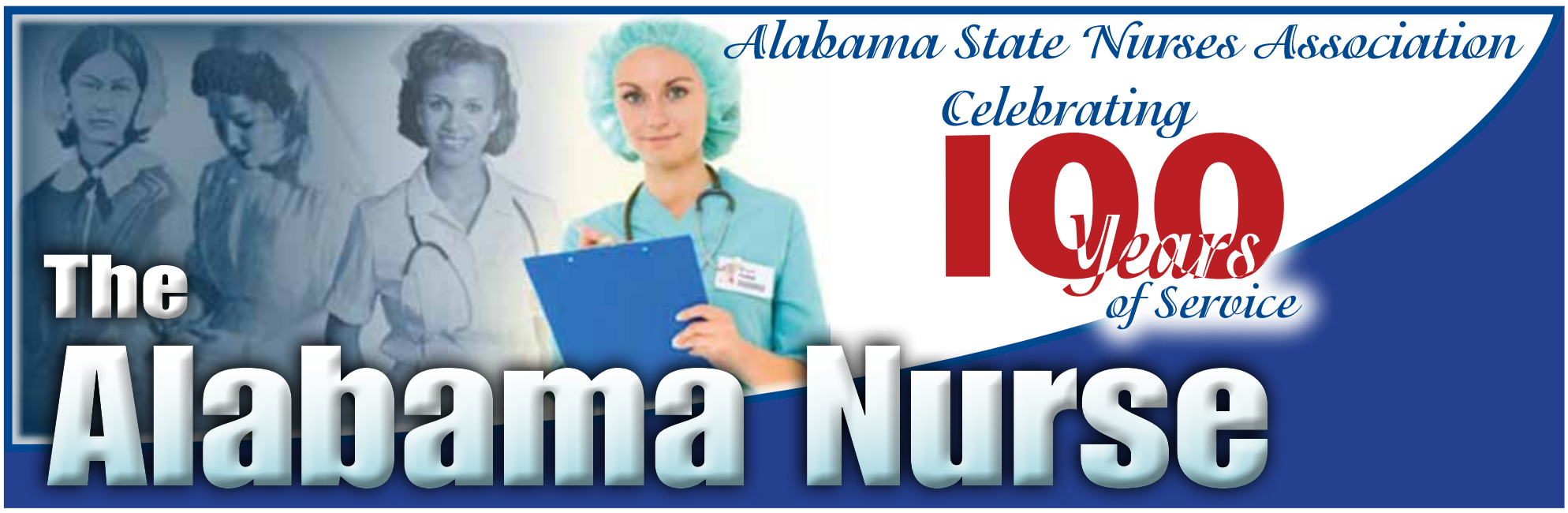

Alabama State Nurses Association

Celebrating 100 Years of Service

The Alabama Nurse

Circulation to more than 80,000 Registered Nurses, Licensed Practical Nurses and Student Nurses in Alabama

Alabama State Nurses Association • 360 North Hull Street • Montgomery, AL 36104

Volume 40 • Issue 1 **March, April, May 2013**

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Elizabeth A. Morris Clinical Education Sessions - FACES '13

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ASNA Leadership Academy

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Inside this Issue

Proclamation Year of the Nurse 2013

Whereas; in 1913, Alabama nurses began organizing the first professional association in the state, which eventually became known as the Alabama State Nurses Association, and

Governor Robert Bentley

Whereas; for 100 years Alabama nurses have bravely served the people of our state and nation through wars, conflicts and healthcare crises, and

Whereas; the Alabama State Nurses Association has served the profession as an influence in shaping health policy and law with Alabama preceding federal requirements to honor a 40 hour work week with subsequent hours designated as overtime, and

Whereas; the mission of the Alabama State Nurses Association is to promote excellence in nursing, and

Whereas; the Alabama State Nurses Association provides members with continuing educational opportunities and networking opportunities with other professionals, and

Whereas; the Alabama State Nurses Association partners with the American Nurses Association in providing members with current information and advocacy regarding national issues that may affect the nursing profession, and

Whereas; more than 25 nursing organizations and institutions in Alabama collaborate to raise awareness and legislative mindfulness through the annual "Nurses Day at the Capitol," and

Whereas; nurses are at the heart of patient care providing surveillance around the clock across all settings of care to save lives, and

Whereas; more than 81,000 licensed nurses in Alabama, by their exemplary service, have maintained the status of nursing as the most trusted profession,

Therefore; I Governor Robert Bentley for their 100th anniversary, do proclaim 2013 as "The Year of the Nurse" in Alabama.

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The President's Message

Many Voices for Our One Profession

by Arlene H. Morris, EdD, RN, MSN, CNE
ASNA President

How many times has a friend or family member told you what a nurse did as part of their care? Often, these friends or family members laud actions of nurses as vital for their health promotion, recovery or rehabilitation. Again in Gallup's 2012 poll, nurses were voted as the most ethical, honest, and trusted profession! The trust that America places in nurses is to be highly valued, and all nurses must make efforts to maintain that trust.

Nurses have earned the most trusted position, in part, by the nurse role of client/patient advocate. Inherent in this role is establishing a trusting relationship based dignity and respect for all, focusing on the needs and goals of the patient/family/community, and considering their values and priorities. Competent and compassionate care is pivotal for all nurses. This function is critical to fulfilling nursing's professional role and is vital for promoting quality and safe care in all settings and across transitions of care settings. Required skills include communication and collaboration with patient/family and other healthcare team members, prioritization, conflict management, and active participation in developing a system for quality at each level of healthcare by each level of nursing.

Perhaps your friend or family member complained about the nursing care they received. When listening to your friend or family, did you identify the particular setting of care, the level of education and the scope of practice legally approved for the educational preparation

The President's Message continued on page 3

Hundreds attend 2013's Nurses Day at the Capitol.

ASNA Board of Directors

ASNA STAFF

VISION STATEMENT
Our Vision

ASNA is the professional voice of all nurses in Alabama.

OUR VALUES

- Modeling professional nursing practices to other nurses
- Adhering to the *Code of Ethics for Nurses*
- Becoming more recognizably influential as an association
- Unifying nurses
- Advocating for nurses
- Promoting cultural diversity
- Promoting health parity
- Advancing professional competence
- Promoting the ethical care and the human dignity of every person
- Maintaining integrity in all nursing careers

OUR MISSION

ASNA is committed to promoting excellence in nursing.

ADVERTISING

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www.alabamanurses.org

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Condolences to:

Charlene Roberson in the death of her brother, Robbie Roberson.

Monariee Parker Jones in the death of her Father.

Carol Stewart in the death of her Father.

Ginny Langham in the death of her Grandmother.

The family of Helen Wilson former Interim Executive Director of ASNA, active member of District 5.

Alabama Board of Nursing Vacancies

There will be **3 RN** positions open and **1 LPN** position open as of January 1, 2014. The term of Martha Lavender, Nursing Education, Lynda F. LaRue, Nursing Practice, E. Laura Wright, Advance Practice and Maggie Hopkins, LPNAA will expire December 31, 2013. RN applications only are available from the ASNA office. Call Betty!

PUBLICATION

The Alabama Nurse Publication Schedule for 2013

Issue	Material Due to ASNA Office
June/July/Aug	April 29, 2013
Sep/Oct/Nov	August 5, 2013
Dec/Jan/Feb2014	October 28, 2013

Guidelines for Article Development

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

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

Submissions should be sent to:
edasna@alabamanurses.org
or
Editor, *The Alabama Nurse*
Alabama State Nurses Association
360 North Hull Street
Montgomery, AL 36104

SAVE THIS DATE

ASNA/AANS/ ALAONE ANNUAL CONVENTION October 10-12, 2013 (at the Renaissance in Montgomery, AL).

Full convention materials will be printed in the June/July/August issue of The Alabama Nurse.

Working to Reduce Obesity One Project at a Time

Maggie Antoine, MEd, RN

A small grant from the National Initiative Children's Healthcare Quality; Be Our Voice initiative has brought some major community changes to the city of Tuskegee. The grant required advocacy training and one policy, system, or environmental change. Thanks to Maggie Antoine and Ada Britt the grant was able to establish a strong advocacy support and collaboration the Macon County Parish Nurses, Tuskegee University staff, university students, several church groups, and city leaders.

The environmental change selected was to promote healthier lifestyles by developing a community garden.

Maggie Antoine chose to take this on as her project for the ASNA Leadership Academy.

Land for the garden was donated by a local church. Reverend Jones and his wife Cathy were enthusiastic about the garden from the planning stage through the harvesting stage.

Mr. Paris from the Extension Service not only acted as consultant but contributed a lot of valuable support from the beginning of this project. A church member, Larry Davis, donated his time and tractor to prepare the soil for planting. It was decided that planting fall vegetables would be best because of the time of year. The garden was a tremendous success. Community members turned out in droves to purchase collards.

Maggie Antoine and the Macon County Parish Nurses have plans to expand this project to include educational sessions such as reading food labels with a focus on children.

As a result of the collaboration efforts and increased awareness about obesity:

- The University will be looking at ways to increase physical activity on campus
- Twenty five (25) girls from local churches will be selected to participate in a 5 week course offering a series of health topics, including nutrition, physical activity, and coping mechanisms.
- Nurses in Tuskegee, as well as other adults in the community, are more aware of their need to be role models and weight loss efforts have started.

This is a great beginning for Tuskegee.

The President's Message continued from page 1

of the nurse involved? Two aspects are involved in the discussion: nurses must determine expectations of those for whom we care, and assure that staffing at each level of care matches the needs of the patient/family/community. What were the goals of the one receiving nursing care? How could nurses have better contributed to meeting those goals? Quality improvement is important for all. Healthcare consumers deserve and should expect information regarding the level of education, licensure, certification, and legal scope of practice of the ones providing care for them. It is the responsibility of all nurses to educate consumers about what care is to be expected from each level of preparation (vocational, associate, baccalaureate, masters or doctoral) and among the advanced practice roles of nurse practitioner, nurse anesthetist, nurse midwife, clinical nurse specialist, nurse educator, or nurse researcher. Nurses at each educational level can provide care at the patient's side across settings, or nurses at advanced levels may plan care for specific groups. Nurses advocate for their own profession while also advocating for quality and safe care of those for whom they provide care by clarifying that the term "nurse" designates a licensed professional within a profession that has autonomy to regulate its own practice in the same way that accountants, attorneys,dentists, pharmacists, physicians, social workers, and other professionals regulate their practice.

Buresh and Gordon (2010) encourage nurses to develop strong and authentic voices of agency to explain what they do and how they impact healthcare. This involves careful consideration of needs and expectations of individual/family/community and our individual responsibility for providing quality and safe care. Quality of care will be affected by changes in demographics and healthcare delivery. Many areas in Alabama are in dire need of nurses at all levels of practice. Work for quality in healthcare requires a view toward long-term outcomes. For example, funding to increase the number of educators for future nurses at all levels of preparation must be assured in order to meet the healthcare needs of Alabama. Nurses have a responsibility to be informed and able to articulate rationales regarding issues. Although all nurses will not agree about all issues, civil discussions help to refine our practice. All nurses actually are advocates for issues that affect their profession, whether they are aware of it or not, because others look to nurses for information and as an example of maintaining personal health.

This, the 100th year of the Alabama State Nurses Association (ASNA), is an opportune time to consider our individual roles and responsibility to ourselves, to our patients and to our profession. Membership in ASNA provides opportunity to impact our profession. In the past 100 years, nurses in ASNA have led efforts in Alabama related to employment standards and other professional issues. As we look to the future, let us be aware that nurses comprise the greatest numerical percentage within the healthcare delivery team. Trust for nurses must be maintained.

ASNA welcomes Dr. John Ziegler as our new Executive Director. He brings a varied background, with a strong emphasis on articulating messaging for Alabama Nurses. We look forward to his contributions in this exciting centennial year as plans are underway to celebrate a Century of Service for nurses within our state. Please contact the ASNA office for information regarding membership. The mission of ASNA is to promote excellence in nursing!

Legal Corner

by Don Eddins, BS, MS, JD

Recently, the Board of Directors of the Alabama State Nurses Association approved a resolution expressing the importance of nurses' having information on end of life choices. This is appropriate because too many people put the matter off until it is literally too late.

Preparation of a will, for instance, can negate the Probate Court's having to name an administrator and save the family hundreds or thousands of dollars, depending upon the size of the estate, in administrator's bond fees.

Basically, if a person dies intestate, without a will, the state will decide how the individual's belongings are divided. But if the estate is worth more than a few thousand dollars, the Court will require the person named administrator to post a bond as security. When the assets are divided, the administrator then has to make a satisfactory report to the Court to be released from the bond.

If a person makes a will, the individual normally states in the will that his/her personal representative will be exempt from any bond and will not have to make a report to the Court.

But the most important reason to make a will is that the individual can decide to whom his/her property will go after death. That often is radically different from the intestate scheme in the law.

Another important choice is whether to make a so-called "living will." Such a document allows the individual to decide whether he/she wants to be connected to life support devices during a terminal illness.

This is a very personal matter. For religious or other reasons, some people absolutely want to be kept alive as long as possible. Others absolutely do not want to be kept alive artificially if they are in a so-called vegetative state.

The good thing about a living will is that an individual can make the choice – whatever it is – before he/she is near death. The burden of making the choice to disconnect, or continue life support measures, is lifted off the children or other loved ones.

Alabama has a model advanced directive that is written into the code. It includes a living will and allows an individual to select a health care proxy.

Another important component of estate planning is a durable power of attorney. That document allows someone else to act on your behalf on fiscal matters. Normally it would be used only in special circumstances or if you became incapacitated. A word of caution: Don't give a power of attorney to someone unless you have ultimate trust in that person, because the POA essentially allows the holder to do all those things that you do.

Estate planning is something people tend to put off, but it is something no one should put off too long. Right now, you have the power to make the choices. Later, they could be a burden for loved ones or could be determined by the government.

LPN Corner

"The Future of Practical Nursing"

by Gregory Howard, LPN

The theme of the 2012 National Convention of The National Federation of Licensed Practical Nurses, Inc. held in Las Vegas was, "The Future of Practical Nursing."

Our National President, Ottamissiah "Missy" Moore was successful in recruiting some of the top leaders in nursing to give the attendees a snap shot of healthcare transformation and its implications for L.P.N.'s. Our first speaker, who set the tone for the convention, Dr. Beverly Malone, spoke about "Trends for Practical Nursing and the Support of NLN to Practical Nursing." Her concerns were both national and international. The nurse and nurse educator shortage was a critical issue, as well as ensuring access to safe, quality, culturally competent care to our diverse patient population. She believes L.P.N.'s/L.V.N.'s should have a place at the table… but it is up to us to convince decision makers of that fact.

Benita Jenkins, EdD, RN, CNE, Nurse Consultant for the D.C. Board of Nursing, reminded us of systemic changes with respect to our interaction with Unlicensed Assistive Personnel. Employers welcome everyone to the table when it comes to service and/or patient care, and economics will drive, who will provide the service. Again, L.P.N.'s/L.V.N.'s have to carve out our place by being active participants in policy and planning opportunities.

The lady who "broke it down," drove the message home, was Debra A. Toney, PhD, RN, FAAN Director of Nevada Health Centers. Dr. Toney shared her perspective on the "Future of Nursing" which is based on experience, exposure, and work in the Nevada Legislature. She challenged each of us to never stop learning and to be sure to interact with the people making the decisions concerning health care. She also challenged us to be passionate, focused and constant in our actions. She said that for our profession unity, self improvement and growth in skill sets was the key to success.

Change is constant and we must keep up with the changes to be successful. As well as being the best person qualified for the position.

Each of the speakers gave a powerful message. It would have been huge if they could be bottled and shared with all of my colleagues with hopes of motivating every L.P.N. to action and to the realization that we must enhance our own value.

The message the speakers wanted all attendees to leave with was "be prepared, with as many skills as you can, to meet the need of today's employer." The evolution of the Practical Nurse has been a noble endeavor and worthy of a prominent place in the health care arena. Let's stick together… there is power in unity. To grow our profession, the equation we need to keep before is:

Unity + Power = Change
Change + Growth = Maturity
Maturity + Change = Responsibility

The E.D.'s Notes

A New ED…What's Up for 2013?

Dr. John Ziegler

Joining ASNA as your new Executive Director is an exciting challenge. Retiring ED Joe Decker left "large shoes" to fill. Joe is a good communicator and remains available to assist me with any questions, etc. My gratitude is also extended to our staff and President Arlene Morris. They have been most helpful by facilitating a quick learning curve for me at ASNA.

As most of our readers know, we begin the year with our Nurses Day at the Capitol on February 14. This event sets the stage for our "visibility" with the Alabama Legislature. Don Eddins and I are registered lobbyists representing your profession. We will be frequently walking the halls of the State House to monitor any legislation affecting nursing. In the past, I have worked on a governor's staff, a lieutenant governor's staff and served as public information officer for the Alabama Department of Mental Health. With Don's help and a spirit of unity within the nursing profession, I believe that we can be effective in promoting good legislation and opposing legislation that may, in its proposed form, cause concern to our Board. With rapidly evolving changes in our healthcare system, this should be an interesting year.

To celebrate the 100th year of the Alabama State Nurses Association, Governor Bentley is proclaiming 2013 as "The Year of the Nurse in Alabama." Through publications, venues and web-based media, ASNA will use this historical milestone for promoting the invaluable contributions made by nurses through numerous wars, natural disasters, and health crises in our country over the past century. Nurses are the heart of the healthcare system providing round the clock care in all settings of care to promote wellness and save lives! ASNA wants to tell this story in a variety of ways, which brings me to my closing comments about COMMUNICATION.

The following are several of our ASNA communication goals:

- **Elevate the brand.**
  ASNA has been the flag ship of nursing associations in Alabama for 100 years.
  ASNA serves nurses from all specialties.
  ASNA membership benefits exceed dues.
  ASNA publications reflect the exemplary standards and contributions of the profession.

- **Simplify membership.**
  Make it easier to join.
  Make it easier to join.
  Make it easier to join.

- **Outreach.**
  Revamp the website and expand the use of social media.
  Meetings should be fun and promote relationships as well as conduct business.
  Members reach out to students, coworkers and others through District participation.
  Present opportunities to join in all publications and events.

ASNA promotes the profession, helps members grow and serves as a collective voice to policy makers. To stay true to my fourth point under "outreach" mentioned above… **If you're are not a member, JOIN!** Go to www.alabamanurses.org and follow the membership menu. Or, you can give April Bishop a call at 334-262-8321 and she will walk you through the application and answer any of your questions. Serving as your ED is a privilege and I look forward to celebrating the 100th year of ASNA with you.

John Ziegler
Executive Director

Research Corner

Elderly Health and Long-Term Care

Studies link adverse drug interactions to elevated risk for hospitalization among the elderly

The elderly population consumes a disproportionate share of prescription and over-the-counter drugs relative to younger persons. These factors, combined with age-related changes in the ability of the body to process and respond to drugs, make the elderly population more susceptible to drug interactions. A review of 17 studies that assessed specific drug interactions in elderly patients found that 16 of the studies reported an elevated risk for hospitalization in older adults associated with drug interactions.

These interactions included angiotensin-converting enzyme (ACE) inhibitors and potassium-sparing diuretics; ACE inhibitors or angiotensin receptor blockers and sulfamethoxazole/trimethoprim (SMX/TMP); benzodiapines or zolpidem and other medications; calcium channel blockers and macrolide antibiotics; digoxin and macrolide antibiotics; lithium and loop diuretics or ACE inhibitors; phenytoin and SMX/TMP; sulfonylureas and antimicrobial agents; theophylline and ciprofloxacin; and warfarin and antimicrobial agents or non-steroidal anti-inflammatory drugs.

The researchers conclude that when the elderly receive drug therapy, it should be absolutely necessary for the achievement of well-defined goals. They also recommend that an evidence-based, high–priority list of drug interactions in the elderly be developed and maintained. This study was supported in part by the Agency for Healthcare Research and Quality (HS192220, HS17001).

See "Potentially harmful drug-drug interactions in the elderly: A review," by Lisa E. Hones, Pharm. D. and John E. Murphy, Pharm.D. in the *American Journal of Geriatric Pharmacotherapy* 9, pp. 364-377, 2011. MWS.

Self-monitoring of blood pressure along with nurse counseling leads to greater blood pressure control

High blood pressure (HBP) remains a major public health concern both in the United States and worldwide. Since managing HBP is often a lifetime effort, it is important to find effective ways to improve both self-care skills and motivations for individuals with HBP. A community-based lifestyle modification program using telephone-transmitted self-monitoring BP technology and nurse-led counseling more than doubled the percentage of people maintaining BP control)from 30 to 73 percent) during an initial 3-month education period. This control was sustained and even improved during a 12-month follow-up period, according to a new study.

In addition, the more-counseled group improved their BP and psychosocial outcomes more than the less-counseled group. The authors point out that maintaining optimal BP over time directly leads to declines in stroke and coronary artery disease incidence and mortality. The study population consisted of 359 middle-aged (40-64 years) Korean immigrants who completed a 15 month intervention. The intervention consisted of 6 weeks of behavioral education followed by home telemonitoring of BP and bilingual nurse telephone counseling for 12 months. This study was supported by the Agency for Healthcare Research and Quality (HS13160).

See "Teletransmitted monitoring of blood pressure and bilingual nurse counseling-sustained improvements in blood pressure control during 12 months in hypertensive Korean Americans" by Miyong T. Kim, Ph.D, Hae-Ra Han, Ph.D., Haley Hedlin, Ph.D., and others in the *Journal of Clinical Hypertension* 13, pp. 605-612, 2011, *MWS*.

CE Corner

MANopause (Andropause)

Authored by: Joyce McCullars Varner, DNP, ANP, GNP-BC, GCNs,

Professor and Program Director of Adult – Geron Primary Care NP Program & the BSN-DNP adult-Geron Primary Care NP with Palliative Care Specialty Program University of South Alabama College of Nursing (jvarner@usouthal.edu)

Intended Audience: RN and LPN

Disclosures:

1. The author and planning committee discloses no conflict of interests.
2. The activity is valid through 1 February 2015.
3. Course requirements – see directions

Goal/Purpose: Examine the impact of andropause on men.

Objectives: At the completion of this course the participant should be able to:

1. Compare the impact of andropause in men to menopause in women.
2. Describe the impact of the reduction of testosterone in the body.
3. List the typical symptoms of andropause.

Directions: Read the monograph *MANopause*. Complete the Post Test and evaluation and return both completed forms to ASNA (360 N. Hull Street, Montgomery, Alabama 36104 or (F) 334-262-8578). A Continuing Nursing Education certificate of completion will be sent to you upon successful completion of the post-test and evaluation sheet. You must score at least 80% on the post-test to pass. Should you score below 80%, you will be notified and offered the opportunity to retake the post-test for an additional cost of $5.00.

Board of Nursing Transcript: ASNA will enter the course on your Alabama Board of Nursing transcript **(you will be unable to successfully enter the course on your transcript yourself)** within two weeks of successful completion of the activity.

Contact hours & Accreditation:

This 1.25 contact hour course (60 minutes equal 1.0 contact hour) activity is provided by the Alabama State Nurses Association.

The Alabama State Nurses Association is an accredited provider of continuing nursing education by the American Nurses Credentialing Center Commission on Accreditation (ANCC).

Pharmacology hours: 0.5

This 1.5 contact hour course (50 minutes equal 1.0 contact hour) activity is provided by the Alabama State Nurses Association, which is approved by the Alabama Board of Nursing, provider number ABNP002 (valid through 30 March 2013). **Approval of this activity expires 31 January 2015.**

Fees:

ASNA Member: $ 11.00 Non-member: $ 15.00

Shipping & Handling (if we mail the program to you) $7.50

MANopause (Andropause)

Mark Twain once said, "Age is an issue of mind over matter. If you don't mind, it doesn't matter." Unfortunately, Mark was off the mark here! We know that even if you don't mind, it just might matter. Ask any man who suffers from low testosterone levels or ask any woman who has a man going through this phenomenon. This "decline of maleness" with age has given rise to a term: "andropause."

The "Change of Life" Is Viewed Differently by Men and Women

Male hormones are called androgens from Greek words andro meaning man, and gen meaning giving birth to. Primary among them is the natural hormone testosterone, which is produced in the testes, ovaries and adrenals. Females also produce testosterone in the adrenals and as a precursor to estrogen, but the amount of circulating testosterone is generally far less than in males, although the ranges on the two sexes overlap. Both sexes also produce an androgen precursor called dihydroepiandrostene (DHEAS) from which the body can make androgens. Androgens cause the secondary sex characteristics of males: facial hair, thicker skin, low body fat, deeper voice, muscularity, penis and scrotal growth and darkening, broad shoulders, body hair, erection of the penis, etc. With increasing age, testosterone production declines, and many of these changes start to reverse.

Women have always approached menopause with dread, thankfulness, and humor. The humor is necessary to avoid homicidal or suicidal thoughts! The dread is that we know it is coming for us. The thankfulness is that for most, life changes for the better with no more reproductive fears or issues. The term andropause describes a process that may or may not be universal and tends to occur over time whereas menopause occurs universally in women and usually happens dramatically. While familiar among healthcare professionals, surprisingly few men are aware of male menopause. The condition has been found in medical literature since the 1940's, but since medical professionals lacked a method to properly diagnose the condition and symptoms are so gradual and vary from man to man, little was done to educate the population. Luckily, blood testing methods have been created that can properly monitor testosterone levels and diagnose andropause. The condition is now much better understood, as is treatment.

Good News: "They" Have it "Too"

Andropause, also known as the male menopause or MANopause, is the result of a gradual drop in testosterone (which is an androgen), giving the condition its name. When men enter their early 30s they begin losing testosterone at a rate of 1-2% a year. Up until recently this normal change was simply not discussed by men unless it was in secret talks with their male physician. Lately, men have been bringing this out into the open and seeking help. This is a direct result of a more open society in which men are free to express their feelings and explore issues that were taboo in the past. Magazines that cater specifically to men publish articles regarding andropause and this takes the subject out of the shadowy area and out into the open and as a consequence, more men are getting diagnosis and treatment. The invention of Vitamin V (Viagra) also made men realize that low libido is not a shameful secret and that there is help out there for this problem.

U.S. Census Bureau Data

The sexuality for a man whose age is between 15 to 30 years old and whose testosterone level is at its peak 1000-1200ng/dl drops during andropause where the average of testosterone level of a man in his 80s is probably only 200ng/dl: a drop of almost 80%. Approximately 4-5 million men have symptoms of low testosterone levels and only 5-10% of these men will seek treatment. A recent World Health Organization (WHO) report analyzed male hormones and found that testosterone levels in most 70 year old men were 10 % of the level in males that are 25 years old. By the time men are between the ages of 40 and 55 they can begin experiencing symptoms of andropause. At 40-49 years of age, about 2% to 5% of men have symptoms. From 50-59 it jumps to anywhere from 6% to 40% of the population. From 60-69 years-of-age the likelihood is somewhere in the 20-45% range. From 70-79 it affects about 34% to 70%. And over age 80 about 91% of men have symptoms. For most men, since this happens at a time when they are beginning to take stock of their achievements and direction in life, it's often difficult to realize that the developing changes are related to more than just outside circumstances. Unlike menopause, which generally occurs in women during their mid-forties to mid-fifties, men's "transition" may be much more gradual and extend over many decades. Attitude, psychological stress, alcohol, injuries or surgery, medications, obesity and infections can contribute to its onset. Premature andropause can occur in males who experience excessive female hormone stimulation through workplace exposure to estrogen. Men who work in the pharmaceutical industry, plastics factories, near incinerators, and on farms that use pesticides are high-risk for early andropause.

The Importance of Testosterone

Testosterone is a hormone that has an effect on almost every aspect of a man's body. It helps the body build the various proteins that play key roles in virtually every bodily function. It is to males what estrogen is to females. Testosterone assists the male body in building protein and is crucial for normal sexual drive and stamina, and in producing erections. Testosterone also contributes to several metabolic functions including bone formation, liver function, prostate gland growth and production of blood cells in bone marrow. When testosterone is declining in men, the Sex Binding Hormone Globulin (SHBG), also called androgen-binding protein, increases in levels. SHGB inhibits a substantial portion of remaining testosterone from working; the remaining working testosterone is referred to as bioavailable testosterone. Bioavailable testosterone declines with time, causing gradual male menopause symptoms.

Cardiovascular Risks

It is now well accepted that women's risk of atherosclerosis (hardening of the arteries) increases after menopause. Estrogen replacement therapy seems to reverse this trend. New evidence suggests that a similar phenomenon occurs in men as their testosterone levels diminish with age. While research is not as complete as for women, the clinical findings point to an association between low testosterone levels and an increase in cardiovascular risk factors in men. The link between low testosterone and heart disease applies only to men. Women with high testosterone levels are at increased risk of heart disease. In a way, the new findings are ironic. Researchers once thought that the female sex hormone estrogen was the reason why women have relatively less heart disease than men do. Now it appears to be the male sex hormone testosterone that protects men. Low serum testosterone levels are also noted to be a risk factor for diabetes, metabolic syndrome, inflammation and dyslipidemia. These metabolic and inflammatory complications are not without consequences. Recent studies have shown low serum testosterone levels to be an independent risk factor of cardiovascular and all-cause mortality.

Andropause Symptoms

There are many signs and symptoms of andropause that healthcare providers and males and those who care for them need to be aware of. The first sign may be seen in increased irritability and a tendency to be short-tempered without cause (this is known as the Irritable Male Syndrome). Men may also experience weight gain, sleep apnea, memory loss, diminished libido, hair loss, erectile dysfunction, hot flashes, muscle loss, depression, fatigue, night sweats, gynecomastia, decrease in bone density, and a loss of body hair. Bone density decreases resulting in osteoporosis leading to the occurrence of bone fractures and breaks. There is also an increase in fat around internal organs.

Some men may have one or two of these symptoms, and may just notice the other andropause symptoms occurring minimally or not at all. The imbalance of even one hormone causes imbalance in other hormones and leads to a domino effect of sorts. Men may not experience all of the above andropause symptoms, but instead commonly experience a combination of symptoms. While these symptoms are signs of andropause, they may also be symptoms of other conditions like adrenal fatigue and poor thyroid health so a thorough history and physical needs to occur with complaints of these symptoms and a testosterone level drawn for evaluation.

In clinical practice most healthcare professionals use the ADAM Questionnaire (androgen decline in the aging male) to assist with diagnosis. This questionnaire consists of the following questions:

- Do you have a decrease in libido (sex drive)?
- Do you lack energy?
- Is your strength or endurance decreased?
- Have you lost height?
- Have you noticed decreased "enjoyment of life?"
- Are you sad or grumpy?
- Are your erections less strong?
- Have you noticed a recent deterioration in your ability to play sports?
- Do you fall asleep after dinner?
- Has there been deterioration in your work performance?

If even one question has a yes answer then blood tests are warranted.

Blood Tests Measure Testosterone Levels

To determine a diagnosis of andropause, a blood test is

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necessary for measuring testosterone levels. While it's true that decreased testosterone levels are a factor, other issues may weigh in. For instance, more sex hormone-binding globulin may limit testosterone from traveling to the tissues. Also, where testosterone levels would rise and fall when the patient was younger, they may now be experiencing a flattening and lower level of production.

Issues to Be Aware Of

The definition of low testosterone varies. Generally, two standard deviations below the usual rate for a younger man is considered deficient. It's important to look at the testosterone levels over a period of time because they may vary from one day to the next. In older men, affected organs may respond differently to androgens. The patient and healthcare provider need to work together to establish the best level for each patient.

Testosterone Levels

Normal levels are 300-1,200 nanograms per deciliter. A testosterone level less than 200 ng/dl is considered low. If total testosterone levels are over 600 ng/dl then low testosterone is probably not the cause of andropause. A healthcare provider will look at testosterone levels as well as other symptoms, such as low sex drive and erectile dysfunction before making a diagnosis of andropause.

Other Factors Contributing to Low Sex Drive in Men

- Sex drive and hormonal imbalance may be attributed to one or a combination of physical or psychological factors. These include: Lifestyle (smoking, drinking, drugs, lack of exercise)
- Psychological (stress, anxiety, depression)
- Disease (diabetes, blood pressure, cholesterol, obesity)
- Use of certain medications (antidepressants, antihypertensives, antiepileptics)

Hormone Replacement Therapy

Hormone replacement therapy can increase interest in sex, produce more frequent erections, reduce depression, anger, and fatigue. Therapy can also help to maintain male traits such as beard growth, increase muscle mass and bone density and strengthen the hand and leg muscles. Different types of hormone replacement therapy are available:

- Oral testosterone-Testred (methyltestosterone) is associated with liver toxicity and live tumors so are used sparingly.
- Transdermal patch-Androderm or Testoderm. Androderm is applied to the abdomen, lower back, thigh, or upper arm and is applied each evening between 8pm and midnight.
- Testoderm is applied to the scrotum at the same time as Androderm nightly. Adverse effects include fluid retention, acne, and temporary breast enlargement.
- Transdermal gel-AndroGel and Testim. Applied once daily to clean and dry skin on the upper arms or abdomen. It delivers testosterone for 24 hours at controlled intervals. Must be allowed to dry on the skin before dressing and must be applied at least 6 hours before showering or swimming. Cannot be applied to the genitals.
- AndroGel is available in a metered-dose pump, which allows for dosage adjustment by the provider. Side effects include adverse reactions at site: acne, headache A, hair loss.
- Buccal strips-Striant. The newest form of therapy. A tablet is placed between the gums and upper lip every 12 hours. It is absorbed into the blood and is released slowly, like with the gel or patch. Side effects include gum or mouth irritation, bitter taste, pain or tenderness in the gums, headache, and distorted sense of taste. Most or all of these side effects go away within 14 days.

Possible Dangers of Hormone Replacement Therapy

Fluid Retention: It is possible, especially within the first few months of treatment, for a man to retain fluid. Studies of healthy older men have shown problems with fluid retention leading to ankle or leg swelling, worsening of high blood pressure or congestive heart failure. It is unclear whether there would be an effect in men who are ill, for example those with congestive heart failure.

Liver Toxicity: There have been no reports of liver toxicity from transdermal testosterone replacement. However, oral testosterone replacement can cause significant liver problems. Interestingly, every manufacturer (even those producing transdermal testosterone) mentions the possibility of liver problems.

Problems with Fertility: Spermatogenesis (the production of sperm) in all men is dependent on production of testosterone by the testes. If testosterone is given from outside, the testes will stop producing their own testosterone. This will shut down sperm production either significantly or completely in nearly all men. This may be a temporary or permanent testosterone side effect. Younger men, who still plan to have a family, must take this into account when considering the effects of testosterone replacement therapy. Some men have "banked" their sperm. Other men have delayed testosterone replacement until they have finished having children. It is important that any man considering a family be very careful in starting testosterone treatment of any kind.

Sleep Apnea: Sleep apnea is a condition in which individuals stop breathing for periods of time while sleeping. This can have significant medical effects. There have been reports that increased testosterone levels exacerbate pre-existing sleep apnea.

Tender Breasts or Enlargement of Breasts: This may occur in some older men who are on testosterone therapy. This may be due to the conversion of testosterone to estrogen. Breast tissue in both men and women is very estrogen sensitive. Sometimes this testosterone side effect can be overcome by decreasing the dosage of the testosterone.

Increased Red Blood Cell Concentration (Polycythemia): One of the most important side effects of testosterone replacement therapy can be an increase in the red blood cell mass and hemoglobin levels. This is particularly true of older men. Increased blood cell mass may increase thromboembolic events (heart attacks, strokes or peripheral clotting in the veins). Men who develop increased hematocrit can decrease testosterone replacement or can donate blood to decrease their blood cell mass.

Prostate Growth: The growth of the prostate can have a negative effect on men in two ways. First, the prostate may increase in size. This may cause problems with urination. Second, it may promote the growth of cancerous prostate cells. It is important to remember that prostate cancer is a common cancer for older men and is the second most common cause of cancer deaths in older men.

Conclusions

While we look at both menopause and andropause with some trepidation and some laughter we realize both may occur and we must be able to recognize and treat to increase quality of life and health. So…. we approach this subject with great delicacy when discussing with our patients. As with hormone replacement for women, healthcare providers must be well aware of the risks and benefits and educate our patients so they can be part of the decision. It is ultimately, their call.

MANopause Post Test continued on page 9

CE Corner

MANopause continued from page 8

Post-test
(Select the one (1) best answer)

1. The use of hormone replacement cause enlarged breasts in older men?
   a. True
   b. False

2. Testosterone is produced in the
   a. Thymus
   b. Kidney
   c. Thyroid
   d. Adrenal

3. Psychological stress can contribute to the development of andropause
   a. True
   b. False

4. The link between low testosterone and heart disease applies only to men
   a. True
   b. False

5. The first sign of low testosterone in men may be:
   a. Irritable Male Syndrome
   b. Rootles Male Syndrome
   c. Roaming Male Syndrome

6. Do you have a decrease in libido (sex drive)? This is the first question on the
   a. ADAM questionnaire
   b. NOT-EVE questionnaire
   c. ADSTOCK questionnaire

7. One of the most important side effects of testosterone replacement therapy can be an increase in the red blood cell mass and hemoglobin levels
   a. True
   b. False

8. Male hormones are called androgens from Greek words andro meaning ___
   a. Woman
   b. Man
   c. Child

9. Testosterone levels in a man of 81 has likely dropped 10%
   a. True
   b. False

10. Men at a high-risk for early andropause have a history of working on a farm and being exposed to
    a. Pesticides
    b. Farm animals
    c. Nematodes

MANopause (Andropause)

Contact Hours 1.25 (ANCC) 1.5 (ABN & PHARM) Activity #: 4-0.946

Goal: The purpose of this activity is to examine the impact of Andropause on men.

Name, Credentials: _____ ____ **Member ($11)**

Address: _____ ____**Non Member ($15)**

_____ **ABN License#:**_____
City State Zip

Phone:_____ **Email:** _____

_____ / _____ _____ _____
Credit Card Number Exp. Date CVV Code Signature

The Alabama State Nurses Association is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.
Alabama Board of Nursing Provider Number ABNP0002 *(valid through March 30, 2013).*

Place answers to post test in designated boxes, and <u>return only this page</u>.

1	2	3	4	5	6	7	8	9	10

ACTIVITY EVALUATION
Circle all responses using this scale: 3 – *Yes* 2 – *Somewhat* 1 – *No/NA*

Goal was achieved.	3	2	1
Objectives were met.			
1. Compare the impact of andropause in men to menopause in women.	3	2	1
2. Describe the impact of the reduction of testosterone in the body.	3	2	1
3. List the typical symptoms of andropause.	3	2	1
Program free of commercial bias.	3	2	1
On a scale of 1 – 5 / 1 (low) 5 (high) knowledge of topic before home-study	5	4	3 2 1
On a scale of 1 – 5 / 1 (low) 5 (high) knowledge of topic after home-study	5	4	3 2 1

How much time did it take you to complete the program? _____hours _____ minutes.

ADDITIONAL COMMENTS:

Elizabeth A. Morris Clinical Education Sessions–FACES '13

Time	AANS	Clinical 1	Clinical 2	Clinical 3	Education/ Research	General	Nutrition	Practice Issues	PSY/Social	Workplace Issues
0800 -0915	PLENARY A – Genomics – Dr. Ramona B. Lazenby									
0915 -1000	BREAK – VISIT EXHIBITORS, VIEW POSTERS									
1000 -1100	Pharmacology Insanely Easy! (No CE Credit)	Improving the Pt. Discharge	Lead the Way with EKG …	Dialysis Options in the ICU…	More than a Fire Drill:…	Back Off Baby, I'm in School!	Fighting Obesity One Surgery at a Time	The Impaired Nurse	Screening for Adolescent Depression…	Human Trafficking: *The Nurses Role…*
1115 -1215	NCLEX Review	Enteral Feeding Tubes:…	Strategies for Improving Pt. Safety…	Congenital Heart Disease & Pulmonary...	Improving Adjunct Faculty Experience	What's New In Clinical Quality…	Essential Foods for Fighting Cancer		An Overview of Natural Supplements	Civility & Nursing Retention…
1215 -1315	Lunch Sponsored by Arthur L. Davis Publishing, Inc. Optional Lunch & Learn ~ Challenge of Growth (No CE Credit)									
1315 -1430	PLENARY B ~ When the Nurse Is A Patient									
1430 -1440	BREAK – VISIT EXHIBITORS, VIEW POSTERS									
1440 -1540	Transition to Practice	CAUTI Prevention	Can I Still Have Sweet Tea?	Sports-related Concussion	The Lived Experience of Nurse Ed… AND Benefits & Barriers to Pediatric…	Clinical Research Nursing…	Malnutrition in the Hosp. Elderly…	Trends in Substandard Nursing…	Anxiety Disorders:	
1550 -1650	Time Management	Fall Prevention	Hypoglycemia	Early Management of Head Injury			Malnutrition in Hosp. Pts	Practices Among RN…	Coaching: It's Not Just…	Stop Bullying…

Elizabeth A. Morris Clinical Education Sessions - FACES '13

Preliminary Exhibitors:

Alabama Organ Center
AU/AUM Schools of Nursing
Jackson Hospital
JSU College of Nursing
Middle Tennessee School
Sylvia Rayfield & Associates
The University of Alabama

Elizabeth A. Morris Clinical Education Sessions–FACES '13

Elizabeth A. Morris Clinical Education Sessions
FACES '13
Tuesday, April 23, 2013
Eastmont Baptist Church
4505 Atlanta Hwy, Montgomery, AL

7:15 – 8:00 AM
REGISTRATION

8:00 – 9:15 AM
OPENING PLENARY

PLENARY A
Genomics
Dr. Ramona B. Lazenby

For many, the word "genomics" sparks feelings of fear and intimidation. This presentation will address these, and other issues related to genomics. After a brief overview of exactly WHAT is meant by genomics, the reasons WHY healthcare professionals need to be competent in this area will be addressed. Using case studies, the WHO will involve specific examples of how genomics can be incorporated to improve safety and quality in the health care setting.
At the conclusion of the presentation the participant should be able to:
1. Discuss the roles and responsibilities of the nurse related to genomics.
2. Describe the importance of pharmacogenetics.
3. Identify high risk individuals who would benefit from extensive genetic testing.

9:15 – 10:00 AM
BREAK
VISIT EXHIBITORS, VIEW POSTERS

10:00 – 11:00 AM
SESSION A

AANS A – Pharmacology Insanely Easy!
*Tina Rayfield, BS, RN, PA-C – **No CE credit will be awarded for this session***
Feeling anxious about learning Pharmacology? If your answer is YES, this program is for you! Sylvia Rayfield & Associates and ICAN Publishing brings you *"Pharmacology Made Insanely Easy!"* This program makes learning pharmacology fun, easy, and memorable. With increased pharmacology on the NCLES-RN®, we want to provide you with a program that is guaranteed to increase your confidence in answering questions successfully. So sit back, relax and laugh while we help you study this challenging topic.

CLINICAL 1 A – Improving the Patient Discharge Experience through Interdisciplinary Teams
Terry Motes, BSN, RN, MPA; Antoinette Shedlarski, BSN, RN; Terah Simpson, MSN, RN CNL; Joy Friday, BSN, RN; Charyl Alexander, BSN, RN; Martha Gaston, ADN, RN; Brittney Knight, ADN, RN
At the conclusion of the presentation the participant should be able to:
1. List key components to improve the discharge process.

CLINICAL 2 A – Lead the Way with EKG Placement
Rachel N. Kummer NS; Joseph D. Ciuzio, NS; Chris Jungboo Lee, NS; Heidi Johnston, NS; Latosha Jones, NS; Margaret Jones, NS; Ashley Colburn, NS & Chase Cohron, NS
At the conclusion of the presentation the participant should be able to:
1. State two implications of cardiac dysfunction.
2. List two differences in the EKG with improper lead placement.
3. Identify one way to correctly measure EKG result.

CLINICAL 3 A – Dialysis Options in the ICU: What is the Buzz about CRRT?
Dr. David H. James
At the conclusion of the presentation the participant should be able to:
1. Discuss the impact of Acute Kidney Injury (AKI) in the critical care setting.
2. Describe the fundamental transport mechanisms for solute removal.
3. Compare and contrast the advantages and disadvantages of various dialysis options for AKI including intermittent hemodialysis (IHD), peritoneal dialysis (PD), and continuous renal replacement therapy (CRRT).

EDUCATION/RESEARCH A – More than a Fire Drill: Disaster Planning for School Nurses
Dr. Allison J. Terry, & Ginny Langham, MSN, RN
At the conclusion of the presentation the participant should be able to:
1. Assess the disaster procedure present in his/her own work setting for adequacy.
2. Practice the triage procedure on a variety of patients in multiple settings.
3. Discuss lessons that have been learned from recent disasters in educational settings.

GENERAL A – Back off Baby, I'm in School!
Susan Mack, MSN, RN, & Ann W. Lambert, RN, MSN, CRNP, Monica Dunn, NS, Tamara LaFever, NS, & Marcus Simpson, NS
At the conclusion of the presentation the participant should be able to:
1. Present how to incorporate information about unplanned pregnancy into academic college courses.
2. Raise awareness and provide resources about the connection between unplanned pregnancy and student retention and college completion.
3. Demonstrate how to involve student leaders, student groups and community partners to address pregnancy planning and prevention to achieve educational goals.

NUTRITION A – Fighting Obesity One Surgery at a Time
Dr. Cam Hamilton
At the conclusion of the presentation the participant should be able to:
1. Develop an understanding of driving forces leading to obesity.
2. Discuss current trends in therapies to assist with obesity.
3. Identify potential complications as a result of bariatric surgery.

PRACTICE ISSUES A – The Impaired Nurse
Dr. Laura Pruitt Walker & Lori Hill, MSN, RN
At the conclusion of the presentation the participant should be able to:
1. Explore the impact of substance abuse on the nurse.
2. Identify five behaviors suggestive of an impaired nurse.
3. Describe three measures to take when reporting a colleague suspected of impairment.

PSY/SOCIAL A – Screening for Adolescent Depression in Primary Care Settings
Dr. Darlene C. Pierce
At the conclusion of the presentation the participant should be able to:
1. Apply the utilization of the PHQ-9 Screening tool.
2. Relate principles and examples of active monitoring adolescents with mild to moderate depressive symptoms.
3. Describe the importance of asking an adolescent about their mental health.

WORKPLACE ISSUES A – Human Trafficking: The Nurse's Role in Recognition and Intervention
Sherron B. DeWeese, MSN, RN, WHCNP
At the conclusion of the presentation the participant should be able to:
1. Identify at least one red flag that might indicate a potential victim of human trafficking.
2. Verbalize nursing actions needed after recognition of a possible victim of human trafficking.

11:15 AM – 12:15 PM
SESSION B

AANS B – NCLEX Review
N. Genell Lee, MSN, RN, JD, Executive Officer, ABN
At the conclusion of the presentation the participant should be able to:
1. Describe the process for application of NCLEX and licensure.
2. Discuss NCLEX computer-aided testing.
3. Identify day of testing activities.

CLINICAL 1 B – Enteral Feeding Tubes: Are You Using Them Correctly? Update on Current Evidence-Based Practice
Kristina Miller, MSN, RN, PCNS-BC & Ashley Marass, MSN, RN, CPNP
At the conclusion of the presentation the participant should be able to:
1. Summarize current evidence based practice guidelines pertaining to enteral feeding tubes and their maintenance.
2. Describe insertion techniques and troubleshooting mechanisms for enteral feeding tubes.
3. Discuss new evidence based placement confirmation techniques for both insertion and routine verification.

CLINICAL 2 B – Strategies for Improving Patient Safety by Preventing Healthcare Acquired Clostridium Difficile Infection
Dr. Lygia Holcomb
At the conclusion of the presentation the participant should be able to:
1. Review state of the science from the literature related to prevention of healthcare acquired Clostridium Difficile (C. Diff.) infections.
2. Describe present healthcare worker and patient education materials available to protect patients from contracting C. Diff. infection.

CLINICAL 3 B – Congenital Heart Disease and Pulmonary Blood Flow
Paula Midyette, MSN, CCRN, CCNS
At the conclusion of the presentation the participant should be able to:
1. Describe three causes of abnormal fetal heart development and circulation that contribute to the formation of Congenital Heart Defects.
2. Differentiate between the physiology, symptoms and management of children with heart defects that increase pulmonary blood flow and defects that decrease pulmonary blood flow.

EDU/RESEARCH B Improving Adjunct Faculty Experience
Elizabeth Fogle, BSN, RN
At the conclusion of the presentation the participant should be able to:
1. Identify the trends in nursing education related to adjunct faculty.
2. Identify deficiencies utilizing adjunct faculty.
3. Identify evidence based practice tools to implement increased efficacy of adjunct faculty.

GENERAL B
What's New in Clinical Quality and Safety?
Dr. Judith St. Onge
At the conclusion of the presentation the participant should be able to:
1. Trace history and trends leading to redefinition of quality and safety within healthcare profession.
2. Contrast traditional approached to the quality and safety to QSEN's Model.
3. Identify at least two practical ways to increase quality and safety competencies in clinical settings.

NUTRITION B – Essential Foods for Fighting Cancer
Dr. Robin Lawson
At the conclusion of the presentation the participant should be able to:
1. Identify how a patient's diet can affect his/her health status.
2. List foods that help boost the immune system and prevent cancer.

PSY/SOCIAL B – An Overview of Natural Supplements for Women Experiencing Depression
Drs. Beverly J. Myers & Linda Forte
At the conclusion of the presentation the participant should be able to:
1. Name at least three factors that place women at greater risk for depression.
2. Discuss several side effects associated with natural supplements for depression.
3. Discuss drug interactions associated with natural supplements for depression.

WORKPLACE ISSUES B – Civility and Nursing Retention: A Solution That Works
Sheila Ray Montgomery, RN, BSN, CSRN & Larry Dean, MSN, RN
At the conclusion of the presentation the participant should be able to:
1. Define civility as an important part of communication between nurses.
2. Identify one way teamwork is important within an ICU.
3. Define the importance of reducing nursing turnover rates.

12:15 – 1:15 PM
LUNCH – Sponsored by
Arthur L. Davis Publishing, Inc.

OPTIONAL LUNCH & LEARN
(No C.E. is awarded for this program ~ bring your lunch to the room)
Challenge of Growth ~ *Carolyn Crawford, MA*
The session will focus on Retirement Planning, Social Security, Pre-Taxable Benefits, Medicare Supplements, Estate Planning and Various insurances – Health, Disability, LTC, Life.

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1:15 – 2:30 PM
AFTERNOON PLENARY

PLENARY B
When the Nurse is a Patient: Lessons Learned
Dr. Allison Terry
At the conclusion of the presentation the participant should be able to:
1. Discuss important coping methods for the person assuming the patient role.
2. Discuss the importance of discharge teaching for each patient.
3. Verbalize 3 ways in which he or she can help each patient cope with the patient experience.

2:30 – 2:40 PM
BREAK

2:40 – 3:40 PM Session C

AANS C – Transition to Practice: Tips and Strategies for the new RN to Succeed
Dr. David H. James
At the conclusion of the presentation the participant should be able to:
1. List 5 common myths associated with on-boarding.
2. Describe the typical transition to practice for a new graduate.
3. Discuss effective goal setting strategies.
4. Describe techniques for effective constructive feedback.

CLINICAL 1 C – CAUTI Prevention – Foley Best Practice
Brian Buchmann, BSN, RN, MBA
At the conclusion of the presentation the participant should be able to:
1. Review criteria to determine when catheterization is necessary.
2. Discuss risk factors associated with CAUTIs.
3. List components that will aide in prevention of CAUTIs.
4. Implement effective strategies for preventing CAUTIs.

CLINICAL 2 C – Can I still have sweet tea?" Seven Teaching Pearls from the Low Income Population with Diabetes
Dr. Anita H. King
At the conclusion of the presentation the participant should be able to:
1. Identify 5 obstacles of the low income population with diabetes.
2. Describe 7 teaching pearls from the low income population with diabetes.
3. Compare and contrast 5 creative strategies to provide effective diabetes education.
4. Outline a teaching plan to "train the trainer" for those working with vulnerable populations.

CLINICAL 3 C – Sports-related Concussions: What's all the Hype?
Ashley Marass, MSN, RN, CPNP
At the conclusion of the presentation the participant should be able to:
1. Describe the signs and symptoms of a concussion and possible complications including second impact syndrome.
2. Discuss current evidence based practice regarding treatment and policies surrounding sports-related concussions.
3. Discuss the new Alabama state law pertaining to sports-related concussions.

ED/RESEARCH C Part 1 – The Lived Experience of Nurse Educators with Chronic Pain
Moniaree Parker Jones, Ed D(c), MSN, RN, COHN-S, CCM
At the conclusion of the presentation the participant should be able to:
1. Describe the view of chronic pain education for nurses as cited in the current literature.
2. Examine ways nurse educators articulate their personal lived experience of chronic pain.
3. Determine needs related to pedagogical discourse in nursing education related to chronic pain.

– And –

EDUCATION/RESEARCH C Part 2 – Benefits and Barriers to Pediatric Weight Management Programs
Dr. Cindy Grimes-Robison
At the conclusion of the presentation the participant should be able to:
1. Evaluate families perceptions about outcome expectations and quality of care provided to their children in a pediatric weight management program.

GENERAL C
Clinical Research Nursing…a Lucrative and Important Career You Don't Hear About as a Nursing Student!
Carolyn Thomas Jones, RN, MSPH
At the conclusion of the presentation the participant should be able to:
1. Describe drug and device development processes in the United States.
2. Examine regulations that protect human participants in clinical research.
3. List core competencies for clinical research nursing.

NUTRITION C – Malnutrition in the Hospitalized Elderly
Dr. Vicky Knapp
At the conclusion of the presentation the participant should be able to:
1. Identify the signs and symptoms of malnutrition.
2. Identify screening tools used to assess patients for malnutrition.
3. Discuss the importance of actually weighing and measuring your patient's height.

PRACTICE ISSUES C – Trends in Substandard Nursing Practice
LaDonna Patton, MSN, RN, CEN & Mary Ed Davis, MSN, RN
At the conclusion of the presentation the participant should be able to:
1. State standards of practice adopted by the Alabama Board of Nursing.
2. Identify actions that violate the standard of practice and may result in discipline of a nursing license.
3. Discuss various types of substandard practice.

PSY/SOCIAL C – Anxiety Disorders: An Overview
Drs. Laura Pruitt Walker, Betsy D. Gulledge, & Kimberly Helms
At the conclusion of the presentation the participant should be able to:
1. Describe the term anxiety.
2. Describe the various types of Anxiety disorders as outlined in the DSM IV-TR.
3. Recognize the characteristics and symptoms of Anxiety Disorders.

3:50 – 4:50 PM
SESSION D

AANS D – Time Management: Taming the Time Eating Tiger
Ann Colvin, MSN, RN-BC
At the conclusion of the presentation the participant should be able to:
1. Discuss proven strategies that improve efficiency and organization.
2. Describe tools to assess how time is being used and strategies to improve time management.

CLINICAL 1 D – Fall Prevention in an Acute Care Facility
Tochie Johnson-Lofton, MSN, RN, ACNS-BC
At the conclusion of the presentation the participant should be able to:
1. Identify the cost to the healthcare industry related to patient falls in an acute care facility.
2. Identify the extrinsic and intrinsic risk factors that play a role in patient harm in acute care facility.
3. Implement fall prevention measures that can be implemented to prevent or reduce the risk of a patient fall.

CLINICAL 2 D – Hypoglycemia – Considerations in Nursing Care: Causes, Treatment, and Prevention
Lisa B. Smith, BSN, RN, CDE
At the conclusion of the presentation the participant should be able to:
1. Identify the difference between diabetic and reactive hypoglycemia.
2. Discuss current recommendations for the recognition, treatment, prevention of hypoglycemia.
3. Identify patients that are at risk for developing hypoglycemia, whether diabetic or not.
4. Suggest a method of tracking hypoglycemia in the hospital setting and the benefits of surveillance.

CLINICAL 3 D – Early Management of Head Injury (mTBI): Recognizing Mild Traumatic Brain Injury in Clinical Practice
Amanda Hargrove, BSN, RN, CNOR
At the conclusion of the presentation the participant should be able to:
1. Identify and describe criteria for mTBI.
2. Identify the primary causes of mTBI.
3. Review possible signs and symptoms of mTBI.
4. Review readily available assessment tools endorsed by the VA, CDC, and WHO.

NUTRITION D – Malnutrition in Hospitalized Patients
Patricia Dudley, MSN, FNP-BC, CRNP
At the conclusion of the presentation the participant should be able to:
1. Explain the differences between the two types of malnutrition which can affect hospitalized patients.
2. Correlate a basic understanding of essential nutrients, energy expenditure, standards for a healthy diet, and factors affecting nutrition with how these elements affect the patient's nutritional status.
3. Utilize the knowledge obtained to perform a nutritional assessment on the hospitalized patient for risks or potential risks and signs and symptoms of malnutrition in order to develop a plan of care for hospitalized patients.

PRACTICE ISSUES D – Practices Among Registered Nurses for Promoting Advance Directives
Timiya Nolan, MSN, CRNP, ANP-BC
At the conclusion of the presentation the participant should be able to:
1. Describe the registered nurse's role in promoting advance directives as illustrated by the Scope and Standards of Nursing Practice.
2. Identify barriers and facilitators to advance directive decision-making.
3. Discuss practices among registered nurses that increase the number of hospitalized individuals with advance directives.

PSY/SOCIAL D – Coaching: It's Not Just for Sports Anymore! Changing from Disease Focused Care to Patient Centered Care
Dr. Durinda N. Warren
At the conclusion of the presentation the participant should be able to:
1. Contrast traditional patient education methods with health coaching methods using Motivational Interviewing framework.
2. Describe the criteria for SMART Goals (specific, measurable, action-oriented, realistic, and timetable to complete) as they relate to behavior change.

WORKPLACE ISSUES D – Stop Bullying in the Workplace
Gwendolyn Pernell, MSN, RN-BC
At the conclusion of the presentation the participant should be able to:
1. Define bullying.
2. Identify specific bullying behaviors that occur in nursing.
3. Identify ways that individuals can stop bullying.
4. Identify ways that organizations can stop bullying.

Poster Session:
1. **Use of Statin Therapy in the Elderly** – *Ashley Carnley Morrow, BSN, RN*
2. **How Long is Too Long? When to Discontinue use of Bisphosponates in Treatment of Osteoporosis** – *Monica Darty, BSN, RN*
3. **Potential Dangers of High Caffeinated Energy Drinks** – *James McGough, BSN, RN*
4. **Updated Cervical Cancer Screening Guidelines** – *Carey L. Holloway, BSN, RN*
5. **The Impact of Impaired Cognitive Function on Medication Adherence Among the Elderly** – *Jessica Harrison, BSN, RN*
6. **Anarchy in Ambulatory Care** – *Drs. Kimberly D. Helms, Laura Pruitt Walker, & Christie Shelton*
7. **Incorporating the QSEN Competency on Evidence Based Practice in a Mental Health Clinical Rotation** – *Drs. Kimberly D. Helms, Laura Pruitt Walker, & Betsy D. Gulledge*
8. **Culturally Competent, Distance Accessible Doctorate of Nursing Practitioner with Advanced Management of Diabetes (CCDNP-AMD)** – *Drs. Mary Annette Wright; Michele Talley, MSN, ACNP-BC: Peggy R. McKie, MPH & Darnell Mompoint-Williams*
9. **Nurse-Initiated Mobilization Practices in the ICU** – *Dr. Cathy A. Maxwell; Tiffani Chidume, BSN,RN; Marie McIntosh, BSN, RN*
10. **Improving the Patient Discharge Experience through Interdisciplinary Teams** – *Terry Motes, BSN, RN, MPA; Antoinette Shedlarski,BSN, RN; Terah*

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Simpson, MSN, RN CNL: Joy Friday, BSN, RN; Charyl Alexander, BSN, RN; Martha Gaston, ADN, RN; Brittney Knight, ADN, RN

11. **Adolescent Use of Mobile Technology for Diabetes Self-Management: A Research Proposal** – *Gwendolyn Miller, RN; Lorean Long, RN; Terricenna Triggs, RN; & Dr. Beverly J. Myers*
12. **Mandalas as Sacred Space for Healing** – *Dr. Beverly J. Myers*
13. **JNC 7 Now and the Future** – *Shelby Knight, BSN, RN*
14. **Prescribing Factors Related to Antihypertensives** – *Dr. Tracey Hodges & Monica Moorer-Barlow, RN*
15. **Increasing Breast Cancer Screening Awareness in African American Women "One Step Closer to the Cure"** – *Amy M. Curtis, MSN, RN & Valarie F. Thomas, MSN, RN*
16. **Geriatric Hip Fractures and Delirium Project** – *A Pilot Program for Improved Outcomes – Ann Gommo, MSN, RN, GNP, OCNS-C*
17. **Improving Adjunct Faculty Experience** – *Elizabeth A. Fogle, BSN, RN*
18. **Effect of a Mentorship Program on Nurse Satisfaction and Retention** – *Karry Clark, MSN, RN, CNOR*
19. **Recognizing Depression in the Elderly** – *Kristopher Nathan Adams, BSN, RN & Dr. Tracey Hodges*
20. **Diabetic Foot Exams** – *Jill Dunn, BSN, RN*
21. **How the Media Influences Adolescent Views on Safe Sex** – *Meredith Cheatum,NS; Erinn Vaughn, NS; Kaneesha Knight, NS & Katilya Harris, MSN, RN*
22. **Newly Diagnosed Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome in the Older Adult** – *Leana Cameron, NS; Krysta Belton, NS; Rachel Clarke, NS & Katilya Harris, MSN, RN*
23. **Herpes in the Neonate** – *Gloria Archie, NS; Deirdre Bellamy, NS; Alexis Griffin,NS & Katilya Harris, MSN, RN*
24. **The Psychosocial Consequences of Herpes in Adolescents** – *Terricka Birt, NS; Nakia Edwards, NS; A'driese Bazile, NS & Katilya Harris, MSN, RN*
25. **Who is the Decision-Maker in the Human Pappillomavirus Vaccine?** – *Cara Adams, NS; Jordan Ray, NS; Courtney Sharpe, NS & Katilya Harris, MSN, RN*
26. **Approaches Related to PTSD Prevention** – *Dr. Robin B. Parnell & Joy Gandy, BSN, RN*
27. **Environmental Cleanliness and Multidrug-Resistant Organism Infection Prevention** – *Shanna Grubbs, MAT, BS & Stephanie Vlasis, BS*
28. **Using Shared Governance to Evaluate Appropriate Use of Underpads for Pressure Ulcer Prevention** – *Jeanne Dockery, RN, OCN; Robert Fravel, RN & Pamela Patterson, MSN, RN*
29. **VAP: A Preventable Killer** – *Stephanie L. Dollar, NS & Abbey S. Mask, NS*
30. **Peripheral Pulses an Indicator of Cardiovascular Disease** – *Judith W. Holloway, BSN, RN*
31. **Improving Cardiovascular Disease (CVD) Risk Factors in Women** – *Drs. Robin Lawson & Linda Roussel*
32. **E-Prescribe and Medication Error Reduction** – *Joyce W. Purvis, BSN, RN*
33. **Nursing Shared Governance: Bringing a Multidisciplinary Team Together to Revise the Check-Off Tool for Safe Patient Transport** – *Jeanne Dockery, RN, OCN; Robert Fravel, RN, & Pamela Patterson, MSN, RN*
34. **Therapeutic Hypothermia in Adults after Cardiac Arrest** – *Dekozlymn Anderson, BSN, RN*

Contact Hours:
ANCC = 1.0 CH/session – 7.0 CH Possible (includes posters)
ABN = 1.2 CH/Session – 8.4 CH Possible (includes posters)

ASNA Leadership Academy

Dr. Marilyn Rhodes, Dr. Ellen Buckner

The Alabama State Nurses Association Leadership Academy (LA) graduated a phenomenal first cohort of participants at the 2012 ASNA Convention held in September. This group of nurse leaders presented their capstone projects that have and will continue to positively impact nurses' workplaces and communities:

- Macon County Obesity Prevention Task Force, *Maggie Antoine. (See Alabama Nurse page 3)*
- Tourette Syndrome, Building Community Support, *Julie Savage Jones*
- Fostering Engagement and Leadership through Implementation of Shared Governance, *Annie Shedlarski*
- The Future of Alabama Nursing: Leading the Charge of the Institute of Medicine, *Dr. Leigh Anne Minchew*
- Healthy Eating for Kids, *Drs. Sara Kaylor, Mary Beth Bodin, Beverly Myers*
- At Risk Students: Mentoring Needs in a Community College Setting, *Dr. Rosalynde Peterson*
- Perceptions of the Orientation Process to Academia by Part Time Clinical Faculty, *Dr. Loretta Lee, Dr. Marilyn Whiting, Dorothy Peten*
- Faculty Readiness for a Campus Disaster, *Dr. Cindy Berry*

Comments from participants reflected a broadening of leadership skills and confidence in leadership skills:

- "The Leadership Academy is an excellent resource to help engage and empower Alabama nurses to action in our state." *Julie Savage Jones*
- "The strengths of the Academy were the passion that was exhibited, the availability of the mentors and their willingness to share information, and the opportunity to mentor nurses who have a desire to promote the nursing profession and the individuals who have put their trust in our abilities." *Dr. Marilyn Whiting*

The mission of the ASNA Leadership Academy is to create a community of effective nurse leaders. Our vision continues to be the preparation of the next generation of nurse leaders for the state of Alabama.

The next ASNA Leadership Academy will begin on Monday evening, April 22, 2013, and continue the next day at the ASNA FACES in Montgomery, AL. A summer one-day retreat will be scheduled and the Academy will conclude at the ASNA 100th Anniversary Convention in Montgomery. Application and registration information will be coming soon!!

The first LA graduates and Steering Committee.

Elizabeth A. Morris Clinical Education Sessions - FACES '13 – Registration Form

Print Name: _____ ABN License Number: _____

Address: _____

_____
City State ZIP

Credentials: _____ Day Phone: _____

*Email: _____

***Confirmations by Email Only**

ASNA is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation

Alabama Board of Nursing (ABNP002) expires March 30, 2013.

Refund/Substitutions:
If cancellation is received in writing prior to April 16, 2013, a refund minus a $20 processing fee will be given. After April 16, 2013, no refund will be given. We reserve the right to cancel the program if necessary. A full refund will be made in this event. A $30 return check fee will be charged for all returned checks/payments.

Make check payable to:
Alabama State Nurses Association

Mail Registration form and fee to:
ASNA ~ 360 N. Hull St. ~ Montgomery, AL 36104

Fax Registration form to:
334-262-8578

Online registration open until 11:59 PM, April 16, 2013 at www.alabamanurses.org

If unable to register prior to 11:59 PM, April 16, 2013, you may register at door. Please note that you will be charged a $10 late fee.

***The optional lunch is available only until April 16, 2013–it is not available after April 16, 2013 OR for at door registrations**

Credit Card #: _____

Exp. Date: _____ CVV# _____

Signature: _____

Fees if received by April 16, 2013:

( ) $59 ASNA Member ( ) $79 Non Member
( ) $20 Student ( ) $0 Primary Presenter
( ) Co Speaker $30 ( ) $15 Co Poster Presenter
( ) $12 *Optional Lunch ( ) $0 Presenter Lunch

Amount Enclosed _____

Concurrent Session Choices–Circle Only 1 (One) Class for Each Time Frame:

10:00 AM	2:40 PM
AANS A	AANS B
CLINICAL 1 A	CLINICAL 1 C
CLINICAL 2 A	CLINICAL 2 C
CLINICAL 3 A	CLINICAL 3 C
ED/RESEARCH A	ED/RESEARCH C
GENERAL A	GENERAL C
NUTRITION A	NUTRITION C
PRACTICE ISSUES A	PRACTICE ISSUES C
PSY/SOCIAL A	PSY/SOCIAL C
WORKPLACE ISSUES A	

Optional Lunch Program–Prepare for Your Retirement
(May take lunch to the room ~ No C.E. will be awarded for this program)

11:15 AM	3:50 PM
AANS B	AANS D
CLINICAL 1 B	CLINICAL 1 D
CLINICAL 2 B	CLINICAL 2 D
CLINICAL 3 B	CLINICAL 3 D
ED/RESEARCH B	NUTRITION D
GENERAL B	PSY/SOCIAL D
NUTRITION B	PRACTICE ISSUES D
PSY/SOCIAL B	WORKPLACE ISSUES D
WORKPLACE ISSUES B	

ANA News

New Medicare Provisions to Recognize and Pay for Core Nursing Services

ANA Advocated Including Care Coordination, Transitional Care in Reimbursement Policies

SILVER SPRING, MD – In a major advancement for registered nurses (RNs), a new Medicare rule calls for paying RNs for services intended to effectively manage patients' transitions from hospitals to other settings and to prevent complications and conditions that cause expensive hospital re-admissions.

The rule also creates new payment codes for "care coordination" activities performed by RNs that reduce costs and improve patient outcomes, increasing likelihood of direct reimbursement for these services and potentially creating more RN jobs to fill this need.

With up to 20 percent of Medicare patients re-admitted to hospitals within 30 days of discharge, more value is being placed on effective transitional care and care coordination.

"The American Nurses Association has been advocating for years that government and private insurers need to recognize nurses' contributions to transitional care and care coordination and pay appropriately for these essential services," said ANA President Karen A. Daley, PhD, MPH, RN, FAAN. "This Medicare rule is a giant step forward for nurses whose knowledge and skills play major roles in patients' satisfaction and quality of care."

ANA's 2012 report, "The Value of Nursing Care Coordination," highlights numerous studies showing the positive impact of nurse-managed care coordination. Studies show that care coordination reduces emergency department visits, hospital re-admissions, and medication costs; lowers total annual Medicare costs; improves patient satisfaction and confidence to self-manage care; and increases safety for older adults during transitions between settings.

ANA participates on the American Medical Association CPT and RUC panels that set codes describing medical, surgical, and diagnostic services and place price values on them – the foundation for the Centers for Medicare & Medicaid Services' (CMS) payment policies.

"There's no doubt that ANA's involvement on these panels had a strong influence on the new provisions that account in real dollars for nurses' crucial contributions," Daley said. "Patients benefit from our work. Now the value of our work is being recognized through payment policy."

New payments will be awarded to nurse practitioners, clinical nurse specialists, certified nurse midwives, and other primary care professionals for "transitional care management" services provided within 30 days of a Medicare patient's discharge from a hospital or similar facility. To qualify for reimbursement, the primary care professional must: contact the patient soon after discharge; conduct an in-person visit; engage in medical decision-making; and provide care coordination. Care coordination involves effectively communicating and delivering a patient's needs and preferences for health services and information among a continuum of health care providers, functions, and settings.

The Medicare Physician Fee Schedule Final Rule, issued Nov. 1 by CMS and set to take effect Jan. 1, 2013 after publication in the Federal Register, also includes new codes that describe "complex chronic care coordination," a service typically provided by RNs. Though the rule will not allow separate billing for care coordination, some private insurers are likely to use the codes to reimburse providers directly for the service. Such reimbursement policies for care coordination could expand the RN job market. They could also raise recognition for nurses performing this long-held, core professional standard and competency considered integral to patient-centered care and the effective and efficient use of health care resources.

The rule contains several other provisions that benefit nurses by:

- Clarifying that certified registered nurse anesthetists will continue to be reimbursed for providing chronic pain management services in states where permitted by license.
- Permitting advanced practice registered nurses to order portable X-rays.
- Ensuring nurse practitioners and clinical nurse specialists can conduct the in-person encounters required for ordering durable medical equipment for patients.

A Call to Action from the Nation's Nurses in the Wake of Newtown

Like the rest of the nation, America's nurses are heartbroken as we grieve the unthinkable loss and profound tragedy that unfolded last week in Newtown, Connecticut. This horrific event is a tipping point and serves as a call to action. The nation's nurses demand that political and community leaders across this country address longstanding societal needs to help curb this endless cycle of senseless violence.

Our country has witnessed unspeakable acts of mass shootings. The common thread in each of these tragedies has been the lethal combination of easy access to guns and inadequate access to mental health services.

As the largest single group of clinical health care professionals, registered nurses witness firsthand the devastation from the injuries sustained from gun violence. We also witness the trauma of individuals, families, and communities impacted by violence.

The care and nurturing of children in their earliest years provides a strong foundation for healthy growth and development as they mature into adulthood. Children, parents, and society face growing challenges with respect to widespread bullying and mental illness, and nurses understand the value of early intervention. Over the past decade, ill-advised and shortsighted cutbacks within schools and community health care systems have seriously impeded critical and needed access to school nurses and mental health professionals trained to recognize and intervene early with those who are at risk for violent behavior.

The public mental health system has sustained a period of devastating cuts over time. These cuts have been exacerbated during the Great Recession despite an increase in the demand for services for all populations, including our nation's veterans. States have cut vital services, such as community and hospital-based psychiatric care, housing, and access to medications. Looming budget cuts could lead to further cuts in services.

It is time to take action. The nation's nurses call on President Obama, Congress, and policymakers at the state and local level to take swift action to address factors that together will help prevent more senseless acts of violence. We call on policymakers to:

- Restore access to mental health services for individuals and families
- Increase students' access to nurses and mental health professionals from the elementary school level through college

The nation's nurses raise our collective voice to advocate on behalf of all of those who need our care. As a nation, we must commit to ending this cycle of preventable violence, death, and trauma. We must turn our grief into action.

Academy of Medical-Surgical Nurses
Alabama State Nurses Association
American Academy of Nursing
American Association of Neuroscience Nurses
American Holistic Nurses Association
American Nurses Association
American Psychiatric Nurses Association
ANA-Illinois
ANA-New York
ANA-Michigan/RN-AIM
Arizona Nurses Association
Arkansas Nurses Association
Association of Nurses in AIDS Care
Association of periOperative Registered Nurses
Association of Public Health Nurses
Association of Women's Health, Obstetric and Neonatal Nurses
Colorado Nurses Association
Connecticut Nurses' Association
Delaware Nurses Association
Infusion Nurses Society
Louisiana State Nurses Association
Massachusetts Association of Registered Nurses
Minnesota Organization of Registered Nurses
Missouri Nurses Association
Montana Nurses Association
National Association of Clinical Nurse Specialists
National Association of Orthopaedic Nurses
National Association of School Nurses
National League for Nursing
New Hampshire Nurses' Association
New Jersey State Nurses Association
New Mexico Nurses Association
Nurses Organization of Veterans Affairs
Ohio Nurses Association
Oklahoma Nurses Association
Pennsylvania State Nurses Association
Preventive Cardiovascular Nurses Association
Public Health Nursing Section of the American Public Health Association
Rhode Island State Nurses Association
Society of Trauma Nurses
Utah Nurses Association
Virginia Nurses Association
Washington State Nurses Association
Weber State University School of Nursing
Wisconsin Nurses Association
Wound, Ostomy and Continence Nurses Society

ANA News

Nurses Earn Highest Ranking Ever, Remain Most Ethical of Professions in Poll

ANA Urges Policymakers to Listen to Nurses on Health Care Policy, Funding

SILVER SPRING, MD — The public continues to rate registered nurses (RNs) as the most trusted profession according to this year's Gallup survey that ranks professions based on their honesty and ethical standards.

"This poll consistently shows that people connect with nurses and trust them to do the right thing," said ANA President Karen A. Daley, PhD, MPH, RN, FAAN. "Policymakers should do the same as they debate crucial budget decisions that will affect health care quality and access for millions of Americans."

Registered nurses are increasingly being recognized as leaders in transforming the health care system to meet the burgeoning demand for prevention, wellness, and primary care services with a focus on improving quality and managing costs. In addition to their clinical expertise, they are being sought out to serve in a variety of leadership posts on bodies developing policy recommendations related to a wide-range of health care policy issues.

Along with physician and hospital associations, ANA released a report in September that found up to 766,000 health care and related jobs could be lost by 2021 as a result of the 2 percent sequester of Medicare spending being debated as part of Congress' broader "fiscal cliff" negotiations. ANA has warned against making hasty, large-scale Medicare spending cuts that could decrease the quality of care for patients as a deficit-reduction measure. ANA is working with coalitions representing health care professionals, consumers, and other groups to prevent potential declines in quality and is urging nurses across the country to tell Congress to avoid harmful Medicare actions.

Additionally, as states develop health insurance exchanges, ANA and its state nurses associations are advocating for nurses to serve as members of governing boards for state exchanges and for the recognition of qualified nurses to fully participate in Qualified Health Plans.

For the 13th out of 14 years, nurses were voted the most ethical and honest profession in America in Gallup's annual survey. Eighty-five percent of Americans rated nurses' honesty and ethical standards as "very high" or "high," the highest rating for RNs since nurses were first included in the poll in 1999. Since the profession's first appearance, nurses have received the highest ranking each year except in 2001, when firefighters ranked first after the 9/11 terrorist attacks.

Nurses consistently capture patient and public trust by performing in accordance with a Code of Ethics for Nurses that supports the best interests of patients, families, and communities. They often are the strongest advocates for patients who are vulnerable and in need of support.

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

American Nurses Foundation to Award $200,000 in 2013 Research Grants

Priorities Include Nurse Impact on Health Care Quality and Efficiency

SILVER SPRING, MD – The **American Nurses Foundation** (ANF) today announced the launch of its 2013 **Nursing Research Grant (NRG) Program** that will provide 29 research awards totaling more than $200,000 to beginner and experienced nurse researchers.

ANF is the charitable and philanthropic arm of the American Nurses Association (ANA). The 2013 grant program will focus on ANA's **research priorities** and applications which use ANA's National Database of Nursing Quality Indicators® **(NDNQI®).**

"Nursing research is vital to patients, nurses, and our colleagues in health care. Our perspective, our expertise, and our problem-solving is distinct and of critical importance," said Geri L. Wood, PhD, RN, FAAN, chair of the ANF Nursing Research Grant Program, and associate professor and director of nursing research and evidence-based practice at the University of Texas' M.D. Anderson Cancer Center.

Individual grants range from $5,000 to $25,000. The largest award, the Margretta Madden Styles Credentialing Research Award, is named for a past president of the American Nurses Credentialing Center, ANA, and the International Council of Nurses. The award funds research on the impact of nurse credentialing programs for patients, nurses, and health care organizations.

Information and access to the online application are available on ANF's website at www.anfonline.org. The application process is open through May 1, 2013.

The American Nurses Foundation is the charitable and philanthropic arm of the American Nurses Association (ANA), the only full-service professional organization representing the interests of the nation's 3.1 million registered nurses through its constituent and state nurses associations and its organizational affiliates. The Foundation supports ANA programs which promote the welfare and well- being of nurses, advancing the nursing profession, thereby enhancing the health of the public.

Convention News

ASNA Leadership Opportunities: 2013

Consent to Serve Form for Alabama State Nurses Association Office

- ❑ Vice President
- ❑ Secretary
- ❑ Commission on Professional Issues

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

- ❑ Nominating Committee

The Nominating Committee has openings for 2 positions this year. 1 each from Districts 4 & 5.

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

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

Nominations Procedure for 2013
Criteria for Eligibility
Deadline: May 6, 2013

The person nominated for each office on the state level should:

1. Be a current member of ASNA.
2. Have sufficient education and experience within the organization that will demonstrate his/her understanding of the requirements of the office as evidenced by being active at the local and/or state level.
3. Have commitment for time involved with the position compatible with employment.
4. Have ASNA District Board of Directors verify participation and attendance on the local level and his/her ability and willingness to give time and effort to accomplish tasks.
5. Be assertive, understand appropriate methods of confrontation, exhibit good decision-making abilities, and have leadership qualities.
6. Submit a statement, typed or printed in 200 words or less, regarding your views of issues facing the nursing profession, the Alabama State Nurses Association, and the office you are seeking.
7. Because of time involved in serving the professional organization, we assume that you have cleared time with your employer to attend meetings. Applicants should be willing to absorb own expenses.

Name and Credentials _____ Home Phone: _____

Address: _____ Work Phone: _____

E-Mail Address _____ Fax Number: _____

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

Because of the time involved in serving the professional organization, we assume that you have cleared time with your employer to attend meetings. Applicants should be willing to absorb own expenses.

My Views of the issues facing the nursing profession, the Alabama State Nurses Association, and the office I am seeking are: ***(200 words or less - typed or printed)***

Alabama State Nurses Association
360 North Hull Street Montgomery, Alabama 36104
(334) 262-8321 Fax # (334) 262-8578 Members (800) 270-2762
E-Mail: alabamasna@alabamanurses.org

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

What Is a Resolution?

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

Call for Resolutions

Any ASNA member may research, write, and/or submit a resolution for consideration by the ASNA House of Delegates. Resolutions should be submitted to the Governance Committee through the ASNA office at 360 N. Hull St., Montgomery, AL 36104 by **May 2, 2013**. Only an emergency resolution will be accepted after the designated date.

Types of Resolutions

Resolution are classified according to the following:

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

How is a Resolution written?

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

Save These Dates

October 10-12, 2013

The Alabama State Nurses Association will hold its 100th Annual Convention co-sponsored by the Alabama Organization of Nurse Executives and the Alabama Association of Nursing Students at the Renaissance Montgomery Hotel and Spa. We invite each of you to attend. Thursday, October 10, 2013 will be a Pre-Convention CE day. This is a great opportunity for all you LPNs, who haven't quite met the ABN requirements during the LPN renewal cycle, to finish getting your 24 hours. RN's are also encouraged to attend. Friday and Saturday, October 11th, 12th will be the Full Convention days. You'll have the opportunity to hear a quality Keynote Address. ASNA members who are delegates to the convention will have the opportunity to debate on issues of current concern to the association and the nursing community. Complete convention registration materials will be printed in the pull-out section of the June/July/August issue of *The Alabama Nurse*. Mark your calendars today and plan to attend an exciting convention.

For Awards Information and Application go to alabamanurses.org

Call for Abstracts

Alabama State Nurses Association
Annual Convention
10 October – 12 October, 2013
Montgomery, Alabama

See ASNA webpage for details
alabamanurses.org

Like Nurses, Not All Midwives are Alike

Marilyn Rhodes, EdD, RN, MSN, CNM

Midwives have been delivering babies since the dawn of time. Midwife means "with woman." Until the 20th century, midwives delivered most of the babies in the United States. In the 1920's, British nurse midwives were recruited to provide prenatal care in the mountains of KY with the goal of improving birth outcomes (ACNM, 2008). They succeeded, and soon after, nurse midwives were also successful in improving birth outcomes in New York City. Since then, nurse midwives have been educated in U.S. programs and these dedicated graduates have continued to achieve favorable birth outcomes.

The International Confederation of Midwives (ICM) and World Health Organization (WHO) define midwife as a person who, having been regularly admitted to a midwifery education program duly recognized in the country in which it is located, has successfully completed the prescribed course of studies in midwifery and acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery. (ACNM, 2008, p. 3)

The ICM, WHO and the International Federation of Gynaecologists and Obstetricians (FIGO) differentiate *skilled birth attendant* as one who is formally educated and trained to care for normal and complicated births from the *traditional birth attendant*, "non-formally trained and community based provider of care during pregnancy, childbirth and the postnatal period." (ACNM, 2008, p. 3). To improve birth outcomes world-wide, these groups stressed the need to increase the number of *skilled birth attendants* to replace *traditional birth attendants*. In the U. S. *skilled birth attendant* describes physicians, certified nurse midwives (CNM), certified midwives (CM), and only those certified professional midwives (CPM) who have completed programs accredited by the Midwifery Education Accreditation Council (MEAC). The *traditional birth attendants* include those midwives who have not met those requirements.

Certified nurse midwives (CNM) are educated in the disciplines of nursing and midwifery. Nurse midwives must earn a graduate degree and test for certification by the American Board of Midwifery Education (ACMB), an independent arm of the American College of Nurse Midwives (ACNM, 2008). The ACNM is recognized by the U. S. Department of Education to accredit nurse midwifery education and certify nurse midwives. Certified midwives (CM) must also earn a graduate degree and test for the same certification; these midwives did not obtain a nursing degree prior to their midwifery education. Unlike certified nurse midwives who are legal and are licensed in every state and the District of Columbia, certified midwives are licensed only in New York, Rhode Island, and New Jersey, and may practice by permit in Delaware and Missouri (ACNM, 2011). Full scope practice for CNMs and CMs includes providing primary care to women from adolescence to post-menopause as well as providing prenatal care, delivering babies, caring for the newborn, and providing care to the postpartum woman (ACNM, 2008). In all U.S. jurisdictions, CNMs have prescriptive authority and are reimbursed by most private insurances, TriCare, Medicaid and Medicare.

Certified professional midwives (CPM) are certified by the North American Registry of Midwives (ACNM, 2011). There are two primary educational tracks for CPMs. The majority of CPMs are certified via the Portfolio Evaluation Pathway, having completed an apprenticeship with a midwife preceptor; no degree is required (ACNM, 2011). Some CPMs completed a state licensure program and some graduated from a Midwifery Education Accreditation Council (MEAC) accredited program. This agency is recognized by the U.S. Department of Education to accredit midwifery programs (ACNM, n.d.). Certified professional midwives are regulated in 26 states, (licensed, voluntary license permit, registration or certification) and perform prenatal care, deliver babies, provide newborn and postpartum care in homes and birth centers. In some states they are reimbursed by private insurance and in 10 states, are eligible for Medicaid reimbursement for home births and in additional states for birth center births (ACNM, 2011).

Toward a common goal of a providing competent, sensitive maternity care and one profession of midwifery, the ACNM, NARM, and MANA are working together to create a unified profession. Until that time occurs, the American College of Nurses Midwives states.

A professional midwife in the United States is a person who has graduated from a formal education program in midwifery that is accredited by an agency recognized by the US Department of Education. The professional midwife has evidence of meeting established midwifery competencies that accord with a defined scope of practice corresponding to the components and extent of coursework and supervised clinical education completed. In addition, this person has successfully completed a national certification examination in midwifery and is legally authorized to practice midwifery or nurse-midwifery in one of the 50 states, District of Columbia, or US jurisdictions. (ACNM, 2008, p.1)

References

American College of Nurse Midwives. (2011). Comparison of certified nurse-midwives, certified midwives, and certified professional midwives: Clarifying the distinctions among professional midwifery credentials in the U.S. Retrieved from ACNM website at http://www.midwife.org/ACNM/files/ccLibraryFiles/Filename/000000001385/CNM%20CM%20CPM%20ComparisonChart%20082511.pdf

American College of Nurse Midwives. (2008). Midwifery certification in the United States. Retrieved from the ACNM website at http://www.midwife.org/ACNM/files/ACNMLibraryData/UPLOADFILENAME/000000000077/Midwifery%20Certification_in_the_United_States_3_31_09.pdf

American College of Nurse Midwives. (n.d.). *What is a midwife?* Retrieved from the ACNM website at http://midwife.org/WhatIsAMidwife

Email: Marilyn Rhodes at mrhodes2@aum.edu

AMERICAN COLLEGE of NURSE-MIDWIVES

Comparison of Certified Nurse-Midwives, Certified Midwives, and Certified Professional Midwives

*Clarifying the distinctions among professional midwifery credentials in the U.S.**

	CERTIFIED NURSE-MIDWIFE (CNM®)	CERTIFIED MIDWIFE (CM®)	CERTIFIED PROFESSIONAL MIDWIFE (CPM)®
PROFESSIONAL ASSOCIATION			
	American College of Nurse-Midwives (ACNM)		Midwives Alliance of North America (MANA) and National Association of Certified Professional Midwives (NACPM)
CERTIFICATION			
Certifying Organization	American Midwifery Certification Board (AMCB)**		North American Registry of Midwives (NARM)**
Certification Requirements (minimum degree and other requirements prior to taking national certifying exam)	Graduate degree required		No degree required
	1. Graduation from a nurse-midwifery education program accredited by ACNM Accreditation Commission for Midwifery Education (ACME); AND 2. Verification by program director of completion of education program; AND 3. Active registered nurse (RN) license	1. Graduation from a midwifery education program accredited by ACNM Accreditation Commission for Midwifery Education (ACME); AND 2. Verification by program director of completion of education program	1. Completion of NARM's Portfolio Evaluation Process (PEP) pathway; OR 2. Graduate of a midwifery education program accredited by Midwifery Education Accreditation Council (MEAC); OR 3. AMCB-certified CNM or CM; OR 4. Completion of state licensure program.
Recertification Requirement	Every five years		Every three years
EDUCATION			
Minimum Education Requirements for Admission to Midwifery Education Program	Bachelor's degree from accredited college/ university 1. Some programs require RN license. If the applicant has a bachelor's degree, but not an RN license, some programs will require attainment of an RN license prior to entry into the midwifery program; others will allow the student to attain an RN license prior to graduate study; OR 2. If the applicant is an RN but does not have a bachelor's degree, some programs provide a bridge program to a bachelor's degree prior to the midwifery portion of the program; other programs require a bachelor's degree before entry into the midwifery program.	Bachelor's degree from accredited college/ university and successful completion of specific science courses	There are two primary pathways for CPM education, with differing admission requirements: 1. Portfolio Evaluation Process (PEP) pathway: an apprenticeship program; no degree or diploma required. Student must find a midwife preceptor who is nationally certified or state licensed, has practiced for at least 3 years, and attended at least 50 out-of-hospital births; OR 2. Accredited formal education pathway: For this pathway, a high school diploma from an accredited state or private school is required for admission.
	Note: Currently, the majority of AMCB-certified midwives enter midwifery through nursing.		*Note: Currently, the majority of CPMs have completed the apprenticeship-only (PEP) pathway to the CPM credential.*
Clinical Experience Requirement	Attainment of clinical skills must meet Core Competencies for Basic Midwifery Education (ACNM 2008). Clinical education must occur under the supervision of an AMCB-certified CNM/CM or Advanced Practice RN (APRN) who holds a graduate degree and has clinical expertise and didactic knowledge commensurate with the content taught. Clinical skills include management of primary care for women throughout the lifespan, including reproductive health care, pregnancy, and birth; care of the normal newborn; and management of sexually transmitted infections in male partners.		Attainment of clinical skills must meet the Core Competencies developed by the Midwives Alliance of North America. Clinical education must occur under the supervision of a midwife who must be nationally certified, legally recognized and who has practiced for at least three years and attended 50 out-of-hospital births. Clinical skills include management of prenatal, birth and postpartum care for women and newborns.
Degree Granted	Master's or doctoral degree; a master's degree is the minimum requirement for the AMCB certification exam	Master's degree; a master's degree is the minimum requirement for the AMCB certification exam	No degree is granted through the PEP pathway. MEAC-accredited programs vary and may grant a certificate or an associate's, bachelor's, master's, or doctoral degree. Most graduates attain a certificate or associate degree; there is no minimum degree requirement for the CPM certification exam.
ACCREDITING ORGANIZATION			
	The Accreditation Commission for Midwifery Education (ACME) is authorized by the US Department of Education to accredit midwifery education programs and institutions.		The PEP pathway is not eligible for accreditation. The Midwifery Education Accreditation Council (MEAC) is authorized by the US Department of Education to accredit midwifery education programs and institutions.
LICENSURE			
Legal Status	Licensed in all 50 states plus the District of Columbia and US territories	Licensed in New Jersey, New York, and Rhode Island. Authorized by permit to practice in Delaware. Authorized to practice in Missouri.	Regulated in 26 states (variously by licensure, certification, registration, voluntary licensure, or permit)
Licensure Agency	Boards of Nursing, Boards of Medicine, Boards of Midwifery/Nurse-Midwifery, Departments of Health	Board of Midwifery, Board of Medicine, Department of Health	Departments of Health, Boards of Medicine, Boards of Midwifery
SCOPE OF PRACTICE			
Range of Care Provided	Independent management of women's health care throughout the lifespan, from adolescence through menopause. Comprehensive scope of practice including primary care and gynecologic care, family planning, annual exams (including breast and PAP screening), pregnancy, birth in all settings, and postpartum care. Care of the normal newborn. Management of sexually transmitted infections in male partners.		Independent management of care for women and newborns during pregnancy, birth, and postpartum. Birth in homes and birth centers. Care of the normal newborn.
Prescriptive Authority	All US jurisdictions	New York	None. However, may obtain and administer certain medications in some states.
Practice Settings	All settings — hospitals, birth centers, homes, and offices. The majority of CNMs and CMs attend births in hospitals.		Homes, birth centers, and offices. The majority of CPMs attend out-of-hospital births.
THIRD-PARTY REIMBURSEMENT			
	Most private insurances; Medicaid coverage mandated in all states; Medicare; Champus	New York, New Jersey, Rhode Island — most private insurance; Medicaid	Private insurance in some states; Medicaid in 10 states for home birth, additional states if birth occurs in birth center.

** This document does not address individuals who are not certified and who may practice midwifery with or without legal recognition.*

*** AMCB and NARM are accredited by the National Commission for Certifying Agencies, which "was created in 1987 ... to help ensure the health, welfare, and safety of the public through the accreditation of a variety of certification programs/organizations...Certification organizations ... are evaluated based on the process and products, not the content, and are therefore applicable to all professions and industries.." (http://www.credentialingexcellence.org/ProgramsandEvents/NCCAAccreditation/tabid/82/Default.aspx)*

Reviewed ACNM-MANA Liaison Committee February, 2011

Approved by ACNM Board of Directors March, 2011

Last updated August, 2011

Membership News

Do You Live a Little Off the Beaten Path?

ASNA is working to make District/County meetings available to members who don't live right down town. Perhaps your employer is located closer to one of the District/Country meeting places. If you are interested in attending, but have been prohibited by your location, please contact April Bishop, Programs Coordinator at ASNA via email at memberasna@alabamanurses.org or by phone 800-270-2762.

Time to Update Your Information!

ASNA receive literally thousands of returned emails and mailings per year. If you would like to continue to receive *The Alabama Nurse* or email updates remember to contact ASNA when you move; change jobs, emails, or phone numbers. Contact April Bishop, Programs Coordinator at memberasna@alabamanurses.org or 800-270-2762 – or by sending a post card to ASNA, 360 N. Hull St., Montgomery, AL 36104. You can also update your information via our website, http://alabamanurses.org

APPLICATION FOR MEMBERSHIP

ASNA ALABAMA STATE NURSES ASSOCIATION

Please Circle New Application Renewal ANA ID# _____ Today's Date: _____

Name:	**Credentials:**
Home Address:	**Nursing License Number:**
City/State/Zip	**Employer:**
Preferred Phone:	**Employer Address:**
Email:	**(Please circle) Preferred Contact Home Work Email**
RECRUITED BY:	

Member Type	Employed Full/Part Time	F/T Student/New Grad/Unemployed	62 & Retired or Disabled	Alabama State Only	*Combined	Non RN Member
Circle One	$293/Yr $24.92/Mo	$146.50/Yr $12.71/Mo	$73.25/Yr $6.61/Mo	$175/Yr $15.08/Mo	$210	$95/Yr $50/Biannual

* Applies to a **New or Full ASNA/ANA** member who is joining with a new member (or have not been a member in past year). **Both must remain a member for the entire year** or each member will immediately be billed the full amount for membership. **Must be received at the same time.**

Monthly Bank Draft/Credit/Debit Card Authorization:

Read and sign the authorization below. ***Enclose a check made payable to ASNA for the first month's dues (see rates listed above).*** This amount will be deducted from your checking/.credit card account each month.

By signing the form below, I am authorizing ASNA to withdraw annual/monthly dues from the financial institution I have designated. If paying by automatic bank draft, I have enclosed a check for the first month's payment. **Bank drafts will occur on or after the 15th day of the month, Credit Cards will be charged on or after the 1st of the month.**

Authorized Signature: _____ *Date:* _____ *CVV Code:* _____

Card Number: _____ Exp. Date: _____

Payments to ASNA/ANA are not deductible as charitable contributions; however 70% of your dues are tax deductible as a professional organization for Federal Income Tax Purposes. .

Please return this completed application with your payment to **ASNA 360 North Hull St., Montgomery, AL 36104 or Fax to 334-262-8578**