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VIRGINIA Nurses Today

The Official Publication of the Virginia Nurses Association
Circulation 99,000 Registered Nurses and 2,300 Student Nurses

Volume 22 • No. 1 February 2014

Mythbuster: Demystifying School Nursing

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School nursing is a specialty that has been evolving since nurses began working in schools in the 1800's. At the time, their main job was to identify illnesses, quarantine those with communicable diseases, and reduce truancy.

School nursing has advanced since its early days and now has a much broader definition as "the specialized practice of professional school nursing that advances the well-being, academic success, and lifelong achievement and health of students. To that end, school nurses facilitate normal development and positive student response to interventions; promote health and safety including a healthy environment; intervene with actual and potential health problems; provide case management services; and actively collaborate with others to build student and family capacity for adaptation, self-management, self-advocacy, and learning (NASN, 2011).

Regardless of the accomplishments of individual school nurses and strides made within the profession, school nursing continues to be plagued by myths.

Myth: We really don't need school nurses. Kids should stay home from school if they are sick.

Reality: It is estimated that more than three quarter of school aged children (45 million) missed at least one school day in the past 12 months due to illness or injury. About 5% of school-aged children missed 11 or more days of school due to illness or injury in this same time period (NCHS, 2011). Research shows that absenteeism contributes to lower graduation rates. The school nurse supports student attendance and academic success by providing health care through assessment, intervention, and follow-up for all children within the school setting.

A student's health status is directly related to the ability to learn. Healthy children are successful learners; children with unmet health needs have a difficult time engaging in the educational process. Today, more than 25% of children and adolescents have chronic health conditions that may impact the student's ability to be in school and ready to learn. Students come to school with increasingly complex medical problems, technically intricate medical equipment, and complicated treatments. The school nurse addresses the physical, behavioral, emotional, and social health needs of students and supports their achievement in the learning process. The school nurse provides for the safety and care of students and integrates health solutions into the educational environment. The school nurse is a vital member of the academic team who leads change to advance health, thus keeping students safe at school, healthy, and ready to learn.

Myth: School nursing is easy – anyone can do it.

Reality: School nursing is a challenging, fast-paced and demanding job. On any given day, 5 to 10% of the school's population may visit the health office for school nursing care. School nurses perform their duties with very limited medical resources that are readily available to nurses in traditional health care settings. Generally, school nurses function as the sole health care professionals in their buildings and must function with little consultative support from peers.

In Virginia, licensed RNs and LPNs may provide health care in schools. Their roles vary in terms of scope of practice and years of educational preparation. The professional school RN plans, implements, monitors, and coordinates the care delivered by members of the school health team, and is supported by LPNs and unlicensed assistive personnel. School nurses are skilled health care providers who work independently and collaboratively within the education and health care teams. School nurses apply a broad knowledge of public health, pediatrics, other nursing specialties, behavioral health, occupational health, school law, and policy to practice. This specialty requires strong skills in critical thinking, problem solving, creativity, adaptability, resourcefulness, leadership, and case management. School nurses translate broad knowledge into health promotion and intervention strategies in both the student health office and the classroom. They also provide health counseling and emotional support to their clients. School nurses ensure that children are safe, healthy, and in school learning.

Myth: A school nurse is not a real nurse like those working in hospitals.

Reality: According to the Bureau of Labor Statistics (2013), 20% of nurses are employed outside of hospitals and medical care facilities. School nurses have completed a rigorous credentialing process to become licensed and many are nationally certified.

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Virginia Receives Grant from Robert Wood Johnson Foundation to Help Lead Efforts to Transform Health Care through Nursing

The Robert Wood Johnson Foundation (RWJF) announced earlier this week that the Virginia Action Coalition will be part of a $4.5 million initiative, the *Future of Nursing State Implementation Program.* The program is helping states prepare the nursing profession to address our nation's most pressing health care challenges—access, quality, and cost. RWJF announced 10 states that are joining the program today; it launched with 20 states in February.

The State Implementation Program bolsters efforts already underway in 50 states and the District of Columbia—the *Future of Nursing: Campaign for Action*—to improve health and health care through nursing. A joint initiative of AARP and RWJF, the *Campaign* is working to implement the Institute of Medicine's (IOM) evidence-based recommendations on the future of nursing. It provides a vehicle for nurses at all levels to lead system change to improve care for patients and families through collaboration with business, consumer, and other health professional organizations.

"We are confident that this grant will help spur progress in Virginia which already is doing notable work to transform nursing practice, education, and leadership," said Susan B. Hassmiller, PhD, RN, FAAN, RWJF senior adviser for nursing and director of the Future of Nursing: *Campaign for Action.* "The Foundation is committed to helping states build a more highly educated, diverse nursing workforce so that everyone in America can live a healthier life, supported by a system in which nurses are essential partners in providing care and promoting health."

The *State Implementation Program* is providing two-year grants of up to $150,000 to a total of 30 state-based Action Coalitions that have developed or made substantial progress toward implementing the IOM recommendations. States must obtain matching

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The Year of the Nurse

Loressa Cole

The 2010 Institute of Medicine report, *The Future of Nursing: Leading Change Advancing Health*, recommends that nurses must be prepared to lead change in order to enhance and reform our healthcare system. The Future of Nursing: Campaign for Action, a collaboration of the Robert Wood Johnson Foundation and the AARP Foundation, was created to implement the key recommendations of *The Future of Nursing Report* in order to fulfill the vision of providing high quality, patient-centered healthcare to all citizens.

The Virginia Action Coalition (VAC), an initiative of the Virginia Nurses Foundation (VNF), AARP Virginia, and the Campaign for Action, formed a Leadership Workgroup focused on creating a structure that ensures nurses are prepared to lead from the bedside to the boardroom. The initial work of Virginia's Leadership workgroup focused on assessing Virginia's "current state" of nursing involvement on strategic boards.

In mid-January, I was thrilled to represent VAC at a CCNA "Leadership in Action" meeting, along with Dr. Shirley Gibson, VNF president , Janet Wall, VNA CEO, and Lindsey Cardwell, VAC Leadership Workgroup co-lead. Dr. Susan Hassmiller, senior advisor for nursing from the Robert Wood Johnson Foundation and director of the Future of Nursing: Campaign for Action, introduced a key objective in her opening comments: *In order for nurses to take a leadership role in healthcare decisions, change must occur.* She stated, "This is the year of the nurse!"

Over the next two days, coalition leaders from multiple states learned from each other and utilized the staff and resources provided by CCNA to create strategic state-specific work plans to increase nursing involvement on strategic boards, including hospital and health system boards. Dr. Gibson and I were very proud to present the accomplishments of the VAC Leadership Workgroup to attendees. Considered an "exemplar" state, our work to increase nurse leader involvement "from the bedside to the boardroom" is being highlighted for other states, and they are encouraged to consider implementation of similar programs and initiatives using our state as a model.

Our accomplishments include:

- Conducting a survey to determine nurses who are serving on or interested in serving on boards
- Targeting key boards for nurse participation and sourcing candidates for successful placement onto strategic boards
- Establishing a leadership development program (The Nursing Leadership Institute) for emerging nurse leaders
- Providing mentoring assistance for new board members
- Creating a pipeline of future board members through leadership recognition programs such as "40 under 40" (2011) and "Every Nurse a Leader (2013) campaigns
- Producing a video that highlights the benefits of nurses serving on hospital boards

At our meeting, we benefited from a presentation from the New Jersey Action Coaltion, another exemplar state, and our group brought back many exciting new ideas and approaches to engage Virginia's nursing leaders.

We want nurses to be present and help lead the important decisions that will shape the future of healthcare in our state. I look forward to an exciting 2014 and the continued work of our VAC workgroups and other nurse leaders Virginia. This **IS** the year of the nurse, and we have much work to do!

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VIRGINIA Nurses Today

is the official publication of the Virginia Nurses Association: 7113 Three Chopt Road, Suite 204 Richmond, Virginia 23226, a constituent member of the American Nurses Association.
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VNA Mission Statement
The mission of the VNA is to promote education, advocacy and mentoring for registered nurses to advance professional practice and influence the delivery of quality care.

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Virginia Nurses Today is published quarterly every February, May, August and November by the Arthur L. Davis Publishing Agency, Inc.

Subscriber rates are available, 804-282-1808.

For advertising rates, please contact Janet Wall via email jwall@virginianurses.com or at 804.212.0690.

www.VirginiaNurses.com

Published by:
Arthur L. Davis Publishing Agency, Inc.

CEO Report

Pitfalls of Strategic Plans… and Why Ours Won't Fall into that Pit!

Janet Wall

Over the years I've worked with numerous organizations, both those I was employed by and those with which I volunteered, and along the way I became aware of some alarming realities of strategic planning.

Pitfall #1: If you build it they will come.

Strategic plans are the *antithesis* of the Kevin Costner film, *Field of Dreams* and the mantra, "If you build it they will come." In reality, the players *won't* come out of the field unless you've done the legwork to make it happen, and that goes way beyond building a baseball diamond in a field. Too many organizations forget that the real work begins *after* the strategic plan is created, and in 80% of cases, often due to a lack of actionable items in the strategic plan, the document does nothing more than collect dust on some virtual shelf.

Why our plan will succeed: We've taken great pains to ensure that each goal in our strategic framework is a stretch for our organization, but doable. And more importantly, we have the action steps and frames in place to ensure this happens, because we recognize that without action steps, the big picture strategy is useless.

Pitfall #2: Accountability flies out the window.

It can happen all too easily. Staff has worked hard to set up a strategic planning session, from coordinating the logistics to orienting a facilitator in order to ensure a meaningful outcome. And post-planning, staff works to turn concepts and goals into a measurable, achievable, time-stamped action plan that the board will ultimately vote to approve. This takes time. And after it's all said and done, the temptation for staff is to jump to other projects calling their name.

Why our plan will succeed: Accountability is crucial, and not losing the momentum gained during the strategic planning process is essential. We've created a strategic plan grid for each of our goals and action items to ensure that nothing gets lost. Further, I will be reporting to the board at each of the five board meetings throughout the year on our progress toward achieving our goals. And then there's you. Keep us on point, share your ideas and experiences relevant to our goals, and help propel us toward success with your continuing commitment to this organization.

Pitfall #3: A Strategic Plan that attempts to be the "be all, end all."

To be clear, strategic plans are not intended to capture all of the work and all of the goals of the organization. Rather, their purpose is to elevate certain organizational priorities, be they new initiatives or existing ones that have perhaps lost a bit of their mojo and need an infusion of ideas and energy.

Why our plan will succeed: The overarching framework of our plan includes four goals focused on 1).Education & Awareness, 2). Workplace Environment, 3). Relevance / Engagement, and 4). Legislative Advocacy, with very specific action items. This is far from the totality of our work as nursing's voice in Virginia; but these are very important areas – identified by our members, board and staff – for which we want to ensure we make significant headway over the course of the next couple years.

Our detailed strategic plan as well as the grid showing action items and timelines is available for your review as a member. Members can access the VNA Strategic Plan by visiting www.virginianurses.com and logging into the "Members Only" section. Not a member? Now's a great time to consider becoming one; just visit us at www.virginianurses.com and click on "Join."

Done right, strategic planning can drive an organization to new heights… and that's precisely what we intend to do.

Telehealth Nursing Education: The Time is Now!

By Patty Schweickert, RN, FNP-BC, DNP, Nurse Practitioner, Interventional Neuroradiology, University of Virginia Health System and Carolyn Rutledge, PhD, FNP-BC, Director DNP Advanced Practice Program Co-Director DNP Executive Program and MSN Administrator Program,School of Nursing, Old Dominion University

What is telehealth?

Telehealth is the use of technology in healthcare and healthcare delivery. These technologies include real-time videoconferencing using computers and cameras to connect patients and clinicians (for consultation, evaluation, treatment, and education) and remote transfer of patient diagnostic and physiologic data (such as blood pressure, EKG, or radiologic images) from one site to another for evaluation and interpretation.

Healthcare is changing and its effects are palpable, from the initiation of the Affordable Care Act (ACA) to the changing of the fee for service model. Telehealth is part of this revolution. We have entered the age where it is possible to bring the care to the patient rather than have the patient travel for care through the use of technology. The healthcare system of tomorrow is being developed today by those who can creatively apply these telehealth technologies to patient care. The ability to connect with patients remotely allows creation of innovative models of practice by increasing access to care, allowing for improved outcomes, reduced costs and better utilization of healthcare resources.

Why the impetus for using telehealth now?

American Telemedicine Association (ATA) President Dale Alverson, MD, gave a presentation at the 2011 Annual Meeting in which he described a "perfect storm" of factors that have been set into motion that will fundamentally transform healthcare and healthcare delivery.

"This is a time for telemedicine," he said. He was right. Factors including increased acuity of patients, increased chronicity of disease, shortage of nurse and medical providers, widespread changes throughout the country with implementation of the ACA combined with the technological advances meld these entities creating the perfect storm. Now, with the enhanced recognition of the importance of our roles as nurses in the healthcare system, we are well positioned to address the healthcare crisis through telehealth.

What is the nurse's role in telehealth?

Nurses are in a prime position due to their direct contact with patients to integrate telehealth technology into nursing care and develop innovative ways to improve patient care outcomes while addressing the pressing issues in healthcare today. The time for nurses to learn about telehealth is now. There is strong support from influential groups, such as the Institute of Medicine (IOM) and the Health Resources and Services Administration (HRSA) to fully incorporate technology into nursing practice and work interprofessionally to provide patients access to care. Telehealth is an important skill set as the ACA is implemented, and it is one solution to the nursing shortage and misdistribution of healthcare services and providers, making better use of scarce resources. Nurses knowledgeable about telehealth can serve as leaders who are proficient in applying telehealth technologies to patient care, leading the way in developing new models of care for the 21st century. However, knowledge of telehealth and skill in utilizing this technology is not widespread in nursing or nurse education today.

How will telehealth change nursing practice?

As a novice nurse, I was fortunate to work with many experienced nurses, some that had been practicing for over twenty years. Many nurses still wore their white nursing caps and told stories of sharpening needles and reusing equipment. As I have layered on my own nursing experiences, I can tell my stories of using glass chest tube bottles, Sengstaken-Blakemore Tubes, and intra-aortic balloon pumps. All these devices have been replaced with 21st century technologic innovations. The nurses of today are going to have this same experience with telehealth. In the years to come, they will be able to tell the younger generation of nurses, that they practiced before telehealth was standard practice. This will be the revolution in healthcare that we are going to experience in our life time.

As telehealth pioneer Dr. Karen Rheuban said, telehealth is a "transformation tool for healthcare." It is transforming care by providing access to care and improving outcomes for many. Nurses trained and proficient in telehealth technologies can creatively apply this tool to routine and complex patient care issues. Nurses knowledgeable about telehealth can promote new models of practice that improve the effectiveness and efficiency of patient care.

Using telemedicine, nurses in Virginia are already:

- Connecting with patients in their community from a major medical center hundreds of miles away, enabling them to get the wound and ostomy care they need without having to travel long distances
- Providing diabetes education to patients in remote sites to improve their health literacy and self-care knowledge
- Educating high risk stroke patients on stroke risk reduction from more than 300 miles away, improving the patients' knowledge of stroke and increasing their likelihood to decrease stroke risk factors
- Incorporating telehealth into their nurse practitioner owned and managed clinic to provide patients access to specialty care from their rural site to major medical centers.
- Providing care to patients confined in the state's prisons.

How can nurses gain education, experience, and skills using telehealth?

Nurses are more likely to engage in telehealth if they have knowledge, experience, and skills using telehealth. Telehealth knowledge and skills can be gained through formal and informal means. Formal means include enrolling in nursing programs that incorporate telehealth education into their curriculum or offer telehealth courses. Nurses can also explore telehealth webinars and conferences offered by telehealth organizations, such as ATA or the Mid-Atlantic Telehealth Resource Center (MATRC).

Informal ways to explore telehealth include collaborating with telehealth programs within the state, reading articles on telehealth, participating in discussion groups, and joining telehealth organizations. As nurses empower themselves with telehealth knowledge, they must develop communication and collaboration skills in order to utilize telehealth as a tool to enhance interprofessional endeavors. Nurses can collaborate with those using telehealth and connect with the clinical experts within the interdisciplinary team with the technology to address common patient care goals. They can build relationships with others by finding partners in the telehealth community who can help them move forward with their creative telehealth ideas.

How can nurses knowledgeable in telehealth contribute to nursing and healthcare?

Nurses educated in telehealth can make strong contributions to nursing and healthcare as they emerge as the future nursing leaders. The issues facing healthcare and healthcare resource allocation can be improved with telehealth systems of care developed and implemented by nurses. How are nurses going to use telehealth creatively in their practices if they do not have the education and skills to do so? It is essential that nurses become empowered with telehealth knowledge and hands on technical telehealth skills because telehealth has forever changed healthcare. Telehealth is here and is transforming healthcare as we know it. Nurses will be left behind in this new era if they do not educate themselves for this challenge and produce innovative nursing leaders in telehealth that are at the forefront of healthcare. ◆

Medicaid Expansion: A Policy Update

Joyce Hahn, PhD, APRN-CNS, NEA-BC &
Brenda Helen Sheingold, PhD, RN

The Affordable Care Act (ACA) offers the potential to improve population health, health care access, and health care quality, while slowing the rate of increase in health care costs. Accomplishing these goals has proven to be complex and implementing the new law is creating challenges within the states. The expansion of Medicaid eligibility to cover nearly all low-income adults is a principal component of the health care coverage provisions in ACA.

The Supreme Court's ruling on June 28, 2012 (Supreme Court, 2012) upheld the constitutionality of the ACA with one exception, which allows individual states to opt out of Medicaid expansion. Twenty-six states brought the suit to the Supreme Court arguing that mandating Medicaid expansion was "an overreach by the federal government" that placed a large financial burden on the state budgets (Frakt & Caroll, p. 166). Individual state decisions on Medicaid participation remains dynamic and this a rticle will address what is currently known.

Background History of Medicaid

President Lyndon Johnson signed legislation that created the Medicaid program in 1965. Medicaid is a jointly funded federal-state health insurance program that has since grown from its origins as a health coverage program for welfare recipients into a public health insurance program for the nation's low-income population covering millions of additional children and adults in added categories living in or near poverty (Rosenbaum & Westmoreland, 2012). The Medicaid federal-state partnership is funded largely by the federal government with contributions averaging from 50% to 74% of expenses (Henry J. Kaiser, 2013[a]). Today, it is the nation's single largest insurer covering an estimated 70 million children and adults (Rosenbaum & Westmoreland, 2012).

Medicaid and ACA

The ACA expands Medicaid eligibility to Americans with an annual income below 138% of poverty (133% plus a 5% income disregard allowed by the legislation). By 2013 standards, "138% of poverty would be about $15,400 for a single person and $31,800 for a family of four" (Price & Eibner, p. 1031). Children with annual family incomes below 200% of poverty would continue to be covered under the Children's Health Insurance Program (CHIP).

The federal government will have a generous Medicaid match rate under ACA starting at 100% in 2014 and gradually declining until it reaches 90% in 2020 (Center on Budget and Policy Priorities, 2013). This is a more generous federal contribution than the current Medicaid Federal Medical Assistance percentages (Henry J. Kaiser, 2013a). Indeed, if all states were to expand Medicaid, the federal government would cover 93% of the incremental cost during the course of the next 10 years (Holahan, Buettgens, Carroll, & Dorn, 2012).

Coverage Gap

In states that do not expand Medicaid, nearly five million poor, uninsured adults have incomes above Medicaid eligibility levels but below poverty and may fall into a "coverage gap" of earning too much to qualify for Medicaid but not enough to qualify for the State Health Insurance Marketplace premium tax credits (Henry J. Kaiser, 2013[b]). Legal immigrants who have been in the country for five years or less and immigrants who are not lawfully present in the U.S. will not be eligible for Medicaid. Medicaid expansion does not alter the entitlement criteria for immigrants compared to current Medicaid eligibility requirements.

These nearly five million poor, uninsured adults would have been newly-eligible for Medicaid if they lived in states that had chosen to expand coverage. A recent Kaiser Family Foundation report (2013[b]) analyzed the coverage gap revealing that more than a fifth of coverage gap adults reside in Texas, 16% in Florida, 8% in Georgia, 7% in North Carolina and 6% in Pennsylvania. For coverage gap Americans, the barriers to obtain needed health care services will continue.

Community Health Centers, sometimes known as Federally Qualified Health Centers (FQHCs) will continue to be a resource for the coverage gap uninsured. These health centers have operated as "safety net providers" since their creation by Civil Rights legislation in the 1960s and their expansion in 1990s and into the 2000s when they doubled in size under President George Bush. These centers are sustained by nearly $3 billion a year in federal funding and can be found serving inner-city and rural area low income populations. (Dunn, 2013). They accept all patients regardless of ability to pay. Hospital emergency rooms will continue to stretch their resources and provide care for the uninsured as "safety net providers."

Medicaid Expansion and State Decisions

States are divided in their intent to participate in Medicaid Expansion. To date, 25 states and the District of Columbia have said they would participate in Medicaid expansion, 22 states have said they would not move forward with expansion, and 3 states are undecided (Table 1).

There is no deadline for states to decide to participate in expansion and additional states may still decide to move forward. The potential benefits to their economies, their providers and their populations will continually be reassessed and evaluated.

States to Watch

In North Carolina, democratic lawmakers and several advocacy groups are reconsidering the state's decision not to expand Medicaid under ACA. To date, Governor Pat McCrory will not call a special session on Medicaid expansion. McCrory has

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Table 1. State decision to expand Medicaid, November 18, 2013

Not Moving Forward	Debate Ongoing	Moving Forward
Alabama	New Hampshire	Arkansas
Alaska	Pennsylvania	Arizona
Florida	Tennessee	California
Georgia		Colorado
Idaho		Connecticut
Indiana		Delaware
Kansas		District of Columbia
Louisiana		Hawaii
Maine		Illinois
Mississippi		Iowa
Missouri		Kentucky
Montana		Maryland
Nebraska		Massachusetts
North Carolina		Michigan
Oklahoma		Minnesota
South Carolina		Nevada
South Dakota		Nevada
Texas		New Jersey
Utah		New Mexico
Virginia		New York
Wisconsin		North Dakota
Wyoming		Ohio
		Oregon
		Rhode Island
		Vermont
		Washington
		West Virginia

Source: Holahan, Buettgens, & Dorn (2013), kff.org (Sept. 3, 2013)

pushed for Medicaid reform legislation stating it would be foolish to expand the system that has been plagued by cost overruns. House Minority Leader Larry Hall went on record declaring North Carolina lawmakers are experiencing some buyers' remorse as they watch federal tax dollars flow into other states. Hall opined rural hospitals are on the verge of closing because of lower Medicaid reimbursements, and as many as half a million uninsured people in North Carolina are finding out they're too poor to qualify for federal subsidies for coverage under the ACA (Leslie, L, 2013).

In Tennessee the associations representing the state's doctors and nurses are working collaboratively to ask Gov. Bill Haslam and the legislature to expand TennCare, the Medicaid program in Tennessee. Dr. Chris Young, president of the Tennessee Medical Association, and Jill Kinch, immediate past president of the Tennessee Nurses Association are making an economic argument for expansion citing access to care issues and loss of revenue. One such argument from Kinch proports Tennesseans are paying high federal taxes and not expanding Medicaid would see those dollars going to other states. They are asking their state leadership to make pragmatic decisions until future national elections can determine the final fate of ACA (Wilemon, 2013).

Pennsylvania's Governor Tom Corbett is promoting his Healthy Pennsylvania plan which calls for accepting the federal funding to expand Medicaid with caveats. Healthy Pennsylvania would place newly eligible people, mostly low-income adults without children, into the state health insurance marketplace to purchase private coverage insurance. Corbett's idea utilizes the federal expansion funds to subsidize people to purchase individual plans instead of placing additional people into an entitlement program (Gordon, 2013).

In October Ohio became the 25th state to expand Medicaid coverage after an extended fight between Republican Gov. John Kasich and the Republican dominated legislature. Gov. Kasich was unable to bring his Republican colleagues on board to approve Medicaid expansion. The Governor bypassed the Ohio General Assembly going to the state's bipartisan Controlling Board instead for approval. This board is charged with providing legislative oversight over certain capital and operating expenses. They voted to accept $2.55 billion from the federal government to expand the Medicaid program through July 2015. This sparked a lawsuit by the conservative 1851 Center for Constitutional Law over the decision to go through the Controlling Board. They are looking for the Ohio Supreme Court to reverse the vote because it was done without the vote of the legislature (Trip, 2013).

Economic Consequences for the States

Literature and studies indicate there will be significant coverage and fiscal implications tied to the state decisions regarding Medicaid expansion. States not implementing the expansion will not experience the large reductions in the uninsured that would have been gained by implementing the Medicaid expansion. Increased Medicaid expansion is projected to decrease an estimated 30% of uncompensated care expenditures paid for by state and local governments. (Henry J. Kaiser, 2013c). State spending would be modest to implement Medicaid expansion and federal funds would greatly exceed increases in state costs. States do have a fiscal concern over the budgetary effects of eventually picking up the final 10% of the Medicaid expansion cost and a concern over the cost of "ACA related woodwork effects" (Frakt & Carroll, 2013). Woodwork effects refers to all of the ACA related activities to include outreach activities that may result in individuals currently eligible for the marketplace deciding instead to enroll for Medicaid. New state level studies find

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positive macroeconomic effects of the expansion for states including increases in production, employment, wages and state tax revenues directly related to the new spending on Medicaid (Dorn, Holahan, Caitlan, & McGrath, 2013). It is important to remember that budgetary implications will vary and change from state to state.

Economic Consequences for Health Care Facilities

It is estimated U.S. hospitals provided over $40 billion in uncompensated care in 2011 (American Hospital Association, 2013). A significant portion of this amount is likely the result of care provided to uninsured patients. As a result of ACA, hospitals stand to realize significant financial benefits from expanded coverage. Medicaid expansion could increase revenues to hospitals that would offset hospital reimbursement reductions also included in the ACA legislation. ACA reduces Medicare and Medicaid disproportionate share payments (DSH) to hospitals by $56 billion over this 10 year time period. Health care facilities in states not participating in Medicaid expansion will then face a double penalty of not realizing the financial gain from expansion but still being subject to the DSH cuts (Dorn, Buettgens, Holahan & Carroll 2013).

If all states implemented the Medicaid expansion, hospitals would see a 23% increase in Medicaid reimbursement over the 2013-2022 period (Henry Kaiser, 2013c). The Urban Institute estimates that full Medicaid expansion would provide a net financial gain to hospitals of $180 billion from 2013-2022 (Dorn, et al. 2013). These gains will be substantially reduced for hospitals in states that do not expand Medicaid.

Public Support for the ACA's Medicaid Expansion

Collins, et. al. (2013) reporting from a recent health insurance marketplace survey for The Commonwealth Fund found widespread public support for Medicaid expansion. More than two-thirds (68%) of adults strongly or somewhat favor making Medicaid available to more residents in their states. Support is strongest among adults who will benefit most should their state choose to expand Medicaid: 78% of respondents who were uninsured for a time over the previous 12 months and 82% of adults earning less than 138% of poverty are in favor of providing Medicaid to more residents (p.7).

Concluding Thoughts

Since participation in Medicaid expansion by the states is voluntary and without a timeline individual state decision-making remains a dynamic process. Hospitals, other provider associations, and consumer groups have to date lobbied to influence their state decisions, and may continue to press noe nexpansion states to reconsider. Nurses can continue to successfully advocate for Medicaid expansion on behalf of their patients as evidenced this fall in Michigan (Michigan Nurses Association, 2013) and again late fall in Tennessee (Wilemon, 2013). As advocates, nurses may continue to exert influence individually and through their professional organizations by discussing the benefits of Medicaid expansion with their state representatives and Governors (Hahn & Sheingold, 2013). The information in this article together with the citations and tables provides useful resources for following this dynamic policy issue. The reader is directed to Table 2 for websites with interactive updated maps following state Medicaid expansion decisions for the most current state decisions.

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Table 2. Medicaid Expansion Website Resources

Organization	Website
The Commonwealth Fund	http://www.commonwealthfund.org/
Kaiser Family Foundation	http://kff.org/
Center on Budget and Policy Priorities	http://www.cbpp.org/files/status-of-the-ACA-medicaid-expansion-after-supreme-court-ruling.pdf
U.S. Department of Health and Human Services (HHS)	https://www.healthcare.gov/do-i-qualify-for-medicaid/
Centers for Medicare & Medicaid Services	http://www.medicaid.gov/index.html

Virginia Receives Grant continued from page 1

funds to receive the grant. The Virginia Nurses Foundation matched the RWJF grant in with support from the Virginia Council of Nurse Practitioners and AARP Virginia. In addition to Virginia, grants were announced this week in: Alabama, Alaska, Arkansas, Illinois, Minnesota, Nevada, Ohio, South Carolina and Vermont.

The 20 states that received grants in February are: Colorado, Connecticut, Florida, Georgia, Iowa, Idaho, Kansas, Louisiana, Maryland, Michigan, Missouri, Mississippi, Nebraska, New Jersey, Pennsylvania, Rhode Island, Tennessee, Utah, Wisconsin, and Wyoming.

"The diverse leadership of our Action Coalition and our focus on meaningful outcomes that improve care were key factors in Virginia being selected," said Dr. Shirley Gibson, Virginia Action Coalition co-lead and Associate Vice President of Nursing, VCU Health System, "We are part of a powerful movement that is improving health care for all Americans. Virginia Action Coalition is grateful to RWJF for this support, which will strengthen our work immeasurably."

Dr. Gibson noted that the Virginia Action Coalition plans to focus on the areas of education progression, interprofessional team education and diversity.

The Center to Champion Nursing in America (CCNA), an initiative of AARP, the AARP Foundation, and the Robert Wood Johnson Foundation, serves as the national program office for the *Future of Nursing State Implementation Program.*

"This new program will help Action Coalitions get the strategic and technical support required to advance their goals," said Susan Reinhard, PhD, RN, FAAN, senior vice president of the AARP Public Policy Institute and chief strategist at CCNA. "Our hope is that with this support, Virginia will be even more effective in improving health outcomes for patients, families, and communities."

About the Future of Nursing: Campaign for Action

Virginia Action Coalition *is part of the Future of Nursing: Campaign for Action, a joint initiative of AARP and the Robert Wood Johnson Foundation (RWJF), working to implement the Institute of Medicine's evidence-based recommendations on the future of nursing. The Campaign includes Action Coalitions in 50 states and the District of Columbia and a wide range of health care professionals, consumer advocates, policy-makers, and the business, academic, and philanthropic communities. The Center to Champion Nursing in America, an initiative of AARP, the AARP Foundation and RWJF, serves as the coordinating entity for the Campaign, as well as the national program office for the Future of Nursing State Implementation Program. Learn more at www.campaignforaction.org. Follow the Campaign for Action on Twitter at @Campaign4Action and on Facebook at www.facebook.com/CampaignForAction.*

About the Robert Wood Johnson Foundation

The Robert Wood Johnson Foundation focuses on the pressing health and health care issues facing our country. As the nation's largest philanthropy devoted exclusively to health and health care, the Foundation works with a diverse group of organizations and individuals to identify solutions and achieve comprehensive, measurable, and timely change. For more than 40 years the Foundation has brought experience, commitment, and a rigorous, balanced approach to the problems that affect the health and health care of those it serves. When it comes to helping Americans lead healthier lives and get the care they need, the Foundation expects to make a difference in your lifetime. For more information, visit www.rwjf.org. Follow the Foundation on Twitter at www.rwjf.org/twitter or on Facebook at www.rwjf.org/facebook.

About AARP

AARP is a nonprofit, nonpartisan organization, with a membership of more than 37 million, that helps people turn their goals and dreams into real possibilities, strengthens communities and fights for the issues that matter most to families such as healthcare, employment and income security, retirement planning, affordable utilities and protection from financial abuse. We advocate for individuals in the marketplace by selecting products and services of high quality and value to carry the AARP name as well as help our members obtain discounts on a wide range of products, travel, and services. A trusted source for lifestyle tips, news and educational information, AARP produces AARP The Magazine, the world's largest circulation magazine; AARP Bulletin; www.aarp.org; AARP TV & Radio; AARP Books; and AARP en Español, a Spanish-language website addressing the interests and needs of Hispanics. AARP does not endorse candidates for public office or make contributions to political campaigns or candidates. The AARP Foundation is an affiliated charity that provides security, protection, and empowerment to older persons in need with support from thousands of volunteers, donors, and sponsors. AARP has staffed offices in all 50 states, the District of Columbia, Puerto Rico, and the U.S. Virgin Islands. Learn more at www.aarp.org. ◆

School Nursing continued from page 1

School nurses practice in public, private, alternative, early childhood, vocational, tribal, and charter schools. Their primary responsibility is to provide multi-faceted nursing care that supports the physical, mental, emotional, and social health of students. School nurses serve as trusted health care experts within their communities and are a valued resource for students as well as for parents, teachers, administrators and community leaders. Serving as a school nurse provides the opportunity to serve the individual student, the whole school population and the broader community as a care coordinator, health care advocate and consultant. School nurses practice real nursing in a unique non-medical setting.

Myth: There is a shortage of nurses to adequately fill school nurse positions.

Reality: The problem for schools is a shortage of adequately funded positions for school nurses.

Funding for school nurse positions is a local educational agency decision. Virginia's instructional standards require staffing ratios for teachers, resource teachers, counselors, librarians, clerical personnel, and administrators. However, there is no required nurse staffing to student ratio. Depending on the school's model of service delivery and funding pattern, a school nurse may be assigned to one school, travel between assigned schools, or serve as a nurse supervisor to health assistants who are assigned to school buildings. The nurse may be on duty full or part time. Virginia's average school RN to student ratio is 1:900. The National Association of School Nurses recommends a ratio of 1 full time RN to 750 well students. A school nurse in every school building all day, every day, allows teachers to teach and enables students to be healthy, safe, and in school, ready to learn. Every child deserves a school nurse.

Do You Want to Be a school nurse?

School nursing has the benefits of regular school hours, weekends off, and vacation over the summer. If you think that school nursing may be for you, learn more about it by talking to a school nurse. Contact the Virginia Association of School Nurses at www.VASN.US for more information. It is an exciting and rewarding career path that is filled with meaningful impact and life-enriching experiences.

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Following the Money in Nursing Education

By Peter McMenamin, ANA senior policy fellow, for ANA's policy blog One Strong Voice

In the December 2011 issue of *Health Affairs,* Peter Buerhaus and colleagues surprised a number of people with a finding that there had been a resurgence in the number of relatively young RNs entering the health care workforce. They had analyzed Census data from the Current Population Surveys and the American Community Surveys (CPS/ACS) that include individuals' occupations. Lead author David Auerbach was quoted, "Back in 2000, we published a paper in the *Journal of the American Medical Association* that predicted an acute nursing shortage. Organizations such as Johnson & Johnson and HRSA started gearing up to promote nursing. It's unusual to see a turnaround like this, and what that points to is an incredible policy story: We forecast a problem, and it got fixed."

In fact, there are a variety of other nursing related data that are consistent with the CPS/ACS results for the years following the turn of the 21st Century. Perhaps more importantly, however, there is what appears to be a strong association between changes in funding for nurses' education and subsequent changes in nursing student enrollments, graduations, and successful completion of NCLEX examinations leading to RN credentials. Further, this association is not new in the 21st Century but could also have been observed during the 1960s and 1970s.

There are many factors affecting individuals' decisions to pursue and complete the educational requirements to become a registered nurse. As Dr. Auerbach mentioned, there was a substantial effort by the Johnson & Johnson Company to encourage young people to become registered nurses. The Johnson & Johnson Campaign for Nursing's Future, was a public-awareness campaign launched by Johnson & Johnson in 2002, to address the nursing shortage in the U.S. by recruiting new nurses and nurse faculty and help to retain nurses currently in the profession. The VA also had started a program in the early 2000s to increase the educational requirements for RNs it employed. Another program was also started in 2001 to allow military medical corpsmen to receive accelerated retraining to become RNs. Many "Second Career" programs to encourage career switches to nursing were also started by colleges and universities around that time.

But one also needs to review the primary source of funding for nurse training: Title VIII, the legislation that covers nursing education and practice. Originally referred to as the Nurse Training Act, Title VIII was added to the Public Health Service Act in fiscal year 1964 initiated with funding at $9.9 million. This Act was a response to a 1963 report of the Surgeon General's Consultant Group on Nursing. The report, Toward Quality in Nursing, Needs and Goals, anticipated a shortage of nurses and recommended that the supply of nurses be increased from a total of 550,000 professional nurses in practice, to a total of 850,000 by 1970. There were relatively rapid increases during President Johnson's term to $66.7 million in fiscal 1968. Funding during the next two years under Nixon dropped, but saw increases in 1970 and 1971.

There was a very important change in 1971. The Comprehensive Health Manpower Training Act of 1971 significantly amended the Health Professions Educational Assistance Programs contained in the Public Health Service Act. With respect to Title VIII, funding increased by $15 million in fiscal 1971 to $69.4 million. Funding nearly doubled in fiscal 1972 to $138 million, and increased again to $160.6 in fiscal 1973. There was a decline in funding from $160 million in fiscal 1973 to the $50 million range in 1983 and Title VIII funding continued at relatively unchanged levels between 1985 and 1995. Minor increases in funding could be observed over the remainder of the decade.

In fiscal year 2001 Title VIII funds were increased by 20% over the prior fiscal year. Subsequent Congressional deliberations led to the passage of the Nurse Reinvestment Act of 2002. The 2002 law reauthorized programs for Basic Nurse Education and Practice, Advanced Education Nursing, Nurse Education Practice and Retention and Nursing Workforce Diversity and created new ones, including the programs for Nurse Faculty Loans and Comprehensive Geriatric Education. Funding increases continued through 2005, although Title VIII funding remained flat for the remainder of the Bush Administration.

In 2010 President Obama announced his intentions to increase funding for training of primary care clinicians. Support would be provided to train an additional 500 primary care physicians, 500 physician assistants, and 500 registered nurses, reallocating public health funds available under the Affordable Care Act. Title VIII funding was increased by nearly $73 million to $244 million in fiscal 2010, a 43% increase. Subsequent funding has been somewhat reduced but the fiscal year 2012 amount was nearly $232 million.

Data from the American Association of Colleges of Nursing (AACN) on total students enrolled in baccalaureate nursing programs and the number of graduates from 2000 to 2011 also fit this pattern. Baccalaureate RN graduates are approximately 40% of total RNs passing the NCLEX each year. (This percentage has increased from 36.5% in 2000 to 40.8% in 2011.) The most distinct phenomenon observable is the substantial growth in nursing students and new nurse graduates that appeared early in the 21st century, particularly around 2002 and 2003. ◆

Take Health Risk Appraisal to Evaluate Your Health, Wellness, Safety

ANA HealthyNurse™ Program Positions

RNs as Role Models

You are always encouraging your patients to adopt healthy lifestyle behaviors, reduce their stress and improve their wellness. But how much attention do you place on your own health and wellness? If you consistently felt your best, how might that affect the quality of care you provide and outcomes for your patients?

Now you can compare your health, safety and wellness to the overall U.S. population and other nurses within demographic categories, including nursing specialty, by taking ANA's new HealthyNurse™ Health Risk Appraisal. This HIPAA-compliant online survey, which takes about 20 minutes to complete, also allows you to assess your workplace risks such as patient-lifting injuries, workplace violence, and sharp device hazards.

The appraisal is a component of ANA's HealthyNurse™ program, which encourages nurses to focus on self-care so they can be at their healthiest – physically, mentally, emotionally, and spiritually – to provide the highest quality of care and serve as role models, advocates, and educators for their patients.

"When we model the healthiest behaviors ourselves, it becomes easier to help our patients to do the best things for their health," said ANA President Karen A. Daley, PhD, RN, FAAN. "This appraisal will help each nurse to optimize their health and serve as an online check-up on the health risks they face in their personal and work lives."

A partnership between ANA and Pfizer Inc, the data-gathering tool is combined with an interactive "Web Wellness Portal," a website for you to obtain information and educational resources based on your individual results and interests. The appraisal will become a continually accumulating database that will enhance the nursing profession's ability to track trends and set policy and advocacy priorities and strategies.

All RNs and RN nursing students are encouraged to take the appraisal for free and access the Web Wellness Portal at: www.ANAhra.org. ◆

EDUCATION DAY POSTER PRESENTATIONS

Customizing Orientation to Improve RN Satisfaction

Kelly Brown, MHA, MSN, RN, CPAN
Anna Burch, RN
Melody Pillar, BSN, RN, CMSRN
Centra Health

A note from the editor - On September 28, 2013, the Virginia Nurses Association held our annual Education Day conference, and this year, we had a record number of poster presenters (79!) participating our poster session. Nurses from throughout the state shared their research, evidence based best practices, innovation projects, and performance improvements. We were so impressed with the quality of the work on display that we've asked some of our presenters to share the content of their poster with the readers of *Virginia Nurses Today.* We'll be including poster presentation write-ups in the next several editions of this publication. Our hope is that you'll read them, share them, and be inspired by the outstanding work of your fellow nurses.

One of the challenges facing hospital systems today is how to efficiently and adequately orient new nurses. Training nurses to "float" competently between units is even more of a challenge. The Resource Team of Centra Health, serving Lynchburg General and Virginia Baptist Hospitals, is responsible for effectively preparing nurses to work across five different divisions of nursing. This team's approach has been customized to fit the needs of the new hire while encouraging growth in mentoring among their seasoned staff.

The Resource Team is comprised of five distinct divisions: Acute Care, Critical Care, Women's and Children's, Mental Health, and Surgical Services. Each one of the 80 nurses belonging to the team is hired into their specific division, maintaining competencies and functioning as a staff nurse on those units within their specialty. When working outside of their assigned division they assume a "float" role, assisting with nursing tasks and responsibilities inside of their scope of practice, without accepting full responsibility for an assignment of patients.

An employee engagement survey suggested room for improvement in the orientation of the Resource Team nurses. Scoring lower than average on the question "I know what is required to perform my job well," the team drilled into the data and discovered the newer hires of the team had scored this question lower than those with tenure. This prompted a task force of staff nurses, led by representatives of their NGB (Nursing Governance Board), to assess the current process of orienting new hires into their team, and construct a new method for ensuring their ability to perform competently across the various settings.

The current orientation manual was evaluated by a group of nurses from each division and completely revamped. This manual now consists of all procedures relevant to the Resource Team's structure and guidelines, as well as information specific to each unit served by the team. Unit specific information was updated and streamlined for a more efficient learning experience. Additional resources were added to the manual for the benefit of the new hires.

Changes were made to the preceptor role, adapting it into a mentoring position. All preceptors were required to attend a preceptor workshop, designed and taught by the leaders of the task force responsible for the changes. Preceptors learned to assume the role of mentor and accepted full responsibility for customizing the new hire's orientation through the workshop. This new process pairs a seasoned nurse on the Resource Team with a new hire. The seasoned nurse takes full ownership of the preceptee's orientation process, initiating contact, completing a guided tour through both hospital campuses, constructing their schedule to meet their needs, evaluating their progress during orientation, adjusting accordingly, and finally, serving as a future resource to that nurse after orientation is complete.

Seventeen nurses completed the Preceptor Workshop as mentors for the team. 100% of them rated the new process as "excellent" on a follow up survey. New hires were surveyed before the changes took place and those hired after the changes were implemented were also surveyed. The statement "I received adequate orientation time on each unit" increased from 40% pre-change to 100% post change. "There was nothing lacking in my orientation" increased from 75.5% to 83%. Overall the new hires have expressed positive experiences and 100% answered "yes" to the question "Do you feel you were adequately prepared for your job as a Resource Nurse?"

In today's ever changing healthcare system, a strong foundation is the key to improving nurse satisfaction and boosting retention. Involving seasoned nurses while giving them autonomy and ownership is essential to building a strong team of leaders who feel a sense of partnership with their manager and coworkers. Engaging employees within the team has increased a commitment to excellence and a desire by all for the new hires to succeed in their new role.

As many organizations struggle with finding the best process to orient new nurses, this team's approach sets an example of a proven method that provides a solid foundation for new hires an environment where the entire team is invested in the success of the new nurse. This process, whereby new hires are mentored by a trained staff nurse overseeing their entire orientation process ad tailoring it to specific needs has increased RN satisfaction and cohesiveness of the team. While this process has been specifically used by a supplemental "float" pool, the method could be easily be applied to any environment in which nurses are hired. ◆

EDUCATION DAY POSTER PRESENTATIONS

Dissemination and Translation of Evidenced-Based Guidelines to Practices for Nurses: A Systematic Review of Literature

Samuel Kojo Asamoah, MSN, RN, CNE, BC

Studies conducted in the US reported that 30-40% of patient care was not congruent and consistent with current evidenced-based guidelines for optimal care delivery (Grishaw & Eccles, 2004). According to Grol (2001), one way of increasing quality care improvement is through effective development, dissemination and implementation of evidenced-based practice guidelines (EBPG). One of many important considerations of having EBPG is that they help with the reduction of morbidity and mortality, plus offer the health care professional a consistent reference guide to acceptable practices (Miller & Kearney, 2004).

The primary goal of this article is to report a systematic review of the current literature regarding strategies or methods of dissemination and implementation of EBPG. The secondary goal is to propose a framework of universal barriers that obstruct dissemination or impede compliance of EBPG in acute care settings.

METHODS

Search strategy for the identification of EBP studies

This article covers a period of 10 years of literature from 2002 to 2012. The following steps were used: computerized search using the MEDLINE, CINAHL, and Cochrane databases; articles limited to English; key words included nursing, knowledge, evidenced-based guidelines, compliance, implementation and dissemination; and search of titles and abstracts followed by full article reviews.

RESULTS

The review of literature identified a total of 77 relevant articles with abstracts. Twenty (20) of these articles met the inclusion criteria.

Dissemination or Translation Strategies:

Of the selected group of articles, two articles provided detailed approaches for the dissemination of EBPG.

Eight articles mentioned of the use of unit educational outreach to disseminate EBPG information to health care professionals. This approach included information provided by a staff member who went outside to professional meetings and brought back relevant content to the organization. This approach was reported as one of the less effective ways of disseminating information (Oh, 2008). Alternative approaches included utilizing clinical experts from either the same organization or from outside (Oh, 2008) and audit-feedback procedures that update staff with new information on EBPG.

Barriers to Dissemination of EBP Guidelines:

Figure 1 is offered as a useful way of thinking about the multiple factors that can affect dissemination and adherence to EBPG. The model includes primary, secondary and tertiary barriers derived from the literature, and influenced by the earlier work of Krein and colleagues (2006). Primary or local level factors include staff behavior and practice unfamiliarity about guidelines, lack of staff education & training, inexperience and lack of staff competency. Secondary barriers or systematic level factors include ineffective communication, high workloads of staff, lack of necessary supplies, ambiguity, and non- permanent staffing. Tertiary barriers or environmental level factors include lack of leadership support, organizational commitment, and organizational accountability. Environmental factors also include lack of a safety culture, and lack of policy and procedure effectiveness. The primary, secondary, and tertiary domains contribute individual and cumulative forces on adoption practices, which contribute to a climate of low energy and low tolerance for the changes required to improve patient outcomes. Ultimately, EBPGs can be devalued and ignored by the staff. With no support or incentive for change, compliance rates fall and patient care stagnates.

DISCUSSION:

Though the search provided useful information about what others have used to disseminate guidelines to clinicians, many other strategies may also be useful and should certainly be explored within the context of the proposed model. For example, annual competency testing can quickly reveal knowledge and practice gaps that need attention. Employment testing may help pinpoint knowledge gaps among new employees so that job orientation can be better targeted to the needs of new staff members. There must also be more organizational level investments in helping staff members understand the significances of implementing EBPG. Identifying research mentors and opinion leaders in the organization who have influence and resources is critical for success.

CONCLUSION:

Despite barriers to implementing EBPG, it should be noted that there is generally a positive attitude among health care professionals for EBPG (Heiwe et al, 2011). This is good news because, if the proposed model is correct, environments where staff members are respected, valued, educated, and rewarded; and where organizational leadership is effective, will readily overcome most barriers to implementing EBPG.

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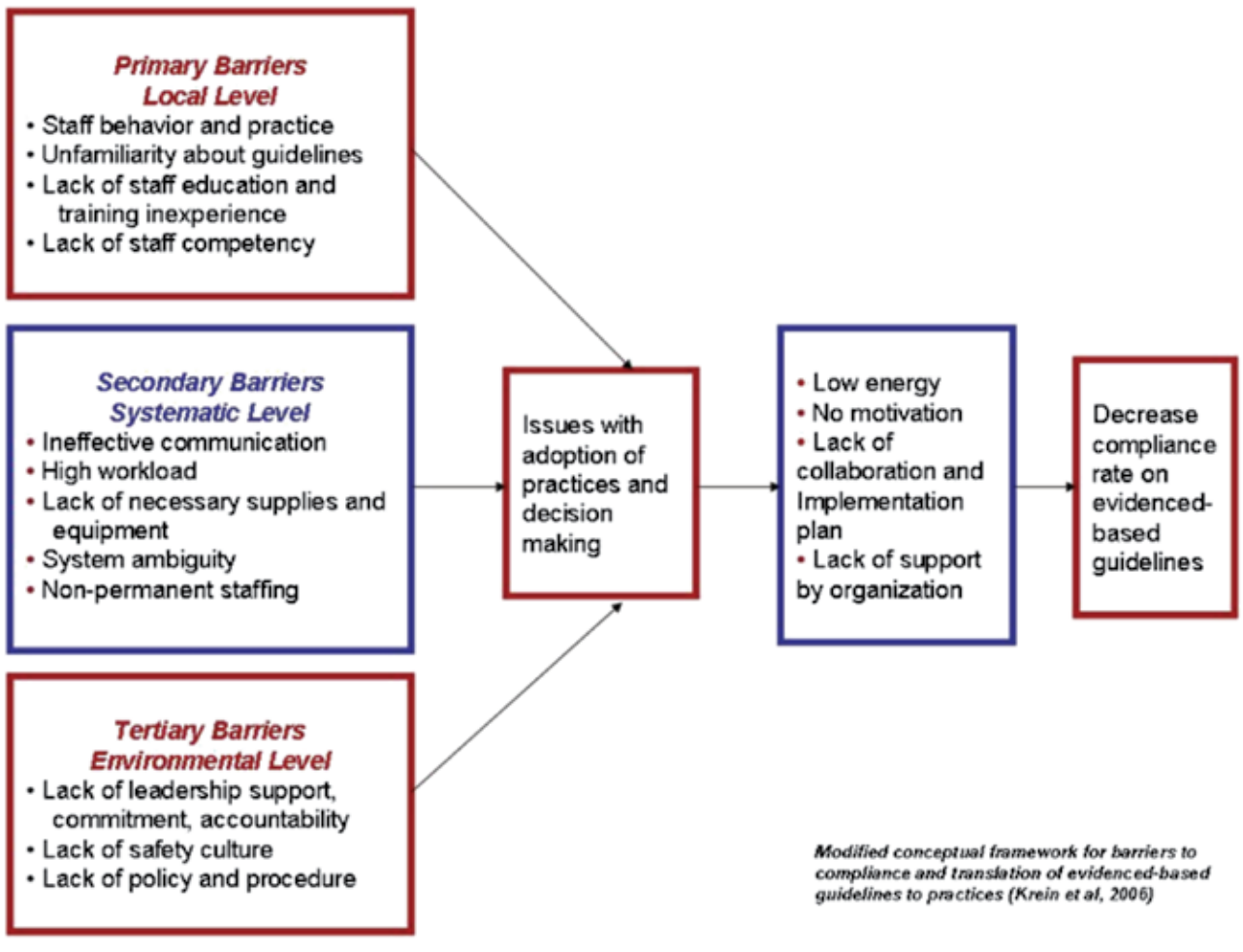
Figure 1: Framework of Universal Barriers



Modified conceptual framework for barriers to compliance and translation of evidenced-based guidelines to practices (Krein et al, 2006)

EDUCATION DAY POSTER PRESENTATIONS

Pressure Ulcer Prevention in the Spinal Cord Injured Hemodialysis Patient

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In our hospital-based dialysis unit at Hunter Holmes McGuire Veterans Administration Medical Center (VAMC), the nurses noted an increase in the number of spinal cord injured (SCI) end-stage renal disease (ESRD) patients requiring dialysis. Due to the multiple comorbidities of the SCI population, the SCI nurses approached the dialysis interdisciplinary team about the need to turn patients while on dialysis. The SCI nurses are dedicated to the prevention of skin breakdown in their patient population. To the SCI nurses this seemed like a reasonable request. However, this proposal to turn SCI patients while on dialysis created problems for the dialysis nurses.

Patients incur little movement during their time on the dialysis machine. Dialysis nurses are concerned about dislodging needles, blood loss due to access problems and machine alarms. The dialysis nurses discussed the request at the interdisciplinary team meeting and identified a need to develop a method to relieve pressure and avoid pressure ulcer development without needle dislodgements or the incurrence of machine alarms.

Pressure ulcers occur when there is constant pressure on an area of skin, usually over a bony prominence. The areas are usually sacrum, elbows, knees, occiput, ischium, coccyx and the ankles (Lyder, 2003).The skin becomes compressed between the bone and the object. This pressure decreases the blood supply to the area. Though prolonged pressure is considered the main factor, other factors contribute to risk; such factors are age, moisture, immobility, spinal cord injury, friction and shear (Brindle, 2012). Renal patients, especially those with diabetes, may be at risk for developing wounds. Patients with kidney disease have wound impairment due to their decrease in dietary intake and metabolic acidosis.

Upon admission into the hospital, each patient has a skin assessment performed. The patient is assessed on sensory perception, moisture, activity, mobility, nutrition, and friction and shear. The skin assessment template format is based on the Braden Scale (Braden, 1988) used to predict the risk for pressure sore development. The SCI patient has impairment of sensation that can be incomplete or complete. Some patients are able to feel pressure, heat, cold or pain and others have no sensation. In addition to lack of sensation, many SCI patients are unable to independently move below their level of injury and quadriplegics are unable to move from their neck down. It is vital to be able to provide pressure relief to this population that is often unable to care for themselves.

The wound care nurse and a core team of dialysis nurses created a plan to prevent pressure ulcer development. The plan was similar to a study done by Todd Brindle on surgical patients at Virginal Commonwealth University Medical Center in Richmond, Virginia. A silicone border sacral shaped dressing was applied pre operatively on all surgical patients admitted to the surgical trauma intensive care unit to prevent pressure ulcer development. (Brindle, 2012) We felt this strategy could be used in our patient population.

Spinal cord injured patients were dialyzed at the bedside or transported to the dialysis unit in their bed. Prior to initialing dialysis the patient was turned on to his nonaccess side. The sacral area was assessed, cleansed with a pH balanced skin cleanser, dried well and a silicone non-adhesive sacral border dressing was applied. The patient was positioned on his side and supported with a wedge/trunk positioner. The patient was positioned for comfort and to ensure easy accessibility to his dialysis access. Two hours into dialysis treatment, the wedge was removed, allowing the nurse to reposition the patient for comfort. As a result, pressure was shifted and this was considered a turn. Turn documentation was charted in the bedside computer, FMiS (Fresenius Medical Information System). After the completion of the treatment the turns and pressure relief are included the hand-off report given to the SCI nurse.

At the conclusion of this ninety-day quality improvement project, there were no pressure ulcer development in the spinal cord injured hemodialysis patient. Overall, the results confirm dialysis nurses can and should be aware of and involved with pressure relief in the spinal cord injured hemodialysis patient. As we become more task oriented, the skin needs of the patient may be ignored. Nursing assessment of the skin and boney prominences are necessary and require diligence to prevent skin breakdown and leading to pressure ulcer development. It is our responsibility to provide quality care during the time the patient is on dialysis. It is always our goal to help prevent any complications that could occur during treatment. Outcomes can be improved by continued communication between the nephrology nurse and spinal cord nurses. The nurse must take the lead in the interdisciplinary meetings to promote accurate assessment of the skin.

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EDUCATION DAY POSTER PRESENTATIONS

Unit-Based Shared Governance Councils for Staff Nurses Impact Care at the Bedside

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Many times a change is driven by management and does not always include staff nurses in the decision making process. This top down approach often creates a barrier to a successful implementation of a change initiative (Fitzsimmons and Cooper, 2012). Shared governance is an organizational model through which nurses control their practice as well as influence administrative areas" (Hess, 2004). The concept of shared governance may come with feelings of apprehension from both management and staff. It takes a concerted effort with management support to start unit-based shared governance councils (Porter-O'Grady, 2012).

Organization is the key to starting a shared governance meeting. Educating managers and staff about the purpose and goals and getting the team excited about having a voice is an important developmental step (Banford-Wade and Moss). In addition, it is vital to get results quickly so the team can see outcomes and want to move forward.

In 2007, Bon Secours Memorial Regional Medical Center, Women's and Children's Services Team developed unit-based shared governance councils. Three councils were created:

- Quality and Practice
- Education and Research
- Recruitment and Retention

Initially, a clinical educator facilitated these councils, but after approximately one year, staff nurses were encouraged to take the lead position for each of the meetings. This created an even greater sense that change was being implemented at the grass roots level.

Reviewing and updating policies was the initial focus of the Quality and Practice Shared Governance Council. Prior to shared governance, updates in policies were made by the educator and/or unit managers and these changes were inconsistently communicated to bedside care providers. With the development of the council, each member was assigned a policy and required to evaluate current evidence. During monthly council meetings, policy changes were discussed, and then the new policies were approved by management and physicians. Policies were shared with all unit staff. Within two months, five policies were changed with staff nurse input. Within two years, all of the unit policies were updated by direct care nurses utilizing current evidence.

The Quality and Practice Council has evolved to utilizing email communication to meet in order to accommodate night shift nursing schedules. The members meet in person as needed to work on policies that affect more than one unit and to welcome new members. As new nurses join the council, they are paired with a mentor to explain the process and expectations.

The Education and Research Shared Governance Council initially worked on the unit-based skills validation education fair. Decisions were made as to what topics would be covered and each council member helped to coordinate the assigned stations. The annual fair progressed to include not only hands-on skills stations but poster presentations from staff as well. Although this is a mandatory event for staff, the input from council members make it relevant and enjoyable to attend.

Another event coordinated by the Education and Research Council was a four-hour conference for the nurses in Labor and Delivery Unit, Mother Infant Unit, Neonatal Intensive Care Unit and Women's Services Unit. The members of the council asked physicians to present on topics most requested based on the annual needs assessment. The overall evaluations were very good and with this positive feedback from peers, the council members were encouraged to provide other educational events.

This conference has become a much anticipated annual event and continues to be supported by leadership. It is a free, local event which keeps non-productive unit costs low. Additionally, it offers continuing education hours which can be used for the hospital's clinical ladder portfolio as well as for certification renewals.

Fundraising and planning the annual summer and holiday parties were initial focuses for the Recruitment and Retention Shared Governance Council. However, this team continued to transform by updating the unit-based staffing guidelines which included holiday schedules and flexing protocol when census was low. Additionally, they developed incentives for long-term employees. With management approval, and after ensuring staffing was adequate, some options given to team members with more than ten years of service were decreased call hours, an additional holiday off, or limited night shifts.

The Recruitment and Retention council members also create a unit-based newsletter featuring physician bios, new employee pictures, and other news from around the units. They organize gatherings to welcome new employees and plan recognition events for current employees. Monthly bulletin boards are also maintained by these members with themes such as "Who's that baby?" and "Where did you go on vacation?"

Beyond the result of three engaged Shared Governance Councils, Women's and Children's Services can share that these councils have transformed care at the bedside as indicated by the following examples:

- Updated recommended practices for surgical attire from the Association of Operating Room Nurses (AORN) changed the dress code for Women's and Children's Services resulting in decreased hospital acquired infection rates and increased infant security.
- Late preterm and developmental care practices have decreased infant length of stay.
- Evidence based nursing assessments to evaluate for congenital heart defects have been implemented for all newborns.

Despite adjustments in membership and leadership changes over the years, the Shared Governance Councils continue to thrive. The data collected from the Agency for Healthcare Research and Quality (AHRQ) Hospital Survey on Patient Safety Culture demonstrates improvement in nurses' overall perception of safety, hospital handoffs and transitions, and organizational learning and continuous improvement with the development of shared governance councils.

The Bon Secours Memorial Regional Medical Center Women's and Children's Services team celebrates more than six years of Shared Governance Council success. Sustainability starts at the beginning with a clear understanding of the process and educating the team. Seeing results quickly and providing the staff nurses the opportunity to lead are vital change agents. However, the most important aspects of making a change to implement unit-based Shared Governance Councils are leadership and physician support and the recognition of success from the entire team.

References

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LGMC-Behavioral Health: Gaining the Upper Hand in Fall Prevention

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Evidence based research shows that psychiatric patient falls happen twice as often as patient falls in medical inpatient settings. Behavioral health patients are typically more mobile, have greater freedom to move around the unit, and often take medications that can contribute to a higher risk for falling.

At Lewis Gale Medical Center's Pavilion (LGMCP), a behavioral health facility, a team of staff members wanted to prevent patient falls from occurring. Together, facility leadership, pharmacy staff, and nurses worked to determine the causes of patient falls and to subsequently develop and implement new initiatives to prevent them from occurring. Leadership and pharmacy staff began by researching the total number of falls, the average fall occurrences on specific days of the week, and also complied a list of medications used by each patient experiencing a fall.

Pharmacy department members educated the unit staff on the half-lives of medication and alerted staff to medications that may contribute to an increased risk of patient falls. LGMCP patients, like many patients in behavioral health facilities, often require anti-psychotic, anti-depressant, sedatives, anti-convulsant, and/or anti-hypertensive medications; all of these medications can contribute to a higher risk of falling.

In addition to increased education on the effects of medication on patients, LGMCP implemented the use of a Falls Risk Worksheet that prints along with unit censuses. This sheet is designed to give a fast, comprehensive overview of any patient fall risk and is included in the unit safety rounds workbook, allowing all staff to be alerted to any potential risk. The Falls Risk Worksheet Worksheet contains important individualized information on patients, including:

- current length of stay
- age
- last documented blood pressure
- current list of medications
- times when medication was given

Patients at LGMCP are often able to use the restroom on their own, unlikely to ask for nursing staff assistance when getting up, and can move freely around the unit while subsequently requiring much redirection. To help eliminate the risks related to these mobile patients unlikely or unable to ask for assistance, the nursing staff implemented a new camera observation room on each unit. This room allows the nurses to to more easily observe mobile patients determined to be a higher fall risk, and staff includes the observation as a important component of the patient's individualized treatment plan.

Finally, as part of implemented protocol, a facility-wide Falls Committee meets weekly to discuss any fall that occurs, the circumstances leading into that fall, and any further action plan that should be implemented.

At LGMCP, staff members are aware that even with the utmost attention and care, falls do sometimes happen. However, rather than accept patient falls as the norm, interdisciplinary staff worked to research the causes and implement evidence based strategies minimize fall percentages and ultimately increase the safety and well-being of patients.

Resources

Patient Falls in Healthcare: Ergonomic Interventions. Hill-Rom 2006.

Malik A, Patternson N. Step up to prevent falls in acute mental health settings. Nursing. 2012 July; 65-66.