by the border police" so that the immigrants had to cross at the most dangerous place. Due to tall grass and bushes on the route, it was difficult to navigate. There was no water. According to the travelers, border police have authority to patrol up to 100 miles outside the border wall into the U.S. The travelers were stopped at least two times on this route by the border police. There are three spy towers near the wall, and helicopters frequently fly over. One traveler described it as a police state. And this was in our own country. Also, the "groomed route" forces immigrants to walk through an active military bombing range (Barry M. Goldwater Range.) https://psmag.com/social-justice/for-many-migrants-the-last-leg-of-the-journey-north-is-through-a-minefield

Pictured: The Reno travelers on the route that immigrants use. It was difficult to maintain eye contact with each other while taking this trail.

Stan described walking on a dangerous and narrow portion of the trail. He fell at least 17 times. Stan served in the Army in Vietnam and was exposed to agent orange. He suffers from symptoms of Parkinson's, which affects his ability to walk. This trip meant so much to him that he refused to give up on the nearly one-and-one-half-mile trek. He finished the trek by placing his hands on the shoulders of a fellow traveler in front of him. They had to take small steps to prevent Stan from falling. I could tell that Stan related to the fear and pain of immigrants trying to cross the desert.

The travelers observed court proceedings while in Tucson. Billie Jean described seeing immigrants who were arrested for trying to cross into the U.S. enter the courtroom in shackles. There is no difference in the treatment of the immigrants, whether it was their first attempt to cross the border (which is a misdemeanor) or not.



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Many are sent to private and isolated detention centers for 15-180 days. The travelers felt the arrested migrants were sent to detention centers farthest from their homes. This was to make it difficult for family members to visit and thus prevent petitioning or disruptions outside of the detention centers. These individuals were arrested because they were trying to escape a horrible and unsafe situation and find a better life in the U.S. They are provided court-appointed lawyers. However, most of the documents provided are in English only. The language spoke in the courtroom was English. Nothing was translated into Spanish. Most didn't understand the proceedings or understand what they agreed to, worsening their outcomes.

For immigrants seeking asylum, their cases are classified as civil. Because the cases are classified as civil, they are not granted court-appointed attorneys. Again, all the correspondence is in English. Less than 1% of individuals seeking asylum are granted asylum.

Providing water to immigrants has been considered "harboring" immigrants and classified as a felony. Dr. Scott Warren of Tucson faced federal charges with the possibility of 10 years in prison for what, during ordinary circumstances, is a humanitarian act. On November 21, 2019, Scott Warren was found not guilty on two counts of harboring unauthorized migrants.

The interview concluded with Pat stating that she is in a state of depression since her return to Reno. Bob stated that listening and speaking with the group today, he is close to tears when he describes what he experienced on the trip.

I heard in their voices and see on their faces how the trip impacted them and that they will never forget what it was like to see first-hand how cruel individuals can be towards each other. The travelers want readers to understand that there are organizations and individuals continuing to help the immigrants seeking a better life. This trip was made possible by the Unitarian Universalist College of Social Justice. Photos provided by Pat Purkey-Entwistle.

Nurses help with disasters either individually or through organizations. National Nurses United (NNU) and Registered Nurse Response Network (RNRN) are two organizations that respond to disasters and humanitarian needs. In an article in the March 2019 edition of *National Nurse*, Cathy Kennedy, RN, and a vice president of NNU stated, "It is extremely important for the RNRN to help migrant families who are fleeing from extreme poverty, widespread violence and political repression, conditions that were brought on in part because of U.S. policies."

Additionally, a press release, "Nurses Speak out about Border Conditions," dated September 17, 2019 is located on the NNU website. https://www.nationalnursesunited.org/press/nurses-speak-out-about-border-conditions

Nurses can be part of the solution. We can ensure that as we care for human beings, regardless of where they were born, we always treat them with dignity and humanity. Universal Declaration of Human Rights can be downloaded from https://www.un.org/en/universal-declaration-human-rights/

To learn more on how you can become involved in humanitarian efforts on the Mexico-United States border, visit: BorderLinks at www.borderlinks.org, No More Deaths at www.nomoredeaths.org, National Nurses United at https://www.nationalnursesunited.org/ and, Registered Nurse Response Network at https://www.nationalnursesunited.org/rnrn

Horizontal or Vertical Violence: It's All Disruptive

Sandra Olguin, DNP, RN

Horizontal violence, lateral violence, vertical violence, and bullying are names used interchangeably. However, lateral and horizontal violence are peer to peer disruption and vertical violence and bullying are inferred to be from the top-down. However, the behavior is dissected, it's disruptive, uncivil, unprofessional, and unhealthy, especially in healthcare.

Bullying behaviors may be blatant or subtle and intentional or unintentional, including verbal innuendos (snide remarks), insults, gossiping, backstabbing, backbiting, exclusion, intimidation, omitting information, and negative non-verbal actions (eye-rolling, arm-crossing).

People in leadership roles may misuse their authority by not only demonstrating the behaviors above, but also by removing or adding roles, responsibilities, and assignments without justification, giving ultimatums and threats, and accommodating, growing, and building some staff but not others for personal, rather than professional reasons.

Mikaelian & Stanley (2016) identified 98% of nurses surveyed reported experiencing some form of incivility. According to Sauer and McCoy (2019), workplace bullying in nursing is a persistent problem, with 40% of the 309 nurses surveyed reported being bullied within the past six months (p. 223). Also noted, 68% of the nurses surveyed witnessed a co-worker being bullied.

The frequency of experiencing bullying, affects nurses' physical and psychological health complaints and leads to depressive symptoms (Dehue, Bolman, Vollink, Pouweise, 2012). These behaviors may also affect productivity, sleep, anxiety, quality care, patient safety, employee, patient, and physician satisfaction, healthcare costs, turnover, burnout, and absences (Giorgi, et al., 2016; Shimp, 2017; Wright, Khatri, 2015).

Davidson, Proudfoot, Lee, and Zisook (2019) completed a longitudinal analysis of nurse suicide rate in the United States and recently published their findings. Firth (2019), from *MedPage Today*, asserts that Davidson stated, "…nurses are at higher risk of suicide than the general population." Although Davidson, et al. (2019) did not discuss or infer a relationship between bullying and suicide, the possibility is valid. Feelings of anxiety, depression, not wanting to go to work, turning inward and feeling hopeless are all feelings, if left untreated, may lead to attempting and committing suicide.

Bullying is an activity that disrupts the health care environment which may negatively impact patient safety and outcomes, according to The Joint Commission (2015). Institutions are responsible for maintaining a healthy work environment and policies were created to hold perpetrators accountable. The American Nurses Association Code of Ethics for Nurses (American Nurses Association [ANA], 2019) guides our nursing practice. It reminds nurses to be respectful and compassionate to everyone, to treat others with dignity and value, to participate in creating "environments and conditions of employment conducive to the provision of quality health care," to collaborate with other members of the healthcare team, and to maintain the integrity of the nursing profession.

An *Incivility in the Workplace Nursing Survey*, after IRB approval, will be available through the Nevada Nurses Association and Nevada Nurses Foundation website. Please complete the survey and share it with your nursing colleagues to find out where we stand after over 20 years of identifying nurse to nurse bullying. Let's be the change we all wish to see in nursing and support one another, model the behaviors we wish to see, and "do unto others as we would have them do unto us."

For more information, please email me at solguin@NVNurses.org.

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Healing Through Your Hands

By Tracey Long RN, APRN, PhD, MS, MSN

Nurses are used to using their hands to help heal patients, but how can patients help heal themselves by their own hands? Using hands to create art can help heal the soul. Eliane Balsewich has used her hands to create the Healing Art Program at Summerlin Hospital, Las Vegas. Inspired by her own background of coping with postpartum depression through painting, she realized how powerful art can be in the healing process. She also taught art to children in a behavior school years ago, and the school faculty were amazed at the improved school moral and behavior of the children when they could express themselves through paint and crafts.

She began her nonprofit company Busy Bee Art Foundation to schools and eventually to the hospital. Her foundation's goals are to continue reaching hospitals, senior centers, and schools and to heal, empower, and encourage children and adults through artistic expression. She started in the pediatric unit where children could become an artist and not just a cancer patient or a sick child. The program was very successful to improve the positive energy and spirit of fun on the unit, in addition to decorating the unit walls and halls with the drawings and artwork of the children.

The success continued with adults. One particular patient named Dalilah was struggling with a new diagnosis of cancer. She was treated as an inpatient for extensive IV chemotherapy and was in the hospital for several months. As to be expected, she became depressed and disinterested in everything. Then Eliane brought her Busy Bee Art program to the oncology department by request of the oncology nurses where she offered her free program once a week. Each Monday Dalilah would attend and create art. Soon the nurses noted how improved her mood was after each session. Family members would also attend and could see the joy of the patients in the process of self-expression and the creation of art. The nurses also noticed their own increased enjoyment by seeing the art being created, and recognized it was healing them. This time the patients helped heal the frequently weary nurses!

Eliane's advice for nurses is that art can heal even if it can't cure. It affects the patient, the nurse and often the family who can see and feel the sincere care for their loved one. Nurses can become the catalyst for art therapy by inviting artists into their department, with administrative approval of course, and promote the expression of their patients through different mediums of art. Sometimes the negative emotions of anxiety, stress, depression and fear can be dealt with on paper through paint or crayons better than words can express. Nurses recognize the importance of treating the whole patient and art therapy can be a remedy. One of her favorite quotes is "Earth without ART is just EH" by Demetri Martin.

For more information, or to explore the possibility of developing an art program in your healthcare facility, contact Eliane at Busy Bee Art Foundation at https://www.busybeeartfoundation.org/ or busybeeartstudio@yahoo.com

Eliane Balsewich (Foundation Artist) with Carla Stevens, RN, Oncology Department Coordinator

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APRN Corner

The Benefits of a Nursing Network: Building Relationships in our Nursing Community

Susan S. VanBeuge, DNP, APRN, FNP-BC, FAANP

Networking is a fabulous tool in our box of skills and accessories within our profession. Many times you meet someone for the first time, and it doesn't take long to discover the common thread – nursing! This connection happens more often than not, as this invisible bond seems to bring us together. According to the American Association of Colleges of Nursing (2019),[1] nurses represent the largest healthcare profession, with nearly four million registered nurses nationwide. According to the Nevada State Board of Nursing 2017-2018 Annual Report, there are 44,555 licensed nurses in the state.[2] According to the International Council of Nurses (ICN), there are more than 20 million nurses worldwide.[3] With all of these licensed nurses in our midst, it's no wonder we have such a vast and diverse network of colleagues nationally and internationally.

Building your network of colleagues and friends can be a powerful tool for learning, advocacy, and improving the community. In my experience, I've had many opportunities to network with others to advocate and work to modernize legislation to reflect current nursing practice as well as health care delivery. These experiences, to make a positive change, don't happen in a silo but require a network to mobilize so that our voice can be heard. Think of the huge voice of nearly four million in our country alone and how this network could work together to change the world!

But what about your local work? How many times do we see issues requiring a call to action? These issues may be small in your community or more significant in the state. Our relationships with each other as professionals, as well as those within our communities, are so important to health and wellbeing. These relationships can be mobilized to make change or simply be nurtured for development and fellowship.

As the Director of Clinical and Community Engagement at the University of Nevada, Las Vegas, I've had the privilege of meeting with many nurses and leaders over the last year throughout Nevada. From Battle Mountain to Caliente to Las Vegas and Reno, nurses are leading the way. In these meetings and discussions, two common themes reoccurred - networking and fellowship. Nurses want to be connected and share their ideas, thoughts and have a common bond and a place to make this happen. One of the ideas that came out of my fact-finding mission was to create a place where nursing leaders, engaged in clinical education in Southern Nevada, could gather to meet each other face to face, share ideas, and learn from each other. Out of this, the Southern Nevada Nursing Practice Alliance (SNNPA) was born. Our group includes nurse leaders in the area of education who showed an interest in being part of a powerful alliance to identify, discuss, and work together to see what is available in our community as well as share ideas on good things happening in their communities.

The SNNPA, formed officially in early 2019, has been off to a great start. We've made new friends and have shared ideas for a common goal - networking to create meaningful, deep, and lasting relationships as nurses. At our last meeting, an expert panel discussed telehealth implementation in Nevada. We heard from nurses in private organizations, public institutions, and a national government healthcare organization. The panel gave their perspective on what technology is being utilized to deliver the best care possible with sometimes limited resources and often limited access (think rural).

Another nursing network I'm proud to be part of is in my church community. I've been working as a volunteer for many years, taking blood pressures on the first Sunday of every month for members of my church community. This activity has built a wonderful fellowship with parishioners' but also with my nurse colleagues in my church. Over time, other nurses wanted to be engaged and make plans to be a bigger part of our community. We met and made a list of goals for the church community. From this initial meeting, our nursing network has ensured the installation and maintenance of automatic defibrillators (AEDs) and started a discussion regarding disaster planning for the church campus. What an excellent opportunity to work with other nurses to demonstrate leadership, collaborate with others, and make a positive change in our local community.

Take time to think about networks within your community. It's likely they are deep and well developed as they are second nature for many. Next, consider how to build your network further to meet goals of improving a community, organization, or making change in the world. We all have that power within us to mobilize, connect, and utilize our fellow nurses to make positive change in the world.

References:
1 American Association of Colleges of Nursing (2019). Downloaded from https://www.aacnnursing.org/News-Information/Fact-Sheets/Nursing-Fact-Sheet
2 Nevada State Board of Nursing Fiscal Year 2017-2018 Annual Report (2018). Downloaded from https://nevadanursingboard.org/wp-content/uploads/2018/12/87798-NV-State-Board-of-Nursing-book.pdf
3 International Council of Nurses (2019). Downloaded from https://www.icn.ch/

Meet the New 2019-2020 NNA Board of Directors

President	Vice President	Secretary	Treasurer	Director at Large	Director at Large	Director at Large	District 1 President	District 3 President
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COMMUNITY FOUNDATION of Western Nevada

Tips and Resources on Preventing Financial Scams

The Community Foundation of Western Nevada is a 501 (c) 3 nonprofit organization.

Our mission is to connect people who care with causes that matter. The Community Foundation is leading a new initiative on Preventing Financial Scams. Unfortunately, there are many types of scams and financial abuse. Here are some common scams and tips to protect yourself:

1. Collection Fraud Scam.

If a company you're unfamiliar with is calling you and claiming that you owe them money, then you might be subject to a collection fraud scam. Here are the signs to look out for:

- A caller claims there is a warrant for your arrest and advises you to make an immediate payment to avoid legal trouble.
- A caller pressures you to pay money by claiming that someone will visit your home or place of employment.
- A caller claims to be from the IRS.
- You are instructed to send payment to someone other than the party to which you supposedly owe money.

2. Grandparent Scam

Scam artists try to tug at the heartstrings of their targets by pretending to be related to them. Here are the signs of a grandparent scam:

- A grandchild contacts you instead of his or her parents to ask for money.
- The caller asks you to wire money to a person or place that you don't recognize, or to a country other than where the caller says he is located. (For example, the caller might claim to be in a Canadian jail but ask you to wire money to Jamaica.)
- You receive a call from someone who doesn't really identify himself or makes you guess who he is.

If you believe you have become the victim of a grandparent scam, please contact your local law enforcement agency and immediately notify the financial institution(s) the funds were sent from.

Source: William Palmer III, Financial Advisor

Here are tips to protect yourself from scams:

Consumer Financial Protection Bureau – According to the Consumer Financial Protection Bureau, here are easy ways to protect yourself from scams:

1. Don't give out the basics: numbers, passwords, credit cards, or Social Security.
2. Do not pay for something promised upfront to receive it – fees, taxes, or prizes.
3. Do your research and compare prices after hearing a sales pitch.
4. Put your number on the National Do Not Call Registry. Go to www.donotcall.gov or call (888) 382-1222.

Other tips:

- Inspect your credit report. For more information, visit www.AnnualCreditReport.com or call 877-322-8228.
- Do your research on a business before making any kind of payment or signing a contract. (The Better Business Bureau is a good source of information.)
- Be cognizant of phone calls and junk mail.
- Download the HIYA App: Caller ID, Call Blocker for protection from scam calls.
- Have a healthy skepticism when it comes to individuals to avoid falling prey to scams and fraud.
- If you have been affected by a scam, fight back. Do not stay silent.
- Be mindful of any message with emotional amplification or a sense of urgency.
- Never give your Social Security Number, car's VIN number or other personal information to someone you do not know.
- If you do not know who is calling you, do not pick up the phone.

Reporting the fraud:

If you believe you have been victimized by fraud, report the incident to:

- Your state Attorney General's office (www.naag.org)
- The Federal Trade Commission (FTC) at 877-382-4357 or www.ftc.gov
- The Consumer Financial Protection Bureau at 855-411-2372 or www.consumerfinance.gov

You can find additional information on financial planning by downloading the Washoe Caregivers Guidebook at https://washoecaregivers.org/documents/washoe-caregivers-guidebook/

SAVE the DATE!

On Saturday, March 28, 2020, join us at the 6th annual Wild West: Tea on the Comstock Big Hat High Tea at the Governor's Mansion. Tickets will go on sale after confirmation from the NV Governor's Mansion, 90 days prior to the event! Tickets go fast so purchase your ticket ASAP!

Veteran's Administration (VISN 21) Nursing Research & Evidence-based Practice Collaborative Conference

July 19, 2019

Submitted by Bernadette Longo, PhD, RN, CNL, FAAN and Kelly Presser, MSN, RN, CNL

Over 80 nurses from across VISN21 gathered for the 2nd annual Nursing Research and Evidence Based Practice Symposium, titled "Blueprint for Excellence Utilizing Research and Evidence-based Practice." This year's meeting was held at the VA Sierra Nevada Health Care System's hospital in Reno. Attendees came from as far as Hawai`i, Palo Alto, San Francisco, Fresno, and Las Vegas to gather and spend the day networking. Conference coordinator Kelly Presser, MSN, RN, CNL shared "*this is a wonderful opportunity for VA nurses to share the amazing work they are doing with their colleagues. Our goal is to spread best practices throughout the VA, to inspire nurses and to demonstrate the amazing things that nurses are doing.*"

The event started with a warm welcome from the acting nurse executive of the host institution Maisha Moore, MSN, RN, CNL. There was a dynamic keynote presentation from Dr. Mary Foley, a research expert from UCSF's School of Nursing, on the use of evidence to improve care to our Veterans. A Hawai`i VA nurse scientist Dr. Judy Carlson presented on neurofeedback's positive impact on sleep, headache and attention deficit disorders experienced by Veterans with minor traumatic brain injuries. The San Francisco VA System had several researchers who reported on new interventions for colon cleansing prior to colonoscopy and improving advanced care planning for Veterans with late-staged illnesses. A presentation on the evolution of data-driven strategies to decrease readmissions for heart failure was delivered by the VA's Palo Alto-based statistician Dr. Satish Mahajan. Other nurse scientists with a Nevada connection also presented at the conference. UNR Orvis School of Nursing's Dr. Bernadette Longo shared evidence-based interventions for use during wildfire smoke events and volcanic eruptions, highlighting last summer's Kilauea volcano eruption. Dr. Michelle Pelter, a former faculty member with Orvis and currently with UCSF, presented on alarm fatigue and EBP interventions to reduce its impact. In addition, Dr. Terri Kozik, formerly with St. Mary's Hospital in Reno and currently with St. Joseph's Medical Center in Stockton, presented on a few studies including an enlightening investigation on arrythmias emerging from energy drink consumption during exercise. Moreover, several EBP initiatives from across VISN21 were featured on posters that attendees reviewed. All these presentations highlighted the growth of the VA's EBP initiative and clinical advances now in place for our Veterans.

Several nurses attended from the VA's Southern Nevada Health Care System Nursing and Evidenced Based Practice Sub-Committee. Cindy LeVee, MSN, RN, CNL a committee member stated, "*The most important thing I took away from the Symposium was the statement: 'If you have meaningful interventions, you will decrease readmission rates.' I will add that we cannot have meaningful interventions unless we find and evaluate the evidence or conduct research.*" Alexis Starks, an RN from the VA Sierra Nevada Healthcare System, shared, "*This was a truly inspiring experience to see the innovations made in healthcare led by nurses. It left me feeling inspired.*"

Collaboration is a key to building clinical research and enhancing EBP for Veteran's care. One of the conference organizers Vonnie Doolin, MSN, RN states, "*It was exciting to bring the VISN 21 VA EBP Workgroups and Universities from California and Nevada together to collaborate. The quality and content of the presentations got a lot of the staff and the professors excited about nursing research. Since the symposium, I have received a lot of requests from our VA employees for nursing certification books and for guidance on best practice projects.*"

Sponsors for the conference included the VA's Suicide Prevention program, Alzheimer's Association, American Parkinson Disease Association, Donor Network West, EBSCO, Wolters Kluwer, The Western Regional International Clinical Nurse Leader Association, and the Orvis School of Nursing from University of Nevada Reno.

Conference Organizers: (From left to right) Michelle McNary, Cindy Snell, Linda Franke, Makenzy Garvey, Vonnie Doolin, Jeanne Meacham, Maisha Moore, Liz Cianci, Kelly Presser, Jennifer Stathes, Brenda Darden. Not pictured, Drew Hill.

Evidence-based project poster: "Implementation of Animatronic Companion Pets to Improve Quality of Life, Reduce Falls and Reduce Medication Use in the Community Living Center" by Clinical Nurse Leader Kelly Presser, Socorro Conway, RN, MBA, and Joanne Farris ACC/MC, CCI, CDP, MS.

Presentation: University of Nevada's Orvis School of Nursing researcher Bernadette Longo speaking on evidence-based interventions to use for Veterans during air pollution events

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Nurses in the News

Celebrating our Exemplary Nurses

By Tracey Long PhD, RN, APRN

The true spirit of nursing is exemplified by Carla Stevens and Laura Devine at Summerlin Hospital in Las Vegas, Nevada. They have both been oncology nurses for many years and currently Carla is the Oncology Program coordinator and Laura is the specialty case manager for the unit's oncology patients providing resources and support. In addition to supporting their staff with education, together they have gone above and beyond to invite an art therapist to provide creative expression for their patients on their unit, organize and promote donations of wigs and blankets and create a meditation room for staff and patients on the unit.

Oncology nurses have an extra measure of compassion as they help patients deal with cancer diagnoses and treatments who are often hospitalized for weeks to months. Carla noticed many of the female patients who lost their hair also lost their self-confidence and hope. She turned a small supply closet into the oncology wig and hair supply center and brought wigs to her patients directly on the unit. She also promoted and received crochet hats and blankets from outside volunteers to stock the closet. Patients helped paint the display heads for the wigs in one of the weekly art classes and she began to see new joy among the women. Hair is generally considered dead however it can bring life to someone suffering from cancer.

Cancer is still the second leading cause of death after heart disease for both men and women. According to the American Cancer Society, an estimated 1,800,000 new cases of cancer occurred in 2019 with 600,000 deaths from cancer in the United States annually. The good news is that annual statistics reveal a 27% decrease in cancer death rates in the past 25 years. Health Professionals estimate the decrease is due to reductions in smoking, early detection from screening and early treatment. The most common types of cancer still remain lung cancer for both genders, followed by prostate cancer for men and breast cancer for women. PSA blood tests for screening are no longer recommended due to the high number of false positives and over diagnosis. Mammograms are recommended beginning age 50 every two-three years until age 75, unless there is a family history of breast cancer. Breast cancer accounts for 30% of all new cases and due to recommended mammograms and screening, many are treatable with favorable outcomes. The incidence of colon cancer has also declined in the past decade due to earlier detection and promotion of a colonoscopy every ten years after the age of 50 and use of fecal occult blood test (FOBT) annual screenings. There is still a higher incidence of all types of cancer among African Americans and lowest for Asian Americans. Lower socioeconomic groups also see a higher incidence of cancer and poorer prognosis due to lower rates of screening, later stage at diagnosis and delays obtaining treatment.

Certified oncology nurses represent 35,000 in the United States and are a strong voice for screening and healing modalities. According to salary.com, oncology nurses in Nevada receive an annual salary range between $68,700-85,900. There is specialty certification for oncology nurses through the Oncology Nursing Certification Corporation (ONCC) that requires 12 months of work experience, 1,000 hours of oncology nursing experience, and passing a 165 multiple-choice exam. For more information on how to become certified go to: https://www.oncc.org/

Oncology nurses make a difference. To donate wigs, blanket or hats to the oncology unit at Summerlin Hospital or to learn more how to help contact Carla Stevens at laura.devine@uhsinc.com.

Online Resources

American Cancer Society - https://www.cancer.org/latest-news/facts-and-figures-2019.html

Oncology Nursing Society - https://www.ons.org/

Chemotherapy and Immunotherapy Guidelines and Recommendations for Practice - https://ebooks.ons.org/book/chemotherapy-and-immunotherapy-guidelines-and-recommendations-practice

Carla Stevens in the Oncology wig and supplies closet at Summerlin Hospital, Las Vegas, NV.

Nevada Nursing Student Association Participates in Nevada Nurses Foundation's Annual Gala

Submitted by Shauna Aranton, UNLV Graduate December 2019, Immediate Past Communications Director, NVNSA

On October 26, 2019, our organization, the Nevada Nursing Student Association (NVNSA), had the pleasure of attending and assisting with the production and execution of the Nevada Nurses Foundation's annual gala, the Shining Stars of Nursing in Nevada (SSON). Some of our NVNSA board members even received awards! It was truly inspiring watching our mentors, our instructors, and even our peers receive recognition on their hard work and contributions that make an impact on our community. At the SSON gala, the Nevada Nurses Foundation honored 'nurses on boards,' student nurse leaders, nurses who achieved professional progression (advanced degrees or certifications) and presented awards such as the People's Choice CNO/DON, 50 under 50, and Distinguished Nurse Leader with Lifetime Achievement. Not only did everyone look fabulous in their gala attire, but everyone had an incredible time!

Earlier in the day on October 26, the NVNSA hosted a well-attended student event at the Clinical Simulation Center of Las Vegas. The students had opportunities to speak with exhibitors, participate in a test-taking strategies workshop, and listen to a nurse roundtable. As a student, it was incredibly motivating to see the endless opportunities in nursing and scholarships for continuing education or research, peer recognition, and networking for our future practice. It was encouraging to know that as a community, nurses can, and are, making a difference in health and healthcare.

Student nurses are encouraged to join your local professional organizations, attend their events, and apply for scholarships. As a student, and soon to be a nurse, know that this is our collective community, so join in and make an impact; you will have fun while learning about leadership in nursing!

Nevada Nurses Foundation EST 2014

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On behalf of the Nevada Nurses Foundation (NNF), thank you to all the individuals and organizations who supported the Shining Stars of Nursing in Nevada, the 4th annual Nevada Nursing Gala, on Saturday, October, 12, 2019, at the Blind Center of Nevada. Thank you, to the brilliant co-leaders, Rev. Dr. Denise Ogletree McGuinn and Karen Bearer for taking the lead and creating an elegant and "glamazing" event on a dime! Thank you, to the wonderful team of nurses, community members, and student nurses for your contributions! The event was sold out! Thank you to Dr. Jameson, Boyd Gaming Enterprise, and Dr. Glenn Hagerstrom for your generosity and allowing several awardee's to receive a complimentary ticket to the Gala! Thank you to all of our event sponsors!

We were honored by the distinguished Congresswoman, Susie Lee giving the opening speech which included her gratitude and recognition of the tremendous work nurses do every day. The Nevada NURSING STARS from Pahrump, Las Vegas, Carson City, Henderson, Elko, Reno/Sparks, and Lake Tahoe were shining brightly as we celebrated generous partners and sponsors, amazing nurses and student nurses, and five years of being a federally recognized 501(c)(3)!

The Nevada Nurses Foundation came to fruition in 2014 and began awarding scholarships in 2015 and grants in 2018. The NNF has recently exceeded $100,000 in scholarships and grants! The NNF grant application is open now at https://NVNursesFoundation.org until February 2020 and scholarship applications are open two times a year, in February 1-28 and August 1-28. To qualify, you must be a Nevada resident pursuing a career in nursing (CNA, LPN, RN) or you are an unencumbered Nevada nursing license holder looking to advance their nursing degree from an accredited nursing school or certification program.

To eliminate bias and maintain the anonymity of each applicant, applications are redacted before judges review them. The demographic breakdown recently moved from 40% in both the north and south and 20% in the rural area to north, 32%, south, 50%, and 18% rural area. There are several legacy scholarships with demographic criteria for a southern candidate that may influence the increase in awardees from the south.

The NNF Executive Board recently approved the addition of another NNF scholarship to meet the needs of the graduate nurse who is pursuing a post-graduate degree. This type of scholarship will benefit a nurse who already has their MSN or Doctorate and is pursuing a post-graduate certificate. The NNF will now be sponsoring and awarding the following scholarships:

- Certified Nursing Assistant (CNA)
- CNA to Registered Nurse (RN)
- Licensed Practical Nurse (LPN)
- LPN to RN
- RN to Bachelors of Science in Nursing (BSN)
- Pre-licensure to Nursing (Associates or Bachelors Degree in Nursing)
- Masters of Science in Nursing (MSN)
- Doctorate
- Post-Graduate

Legacy Scholarships or Endowments are funds donated by a generous individual or organization. The amount of the award and the criteria is identified by the donor.

When considering making a charitable donation to a transparent and reputable organization, please consider the Nevada Nurses Foundation. Aside from the cost of doing business, marketing, and some travel expenses, 70% of funds go to scholarships and grants. The NNF values your support to carry out the NNF mission. Giving a gift to increase access to healthcare in Nevada, not only benefit you, it also benefits someone you care about receiving care as well as the recipient. If you would like more information about how you can get involved, make a donation, or sponsor a scholarship or event, please contact us at NNF@NVNursesFoundation.org.

Thank you and have great days,
Sandy M. Olguin, DNP, MSN, RN
President and Chief Executive Officer
Nevada Nurses Foundation

Program Director
Graduate Nursing Program

Midwestern University College of Health Sciences, Glendale, Arizona invites applications for the administrative position of Program Director to oversee the establishment of master's (MSN) and doctoral (DNP) Nurse Practitioner degree programs.

The University seeks an individual with leadership, vision, creativity with a record of scholarly activity, administrative experience and qualifications for a faculty position at the rank of Associate Professor or higher. Salary and benefits are commensurate with experience and the responsibilities of this key position. Review of applications will begin immediately and continue until the position is filled.

Job Requirements:

1. A current unencumbered RN license and eligibility to practice in Arizona,
2. An earned doctorate in nursing or health-related field,
3. At least two years of clinical experience as an Advanced Practice Registered Nurse (APRN) and a current national certification as an APRN.

Contact: Jacquelyn M. Smith, Ph.D.
Dean, College of Health Sciences
jsmith@midwestern.edu | 623-572-3600

MIDWESTERN UNIVERSITY

Application Instructions:

Please submit your application packet through MWU's online job board at **www.midwestern.edu**

1. Select "Employment at MWU" from the Quick Links then "View Current Job Openings" to view the job board
2. Select "Faculty" for job category and "Arizona Campus" for company location to narrow down the search
3. A complete online application should include a cover letter and CV.

Nevada Nurses Foundation EST 2014

Nevada Nurses Foundation EST 2014

Our Recent Fallen Heroes

Lori Griffin

Lori Griffin found nursing later in life, and blossomed as an individual, as a peer, and as a colleague within the School of Nursing at Nevada State College. Her journey took her across the world and back, and like the sun, her smile lit up a room. She was a shrewd business woman and had a thriving career as a travel consultant prior to dreaming about a career as a nurse, family and achieve a desire to help others. Her nursing career had barely started as she had much to achieve. Unfortunately, she leaves us far too soon to realize those dreams.

Jami-Sue Coleman

Jami-Sue held a BSN, two master's degrees, and a doctorate in Nursing Education. She worked at Carson Tahoe and St. Mary's Medical Center in a variety of departments. She enjoyed caring for children in the intensive care nursery and pediatrics at St. Mary's. She spent five years as a nurse missionary working with the poor in Papua New Guinea, the Himalayas, and Turkey. Family and friends of Jami-Sue have established the **Jami-Sue Coleman Scholarship**.

Patricia Alfonso

Pat earned her BSN from Mt. Saint Mary's College just before turning 50 years old after her husband passed away. She went on to earn a MSN from UCLA in 1977. Pat obtained her APRN credentials and served the mental health community of Northern Nevada through private practice, teaching at various local colleges, and serving on the Nevada State Board of Nursing. She retired at the age of 80 having served the mental health community in Northern Nevada for over 15 years. Pat's family and friends have established the **Patricia Alfonso Nursing Scholarship**.

Lauren Delameter

Lauren was a graduate of Carrington College and Orvis School of Nursing. She was completing her Masters in Nursing. She recently obtained a certification in Emergency Room Nursing. This young woman was a strong advocate for advanced education in nursing and was an inspiration to all her peers to pursue higher levels of nursing education. She always promoted excellence in nursing practice through advocacy, hard work, and education on all levels of nursing practice. Family and friends of Lauren's have established the **Lauren Nicole Delameter Nursing Scholarship.**

Deloris Middlebrooks

Deloris served the nursing community for 57 years as a nurse and a nursing instructor. The Nevada Nurses Foundation has established the **Dr. Deloris Middlebrooks Legacy of Nursing Scholars Fund** to honor an icon in Nevada nursing. This fund will be used to further the Foundation's mission to promote professional development of nurses through recognition, grants, and scholarships.

Gayle Wickman

Gayle attended the diploma nursing program in San Francisco. She worked as a staff nurse at the Lindsay District Hospital and became the Director of Nursing in just four years. During her career, she was awarded the "Faculty of the Year" several times at the College of the Sequoias and "Most Inspirational Faculty" several times during her tenure at the University of Nevada, Reno. She received the Lifetime Achievement Award from the Northern Nevada Nurse of Achievement in 2011.

Dr. Susan Adamek

Susan was the former President of the Nevada Organization of Nurse Leaders, treasurer of both the Nevada Alliance for Nursing Excellence and the Nevada Action Coalition, a member of the Education Advisory Board for the Nevada State Board of Nursing, the American Organization of Nurse Executives, and the American College of Healthcare Executives, to name just a few.

As Director of Education for the St. Rose Dominican system, Susan had oversight for New Leaders Orientation and New Nursing Managers Training. She was also a member of the St. Rose Dominican Ethics Committee.

Through her career, Susan became more and more passionate about education, completing her Ph.D. in Nursing Education from the University of Nevada-Las Vegas in 2015.

Susan will be remembered for many accomplishments, but her lasting legacy will be how she empowered people to overcome challenges, reach milestones, and move ahead to be their best.

Linda Platz, RN

Linda Platz graduated from Mead High School outside of Spokane, Washington, in 1963, and then continued to nurses training at Legacy Emanuel Medical Center in Portland, Oregon. After completion of her training, her career as an RN spanned over five decades and included many different aspects of nursing, including at hospitals, the Nevada State Prison System and the Nevada State Health Department. Linda retired from the State of Nevada as a RN in the Vaccines for Children program. Linda passed away April 20, 2019, at the age of 73.

Anytime she met someone who wanted to become a nurse or was in school to become one, Linda's reply was always "Oh good, we need more nurses!"

Margaret Curley

Margaret served many years as Nevada Nurses Association's Executive Director and was highly respected from nurses throughout Nevada. She retired from the position in September 2018. She was the 2018 recipient of the Distinguished Nurse Leader with Lifetime Achievement Award and the Nevada Action Coalition Nurse Nightingale Award. She was one of the founders of the Nevada Nurses Foundation, and served as the NNA/NNF Liaison on the Foundation's Board of Directors. Family and friends of Margaret's have established the **Margaret Curley Endowed Nursing Scholarship**. To contribute to this endowment, please visit the Nevada Nurses Foundation website.

Rev. Dr. Denise Ogletree McGuinn honoring and remembering our Fallen Nursing Stars.

Nevada Nurses Foundation EST 2014

People's Choice CNO/DON

Congratulations to the People's Choice CNO/DON nominees.

Carla Adams, Northern Nevada Medical Center
Anna Anders, Carson Tahoe Health
Toni Bell, Dignity Health: St. Rose Siena
Beth Carlson, Dignity Health: Saint Rose Siena
Judith Cordia, Western Nevada College
Erica Daniels, ProCare Hospice of Nevada
Debra Fox, University Medical Center
Katie Grimm, Saint Mary's Medical Center
Linda Hagemann, Nellis Air Force Base
Lisa Jackson, Sana Behavioral Hospital
Sherri Lindsey, College of Southern Nevada
Jalyn McKelleb, Dignity Health: Saint Rose Dominican Hospitals
Maisha Moore, VA Sierra Nevada Healthcare System
Melodie Osborn, Renown Regional Medical Center
Kathy Raymond, St. Rose Dominican Hospital-San Martin Campus
Jen Richards, Renown Regional Medical
Sandi Scaccia, Sunrise Hospital Medical Center
Stacey Smith, Centennial Hills Hospital
Theresa Tarrant, Touro University Nevada
Holley Tyler, Valley Health Hospital
Janet Wright, Centennial Hills Hospital Medical Center

Congratulations to Debra Fox, People's Choice CNO and Dr. Lindsey, People's Choice DON.

2019 Scholarship Recipients

Congratulations to the 2019 scholarship recipients!
We are so proud of your accomplishments and are excited to see you enter nursing and advance your degree.

Nevada Nurses Foundation Scholarship Recipients

Distinguished Nurse Leaders

Photographed: Ian Curley, Katie Grimm, Doris Bauer, Mary Bondmass, Margaret Covelli, Marissa Brown, Debra Scott

Congratulations to the Distinguished Nurse Leaders with Lifetime Achievement nominees: Doris Bauer, Doreen Begley, Mary Bondmass, Marissa Brown, Margaret Covelli, Stephanie DeBoor, Katie Grimm, and Linda Jacobson!

Nevada Nurses Foundation EST 2014

Thank you, Debra Scott, the inaugural Distinguished Nurse Leader in 2016 and Ian Curley, on behalf of Margaret Curley, the 2018 recipient, for presenting the 2019 award to Dr. Mary Bondmass. Dr. Mary Bondmass lives the Nevada Nurses Foundation mission of increasing access of quality healthcare for Nevada citizens by promoting the professional development of nursing. She is revered as a catalyst for change, advocate in nursing, scholarly writer, and leader in nursing. Thank you, Dr. Bondmass for being of service and making a genuine difference in nursing and healthcare.

50 Nurse Leaders Under 50

Congratulations to the 50 Nurse Leaders Under 50 years of age who are making their mark in nursing! Their fortitude, resilience, motivation, determination, and perseverance to lead the change we need to see in nursing is inspiring. On behalf of the Nevada Nurses Foundation, thank you for all that you do!

Photographed: Sherri Sherk and Heather Shawcross

Professional Progression

There were over 100 nurses who advanced their nursing degree or obtained certification in their practice. Thank you, Heather Shawcross NVNSA President and Sherri Sherk NVNSA Northern Nevada Director for presenting the announcing the Nevada Nurses who professionally progressed by obtaining an advanced degree or certification in their practice.

Professional Partner's Stellar Nurses

Great Basin AACN, Kimmy Fitzgerald (accepted by Jimmy) Western Nevada Advanced Practice Nurses Network, Teresa Praus, Southern Nevada Healing Touch Professional Association, Debbie McKinney, Nevada Nurses Association, Dave Tyrell, Zeta Kappa At Large Chapter of Sigma, Andrew Reyes, Philippine Nurses Association of Nevada, Cristy Sampal, Nevada Emergency Nurses Association, Dustin Bass. Not photographed: Men in Nursing, Stephen Ingerson, Nevada Advanced Practice Nurses Association, Dr. Cindy Pitlock, and Nu Iota At Large Chapter of Sigma, Megan Pratt.

Nevada's Rising Stars Student Nurses

Nevada's Rising Stars Student Nurses

Congratulations to the Shining Star Partnering Professional Organization's Stellar Nurse Award Recipients! Keep shining brightly!

These students are demonstrating leadership, advocacy, community support, and scholarship. They were identified by their educational institution, a professional nursing organization, or community as being a Rising Star! Thank you! We appreciate you choosing to join the nursing profession.

PROGRAM OFFERINGS

Bachelor of Science in Nursing (BSN)

Accelerated Second-degree BSN

Online RN-BSN

Online Master's of Science in Nursing (MSN)

- Clinical Nurse Leader
- Nurse Educator
- Adult Gerontology Acute Care Nurse Practitioner
- Family Nurse Practitioner
- Psychiatric Mental Health Nurse Practitioner

Post-Master's Certificate is offered for all specialties and Pediatric Acute Care Nurse Practitioner.

Online Doctor of Nursing Practice (DNP)

BSN to DNP:

- Adult Gerontology Acute Care Nurse Practitioner
- Family Nurse Practitioner
- Psychiatric Mental Health Nurse Practitioner

MSN to DNP:

- Advanced Practice
- Nurse Executive

Would you like to receive NNA email updates with information relative to nursing & healthcare? YES NO

Membership Options (Check One)

Full ANA/NNA Membership
Includes full membership to both NNA and the American Nurses Association (ANA) for 12 months.

F-Full Membership
_____Employed

R-Reduced Membership
_____ Not employed
_____ Full-time student (must be a RN)
_____ New graduate from basic nursing education program, within two years of graduation
_____ 62 years of age or older and not earning more than Social Security allows

S-Special Membership
_____ 62 years of age or over and unemployed
_____ Totally disabled

***State nurses' association dues are not deductible as charitable contributions for tax purposes, but may be deductible as a business expense.**

State Only NNA Membership

Includes state only membership to NNA only for 12 months. Does not establish membership in the American Nurses Association

_____ Any RN with an active or inactive Nevada license.

***State Only dues must be paid in full at the time of application.**

Payment Plan (Check One)

Full Annual Payment
_____ Check (payable to NNA/ANA)
_____ Visa
_____ MasterCard

Annual Credit Card Payment
This is to authorize annual credit card payments to NNA/ANA. By signing on the line, I authorize NNA/ANA to charge the credit card listed for the annual dues on the 1st day of the month when the annual renewal is due.

_____
Annual Credit Card Authorization Signature*

EDPP (Monthly Electronic Payment)
This is to authorize monthly electronic payments to ANA. By signing on the line, I authorize NNA/ANA to withdraw 1/12 of my annual dues and any additional service fees from my account.
Checking: Please enclose a check for the first month's payment; the account designated by the enclosed check will be drafted on or after the 15th of each month.
Credit card: Please complete the credit card information and this credit card will be debited on or after the 1st day of each month.

_____
EDPP Authorization Signature*

***By signing the EDPP or Annual Credit Card authorizations, you are authorizing NNA/ANA to charge the amount by giving the above-signed thirty (30) days advance written notice. Above signer may cancel this authorization upon receipt by NNA/ANA of written notification of termination twenty (20) days prior to the deduction date designated above. Membership will continue unless this notification is received. NNA/ANA will charge a $5 fee for any returned drafts of charges backs.**

Credit Card Information

_____
Bank Card Number and Expiration Date

_____
Authorization Signature

_____
Printed Name

_____
Amount $

Membership Dues

Full NNA/ANA
Annual $262.00 / Monthly $22.33

Reduced NNA/ANA
Annual $131.00 / Monthly $11.42

Special NNA/ANA
Annual $65.50 / Monthly $5.96

NNA State Only
Annual $105.00 / Monthly — not applicable

To be completed by NNA/ANA

State _____ District _____

Approved by _____ Date_____

Expires _____ Amt. Paid _____

Check # _____

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***Referred to NNA/ANA by:**

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Photographed: Sherri Sherk and Heather Shawcross

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Membership

NEVADA NURSES ASSOCIATION MEMBERSHIP APPLICATION

P.O. BOX 34660, RENO, NEVADA 89533 · 775 747-2333 · FAX 775 201-9002
NNA@NVNURSES.ORG

Please mail your completed application with payment to: NNA, Constituent and Member Billing Services, ANA, P.O. Box 504345, St. Louis, MO 63150-4345.

Please Print Clearly:

Date _____

_____
Last Name/First Name/Middle Initial

_____
Credentials

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Home Address

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City/State/Zip Code + 4

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County

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Email Address

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Home Phone Number

_____
cell phone number

_____
Home Fax Number

_____
Basic School of Nursing

_____
Work Phone Number

_____
Graduation (Month/Year)

_____
Work Fax Number

_____
RN License Number/State

_____
Position

_____
Employer

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Checking: Please enclose a check for the first month's payment; the account designated by the enclosed check will be drafted on or after the 15th of each month.
Credit card: Please complete the credit card information and this credit card will be debited on or after the 1st day of each month.

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Approved by _____ Date_____

Expires _____ Amt. Paid _____

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— Jenevieve S. Kincaid, MD, MPH, RN, USC MPH online Graduate, Class of 2016

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100% of faculty are **certified** in the **APRN** specialty that they teach

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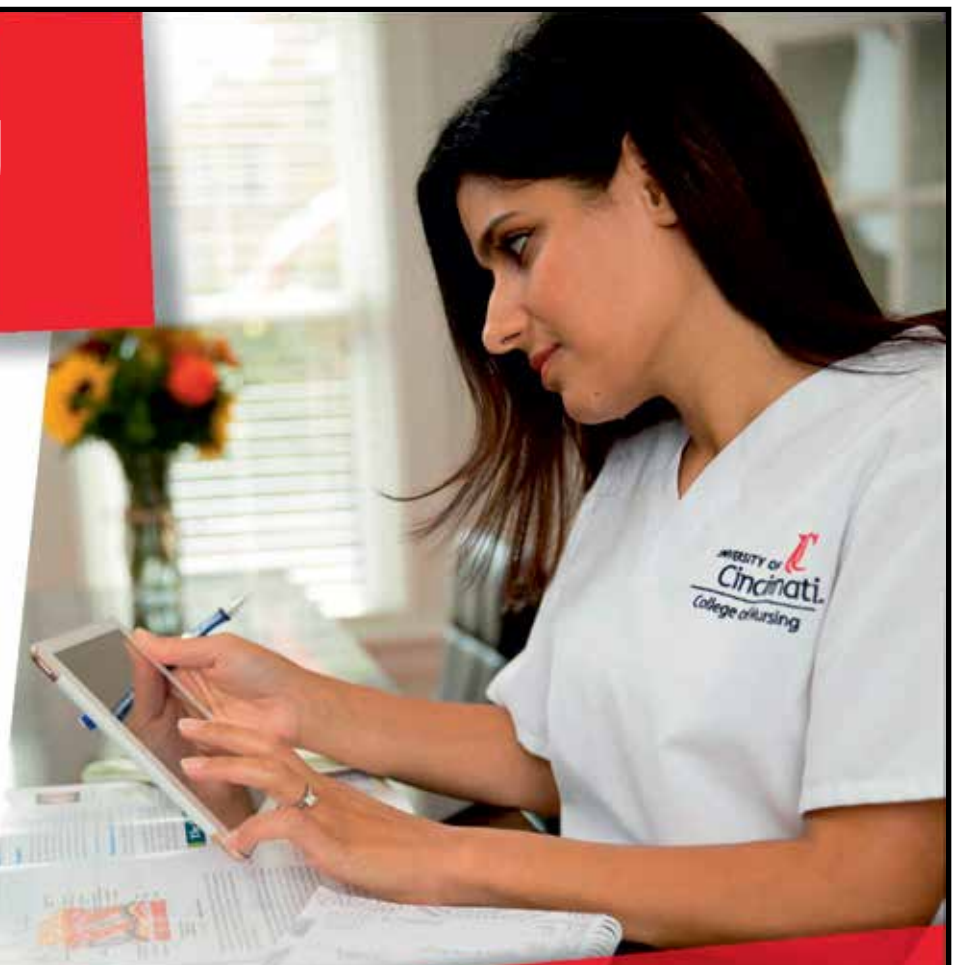

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Post-Master of Science Certificate

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- Psychiatric-Mental Health Nurse Practitioner

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Skilled Nursing (RN & LPN) Home Health under PDGM (Patient Driven Groupings Model) effective January 01, 2020, will revolutionize innovative care delivery standards with additional focus on patient-engagement.

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