The Prairie Rose

NDNA North Dakota Nurses Association

THE OFFICIAL PUBLICATION OF THE NORTH DAKOTA NURSES ASSOCIATION
Circulation 14,000 To All Registered Nurses, LPNs & Student Nurses in North Dakota

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NDNA Annual Election

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ANA Response To Flooding In North Dakota

Karen Daley, PhD, MPH, RN, FAAN
President, American Nurses Association

Dear Colleagues,

On behalf of the American Nurses Association (ANA), I want to express my support and concern as you cope with the severe, statewide flooding that is currently taking place in North Dakota. It is truly devastating to see the magnitude of flooding taking place, and the impact on people and their communities. Our thoughts are especially with those nurses who have been personally impacted by the flooding.

In the fall of 1997, an issue of the *Prairie Rose* reported on how nurses were the "helping hands of disaster," when North Dakota was experiencing the epic "Five Hundred Year Flood" the previous spring. Nurses came together en masse to provide critical services during the chaos, evacuating patients from hospitals and making access to health care possible.

Once again, North Dakota's nurses are answering the call to be the "helping hands" of disaster. Nurses are fully engaged and prepared to provide health care services to those impacted by the disaster. ANA commends the North Dakota Nurses Association (NDNA) and its members for assisting the Red Cross with its disaster response efforts.

Although recovery can be overwhelming, and there is a long road ahead, ANA stands with NDNA and nurses throughout the state, in support always and especially during this time of need.

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CONTENTS

State Department of Health Takes Over Regulation of the Nurse Aide Registry

Changes To the Registry Took Effect July 1, 2011

BISMARCK, N.D.–The North Dakota Department of Health is taking over the regulation and registration of some specific categories of nurse aide registrants starting July 1, 2011. The changes are a result of House Bill 1041, which was passed by the 2011 Legislative Assembly.

As a result of the changes, nurse aides, home health aides, and medication assistants I and II will move from the Board of Nursing's registry to the Department of Health's Nurse Aide Registry. The department will be responsible for the training, competency evaluation, and registration of these groups.

During the 2009 Legislative Assembly, House Bill 1269 directed a study of the steps necessary to enable the Department of Health to administer the registry and to examine the feasibility of one registry and a location for that registry. The study resulted from a need identified by the long-term care industry for one location to check related to the registry of nurse aides in North Dakota. At the request of the Long Term Care Interim Committee, the Department of Health convened a workgroup to study the issue. The transfer of these groups to the Department of Health's registry was a recommendation from that workgroup.

Any initial or renewal applications submitted for nurse aides, home health aides or medication assistants I and II after July 1, 2011, must be submitted to the North Dakota Department of Health, Division of Health Facilities. Applications for re-approval for medication assistants I and II programs also must now be submitted to the Department of Health.

For more information, contact Bruce Pritschet, North Dakota Department of Health, at 701.328.2352.

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info@ndna.org

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Writing for Publication in the Prairie Rose

The Prairie Rose accepts manuscripts for publication on a variety of topics related to nursing. Manuscripts should be double spaced and in APA format. The article should be submitted electronically in MS Word to becky@ndna.org. Please write ***Prairie Rose article*** in the address line.

Articles submitted for continuing education need a purpose, objectives, and a post-test. You may request the necessary contact hour forms from Becky at becky@ndna.org.

Articles are peer reviewed and edited by the staff and RN volunteers at NDNA.

Nurses are strongly encouraged to contribute to the profession by publishing evidence based articles. If you have an idea, but don't know how or where to start, contact the office at NDNA: 701-223-1385.

The Prairie Rose is one communication vehicle for nurses in North Dakota.

Raise your voice.

The Vision and Mission of the North Dakota Nurses Association

Vision: North Dakota Nurses Association, a professional organization for Nurses, is the voice of Nursing in North Dakota.

Mission: The Mission of the North Dakota Nurses Association is to promote the professional development of nurses and enhance health care for all through practice, education, research and development of public policy.

President's Message

Wanda Rose

Offer a Guiding Hand

As this issue goes to press many new graduates will be starting their dream job. As new nursing graduates move from the education environment to the service environment, they must learn how to balance the demands of employment with personal needs as well as professional socialization into the new role. Professional socialization includes learning about the professional role, the associated skills and the knowledge and behaviors that come with the new role.

The new graduate comes with dreams, a fire in their heart and a desire to do the best job they can. They also come with apprehension, multiple unknowns and plenty of mixed emotions. But most of all they want to fit in.

For many of us it may have been a while ago since we were a new graduate, but think back to how you felt as a brand new grad. I clearly remember being offered my first job on a Neurology Floor as a staff nurse and the excitement I had starting my new job as a new graduate. I remember the fear I had if I missed signs and symptoms that would make a difference in my patient's outcome. I remember how I felt when a seasoned nurse or a physician asked a question that I didn't have the answer too. I remember the first patient that died on my shift and wondering what was I going to say to the family. I remember getting orders for a lami and crani check and wondering what is that? I remember the wait to learn if I passed the licensing exam and how excited I was when my mother called to inform me that I had passed. I was so proud the first time I was able to sign my name with RN. That was a long time ago but I still remember that first week, month and year as a new graduate.

One of the best things I remember during that time was the nurses that welcomed me into the profession; the nurses who took my hand and showed me the ropes. I have grateful memories of those who gave me encouragement and told me that I was a good nurse and of those who took the time to answer my never ending questions.

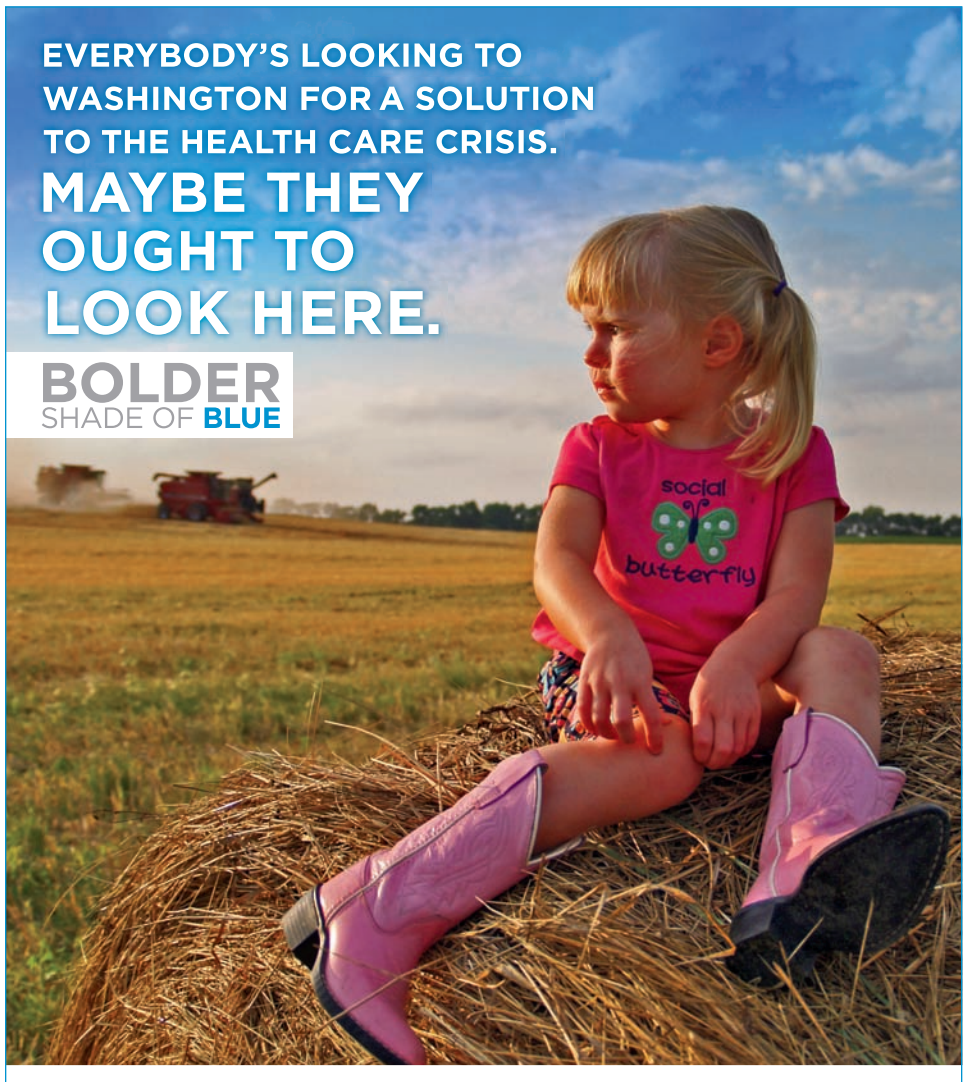
For all you seasoned nurses, your assignment is to reach out a guiding hand to those new graduates on your unit. New graduates need mentors and experienced nurses to show them the way. Welcome them into the most trusted profession in the United States. Take time to introduce them to the staff on your unit. Greet them when they come to work. Go out of your way to ask if they have questions or need assistance. Be available to talk them through a new task rather than thinking or saying, "Didn't they teach you that in nursing school?" The new graduate is fragile and needs nurturing. It is easy to stifle the excitement and passion the new graduate has with words that can hurt.

Evidence suggests that new graduates, who are undervalued by other nurses, feel neglected by having learning opportunities blocked, or given too much responsibility without appropriate support experience psychological distress. Thus, the new graduate becomes disillusioned with the profession and wants to leave the profession.

This is the time of year when we have the opportunity to reflect on our practice and how we welcome the new graduate nurse into the complex workforce of healthcare. The first year of practice is an important confidence building phase for nurses. If the new graduate is exposed to positive reinforcement, words of encouragement and a guiding hand with a positive attitude the new graduate will develop confidence and become a positive role model for other new graduates.

Regardless of your position as a staff nurse, manager, or administrator, you have the opportunity to make a difference in the lives of our newest colleagues to model quality, excellence, kindness, passion and best practices in nursing.

By being a positive mentor you will be giving back to the nursing profession.



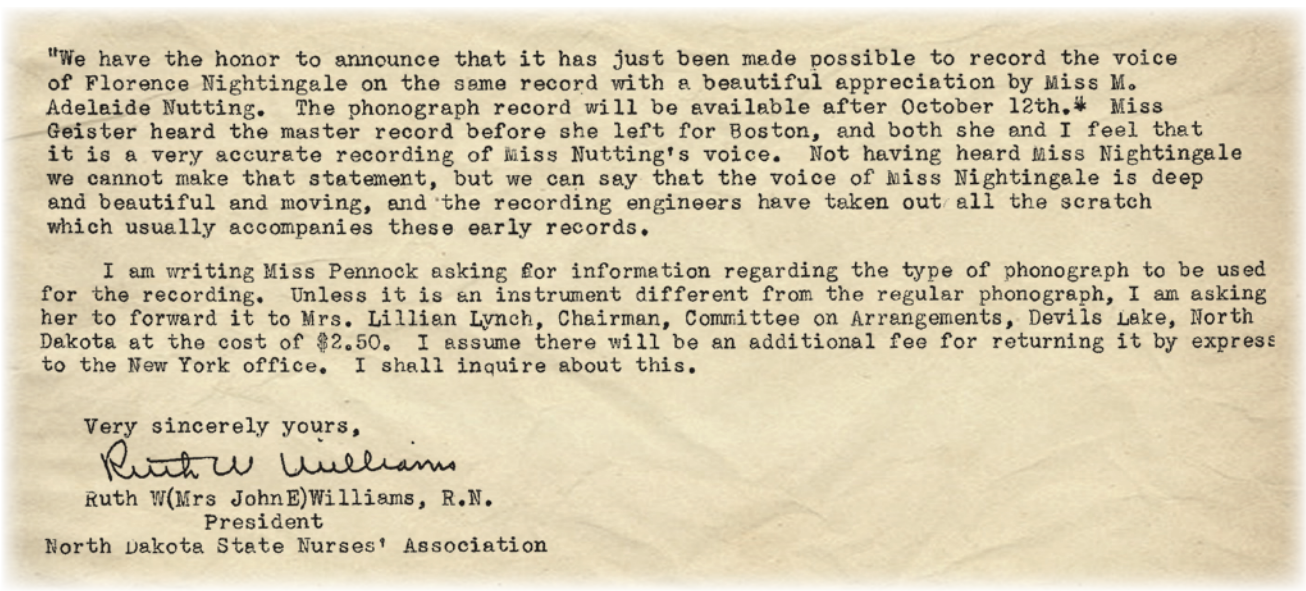
How Far Have We Come?

By Becky Graner MS, RN

In less than a year, NDNA will be 100 years old. NDNA's official 1st annual meeting was held in Grand Forks, in May of 1912. You are reminded to visit the NDNA online history library found under the Prairie Rose Petal tab on the NDNA website. www.ndna.org

While making sure old documents were stored safely in case of flood waters, I came across a collection of letters. The following excerpt was from a letter written October 9, 1939, found in a bundle of correspondence between various NDNA board members and committee leaders that spanned 1920 to about 1940. To place this in context, World War II in Europe had just begun, the Great Depression had decimated the country, and Social Security has just been created. Franklin D. Roosevelt was president. The North Dakota Nurses Association listed 39 members. All members who were married were listed as Mrs. (husband's name) [Last name] with their own first name in parenthesis. Correspondence was elegant, grammar correct, and etiquette rules were adhered to very strictly.

Since Florence Nightingale died August 13, 1910 at the age of ninety and given the technology of the time, I am sure it was a delight to be able to hear her voice re-mastered (and in a way resurrected) then recorded on a phonograph recording–what an achievement! Consider also, the phonograph was "rented" for $2.50 and needed additional return "express" postage fees. These days a few "clicks" and your listening pleasure is downloaded to what ever device you are lucky enough to have just "upgraded" to! And speaking of upgrading, a recent trip to the cell phone store showcased all the newest bells and whistles in cell phone technology. Can you imagine how Mrs. Williams would have reacted with a stroll through the aisles loaded with the options for 2011 communication? The choices in "pads" are neither bandages nor feminine hygiene products…rather the world of touch screens, internet capability and apps! And deciphering a master texter's short cut codes would seem like reading a foreign language.



"We have the honor to announce that it has just been made possible to record the voice of Florence Nightingale on the same record with a beautiful appreciation by Miss M. Adelaide Nutting. The phonograph record will be available after October 12th.* Miss Geister heard the master record before she left for Boston, and both she and I feel that it is a very accurate recording of Miss Nutting's voice. Not having heard Miss Nightingale we cannot make that statement, but we can say that the voice of Miss Nightingale is deep and beautiful and moving, and the recording engineers have taken out all the scratch which usually accompanies these early records.

I am writing Miss Pennock asking for information regarding the type of phonograph to be used for the recording. Unless it is an instrument different from the regular phonograph, I am asking her to forward it to Mrs. Lillian Lynch, Chairman, Committee on Arrangements, Devils Lake, North Dakota at the cost of $2.50. I assume there will be an additional fee for returning it by express to the New York office. I shall inquire about this.

Very sincerely yours,
Ruth W Williams
Ruth W(Mrs JohnE)Williams, R.N.
President
North Dakota State Nurses' Association

In reminiscing with a colleague (about my age), we chuckled about the ordeal we went through in our original nursing school programs to conduct a literature search. Card catalogs, heavy bound editions of journals, copy machines, reams of paper, and miles of library aisles. Today a literature search is accomplished at lightening speed (if you use the right words); what I can find in 20 minutes today, in the past would have taken days. Storage of the complete search fits on a flash drive that slips in your pocket. These days students access full text journals online, in comparison to the hard copy journals that needed to be sent through the copy machine (at 5¢ per sheet) to "save" the desired work. Those articles sported highlighted sentences and circled paragraphs all to be carefully compiled for later typing on a real typewriter!

Think about today's correspondence, now we email, text, Blog, receive e-news, e-journals,

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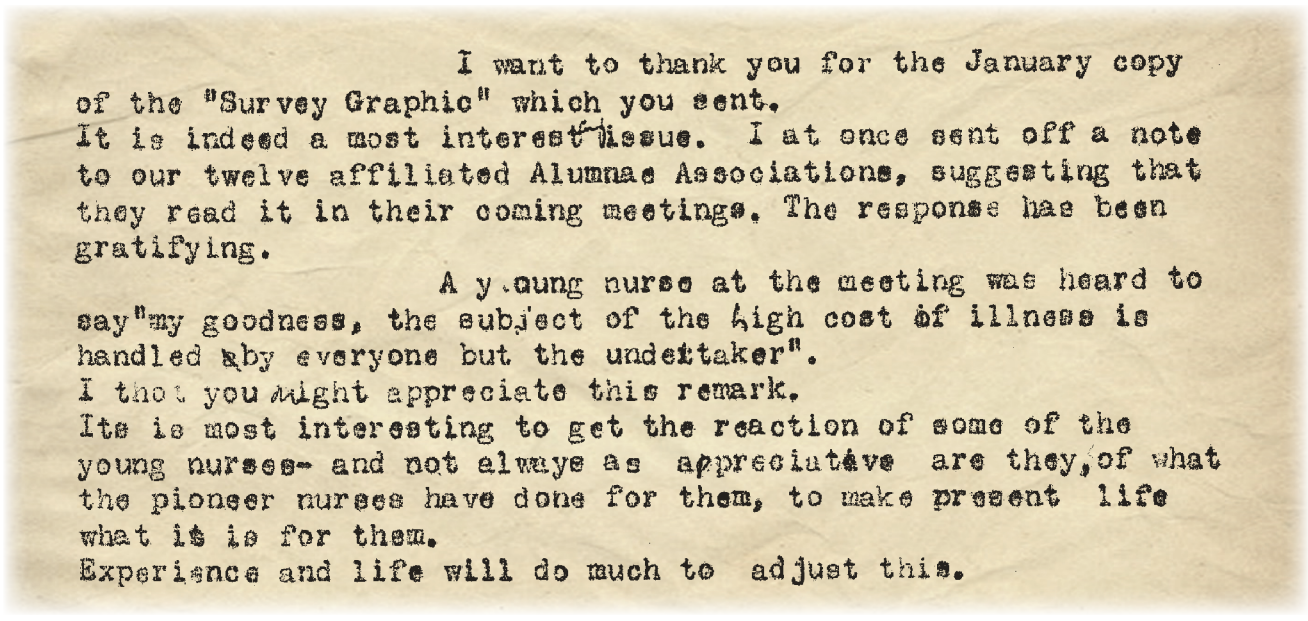
How far have we come? continued from page 4

instant messaging, on and on. The crumbling parchment papers I looked through for this article were truly from a different time. Some pieces were written with fountain pens, others typed, some a carbon copy of the original. Each letter followed the etiquette of the time, all with a formal letterhead, dates, addresses, complete titles, proper greetings, and closing statements. Not once did I see a "Heh," as an opening. Not a "Hi" either, and never the use of someone's first name in the salutation line of professional correspondence, unless the correspondents knew each other very well. I think about the email inquiries I receive at times and I cringe. No capital letters, no punctuation, no spell check. Sometimes there is not even a real name so I know who I am responding to… only an email name that leaves me wondering who "hotlady42" could be and what are they thinking to send out professional inquiries with what would have been considered a CB radio "handle" in my day. Once I was greeted with "hey, Beck"! I thought–OMG!

As much as things change, they in some ways stay the same. The words below came from correspondence between the ANA president and NDNA president in 1930.



I want to thank you for the January copy of the "Survey Graphic" which you sent.
It is indeed a most interest issue. I at once sent off a note to our twelve affiliated Alumnae Associations, suggesting that they read it in their coming meetings. The response has been gratifying.

A young nurse at the meeting was heard to say "my goodness, the subject of the high cost of illness is handled by everyone but the undertaker".
I thot you might appreciate this remark.
Its is most interesting to get the reaction of some of the young nurses- and not always as appreciative are they, of what the pioneer nurses have done for them, to make present life what it is for them.
Experience and life will do much to adjust this.

First, the dilemma of the "high cost of illness," can you imagine their reaction to today's cost of health care? Could they have imagined the cost of illness in 2011? What would they think of our country's huge divide over how health care needs should be addressed?

The reference to young nurses left me contemplating, as many of us were the nurse who spent some time both being "unappreciative" and later being "pioneering." I am now my mentor who used to shake her head at me! To all my past guides, thank you for having a good sense of humor and for being patient!

A browse through past documents provides evidence that nursing has a history of re-occurring cycles. Nursing has a shortage, and then nurses are in abundance. Nursing seeks to standardize the education entry, then those with various degrees cannot come to agreement what the future requirements should be and the various paths to entry remain as is usually due to stalemate. However, some of these cycles are coming to an end. Nursing shortages tend to be the norm, and nurses really do need to have ONE point of entry.

A yellowed and brittle women's newspaper magazine edition called The Home Institute from June 1935 had as the front page story: "Bachelor of Nursing." The article's author (Grace Turner) spoke to the need for women to be well educated to perform the "duties of the RN." She spoke to the need to find a "superior college, not a mediocre training program" (then the paper listed 2 pages of advertising for better quality university nursing programs). The author also encouraged nurses in "furthering" their education. She wrote, "the many, many nurses who have been outdistanced because they have continued over a period of years to rely on their basic education alone. They have not progressed; they have not kept abreast in a rapidly developing field– for nursing today is something quite different from what it was twenty or even ten years ago." Remember the setting; in 1935 the United States was in the midst of the Great Depression. Circumstances were changing family dynamics; young women were seeking employment outside the home. With this need to work outside the home came an opportunity for women to elevate their status by achieving a college degree and taking on work that was held in esteem by society.

And if the author thought 1935 was evolving rapidly, 2011 is at the speed of light. Thumbing through several 1940-1960 editions of "The Principles and Practices of Nursing" serves to illustrate the complete and total changes nursing practice has undergone. For those who have not taken the time to see where nursing practice was just 40 or 50 years ago and compare it to the level of knowledge, skills, and ongoing need to "keep abreast" today; you need a stroll through history as your lesson in becoming "appreciative" for the efforts of the nurses of the past who pioneered and broke the trail for today's nursing practice.

As the author wrote in the 1935 Bachelor of Nursing article… "for the nurse the desire to serve is real and practical... a liking for people is genuine… you need good health, a sense of humor, the capacity for keeping your head, the ability to follow directions and **equal ability to take responsibility** [bold added]. You need intelligence and executive and teaching ability." As then so it is now nursing is not the profession for the "just tell me what to do and I will do it" person. The nursing profession has always intuitively known to be a nurse you need to be a great thinker. A thinker who is accountable and responsible to the standards, codes, and the purpose for which nursing exists: to serve the person, family, community, and public. And as Ms. Turner professed in her article "the diverse opportunities it [nursing] actually offers" still rings true today.

Considering the massive changes we have already witnessed, and the speed of present change and innovation, the future is ours for the making. In 70 years when the next person at the North Dakota Nurses Association sits to "think" an article for the Prairie Rose, how will they communicate and can we even imagine what life, technology, and nursing will be like?

One thing we should consider is that communication while at lightening speed and received on the coolest devices we can imagine should not get in the way of good manners. A little old fashioned etiquette goes a long way. And don't forget there will be a new generation that will laugh someday at your eight track player, oops, I mean your iPod.

NDNA Annual Election of Officers

NDNA annual election of officers opens August 22nd and closes August 26th at noon. Elections are held electronically. MEMBERS can contact NDNA at info@ndna.org or becky@ndna.org for the link to the voting website. Candidates this year are running for VP Communication, VP Membership Services, and VP Government Relations.

Consent to serve forms are found at the NDNA website www.ndna.org under the Prairie Rose Petal Link, click on NDNA documents. If you choose to write in a candidate's name, a consent to serve form must be forwarded to NDNA. Please contact us if you have questions.

Members are encouraged to serve on advisory committees.

Justice Served–Winkler County Sheriff Found Guilty of Retaliating Against Nurses

Silver Spring, MD–The American Nurses Association (ANA) and the Texas Nurses Association (TNA) hailed the guilty verdict in the criminal case against Winkler County Sheriff Robert Roberts who retaliated against two registered nurses for reporting patient care concerns about a physician's practice to the Texas Medical Board. After a week of testimony, it took the Midland County jury less than two hours to find the sheriff guilty of four felony counts and two misdemeanor counts.

"Justice has been served with the jury's guilty on-all-counts verdict for Sheriff Roberts," stated Clair Jordan, MSN, RN, executive director of TNA. "When the safety and rights of patients are threatened, nurses must be able to speak out for them without fear of retaliation. This verdict affirms that retaliation against a nurse for patient advocacy efforts won't be tolerated and those who do will be held fully accountable."

"This is a victory for patients who trust nurses to be their advocates, and for nurses who play a critical, duty-bound role in protecting patients in their care," said ANA President Karen A. Daley, PhD, MPH, RN, FAAN.

As the nation's largest nursing association, ANA joined forces with TNA, one of its state nurses associations, in July of 2009 to strongly criticize and raise the alarm about the criminal charges brought against two Texas nurses and the fact that the results of the case could have a lasting and negative impact on future nurses speaking out as patient advocates.

TNA members and long-time nurses Anne Mitchell, RN, and Vicki Galle, RN, both not only lost their jobs but also faced criminal charges of misuse of official information when they reported a physician to the Texas Medical Board over patient safety concerns. The charges were eventually dropped against Galle, and a jury found Mitchell not guilty in less than an hour. Known as the "Winkler County nurses," their plight drew national attention and tremendous support from nurses and others concerned about patient advocacy and safety.

Sheriff Roberts was convicted on June 14th of retaliation and misuse of official information, both felonies, and official oppression, a misdemeanor. Roberts was sentenced to four years of felony probation and 100 days in jail on the official information and retaliation charges, and fined $6,000. He must also surrender his peace officer license and be removed from office.

Trials for the Winkler County Attorney Scott Tidwell and the physician, Dr. Rolando Arafiles, are still pending.

ANA Member Benefits-at-a-Glance

• Free Online Continuing Education – Available at no or reduced cost through ANA MembersOnly

• ***ANA Smart Brief*** – An electronic daily news feed that brings healthcare and nursing news from around the country to your computer

• ***Mosby's Nursing Consult – ANA Edition*** is a resource tool for nurses to stay informed of new developments in nursing

• ***OJIN: The Online Journal of Issues in Nursing*** – The current issue of this peer reviewed electronic journal is available only through ***ANA Members Only*** on NursingWorld.org

• ***American Nurse Today*** – ANA's official bi-monthly journal packed with information you can use in your practice — is now available online!

• ***The American Nurse*** – published every other month to keep you current on nursing policy and ANA issues you need to know

• Earn cash back while you shop at your favorite stores at ***ANA Cash Rewards Mall***

• Get discounts on Auto Rental & Hotels; Financial & Insurance Products; Tafford Scrubs; ANA Wireless Center products; Whirlpool® Appliances; and much more

• Professional Liability Insurance through ***Marsh***

• Plans for all your needs: ***Life, Major Medical, Dental, Disability, Long Term Care, Cancer, Medicare Part D, Medicare Supplement*** and even pet insurance

• ***ANA Online Nursing Degree Center*** — Receive discounts on advanced online nursing degree programs from partnering colleges and universities

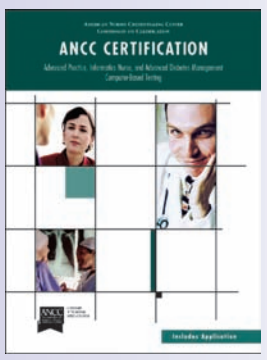
• Save up to $140 on ***ANCC Certification & Recertification****

• ***ANANurseSpace*** – Join ANA's online social network where you can network with your colleagues around the country on nursing issues that matter

• ***Leading edge conferences*** and exciting educational events at the national, state, and local levels

• Discounted products through ***nursesbooks.org,*** the official publishing arm of ANA

• ***Nurse's Career Center*** – to help you find the perfect job



• ***CINAHL®*** – Access to over one million records indexed from more than 1,800 journals and the last 10 years of ***MEDLINE®***

• ***Information*** and ***Position Statements*** – affecting your practice, your profession and the policies that impact us all ***via ANA MembersOnly*** on NursingWorld.org

* Individual Affiliate Members not eligible for Direct or Full Member discount on ANCC Certification or Recertification.

Registration for the October 5 & 6, 2011 NDNA Conference and Business Meeting

(Send form and fee to Becky Graner/ NDNA 5265 Hwy 1806, Mandan, ND 58554 by September 16, 2011)

Name & Credentials	
Full address	
Email (required)	
Phone #	
Payment Type	☐ Check ☐ Credit Card Card #_____ Expiration date: _____
Total registration fee	NDNA Member? Yes ☐ No ☐

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Registration fees*	Includes lunch & breaks
Wed. Oct 5 $65	**(NDNA members only)**
Wed. Oct 5 $75	nonmembers
Thurs. Oct 6 $35	**(NDNA members only)**
Thurs. Oct 6 $45	nonmembers
$90 both days	**(NDNA members only)**
$120 both days	nonmembers
Wed. Oct 5 $40	Non-licensed nursing students
Thurs. Oct 6 $10	Non-licensed nursing students

Those registering for Oct 5, 2011 may attend Dr. Strauss's evening presentation free of charge.

Time	Schedule at a glance Wed., October 5, 2011
8:00-8:30	Registration / Welcome
8:30-9:30	***Nurse to Nurse Bullying: A Sepsis in Healthcare*** (Dr. Strauss)
9:30-10:30	Cont. (Dr. Strauss)
10:30-10:45	Break
10:45-12:00	Cont. (Dr. Strauss)
12:00-1 PM	Lunch
1-2 PM	Cont. (Dr. Strauss)
2-2:50 PM	Cont. (Dr. Strauss)
2:50-3 PM	Break
3-4:30 PM	Cont. (Dr. Strauss)
4:30-4:45	Evaluations
5-6:30 PM	Supper break (on own)/ committee meetings
Public event 7-8:30 PM	**Sexual Harassment and Bullying: Keeping Kids Safe and Holding Schools Accountable** (Dr. Strauss)
Time	Schedule at a glance Thurs., October 6, 2011
8:00-8:30	Registration
8:30-9:30	Business Meeting
9:30-10:30	***"Beam Me Up, Scotty"* Virtual Team Management** (Dr. Strauss)
10:30-10:45	Break
10:45-12:00	Continue Business Meeting
12:00- 1PM	Nightingale Tribute / Close

See the NDNA website for link to conference website. A list of resources, hotel accommodations, contact hour details, and Dr. Strauss's bio are available online. www.ndna.org

The Art of Self Study

Becky Graner MS, RN

Nurses in North Dakota need to attain 12 hours of continuing education (contact hours) every two years to partially meet the requirements for re-licensure. The other requirement for re-licensure is to practice nursing for a minimum of 400 hours in four years.

Many of you choose self study via a variety of methods to meet the 12 hour requirement. You may prefer to "self study" as it fits into a busy life schedule. Your options range from the traditional format of reading a journal or textbook, completing a post evaluation (test) to taking an interactive online course (usually through a college or university). A common misconception is that doing self study is easier and takes less time. If you really engage in self study, it is a commitment of time and a lesson in self assessment. Self study requires identifying your knowledge/skill gap, identifying what you want to achieve (goal), planning (what style of self study will you use), intervention (doing the work), and evaluation of goal achievement. If you don't take what you have learned and improve or change your practice; self study can be a waste of time and resources.

How can you improve your self study habits?

One of the key skills you will need is an ability to assess your learning needs. To be able to know what you need to know, you often times need some insight on what you don't know. In all specialty areas of practice one generally can find standards of practice. ANA's Nursing: Scope and Standards of Practice provides an excellent resource that nurses can (and should) use to guide one's practice. Each standard lists competencies that are expected of the Registered Nurse. These competencies are the measures we can use to assess our practice. Gaps or weaknesses are the perfect starting point to develop a self study program.

Consider this example: Standard 2 (Diagnosis) states: *The registered nurse analyses the assessment data* (obtained by meeting Standard 1) *to determine the diagnosis or issues.* Listed under Standard 2 are five (5) competencies the registered nurse should meet to fulfill Standard 2. Those competencies provide objectives for learning. The first competency listed states: *The registered nurse derives the diagnosis or issues from assessment data.* When evaluating your practice in relation to professional practice standards and guidelines, relevant statutes, rules, and regulations (Standard 14 by the way), you can ask yourself how up to date and competent is my physical, emotional/social, spiritual ASSESSMENT skill set? (You may need a physical assessment course). Would I benefit by updating my assessment skills? How up to date and competent is my critical thinking skill set? (You may need to study critical thinking strategies, clinical reasoning practice). Do I tend to use one way to come to conclusions about patient assessment findings? Do I know my scope of practice? (You may need to review the Nurse Practices Act in your state). Am I practicing within my scope of practice? Do I need to study common diagnosis and issues within my specialty area? As you can see, in a very short amount of time, you can determine areas for self study.

Once those areas are identified the next step is to take some time to explore the options for self study. Will you be able to meet objectives for learning with a short course or do you need a more prolonged exposure. How do you learn? Do you need more interaction or do you do well on your own? And be prepared to go off on a tangent once you start studying. The most often encountered issue that side tracks folks is the use of computer technology, for example learning to navigate in a new software program is often necessary, either for actual practice or for using the online programs for self study activities. Consider all these side adventures as contributing to a richer learning experience.

Self study assumes you as the learner will not short change yourself. What does this mean? It means you really read the recommended material, it means you complete any additional learning activities, you search out additional sources for learning, and you make sure you know what you set out to learn. It does not mean skipping the reading and hoping you pass the post test. It means dedication to ongoing learning that occurs on a regular (and preferably planned out) basis. It does not mean you wait until December 15th of the year for your license renewal and spend several hours taking online courses that have nothing to do with your area of practice just so you can accumulate the required number of contact hours for renewal.

Standard 8 is Education, *the registered nurse attains knowledge and competencies that reflect current nursing practice.* One way to do that is to create a top notch self study program that is individualized for your needs. If you need help planning out your self study needs, NDNA members have access to a number of online education programs and we can help you develop a program that reflects the national standards of practice and performance. info@ndna.org

NDNA Alignment with ANA's Strategic Imperatives (2011)

ANA Strategic Imperatives	**NDNA Actions** that have aligned with ANA's Strategic Imperatives
Strategic Imperative #1 Professional Practice Excellence *ANA champions nursing excellence through standards, code of ethics, and professional development, such as credentialing and lifelong learning.*	NDNA continues to carry out the program as detailed in the ANA Membership Grant awarded fall of 2010. Discussion focuses on the foundation documents: Standard and Scope of Practice, Nursing's Code of Ethics, and Nursing's Social Policy Statement. A Blog has been established by NDNA Nurse Consultant, Becky Graner MS, RN at the ANANurseSpace.org website that carries on the discussion regarding standards, code of ethics and professional development.
Strategic Imperative #2 Healthcare and Public Policy *ANA is an acknowledged leader in the formulation of effective healthcare and public policy as they affect the profession and the public.*	NDNA is the voice of nursing during legislative sessions. A website that focuses on legislative issues is updated during legislative session to keep nurses up to date. Legislative Action Alerts are sent to members as needed via e-newsletter. A legislative platform was developed and is posted to the website, this agenda is the criteria used to evaluate all legislative bills that have the potential to impact nurses and nursing in ND.
Strategic Imperative #3 Knowledge & Research *ANA is the recognized source for accurate, comprehensive health policy information from evidence based research.*	NDNA continues to sponsor the ND Online Nurses Journal Club. ANA calls for member input on draft documents are sent out to NDNA members (who have provided an email address) for input.
Strategic Imperative #4 Unification *ANA facilitates unification and advancement of the profession.*	NDNA is a voting member on the ND Center for Nursing board, works with the local chapters of Sigma Theta Tau, and is exploring affiliate organization membership options.
Strategic Imperative #5 Advocacy for the Workforce & Workplace *ANA with its partners and through its organizational relationships is the leader in promoting improved work environments and the value of nurses as professionals, essential providers and decision makers in all practice settings.*	NDNA has brought a number of continuing nursing education topics related to workforce and workplace improvement. Will be exploring and presenting topics on bullying, fatigue, and continue to educate nurses on the ANA foundation documents. The NDNA 2011 Conference: Bullying: Poison in the Workplace will feature international speaker on bullying and harassment. NDNA's website has a number of CE activities; members are informed of free CE activities via the e-newsletter.

If you have input regarding strategies you would like to assist in implementing that align with the ANA Strategic Imperatives please contact NDNA at info@ndna.org

Is It Time for Hospice?

By Nancy E. Joyner, RN, MS, APRN-CNS, ACHPN

Purpose: Provide an overview of decision making criteria for assisting patients to access Hospice Care.

Nancy Joyner

What is Hospice?

The word "hospice" comes from the Latin "hospitium" which can be traced back to medieval times when it referred to a place of shelter and rest for weary or ill travelers on a long journey returning from religious pilgrimages. The name was first applied to specialized care for dying patients in 1967 by physician Dame Cicely Saunders, who founded the first modern hospice–St. Christopher's Hospice–in a residential suburb of London. St. Christopher's organized a team approach to professional care-giving, and was the first program to use modern pain management techniques to compassionately care for the dying. The first hospice in the United States was established in New Haven, Connecticut in 1974 (Eagan City & Labyak, 2010; NHF, n.d.; NHPCO, n.d.). The hospice program is designed to give supportive care to people in the final phase of a terminal illness with a focus on comfort, dignity and quality of life, rather than cure. The goal of hospice care is to enable patients to be comfortable and free of pain, so that they live each day as fully as possible. Hospice care focuses on relieving symptoms and supporting patients with a life expectancy of months, not years, using a team approach utilizing expert health care, pain management, physical, emotional, and spiritual support (Eagan City & Labyak, 2010; NHF, n.d.).

Hospice focuses on comfort, dignity, quality of life, and relationship closure. Hospice care is care for all age groups, from children to the elderly, during their final stages of life when the goal is comfort and care, not cure. Hospice programs use a multidisciplinary team approach, including the services of the patient's physician/primary provider, hospice medical director, nurses, aides, social workers, and chaplains in providing care at the end of life. This care includes clinical services, bereavement support, volunteer training, and integration. Hospice services include medications to manage pain and other symptoms. Although hospice care does not aim for cure of the terminal illness, it does treat potentially curable conditions such as bladder infections.

Hospice Referral

When to refer to hospice or when someone is appropriate for hospice can be difficult to define and to discuss. Many patients at the end-of-life are referred to hospice care too late or not at all. The National Hospice Foundation (NHF) research on end-of-life care has found that only a quarter of Americans complete healthcare directives and discuss how they want to be cared for at the end-of-life, while others may have thought about it but failed to tell anyone their wishes (Bailey & Periyakoil, 2010). Many patients are candidates but are not being referred or offered hospice as a choice in medical care.

Research has shown that some health care practitioners not only overestimate prognosis but many present a more optimistic prognosis to patients than they privately believe based on the idea that doing so provides patients with hope. However, overestimating a prognosis often ends up disappointing patients emotionally. (Berthold, 2011).

There are common groups of terminal conditions and medical criteria that indicate advancing illness. Patients are eligible for hospice only if certain conditions are met. The attending physician must certify that the patient has a terminal condition with an expected life span of six months or less if the disease was to run its normal course with or without other contributing factors. The patient must decide to forego life prolonging therapies related to the terminal condition. However, a patient does not have to have a do not resuscitate (DNR) order to be eligible for hospice or palliative services. No home hospice can refuse to admit a patient who is still "full code." Patients may still receive some, usually modest, life-prolonging therapy on hospice, but life prolongation is not the major goal of care.

The Hospice Benefit

Hospice care is covered under Medicare Part A (Hospital Insurance). Most insurance plans in the U.S. include hospice as a covered benefit. Patients are eligible for Medicare hospice benefits when the primary physician and the hospice medical director certify that if the disease was to run its usual course, the prognosis is less than six months. Medicare covers these hospice services and pays nearly all of their costs of physician/provider services, nursing care, medical equipment (such as wheelchairs or walkers), medical supplies (such as dressings and catheters), medications for symptom control and pain relief related to the terminal illness, and short-term hospital care. It also pays for home health aide and homemaker services, physical and occupational therapy, speech therapy, social worker services, dietary counseling, and grief and bereavement counseling for support of the patient and family (CMS, 2010).

Hospice programs also offer respite care workers, people who are trained volunteers, who take over the patient's care so that the family or other primary caregivers can leave the house for a few hours. Volunteer care is part of hospice philosophy. Hospices routinely offer family members and loved ones bereavement services for one year to 13 months following the death of the patient (Eagan City & Labyak, 2010; NHPCO, n.d.).

Hospice care is provided in periods of care. Medicare hospice care has two 90-day periods followed by an unlimited number of 60-day periods. At the start of each period of care, the hospice medical director or other hospice doctor must recertify that the illness is still terminal and the patient is still declining. If health improves or the illness goes into remission, patients may be discharged from hospice care. Patients always have the right to stop hospice care at any time for any reason. If a patient becomes eligible for hospice services in the future, he/she may be recertified and can return to hospice care (CMS, 2010).

Setting Goals

Goals of care are set based on physical, social, spiritual, or other patient-centered needs that arise following an informed conversation regarding the current disease(s), prognosis, and treatment options (Weissman & Meier, 2011). Some patients who come into a hospital are unaware of their health status and what may be ahead. They may be aware of symptoms they are experiencing but uninformed of the extent of their current condition and underlying co-morbidities and how these conditions affect their status. Discussions and communication often need to center on medical review of their understanding of their past and present situation. Goals are based on patient's wishes or preferences and best interests. Goals may change from a curative focus to limited/ selected interventions or to comfort measures only (Kaldjian, Curtis, Shinkunas, & Kannon, 2009).

It is important to review and clarify the goals with the patient/decision maker. The physician(s) may explain the medical situation by reviewing what has happened, current status, and what can be expected as days go on. Possible treatments are described, including expected outcomes, benefits, and burdens. The topics of diagnosis and prognosis are vital and need to be included in these conversations (Lorenz, Lynn, Morton, Dy, Mularski, Shugarman, Sun, Wilkinson, Maglione, & Shekelle, 2004; NCCN, 2011). Team members should facilitate ongoing discussion regarding patient goals and expectations with the family as well incorporate these goals into a working care plan. Care plans are then based on patient-centered goals. Patient and family needs, preferences, and desired outcomes should be acknowledged. Once goals are established, any intervention/ therapy that will not help meet the goals should be discussed for potential discontinuation (NCCN, 2011; Weissman, Quill, & Arnold, 2010).

Due to our aging population, many patients live with a serious, chronic condition before they die. When discussions with healthcare professionals lead to difficult choices about futile treatment, the goals of care should give more weight to comfort measures and end-of-life decisions rather than curative, disease-focused care. Palliative care consults often aid in these goals of care discussions. When offered and supported, the goals of patients and families may change from fighting for survival to quality of life needs (McAdam, Dracup, White, Fontaine, & Putillo, 2010). Nurses may feel uncomfortable with discussions

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about prognosis and referral to hospice care with terminally ill patients in the hospital setting. Thus more education for nurses with an emphasis on improvement of communication skills will result in more timely referrals and smoother transitions to hospice (Eagan City & Labyak, 2010; Schulman-Green, McCorkle, Johnson-Hurzeler, & Bradley, 2005).

Performance Scales

Functional status is an individual's ability to carry on the normal daily activities required to meet basic needs, fulfill usual roles, and maintain health and well-being. The decline in functional status is measured by an individual's loss of independence in activities of daily living (ADLs) over a period of time. To become eligible for hospice services, patients must have a life threatening or end stage disease. But their ability to function must also be addressed and assessed. There are three frequently used scales to measure functional status that are recognized by healthcare professionals, researchers and Medicare. These scales and criteria are used by providers and researchers to assess how a patient's disease is progressing, assess how the disease affects the daily living abilities of the patient, and determine appropriate treatment and prognosis. Any healthcare professional can use the following performance scales.

One of the oldest scales is The Karnofsky Performance Scale Index (1948) which allows patients to be classified by their functional impairment. The scale is used to assess the prognosis in individual patients. The lower the Karnofsky score, the worse chance of survival for most serious illnesses. This scale is commonly used for assessing terminally ill patients and often used to determine appropriateness of hospice referral in Medicare guidelines.

The ECOG Performance Status (Oken, Creech, Tormey, Horton, Davis, McFadden, & Carbone, 1982) is a tool oncologists, other physicians, and researchers use to assess how a patient's disease is progressing, how the disease affects the daily living abilities of the patient, and can help to determine appropriate treatment and prognosis. It is an attempt to quantify cancer patients' general well-being. It is also used in randomized controlled trials of cancer as a measure of quality of life.

The Palliative Performance Scale (PPSv2) (Anderson, 1996; Victoria Hospice Society, 2001) is a valid, reliable functional assessment tool developed by Victoria Hospice that is based on the Karnofsky Performance Scale. This tool provides a framework for measuring progressive decline in patients with palliative needs. It has been found to be useful for purposes of identifying and tracking needs changes with disease progression. The Victoria Hospice Hospice Palliative Performance Scale (PPS, version 2) is an 11-point scale designed to measure patients' performance status in 10% decrements from 100% (healthy) to 0% (death) based on five observable parameters: ambulation, ability to do activities, self-care, food/fluid intake, and consciousness level. The scoring starts from the left side and moves across to the final right-hand column to determine the score. They are included here for health care professionals to review.

KARNOFSKY PERFORMANCE STATUS SCALE DEFINITIONS RATING (%) CRITERIA

Able to carry on normal activity and to work; no special care. needed	100	Normal no complaints; no evidence of disease. Able to carry on
	90	normal activity; minor signs or symptoms of disease. Normal activity
	80	with effort; some signs or symptoms of disease. Cares for self; unable
Unable to work; able to live at home and care for most personal needs; varying amount of assist-ance needed.	70	to carry on normal activity or to do active work. Requires occasional
	60	assistance, but is able to care for most of his personal needs. Requires considerable
	50	assistance and frequent medical care. Disabled; requires
Unable to care for self; requires equivalent of institutional or hospital care; disease may be progressing rapidly.	40	special care and assistance. Severely disabled; hospital admission is
	30	indicated although death not imminent. Very sick; hospital
	20	admission necessary; active supportive treatment necessary.
	10	Moribund; fatal processes progressing rapidly.
	0	Dead

Developed by Karnofsky, Abelmann, Craver & Burchenal, 1948

This test was originally published: Karnofsky, DA & Burchenal, JH. *The Clinical Evaluation of Chemotherapeutic Agents In Cancer.* pg. 196. In: MacLeod CM (Ed.). Evaluation of Chemotherapeutic Agents. Columbia Univ. Press, 1949.

No permission is necessary to use or reproduce the scale.

ECOG PERFORMANCE STATUS

Grade	ECOG
0	Fully active, able to carry on all pre-disease performance without restriction
1	Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature, e.g., light house work, office work
2	Ambulatory and capable of all self care but unable to carry out any work activities. Up and about more than 50% of waking hours
3	Capable of only limited self care, confined to bed or chair more than 50% of waking hours
4	Completely disabled. Cannot carry on any self care. Totally confined to bed or chair
5	Dead

Eastern Cooperative Oncology Group (ECOG)

As published in *Am. J. Clin. Oncol.*: Oken, M.M., Creech, R.H., Tormey, D.C., Horton, J., Davis, T.E., McFadden, E.T., Carbone, P.P.: Toxicity And Response Criteria Of The Eastern Cooperative Oncology Group. *Am J Clin Oncol* 5:649-655, 1982.

The ECOG Performance Status is in the public domain therefore available for public use. To duplicate the scale, please cite the reference above and credit the Eastern Cooperative Oncology Group, Robert Comis M.D., Group Chair.

(Oken, M. et al. 1982, ECOG website, http://ecog.dfci.harvard.edu/general/perf_stat.html

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Palliative Performance Scale *(version 2 (PPSv2))*

%	Ambul-ation	Activity Level Evidence of Disease	Self-Care	Intake	Level of Consciousness
100	Full	Normal *No Disease*	Full	Normal	Full
90	Full	Normal *Some Disease*	Full	Normal	Full
80	Full	Normal with Effort *Some Disease*	Full	Normal or Reduced	Full
70	Reduced	Can't do normal job or work *Some Disease*	Full	As above	Full
60	Reduced	Can't do hobbies or housework *Significant Disease*	Occasional Assistance Needed	As above	Full or Confusion
50	Mainly sit/lie	Can't do any work *Extensive Disease*	Considerable Assistance Needed	As above	Full or Confusion
40	Mainly in Bed	As above	Mainly Assistance	As above	Full or Drowsy or Confusion
30	Bed Bound	As above	Total Care	Reduced	As above
20	Bed Bound	As above	As above	Minimal	As above
10	Bed Bound	As above	As above	Mouth Care Only	Drowsy or Coma
0	Death	–	–	–	–

With Permission, Victoria Hospice Society

Is it Palliative Care or Hospice?

Palliative Care- (from Latin palliare, to cloak) is specialized care that focuses on relieving and preventing the suffering of patients. Unlike hospice care, palliative care is appropriate for patients undergoing treatment for curable illnesses and those living with chronic diseases, as well as patients who are nearing the end of life (NCP, n.d.; NHF, n.d.).

The palliative approach is being recognized in advanced disease, especially now in cancer care. It would be seamless for patients with cancer to integrate palliative care into oncology treatment plan across the continuum from diagnosis to advanced disease and end of life care. All patients should have screening for palliative care services at the initial visit and be reassessed throughout the continuum of care. It provides assistance with decision-making, symptom management, and access to services including emotional, spiritual, and psycho-social interventions. A fully integrated program of oncology and palliative care provides the greatest opportunity for care and cure (Sanft & Von Roenn, 2009). For patients with cancer to qualify for hospice Medicare benefit, they would have to show progression of the disease from an earlier stage to metastatic disease with continued decline in spite of disease related therapy or if the patient refuses further cancer treatment. Certain cancers such as small cell lung cancer, brain cancer, or pancreatic cancer may be eligible for hospice without the other criteria. The patient's functioning (performance status) and quality of life are significant factors (Bailey & Periyakoil, 2010; Corridor Group Inc, 2006). There are specific criteria and guidelines for other diagnoses, such as amyotrophic lateral sclerosis (ALS), coma, dementia, heart disease, human immunodeficiency virus (HIV), liver disease, pulmonary disease, renal failure, and stroke. Because these guidelines may change and may be related to location, it is best to check with hospice agencies in your area.

For non-disease guidelines, it is important to observe for worsening clinical status—recurrent or intractable infection, pneumonia, sepsis, urinary tract infection (UTI), weight loss, and dysphagia. Healthcare professionals should observe for worsening symptoms—dyspnea, intractable cough, poorly responsive nausea or vomiting, diarrhea, or pain that requires frequent increases in medication. Worsening signs would include hypotension, ascites, edema, pleural effusion, weakness, and/or change in level of consciousness. A decline in performance scale values along dependence on assistance of two or more for activities of daily living (ADLs) can be criteria for hospice referral.

The presence of co-morbidities may hasten a patient's clinical progression as well. Examples include chronic obstructive airway disease (COPD), congestive heart failure (CHF), ischemic heart disease, diabetes, Parkinson's, multiple sclerosis (MS), and dementia. The functional impairment and the limitation of activity along with these conditions may qualify someone for hospice. In all other conditions, the patient must have a life-limiting condition, be informed and aware of this status, and show clinical progression of the disease. This disease progression is seen through decline in lab values, multiple emergency room visits, inpatient hospitalizations, decline in functional status, impaired nutritional status, and/or the physician's/provider's best medical opinion (Bailey & Periyakoil, 2010; Corridor Group

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Inc, 2006; Meier & Beresford, 2007). This is often a gray area and referral to hospice may be of best interest of the patient, if in doubt, consider a palliative care referral.

So much of the criteria discussed shows cross-over from palliative care to specific hospice benefit under Medicare. Palliative care across the continuum addresses aspects of hospice-hospital partnerships and long term care. Bridging palliative care to hospice-specific needs begins with a collaborative pursuit of improved palliative and end-of-life care (Casarett & Quill, 2007; NQF, 2006) This bridge can become a win/win/win proposition for patients with serious illnesses, their families, and those caring for patients in the hospital and hospice programs. It facilitates and expands access to a continuum of high quality health care services (Meier & Beresford, 2007).

The goal is to create a full range of services for patients and their families from the time of diagnosis throughout the course of the illness. Accurate and current information increases the continuum of care and enhances the ability of both palliative and hospice services to modify care plans to meet patient and family needs and preferences, especially within an inpatient setting or care facility.

Hospitals may benefit by identifying and tailoring successful hospice and palliative approaches that best meet the needs of a more broadly defined palliative care population. Evidence also shows that hospice referrals rise when palliative care services are available in the hospital setting (Lorenz et al., 2004; Weissman et al., 2010). By working together, hospitals, skilled care facilities, group homes and hospices can ensure that patients and their families get the support and services they need and deserve. The challenge is that each healthcare professional needs to be an advocate for the patient who is deserving hospice or palliative care.

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Is it time for Hospice? Evaluation

The North Dakota Nurses Association is pleased to bring you a continuing education article for nurses. Nurses wishing to earn contact hours for **Is it time for Hospice?** (P2.61) in the August-October issue of the *Prairie Rose* require the following:

1. Read the complete article. It takes approximately 60 minutes to complete.
2. Complete the evaluation.
3. Non-Members: Please return the entire completed enrollment form, evaluation, and check or money order for **$20** payable to NDNA.
4. **NDNA MEMBERS WILL RECEIVE CONTACT HOURS FREE-OF-CHARGE.**
5. Please send to: **NDNA c/o Becky Graner 5265 Hwy 1806 Mandan, ND 58554**.

Upon receipt of all required materials you will receive an **emailed** certificate of completion for **1.0** contact hours from CNE-Net.

Please allow approximately two weeks from the time you submit your completed information for your certificate of completion to be processed. *You will need to supply a functional email address to receive your certificate of completion. Certificates will NOT be mailed.*

CNE-Net, the education division of the North Dakota Nurses Association, is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

Accreditation as a provider refers to recognition of educational activities only and does not imply ANCC Commission on Accreditation or CNE-Net approval or endorsement of any product.

Title: ***Is it time for Hospice?***
Author: Nancy E. Joyner, RN, MS, APRN-CNS, ACHPN

No conflict of interest has been declared and no off label drug use will be discussed.

Purpose:
Provide an overview of decision making criteria for assisting patients to access Hospice Care.

Objectives:
- Review the criteria patients need to meet to qualify for hospice care.
- Differentiate between hospice care and palliative care
- Name one performanc scale that may be helpful to use in assessing a patients eligibility for hospice care.

ENROLLMENT FORM EVALUATION FORM

Program Title: ***Is it time for Hospice?***
Program Number: P2.61
Date: Please return the enrollment and the evaluation form by **August 2013** to becky@ndna.org or mail to Becky Graner, 5265 Hwy 1806, Mandan, ND 58554

I. ENROLLMENT FORM

Name _____ Address _____

City, State, Zip _____

Phone _____ Email (must supply) _____

NDNA Membership **Yes ❑ No ❑ No charge to NDNA members**
Non-member $20 fee **Please make check payable to NDNA**

II. EVALUATION (Check Yes or No)

HAVE YOU ACHIEVED EACH OBJECTIVE?	✓Yes	✓No
1. Objectives: ➢ Review the criteria patients need to meet to qualify for hospice care. ➢ Differentiate between hospice care and palliative care. ➢ Name one performace scale that may be helpful to use in assessing a patients eligibility for hospice care.	❑ ❑ ❑	❑ ❑ ❑
2. Did the objectives *relate to the overall purpose/goal of the activity?* ***Provide an overview of decision making criteria for assisting patients to access Hospice Care.***	❑	❑
3. Were the teaching/learning resources appropriate?	❑	❑
4. How would you rate your knowledge of this content ***before*** reading this article? (0-no knowledge to 10-expert knowledge)	**Write number** ➪	
5. How would you rate your knowledge of this content ***after*** reading this article? (0-no knowledge to 10-expert knowledge)	**Write number** ➪	
HOW LONG DID IT TAKE YOU TO COMPLETE THIS ACTIVITY?	**Write MINUTES** ➪	

6. As a result of completing this activity will your competency in the following areas be enhanced? (See definitions below)	**✓Yes**	**✓No**	**✓N/A**
Providing patient-centered care			
Working in interdisciplinary teams			
Employing evidence based practice			
Applying quality improvement			
Utilizing informatics			

Provide patient-centered care: Identify, respect, and care about patients' differences, values, preferences, and expressed needs; listen to, clearly inform, communicate with, and educate patients; share decision making and management; and continuously advocate disease prevention, wellness, and promotion of healthy lifestyles, including a focus on population health.

Work in interdisciplinary teams: Cooperate, collaborate, communicate, and integrate care in teams to ensure that care is continuous and reliable.

Employ evidence-based practice: Integrate best research with clinical expertise and patient values for optimum care, and participate in learning and research activities to the extent feasible.

Apply quality improvement: Identify errors and hazards in care; understand and implement basic safety design principles, such as standardization and simplification; continually understand and measure quality of care in terms of structure, process, and outcomes in relation to patient and community needs; and design and test interventions to change processes and systems of care, with the objective of improving quality.

Utilize informatics: Communicate, manage knowledge, mitigate error, and support decision making using information technology.
—From *Health Professions Education: A Bridge to Quality.* Institute of Medicine, 2003.

Please print your name as you would like it to appear on your certificate of successful completion:

_____

LIST COMMENTS FOR IMPROVEMENTS IN FUTURE CONTINUING NURSING EDUCATION ACTIVITIES:

American Nurses Association

ANA Testifies Before Senate Committee About the Clean Air Act and its Impact on Public Health

SILVER SPRING, MD–The American Nurses Association (ANA) today joined a group of health care professionals to testify before a Senate panel in support of The Clean Air Act. Delaware Nurses Association member Sarah Bucic, MSN, RN, was among the panelists invited to provide remarks to the U.S. Senate Committee on Environment and Public Works. Ms. Bucic spoke to lawmakers about the positive impact The Clean Air Act has had on the public health, and the ongoing threat environmental pollutants pose to public health.

"The bottom line is pollution creates more patients," Bucic testified. "From a nursing perspective, we are fixed in a state of keeping patients with chronic conditions like asthma and other pulmonary and cardiovascular conditions stabilized, when we all know that prevention is the only real, effective and long-term treatment."

According to research from the American Lung Association, 154 million people, more than half the nation, endure pollution levels that make the simple act of breathing hazardous to their health. Recently, at least 19 bills have been introduced in both chambers of Congress seeking to prevent the Environmental Protection Agency (EPA) from enforcing The Clean Air Act, citing negative impact on businesses and the economy. However, the EPA estimates the economic value of substantial air quality improvements realized by the year 2020 would be almost $2 trillion. A study released in April from Health Care Without Harm (HCWH), the Alliance of Nurses for Healthy Environments (ANHE), and the National Association of School Nurses (NASN) showed that the direct and indirect costs of treating the estimated 24 million Americans with asthma exceeds $53 billion.

Registered nurses, who comprise the nation's largest group of health care professionals, have a crucial role in assessing and addressing environmental health issues and their impact on the public's health. ANA has been a leader and advocate for public policy that preserves and improves environmental protections vital to a healthy and productive society. To learn more about ANA's efforts, please visit ANA's Environmental Health website.

ANA Provides Testimony, Launches Website to Help Preserve Medicaid

SILVER SPRING, MD–The American Nurses Association (ANA) is working on several fronts to counter attacks on Medicaid funding and keep nurses informed about the efforts on Capitol Hill that impact this program which provides essential health care coverage for an estimated 58 million Americans.

Today in Chicago, ANA member and Illinois Nurses Association Deputy Executive Director Sharon Canariato MSN, MBA, RN, provided testimony at an informal hearing before U.S. Representatives Danny K. Davis, Mike Quigley, Bobby L. Rush and Jan Schakowsky to discuss the effects of federal cuts to Medicaid. "As nurses on the front lines, we know that lack of health insurance often leads to delayed care, impaired health, and greater mortality," Canariato remarked before the panel. "Now is not the time to reduce access to needed health care services."

"Patient advocacy has always been at the core of nursing and ANA takes that responsibility very seriously," commented ANA President Karen A. Daley PhD, MPH, RN, FAAN, from ANA's Silver Spring, MD headquarters. "The fight to preserve Medicaid is one of life and death–the difference between having access to quality health care or not. It is a battle that we as nurses are ready to take on."

Medicaid provides vital health care coverage to more than 58 million of the nation's most vulnerable populations. Medicaid finances care for 30 percent of all children, 68 percent of low income children and covers 70 percent of nursing home residents. Proposed cuts to Medicaid would swell the ranks of the uninsured and threaten the viability of nursing homes, hospitals, and other needed providers. Furthermore, cuts will contribute to emergency department overcrowding, delayed diagnosis of life-threatening diseases, increased reliance on charity care, and increased expenditures for preventable health complications. ANA will continue to strongly oppose large scale cuts in Medicaid.

ANA has also sent a letter to House and Senate members in support of the Medicaid Advanced Practice Nurses and Physician Assistants Access Act (H.R. 2134/S. 56) which would expand Medicaid coverage of Advanced Practice Registered Nurse (APRN) services. This legislation would allow fee-for-service coverage to be extended to include all nurse practitioners (NPs) and clinical nurse specialists (CNSs). It would also re-define primary care case managers to include all NPs as well as requiring Medicaid managed care plans to include NPs, midwives, nurse anesthetists and CNSs in their provider panels. If passed, it would serve to increase access to care for Medicaid patients.

To keep nurses up to date about all the developments related to Medicaid, ANA has launched a new website, www.rnaction.org/medicaid.

ANA Urges Support for Home Health Care Legislation: Ensures Better Patient Access to Care, Removes Barriers for Nurses as Qualified Providers

SILVER SPRING, MD–The American Nurses Association (ANA) is appealing to lawmakers to support the "Home Health Care Planning Improvement Act of 2011" (H.R. 2267, S. 227).

This bipartisan legislation, just introduced in the House by Reps. Allyson Schwartz (D-PA) and Greg Walden (R-OR), allows Advanced Practice Registered Nurses (APRNs) to sign home health plans of care and certify Medicare patients for the home health benefit. "This legislation will help improve access to care," said ANA President Karen A. Daley, PhD, MPH, RN, FAAN. "APRNs are a vital source of care with the education and training to facilitate home health plans of care. In order to meet our nation's health care needs, an integrated, national health care workforce that optimizes utilization of all qualified providers must be put into action."

"We have a responsibility to provide America's seniors with high quality health care, and a key part of that is ensuring they have access to timely home health care services," Rep. Schwartz added. "These valued health care professionals play a central role in the delivery of primary care, particularly in medically underserved areas, and are essential to the coordination of team-based care."

"This bill will reduce unnecessary and duplicative burdens on providers and seniors in need of home health services," Rep. Walden said. "Particularly in rural areas like central, southern, and eastern Oregon where physicians are scarce, nurse practitioners, physician assistants, clinical nurse specialists, and certified nurse-midwives are essential components of the health care delivery system. Not only are they serving on the front lines of primary care, but also in many areas they are the only option readily available."

APRNs are playing an increasing role in American health care delivery. Medicare has recognized the autonomous practice of APRNs for nearly two decades, and these health care professionals now coordinate the majority of skilled care to home health patients. However, a quirk in Medicare law has kept APRNs from signing home health plans of care and from certifying Medicare patients for the home health benefit. These delays in access to home health services inconvenience patients and their families and can result in increased cost to the Medicare system when patients are unnecessarily left in more expensive institutional settings. The Home Health Care Planning Improvement Act would address these problems by specifically allowing APRNs and physician assistants to certify home health services. ANA thanks Representatives Schwartz and Walden for their leadership on H.R. 2267 and urges all members of the House to support APRNs and their home health patients by cosponsoring the Home Health Care Planning Improvement Act (H.R. 2267).

To learn more about ANA's work on the home health care issue, including the Senate companion bill (S. 227) introduced by Senators Susan Collins (R-ME) and Kent Conrad (D-ND), please visit http://www.rnaction.org/homehealth.

Adding Chocolate to Milk Doesn't Take Away Its Nine Essential Nutrients

All milk contains a unique combination of nutrients important for growth and development - including three of the five "nutrients of concern" for which children have inadequate intakes. And, flavored milk accounts for less than 3.5% of added sugar intake in children ages 6-12 and less than 2% in teens.

5 Reasons Why Flavored Milk Matters

1 KIDS LOVE THE TASTE!
Milk provides nutrients essential for good health and kids will drink more when it's flavored.

2 NINE ESSENTIAL NUTRIENTS!
Flavored milk contains the same nine essential nutrients as white milk - calcium, potassium, phosphorous, protein, vitamins A, D and B12, riboflavin and niacin (niacin equivalents) - and is a healthful alternative to soft drinks.

3 HELPS KIDS ACHIEVE 3 SERVINGS!
Drinking low-fat or fat-free white or flavored milk helps kids get the 3 daily servings* of milk recommended by the *Dietary Guidelines for Americans.*

4 BETTER DIET QUALITY!
Children who drink flavored milk meet more of their nutrient needs; do not consume more added sugar, fat or calories; and are not heavier than non-milk drinkers.

5 TOP CHOICE IN SCHOOLS!
Low-fat chocolate milk is the most popular milk choice in schools and kids drink less milk (and get fewer nutrients) if it's taken away.

These health and nutrition organizations support 3-Every-Day™ of Dairy, a science-based nutrition education program encouraging Americans to consume the recommended three daily servings of nutrient-rich low-fat or fat-free milk and milk products to improve overall health.

AMERICAN ACADEMY OF FAMILY PHYSICIANS — STRONG MEDICINE FOR AMERICA
American Academy of Pediatrics — DEDICATED TO THE HEALTH OF ALL CHILDREN™
eat right™ American Dietetic Association
NHMA National Hispanic Medical Association™
NMA Since 1895
SCHOOL NUTRITION ASSOCIATION — Making the right food choices, together.

www.nationaldairycouncil.org/childnutrition

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*** DAILY RECOMMENDATIONS -** 3 cups of low-fat or fat-free milk or equivalent milk products for those 9 years of age and older and 2 cups of low-fat and fat-free milk or equivalent milk products for children 2-8 years old.