Are the American Nurses Association and the Nursing Profession in Peril?
I never thought I would ever ask this Question!

After graduating in 1970, the American Nurses Association (ANA) was a very strong and politically powerful organization. The expectation was for graduate nurses to join ANA, become lifetime members, and participate in the state ANA association. It was a privilege to be appointed to one of the five Committees or serve as an elected Officer. The legislators and Governor called the state ANA office on matters of health care, nursing education and nursing practice.

With membership dues, ANA had sufficient money to educate the public about the important role nurses played in the nation’s health care. Both nationally and locally, ANA had the finances to address the needs of all nurses in their specialty areas of practice. ANA had the finances to support the efforts of all state Boards of Nursing to protect and advance the scope of nursing practice. ANA had the finances to support nurses in providing testimony to the Legislature and to meet with their local–state–national legislators.

What Happened to the Strong and Financially Stable American Nurses Association?
Several factors led to the present critical situation of ANA and the current attempts from the American Medical Association to curtail and oversee our profession.

Development of Specialty Areas of Nursing Practice
In the 1980s, specialty areas of nursing associations and nursing interest groups emerged with strength. This was appropriate as the advances in medicine and health care led to the need for nurses to advance their education to the master’s level for practice and the doctoral level for the research on patient outcomes. ANA expected each specialty nursing association to conduct research and develop specific guidelines for their areas of practice. ANA approved new standards of practice.

Unfortunately, many nurses believed their specialty nursing associations were the only professional nursing organization and membership continued to decline. ANA Confusion still exists about the relationship between specialty nursing associations and ANA.

Collective Bargaining
Nurses as employees have their salaries and working conditions determined by hospital administrators and health care agencies. After World War II, several nursing shortages resulted in poor working conditions and lower salaries than other professions. ANA in 1946 established an economic and general welfare program to investigate. In 1949, ANA was certified by the National Labor Relations Board (NLRB) as a labor union. ANA state members now had the right to establish collective bargaining units and their ANA members served as representatives in contract negotiations with hospitals and other health care agencies.

By the 1960s, the national ANA labor union was successfully negotiating contracts for salary increases and better benefits. In 1966, ANA adopted the Resolution on National Salary Goal which set the national base for nurses’ salaries.

By the 1990s, hospital management decided to operate hospitals with lesser educated nursing staff. Registered nurses were laid off and replaced by Licensed Vocational Nurses and Certified Nurses Aides. The national ANA Collective Bargaining Unit believed that by linking up with a major non-nurse labor union, it would have more political power against the hospitals.

Unfortunately, this marked the advent of non-nurse labor unions looking at registered nurses as a potential source of income and a way to expand their national and state political power. Non-nurse labor unions, such as SEIU, AFL-CIO, and Teamsters, began to negotiate with staff nurses in hospitals to disaffiliate from the ANA Labor Union and have their unions represent staff nurses in collective bargaining issues. In 1995, this effort was successful in California. The staff nurses voted to disaffiliate with ANA and become the California Nurses Association (CNA), an independent labor union. Since the advent of non-nurse labor unions, the majority of nursing graduates believe these labor unions are their professional nursing associations. Thus, membership in ANA and the specialty nursing associations declined.

Nursing Faculty
Since the 1980s, ANA witnessed a sharp decline in faculty membership. In California, there are 13,260 nursing faculty in 130 pre-licensure programs, and only 125 nursing faculty belonging to ANA. There is great confusion among nursing students regarding the functions and responsibilities for each group of organizations; the non-nurse labor unions, ANA and ANA\C Do Not Participate in Negative Campaign Ads
The ANA and ANA\C office has been inundated with calls and emails chastising us for participating in a very distasteful campaign advertisement against McCain and Palin. Nurses have called, upset about the ad, no matter whose side they are on! They believe the ad is in poor taste and are not happy that it is tied to nursing.

WE DID NOT DO THE AD! Nor, did anyone affiliated with us. The California Nurses Association, an independent union organization is responsible. A reporter, who did not know the difference between nursing organizations attributed the ad to ANA. They have retracted their statement but the damage was already done.

(Continued on page 4)
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ANAC Wants To See You....
IN THE NEWS

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

E-mail to: TheNursingVoice@yahoo.com
Mail to: ANACALIFORNIA IN THE NEWS 1121 L Street, Suite 409 Sacramento, CA 95814

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California School Nurse Organization Legislation Action Day Successful

Sharyn Turner, MA, RN Government Relations

School Nurses throughout the five sections of CSNO journeyed to Sacramento to meet with their state legislators or their aides as part of CSNO’s Annual Legislative Action Day on May 19, 2009. Twenty-five participants attended a pre-conference dinner held at Frank Fat’s in Sacramento on May 18th. Carolyn Veal-Hunter, lobbyist conducted a briefing on “How to Meet with Your Legislator” for the next day.

Thirty-two CSNO members met at the Capitol. New advocacy folders were distributed by the GRCC Committee to each participant to be left with each legislator at the time of the legislative visit. Enclosed in the folder was information on the role of the school nurse; statistics on staffing, RIF notices through the five sections of CSNO or their aides as part of CSNO’s Annual Legislative Action Day.

The CSNO Board accompanied Carolyn Veal-Hunter to the Capitol to meet with the legislators or their aides as part of CSNO’s Annual Legislative Action Day.

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Article Submittal to ‘The Nursing Voice’

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

ANACalifornia’s official publication, ‘The Nursing Voice’ editorial guidelines and due dates for article submittal is as follows.

Next Article Submission Deadline: February 16, 2009 for the March 2009 Edition

1. Manuscripts should be double-spaced and double-spaced on one side of 8 1/2 x 11 inch white paper. Manuscripts should be emailed to Editor at TheNursingVoice@yahoo.com

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

b. The Nursing Voice reserves one-time publication rights. Articles for reprint will be accepted if accompanied by a request for same.

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

d. Manuscripts may be reviewed by the Editorial Staff.

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

2. Photographs should be of clear quality. Black and white photographs are preferred but not required. Write the correct name (s) on the back of each photo. Photographs will be returned if accompanied by a self-addressed, stamped envelope. Mail photographs to: Samantha Hunter, Editor, The Nursing Voice, ANACalifornia, 1121 L Street, Suite 409, Sacramento CA 95814. Or email photographs in jpeg format to thenursingvoice@yahoo.com

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

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The official publication of the ANAC shall be The Nursing Voice. The purpose of this publication shall be to support the mission of ANAC through the communication of nursing issues, continuing education and significant events of interest. The statements and opinions expressed herein are those of the individual authors and do not necessarily represent the views of ANAC, its staff, the Board of Directors, or the publications editors. Likewise, the appearance of advertisers, and/or their views and opinions, do not constitute an endorsement of products or services featured in this, past or subsequent issues of this publication. Copyright by the American Nurses Association/California.

The Nursing Voice is published quarterly and is complimentary to ANAC members, their nursing and their nursing students, affiliates of the association and their memberships. If you would like to submit an article for publication, please see ‘Article Submission for The Nursing Voice’ in this issue for deadlines and submission details.

If you would like to receive this publication or you would like to stop receiving this publication please write or call the ANAC at (916) 447-0225 or fax to (916) 442-4494. Please leave your full name, complete address or address correction and a phone number should we need to contact you. Or fill out and mail in the Update Request Form included in this newsletter.

Reprints and Submissions: ANAC allows reprinting of newsletter material. Permission requests should be directed to the ANAC home office in Sacramento. (916) 447-0225

Advertising: Advertising Rates Contact—Arthur L. Davis Publishing Agency, Inc. 517 Washington St., PO Box 216, Cedar Falls, IA 50613, 800-626-4081. ANACalifornia and the Arthur L. Davis Publishing Agency, Inc., reserve the right to reject any advertisement. Responsibility for errors in advertising is limited to corrections in the next issue or refund of price of advertisement.

www.anacalifornia.org
Thoughts on a Friend

As I was reading your e-mail, I was thinking about Professor Randy Pausch who died today. He was a professor at Carnegie Mellon University. He has a website if you are interested in reading about his life. He made such an impact on the profession of teaching and his, "Last Lectures," series has even got me thinking about what is truly important. Randy said, "In ten years you will want what you have now to do what I do." He talked about giving back and most importantly, having fun and enjoying the journey.

In nursing we are afforded such incredible opportunities to make a difference and to focus people on what is truly important. Randy did more in his last two years to touch humanity then most people do all of their lives. He loved what he did and he was appreciative of the opportunities which life had given him. Yesterday I was offered a position by a large respected university in southern California. I am humbled by their offer which includes a chance to obtain a PhD. I hope I can continue to make an impact on my profession and students like Randy. I want to end my life in a similar manner with great sense of appreciation and pride, knowing that I have made a difference.

Randy also exhorted people to be themselves . . . Dr. Seuss once wrote of a rose plant, "You are a rose! Be yourself! Those that mind don’t matter and those that matter don’t mind." Thank you and God bless you Randy Pausch for your commitment to excellence and fun. Your life proved that those two powerful forces are not mutually exclusive.

Randy and I share a unique connection because you and I both have a unique opportunity to educate potential nurses about palliative care.

Bobbie-Ann Murphy

AB 2747

I have been following AB2747 with intense interest. I applaud the efforts to bring this bill to fruition. I can tell you that generally physicians DO NOT provide information on palliative care and hospice when it is appropriate. Palliative care is a holistic team approach to promote the quality of life for patients and their families facing serious life-limiting illnesses. Palliative Care can be provided earlier on in the disease process and I usually provide consultations to patients who are within the last 18 months of life. Physicians are so reluctant and even upset that I want to discuss life care planning with their patients who have the right to this information. Hospice-physicians are again reluctant to even estimate that their patients are within the last six months or so of life. I can’t tell you how many times I have suggested hospice to a physician and they do not think the patient is ready and then the patient dies within a few days. Patients and their families must have correct and appropriate information on palliative care and hospice so they can make an informed decision. It is also to provide a delay on how our patients do not get the appropriate pain and other symptom management they need.

Physicians and nurses need more education on end-of-life issues.

Gloria Lewis, MSN, MHA, RN, CCM
Inpatient Palliative Care Nurse
Antioch Kaiser Medical Center

To Whom It May Concern,

We, the students at Loma Linda University Masters program are currently enrolled in a health policy class, and would like to commend you for your arduous efforts in actively working to oppose SB 1487. Congratulations on your progress thus far and your continued effort in protecting the Nurse Practice Act which states that "no person shall engage in the practice of nursing as defined in section 2527 without holding a license which is in active status issued under this chapter, except as otherwise provided in this act."

From our recent inquiry with the office of Senator Negrete-McLeod, we understand that SB 1487 is dead. However, the issue of inadequate availability of school nurses, insufficient funding, and the need for the provision of a safe environment which provides high quality care to school children needs to be addressed.

We believe that together we can make a difference and while the proposed solution of one school nurse per 750 students may be ideal, it is not the only answer. In working towards accomplishing this ratio, which we realize may not happen overnight, we would like to suggest the following procedures towards accomplishing this ratio, which we realize may not happen overnight, we would like to suggest the following procedures:

§ Partnering with the Board of Registered Nursing (BRN) to provide continuing educational units (CEUs) to registered nurses for volunteering their expertise in the school setting. Hopefully, this will motivate registered nurses to consider working with children in the schools and therefore make a difference in the lives of diabetic children.

§ Working in collaboration with nursing schools, community colleges and the school districts to encourage student nurse placements in schools as part of their pediatric clinical practicum.

§ Utilization of licensed vocational nurses (LVNs) instead of "health aides" or "health clerks" because LVNs have a higher knowledge base and level of experience with diabetic management. LVNs can also be hired at a comparable pay rate.

We agree with the CSNO that "the nursing shortage is not mutually exclusive.

On January 1, 2013, a historical event will occur at the Tournament of Roses®—a Nurses’ Float honoring all nurses around the world will be on the parade route for millions to see. Creation of the Nurses’ Float was inspired by Sally Bixby, RN, Director of Surgical Services City of Hope National Medical Center and Beckman Research Institute who will be the President of the Tournament of Roses on January 1st that year. Sally’s presidency inspired five registered nurses who believed there would be no better way to put the profession of nursing on the international stage than to form a nonprofit corporation to raise funds to design and build a Nurses’ Float.

We named our corporation Bare Root, Inc. because that is the basic root of any rose plant. Once the bare root is planted it becomes a beautiful rose bush. We believe the Nurses’ Float is the blossom of this project and it offers a unique opportunity to educate potential nurses about the profession, to encourage those seeking a meaningful career to consider becoming a nurse, to showcase the multidimensionality of the career of nursing and to let the world know the importance of nurses to every community.

Bixby’s presidency provides a perfect stage to honor all nurses. “Nursing has been a rewarding and fulfilling career for me,” said Bixby. “I am thrilled and honored that my colleagues are promoting nurses during my tenure as president of the Tournament of Roses.”

Bare Root, Inc. has created a website to encourage nurses to support the float through financial donations, volunteering to decorate the float and spreading the word about the project. The website makes it easy to donate to build the float. You can send eBroquets and eCards to honor other nurses. We will also keep you updated with ongoing status reports regarding the building of the float, which will begin in earnest January 2, 2012. Please visit www.Flowers4theFloat.org now and often. We will be looking for volunteers to decorate the float in the future and that information will be on the website.

This campaign is designed at the grass-root level. We encourage nurses and those who have been helped by nurses to go to our website www.Flowers4theFloat.org and contribute to help us meet our goal. It is with love of our nurses to go to our website www.Flowers4theFloat.org and encourage nurses and those who have been helped by nurses to support the float through financial donations, volunteering to decorate the float and spreading the word about the project. The website makes it easy to donate to build the float. You can send eBroquets and eCards to honor other nurses. We will also keep you updated with ongoing status reports regarding the building of the float, which will begin in earnest January 2, 2012. Please visit www.Flowers4theFloat.org now and often. We will be looking for volunteers to decorate the float in the future and that information will be on the website.

Louise Timmer and Gov. Schwarzenegger Proposition 11 Rally

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nursing specialty associations, specialty interest nursing associations, and ANA. Students need to prepare nursing students be expected to define these differences at graduation? Should there be a program objective that compares ANA to non-nurse labor unions and to professional nursing organizations in all pre-licensure nursing programs? What does it mean to be a “professional” registered nurse today? A recent ANA national survey concluded that only 5% of the million nurses belong to ANA and only 26% of the 3 million nurses belong to any professional nursing organization. Is this what we want for our future nurses?

Nursing faculty must educate and mentor nursing students into the professional nurse’s role before graduation. A professional nurse is more than a graduate from a state approved nursing program. It means acquiring the ten characteristics of a professional person. Otherwise, we are graduating nurses who are technical and occupational in mind and spirit. Students must graduate with a clear understanding of nursing practice before entering the workplace and must know how to extend themselves in practice. I got the message. I joined ANA.

I welcome your feedback. I will end with this story. I asked a new physician how we are graduating nurses who are technical and occupational in mind and spirit. Students must graduate with a clear understanding of nursing practice before entering the workplace and must know how to extend themselves in practice. I got the message. I joined ANA.

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Student Nurses Join ANA/C Members to Provide Care to Children in Tecate, Mexico

UCLA Nursing Students

By sunrise, the van had crossed the border into Mexico, leaving our textbooks and classrooms at UCLA, prepared to learn through experience from nurse leaders in the field. Drawn into the team, we witnessed the dedication, generosity, compassion, and tireless advocacy of nurses who embody both the art and science of nursing and inspire us to reflect on our future profession.

The Rotary Club of Tecate built a surgical facility and requested support from Dr. Jeff Moses to provide a clinic for children with cleft palates and lips and facial deformities in Tecate. Before the clinic, radio and TV ads are done throughout Mexico. At one clinic three vans of children were four hours away. At one clinic three van’s of children were brought in from orphanages in the middle of Mexico. Friday is an all day clinic where volunteers provide entertainment for families and children until they can be seen by the doctors and nurses who volunteer for the clinic. Half the nursing team goes to the surgery facility to clean the rooms and gather supplies for the surgeries performed on Saturday. We always have more children then time.

At our clinic four nursing students from the UCLA Master’s Entry Program requested to join us in Tecate. They had a first hand look at volunteer nursing. The following is their thoughts and comments about the experience.

Kelly Peck

The team work behind the scenes is what makes this clinic possible. The generosity of everyone involved in the mission was incredible. Day two began early in the morning and the team worked late into the night to finish the surgeries. The trip was an amazing example of how much can be accomplished with a vision and a team of people who want to make a difference.

May Wheelwright, Kelly Peck, Barbara Adams, Kelly Peck.

The Myth Of The Travel Nursing 50 Mile Rule

If you are a travel nurse you have probably heard some recruiter, somewhere mention a “50 Mile” Rule. The so called 50 mile rule is the imaginary logistical line that makes a nurse legally qualify for tax free reimbursements. Secondly, let me say that I believe the recruiters that quote the 50 mile rule are misinformed. I don’t think their misguided information comes from malice. Rather, the confusion lies with a misunderstanding between IRS Code and hospital policy. Across the country, many hospitals consider a traveler any professional that lives farther than 100 miles from their hospital. This has nothing to do with the IRS at all. This is strictly hospital policy. Many recruiters confuse hospital policy with IRS rules and set up a traveler to receive tax free reimbursements that they do not legally qualify for.

IRS rules can be confusing because some are based on the subjective data as it relates to the specific individual. For example: If the travel distance requires the nurse to stay overnight to be refreshed to perform her job, then this qualifies. If the nurse travels home after every shift, then tax free reimbursements don’t apply. This distance is different based IRS rules can be confusing because some are based on the subjective data as it relates to the specific individual. For example: If the travel distance requires the nurse to stay overnight to be refreshed to perform her job, then this qualifies. If the nurse travels home after every shift, then tax free reimbursements don’t apply. This distance is different based on the nurse. This is called the Sleep & Rest Test. Example 1: Kerri Hotel, RN travels to work at a hospital 60 miles from her home. The drive takes 1.5 hours each way. Hadley knows that this commute would make her too tired to effectively do her job. She has a tax home and accepts housing from her travel company. She is compliant because she does not return home during her assignment.

Example 2: Shana Comehome, RN travels 70 miles to work at a hospital. The drive takes about 1.75 hours. She drives home at the end of her shift and uses the drive time to unwind and talk to her friends & family on her cell phone. Shana has a tax home and does not qualify for tax free reimbursements because she is returning home at the end of each shift.

Example 3: Kerri Hotel, RN accepts an assignment that’s about 75 miles from her tax home. She works 12 hour shifts and blocks them together so she works 3 days in a row. During these shifts, she stays in a hotel. On her “off days” she returns home. Kerri has accepted a housing allowance from her travel company. However, because Kerri returns home, 4 days per week 47/73s of this housing allowance is taxable. This is because when she returns home she doesn’t have duplication of expenses.

Example 4: Gabby Apartment, RN accepts an assignment that is 100 miles from her home. She has a tax home and accepts the package provided by her travel company. Like Kerri above, Gabby returns home on her off days. This housing allowance qualifies for tax free reimbursements however, the meal allowance must either be returned or added as taxable income. This is because the recurring expense of the apartment remains even while Gabby is at home. There is duplication of expenses.

I truly hope these examples help you gain a better understanding about the myths of the 50 mile rule. Happy travels!

May Wheelwright on Compassion

With the first surgery complete, the recovery nurse settled onto the room’s twin bed, neatly made with donated sheets, and prepared to accept the toddler into her arms from the anesthesiologist. She rocked him gently, continuously assessing and intervening on changes in his status and pain from her intimate proximity. She welcomed him back to consciousness with a medley of English and Spanish. As students newly immersed in the high-intensity environment of the hospital, the science of nursing roars to the forefront as we learn to interpret data, research medications, and decode complex pathophysiological processes. It is the art of nursing that makes the science fit for the patient. We don’t forget to absorb. Our time in the Tecate clinic presented nursing at its raw core—stripped of fancy monitors and machines; pure heart, sweat, open arms, and quick thinking. The integrity, intimacy, and interpersonal nature of our new profession have never been clearer.

Barbara Adams on Advocacy

Volunteering in Mexico was one of the best experiences of my life. I was inspired to realize the difference nurses can make in the lives of their patients. I will never forget the woman who traveled 6 hours with her son for the surgery. The 1 year-old had been abandoned at birth because of his cleft palate deformity. She had taken him in as an infant. She sobbed when the surgeons said the cosmetic part of the surgery had changed the way his faced looked. My classmate also cried as she understood in Spanish the gratitude that was expressed to us by her adopted mother. I felt proud to become a nurse. The nurses advocated for us to become involved and treated us as thinking, intelligent beings instead of hazing us. I got a glimpse into how nurses could advocate for one another. Being a patient advocate can mean being a nurse advocate too, so that nurses feel empowered and treated with dignity, and can in turn have the resources to care for and advocate for patients.

Diana Benitez on Inspiration

I always envisioned my future as a nurse doing international work, but I didn’t think that the opportunity would present itself so soon. We were fortunate to meet the Honorable Tricia Hunter at UCLA, who gave us the opportunity to go with her to Tecate. The services rendered by this group of nurses, doctors, and volunteers to the children suffering from cleft lips and palates were remarkable. It was incredible to see the way that the group fed the children and what an impact it had not only on the child but for the parents as well. Babies who had struggled to grow would now be able to eat and flourish, as well as smile. We knew that our work was giving them an opportunity at a different lifestyle. The trip was very inspirational as well as humbling. Our trip to Tecate confirmed my drive to serve international communities in my future as a nurse.

Kelly Peck on Teamwork

The teamwork behind the scenes is what makes this clinic possible. The nurses advocated for us to become involved and treated us as thinking, intelligent beings instead of hazing us. I got a glimpse into how nurses could advocate for one another. Being a patient advocate can mean being a nurse advocate too, so that nurses feel empowered and treated with dignity, and can in turn have the resources to care for and advocate for patients. The integrity, intimacy, and interpersonal nature of our new profession have never been clearer.

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I always envisioned my future as a nurse doing international work, but I didn’t think that the opportunity would present itself so soon. We were fortunate to meet the Honorable Tricia Hunter at UCLA, who gave us the opportunity to go with her to Tecate. The services rendered by this group of nurses, doctors, and volunteers to the children suffering from cleft lips and palates were remarkable. It was incredible to see the way that the group fed the children and what an impact it had not only on the child but for the parents as well. Babies who had struggled to grow would now be able to eat and flourish, as well as smile. We knew that our work was giving them an opportunity at a different lifestyle. The trip was very inspirational as well as humbling. Our trip to Tecate confirmed my drive to serve international communities in my future as a nurse.
The National Council of State Boards of Nursing (NCSBN) was held in Nashville, Tennessee on August 5 through 8. This is the quasigovernmental organization made up of Boards of Nursing from across the United States. In attendance were Francine Tate, President and Ruth Ann Terry, RN, MN Executive Director California Board of Nursing and Louise Bailey, RN, MN Senior Consultant. Theresa Bello Jones, RN, MN, Executive Director of the Board of Licensed Vocational Nursing and Psychiatric Technicians was a delegate from the Licensed Vocational Nursing Board. This year the Council was able to approve associate members and the first to be approved was the Nebraska Advanced Practice Board. The Council had also changed their bylaws to accept advanced practice Boards and the first to be accepted was the Nebraska Advanced Practice Board.

At the award dinner Ruth Ann Terry, RN MN, Executive Director, California Board of Registered Nursing, received acknowledgment for her 15 years as Executive Director of the California RN Board. Ruth Ann Terry was reelected Treasurer of the NCSBN with no opposition. The primary responsibility of the NCSBN is to develop and maintain the Registered Nurse (RN) and Practical Nurse (PN or LVN in California) examination. The company contracted to provide the examination gives a summary report each year at the council.

NCLEX-RN
Highlights of the examination report stated the examination was offered to test takers throughout the U.S. and in 18 international centers in 11 countries. The examination is given in 222 locations globally. There were 200,215 NCLEX-RN examination candidates in 2007 as compared to 177,029 NCLEX-RN candidates in 2006. This is a 13.1% increase. The overall passing rate was 69.4% in 2007 compared to 73.8 percent in 2006. Approximately 48.6% of the total group ended their tests after a minimum of 75 items. The average time needed to take the examination during the 2007 testing period was 2.5 hours. Overall, 2.1% ran out of time before completing the test.

NCLEX-PN
There were 74,933 vocational or practical nurse candidates in 2007 compared to 70,822 candidates in 2006. The overall passing rate was 78.5% percent in 2007 compared to 78.8% in 2006. The percentage of maximum-time takers who completed the examination was 87.4% in 2007 compared to 78.8% in 2006. The majority of test takers were first-time test takers as 66% of all test takers during this testing period were with a total of 2130. The largest number of test takers, India is second with 5113, followed by China, Japan, Canada, Mexico, Germany, and the Philippines with 4033. South Korea, Hong Kong, Australia, India, Taiwan, and South Korea is third with 2130.

NCLEX-RN
The primary goal of the NCSBN is to develop and maintain the RN and LPN examinations. The company contracted to provide the examination gives a summary report each year at the council.

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Governor Schwarzenegger signed a bill into law that takes effect immediately banning physicians and hospitals from billing the patient when they disagree with insurance companies on their fees. Under new state laws, hospitals and physicians are barred from billing patients for the balance of emergency care not covered by insurers. The State Department of Managed Health Care is going forward with the ban on emergency room balance billing despite the court challenges.

Hospital and physicians are protesting the rules in court. The state Supreme Court is set to hear the first “balance billing” challenge next month. Another court test may come sooner in a challenge by hospital chain Prime Healthcare Services Inc. of Victorville. The State Department of Managed Health Care sued Prime. The state is seeking to bar Prime from billing insured patients for unpaid medical bills that the hospital chain contends it is owed from insurers and is seeking from patients as a last resort.

The Department of Managed Care believes they are getting patient’s out of middle of billing disputes between insurers, hospitals and physicians. Many of these bills are causing California families to lose everything they have because of unexpected medical bills. “No longer will Californians face the possibility that if they have to use an emergency room, they may be stuck with a bill, asking them to pay a second time for emergency care, which they already purchased with their [insurance] policy,” stated Cindy Ehnes, Director of Department of Managed Care.

The disputes typically occur when an insured patient ends up in an emergency room that is not in his or her or his or her spouse’s provider network. The insurers bills that are higher than what the insurance firms usually pay providers in their network. And insurers often balk, sending back less than the full payment. Insurers accuse hospitals and physicians of taking advantage of the situation and sending out inflated bills. Hospitals and physicians counter that it is the insurers that take advantage by paying far less than reasonable and customary rates.

Patients wind up in the middle of such disputes when a hospital or physician bills them for the balance. “There was very little until now the consumer could do,” said Mark Senkel of Tracy, Calif., whose credit was ruined after he refused to pay a balance bill. “This is a great step in helping us. I’m going to use this now to get the insurance company and hospital to negotiate with each other and leave me alone, and then I have to go and repair my credit.”

The department also announced that it would address what Ehnes called “the root cause of balance billing”—the unfair or late payment of legitimate emergency room claims by insurers. She said the department would add resources to speed up the resolution of hospital and physician complaints over such practices. Ehnes said she was confident the rules would pass legal muster in pending court tests.

Several physician and hospital organizations have sued the department to block its enforcement of the ban on balance billing. “The root cause of balance billing is HMOs underpaying providers,” said Ned Wigglesworth, a spokesman for the California Medical Assn., which represents physicians.

The new rules should make it easier for consumers to get patient’s out of middle of borrowing disputes between insurers, hospitals and physicians. Many of these bills are causing California families to lose everything they have because of unexpected medical bills. “No longer will Californians face the possibility that if they have to use an emergency room, they may be stuck with a bill, asking them to pay a second time for emergency care, which they already purchased with their [insurance] policy,” stated Cindy Ehnes, Director of Department of Managed Care.
From them within 10 days. If you did not, call again. Nine months for any new program to be approved. She had renewed. Instance confirmation and at least had that to show you. Vertido suggested doing your renewal online. You receive of the budget problems they had 8 retired annuities who. Advisory Committee roll. She also reported that because is concerned about a quorum for the meetings with four make up of the Board at this time. The Executive Director. Adams sunset. Emergency legislation was passed to create an advisory committee for the 2008 year. A bill to reestablish the board has passed the legislature and they become a board in 2009. They have one more meeting scheduled as an advisory committee.

In November the Department of Consumer Affairs is holding a week-long education and hearing session. They have asked all boards and bureaus to arrange to have a meeting during this week. The BRN and LVN Board will hold their last meeting of the year at this LA site on the same day. The public is invited to attend. John Vertido, LVN was reelected President and Todd D’Braunstein was reelected Vice President. This is the make up of the Board at this time. The Executive Director is concerned about a quorum for the meetings with four vacancies.

John Vertido—LVN. Educator Member, Board President
Todd D’Braunstein—PT. Member, Board Vice-President
Josefina Canchola—Public Member
Martin Mariscal—Public Member
Kenneth Merchant—Public Member
Angelique Stephens—Public Member
Vacant—Public Member
Vacant—Public Member
Vacant—LVN Member
Vacant—LVN Member

Theresa Bella Jones did a good overview of the Advisory Committee roll. She also reported that because of the budget problems they had 8 retired annuities who could not work, they cannot fill 2 positions for nursing consultants. She stated renewals are backlogged. President Vertido suggested doing your renewal online. You receive instance confirmation and at least had that to show you had renewed.

Theresa Bella Jones stated that it would take at least nine months for any new program to be approved. She said they had 67 new requests for programs that staff were reviewing. She reminded everyone to work with the Nursing Consultants and that you should hear back from them within 10 days. If you did not, call again.

Her reported stated that there are 183 LVN programs and 25 intent for programs in the process. California has the largest number of programs on our list as second. New York is second. First time takers pass the NCLEX at 73%; 12,300 LVNs tested this last year.

A bill passed last year stating that LVNs and PTs were required to report incidents that were violations of practice or patient harm incidents. There was much discussion on what this means. Regulations will be proposed in the future. Other licensees have had this requirement for some time. Individual’s would be expected to report incidents that could cause harm to patients.

A number of schools were before the board for deficiencies when the Board visited the schools.

1. ATC College Oakland had poor passing rates; sent in progress reports after the deadline; did not have faculty meeting minutes; lack of communication between faculty and administration; lack of committee meetings and not adhering to admission criteria. Staff had recommended two year provisional approval but the Board changed it to one year, wanting the school to have to come back before them.
2. Career Colleges of America, San Bernardino was placed on two year provisional status because of poor passing rates; delinquent reports to the board; failure to follow screening policies.
3. Center Pointe Learning Institute was recommended for provisional accreditation but when the board heard the testimony from the Director, they voted to not approve. The issues included faculty changes without notification; a faculty member who was hired who's stated qualifications were false; three versions of policies all different from the ones the board had; using head start programs for pediatric clinical without verification from the board; not following screening and selecting policies; sending in reports after the deadline, among a number of other issues. The Director disagreed with the Nursing Consultants interpretation and let the Board know this during the testimony.
4. Coast Health Education Center had issues with the Director (there is not one at this time): passing rates, admission criteria among others. The owner was out of the country and no one was there to present. The board asked staff to have the program have representation at the November meeting and delayed a final decision until someone could be there.
5. Walter Ray MD Institute Vocational Nursing program was granted provisional status. They had problems with passing rates and admission criteria but had taken steps to resolve the deficiencies. They had fired their director and hired a new one that came in, after eight weeks with a detailed plan to resolve the deficiencies.

Gov. Schwarzenegger Signs Legislation to Protect Patients, Prevent Deadly Hospital Infections

Governor Arnold Schwarzenegger signed legislation, supported by ANAC that will create a task force to and surveillance system over deadly hospital infections—fostering improvements within hospitals and providing consumers with important information about hospital reports of infections. Caring hospital infections will also save health care dollars by reducing patients’ length of stay and readmissions, as well as minimizing avoidable deaths and illness.

“These important measures will help save lives and health care dollars by reducing the number of infections that people are exposed to while staying in the hospital.” Governor Schenck announced.

“The Operating Room Nursing Council of California also provided expertise and we appreciate their participation in shaping this legislation.”

The American Nurses Association/California actively supported these bills including testimony and letters and support. “We are proud the Governor recognized the need for legislation to protect patients who are vulnerable when they are ill,” stated ANAC President Louise Timmer.

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SB 1058 by Senator Elaine Alquist (D-San Jose) establishes the Medical Facility Infection Control and Prevention Act or “Nile's Law,” which requires hospitals to develop more comprehensive policies and procedures to improve and ensure effective infection control practices. It also requires the Department of Public Health to establish a health care acquired infection program that will receive reports from hospitals on specified hospital-acquired infection rates. In addition, hospitals would be required to screen certain high-risk patients for Methicillin-Resistant Staphylococcus Aureus (MRSA) and to provide instructions regarding aftercare and precautions to prevent the spread of the infection to others.

SB 158 by Senator Dean Florez (D-Shafter) expands upon existing law that authorizes health facilities that are licensed to provide cardiac catheterization laboratory service in California, and that meet prescribed, additional criteria to perform scheduled, elective primary percutaneous coronary intervention for eligible patients.

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This year has been a very difficult year for anyone involved with health care advocacy. The budget deficit was so large that even though there was a will to legislate, there was not willing to compromise on a solution to resolve the problem. Republicans did not want to raise taxes and Democrats did not want to cut programs. The budget compromise did not pass the program but did limit growth in some areas. The budget passed on dependent loans provided through bonds that have been denied by the bonding institutions. The legislation will have been required to come back and deal with an additional shortfall.

Any bill that required major funding did not get through the legislature. AB 2899 Portanion allows publically funded HIV sites to advise people who have been tested before and are following appropriate public health risk reduction measures and that they do not need any further education services and to determine whether a person should be allowed to self-administer any data collection forms. This bill was signed into law.

Cosmetics
AB 2905 Davis that would have declared the Legislature to prohibit the use of lead in lipstick failed on the Assembly floor.

Aesthetic Nursing
AB 2906 Bill that would have introduced this year that impacted the ability of a Registered Nurse to practice under standardized procedures in many settings were introduced this year. AB 2398 Nakaniho originally would have allowed only physicians to be able do this procedures and only physicians to own the business’s that provided the procedure. The final version of the bill required penalties for existing law. This bill was vetoed by the Governor. AB 1545 Ridley-Thomas was also vetoed by the Governor. This bill would have allowed certain licensees to verbally give their credentials instead of having to wear a name badge and would have set physician supervision for outpatient settings. ANA/C along with many aesthetic nurses opposed this bill.

Department of Consumer Affairs
Three bills were introduced this year that impacted the licensing boards: AB 1545 Eng reestablished the Board of Vocational Nursing and Psychiatric Technicians after they were inadvertently sunseted during the last session. This bill was signed into law in June of 2008 and takes affect over multiple boards including the nursing boards.

End of Life Issues
AB 2565 Eng requires an acute care hospital to adopt a policy for providing family or next of kin with a reasonably brief period of accommodation from the time a patient is declared dead by irreversible cessation of all brain function through discontinuation of support. This bill was signed into law.

Other Issues:
AB 2497 Garrick would have removed the requirement for motorcycle helmets. This bill was vetoed. ACR 99 an Assembly Resolution by Swanson urges school districts to take necessary steps to increase school nurse salaries.
Executive Director Report

The Executive Director, Ruth Ann Terry, MPH, RN, reported that the number of RNs increased by 3.9% this past fiscal year. First time examination applicants increased by 15% and RNs endorsing into California increased by 10%. RNs leaving California are slightly higher than RNs coming in, 12,850 endorsing out and 12,517 endorsing in. There are 356,817 RNs in California up from 307,524 in 2004.

The BRN felt the impact of the budget crisis. All hiring was ceased and there was no authorized overtime. The Board was granted an exemption for terminating services of retired annuitants seasonal and temporary help because there work is directly related to protection of human life and safety.

The Board announced that all documents for upcoming committee meetings and board meetings would be posted on the web and could be downloaded for the public to look at.

Ruth Ann Terry, MPH, RN, attended the National Association of Boards and the American Nurses Association last year. The goal was to promote the BRN's website. The BRN’s website is www.anacalifornia.org. Those who need to be fingerprinted can do so as soon as the regulations become law. The process must go through the Department of Justice. The impact will be very minimal because there is a statute of limitations on the action the BRN can take after a conviction, especially if the nurse demonstrates rehabilitation.

The articles failed to look at the real reason these nurses had not been caught. The 1980’s there was a belief that licensing should be centralized. The Department of Consumer Affairs, the umbrella agency for most licensing agencies, has a lot of control over the budgets of these agencies. The money that the BRN has to work with for doing nothing except investigating nurses who may have had a potential risk to the public. These positions were deleted from the BRN, along with the budget cuts. The funds and positions were then placed in a centralized fund for investigating everything from car repairs to health care licensees. This change meant the Nursing Practice Branch has been charged with investigating positions that were created. This is a problem because it is not only the responsibilities, had to take on looking at many of the complaints to determine whether they merit a hearing. It also means that the BRN is now doing something that was never returned to the BRN. The money goes back into the budget. The BRN has no control over this process.

The BRN is self funded by the licensing fees, yet every time there has been a budget crisis, the money that the BRN has to work with for doing nothing except investigating nurses who may have been a potential risk to the public. These positions were deleted from the BRN, along with the budget cuts. The funds and positions were then placed in a centralized fund for investigating everything from car repairs to health care licensees. This change meant the Nursing Practice Branch has been charged with investigating positions that were created. This is a problem because it is not only the responsibilities, had to take on looking at many of the complaints to determine whether they merit a hearing. It also means that the BRN is now doing something that was never returned to the BRN. The money goes back into the budget. The BRN has no control over this process.

Both the BRN and the California Board of Registered Nursing have been charged with investigating positions that were created. This is a problem because it is not only the responsibilities, had to take on looking at many of the complaints to determine whether they merit a hearing. It also means that the BRN is now doing something that was never returned to the BRN. The money goes back into the budget. The BRN has no control over this process.

The BRN held an emergency hearing in October to post the proposals for a 30 day hearing. If this process is approved the regulations will go into effect in March of 2009. These regulations must go through the traditional regulation process to be placed permanently in law. The BRN started the emergency process and the traditional process to be placed permanently in law. The BRN started the emergency process and the traditional process to be placed permanently in law. The BRN started the emergency process and the traditional process to be placed permanently in law. The BRN started the emergency process and the traditional process to be placed permanently in law. The BRN started the emergency process and the traditional process to be placed permanently in law. The BRN started the emergency process and the traditional process to be placed permanently in law. The BRN started the emergency process and the traditional process to be placed permanently in law. The BRN started the emergency process and the traditional process to be placed permanently in law. The BRN started the emergency process and the traditional process to be placed permanently in law. The BRN started the emergency process and the traditional process to be placed permanently in law. The BRN started the emergency process and the traditional process to be placed permanently in law. The BRN started the emergency process and the traditional process to be placed permanently in law. The BRN started the emergency process and the traditional process to be placed permanently in law. The BRN started the emergency process and the traditional process to be placed permanently in law. The BRN started the emergency process and the traditional process to be placed permanently in law. The BRN started the emergency process and the traditional process to be placed permanently in law. The BRN started the emergency process and the traditional process to be placed permanently in law. The BRN started the emergency process and the traditional process to be placed permanently in law. The BRN started the emergency process and the traditional process to be placed permanently in law. The BRN started the emergency process and the traditional process to be placed permanently in law. The BRN started the emergency process and the traditional process to be placed permanently in law.
The American Nurse Association (ANA) is collaborating with nearly two dozen national nursing organizations to commission the first comprehensive study of its kind in 20 years addressing the positive impact the 240,000 Advanced Practice Registered Nurses (APRNs) have on health care quality and patient outcomes.

“An Assessment of the Safety, Quality, and Effectiveness of Care Provided by Advanced Practice Nurses, for the first time, when implemented by January 2009, will standardize each aspect of the regulatory process for APRNs, resulting in increased mobility, and will establish independent practice as the norm rather than the exception. This will support APRNs caring for patients in a safe environment to the full potential of their nursing knowledge and skill,” said ANA President Rebecca M. Patton, MSN, RN, CNOR.

Substantial challenges to educational expectations and certification requirements for APRNs, and the proliferation of nursing specializations have sparked debates on appropriate credentials, scope of practice, and state-by-state regulation of nursing scope of practice. To that end, the consensus model for APRN regulation focuses on the regulation and credentialing of nurses.

Though APRNs have been linked to improved access to health care services, enhanced patient safety, and cost-effective care, a contemporary systematic review is needed to gauge the overall impact these providers are having in today’s health care system.

Researchers will examine research-based evidence connected to care provided by nurses in the four APRN roles—certified registered nurse anesthetist (CRNA), certified nurse-midwife (CNM), certified clinical nurse specialist (CNS), and certified nurse practitioner (CNP). Additionally, APRNs focus on at least one of six population foci: psych/mental health, women's health, adult-gerontology, pediatrics, neonatal, or family.

The American Nurses Association (ANA) has been an active participant in both the APRN Consensus Work Group and the subsequently formed Joint Dialogue Group. In addition to ANA, members of the Joint Dialogue Group are the: American Academy of Nurse Practitioners Certification Program, National Association of Clinical Nurse Specialists, American Association of Colleges of Nursing, American Association of Nurse Anesthetists, American College of Nurse-Midwives, American Organization of Nurse Executives, National Organization of Nurse Practitioner Faculties, National Council of State Boards of Nursing, American Association of Colleges of Nursing APRN Advisory Committee, National League for Nursing Accrediting Commission and nursing compact administrators.
The following four scholarships/awards are available through the Golden State Nursing Foundation.

The Jo Anne Powell Innovation in Nursing Award provides monetary recognition to Registered Nurses who have been creative in their practice.

The Betty Curtis Career Advancement Award provides funds for Registered Nurses embarking on an activity that will result in significant career advancement within nursing.

The Catherine J. Dodd Health Policy Scholarship provides funds for Registered Nurses enrolled in a graduate level academic program who have demonstrated some experience in government relations or health policy activities and express an intent to pursue health policy issues and activities in the future.

The Tony Leone Scholarship provides funds for Registered Nurses seeking a Bachelor's degree in nursing.

Visit our website at www.anacalifornia.org
I was asked to share my professional experience as a Clinical Nurse Specialist (CNS) with prescriptive authority. My professional practice as a CNS began in the 1990s in a state that recognized all Advanced Practice Nurses as equally prepared to assess, diagnose, and plan treatment including writing orders and prescribing. In fact, all Advanced Practice nurses were included under the umbrella term “Advanced Registered Nurse Practitioner” (ARNP). We completed the same core course work with differentiation by our clinical specialty areas. The Family Nurse Practitioners (FNPs) and Clinical Nurse Specialists (CNSs) graduated together and found support, strength, and unity in our professional careers.

As we entered the clinical practice area, we found that the unity among our ARNPs set the stage for physicians to readily collaborate with us. There was no limit to the number of ARNPs with whom a physician was allowed to collaborate. However, there were limitations on the number of Physician Assistants (PAs) to be supervised by physicians on site.

With the achievement of national certification, our Advanced Practice Nurses were entitled to bill for and receive 3rd party reimbursement. We operated with collaborative agreements i.e. agreements made between each Advanced Practice Nurse and a physician. These collaborative agreements were in place to ensure patients that they would never be caught in the middle of any professional conflicts, and that they would be guaranteed access to an appropriate provider without delay.

For the first 10 years ARNP prescriptive authority was limited to those working in rural areas. Then, based on evidence of successful patient outcomes in rural areas, legislation was passed to extend the prescriptive authority to ARNPs working in all geographical areas and all settings. Our prescriptive authority included ordering Controlled Substances schedules II-V. We knew that medication management was more that just the act of prescribing. It was only a small part of a holistic approach to patient care. Medication evaluation and management, which today includes medication reconciliation, meant that we did a complete review of all medications, assessed what each patient needed, and tracked their previous responses to medications. We actively looked for ways to minimize the number, the dose, and the frequency of medications that any one patient was receiving. We were responsible for establishing and maintaining regular dosage reduction plans.

In the interest of professional advancement, states need to work toward legislation that provides the option of prescriptive privileges for all Advanced Practice Nurses. Legislation that clarifies required education, supervised clinical practice hours, and appropriate titling should be standardized across the states. Practicing with prescriptive authority has enabled me to offer a more complete package of services to patients.

Because of the unique role of Clinical Nurse Specialists, prescriptive authority may not be considered by some to be necessary and should remain optional. However, as an Advanced Practice Nurse group, we need to acknowledge the value of enhancing our own educational foundation. With the rapid changes in our healthcare system, and emphasis on evidence-based practice, we have a professional and ethical responsibility to stay current in all areas of our practices.
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CAPNAP
Advanced Practice Nurses Hold Summit
Sponsored by CAPNAP and ANA/C

On September 13, 2008 the first California Advanced Practice Registered Nurse Summit was held on September 13th at West Coast University in Anaheim. This was an opportunity to collaborate on common issues including prescriptive authority for all APRNs in California. The Summit was also held to start a collaborative effort to improve the delivery of patient care, through increased access to highly qualified APRNs. Topics included political pathways, healthcare reform in California, and discussion around prescriptive authority for each of the four APRN roles.

Approximately 60 advance practice nurses representing the California Nurse Midwife Association, the California Association of Nurse Practitioners, the California Association of Nurse Anesthetists, Clinical Nurse Specialists North and South, the American Psychiatric Nurses Association, California Chapter, California School Nurses Association, faculty from a number of programs and the Board of Registered Nursing attend a summit at West Coast University in Orange County. The Summit was sponsored by the California Association of Psych/ Mental Health Nurses in Advanced Practice (CAPNAP), an Affiliate of ANA/C and the American Nurses Association - California. Funding for the program was provided by a grant from Pharma and through the generosity of West Coast University.

Susanne Phillips, MSN, RN, and Doctor Elizabeth Dietz, RN plus staff members Miyo Minato, RN and Jeannette Wackerly, RN represented the Board of Registered Nursing. Tricia Hunter discussed political pathways, Terri Roberts, RN from Kansas presented their story of working together to achieve legislation for all Kansas APRNs. Lisa Kalustian, Chief Deputy Director of the Los Angeles Office for Governor Arnold Schwartzenegger gave a presentation about the status of “Healthcare Reform in California.” A panel from all of the APRN associations plus 2 APRNs on the BRN presented the barriers to practice for each group. In the afternoon five breakout sessions included nurses from each specialty, education and the BRN, who further discussed the barriers to practice and how we could collaborate and strategies for continuing to work together toward achieving common goals.

All in attendance were excited about the discussion and potential for nursing and advanced practice nursing in California. Future meetings will be planned as well as a permanent communication network and other ongoing activities.

We thank everyone who attended for their support in making this Summit so successful. We look forward to a future of working as a coalition to keep the momentum going!
Influenza Viruses Disease among all age groups. Rates of infection are highest among children, but rates of serious illness and death are highest among people over 65 years of age and people of any age with medical conditions that place them at increased risk for complications from influenza.

Influenza vaccination is the primary method for preventing influenza and its severe complications. Such vaccination helps reduce influenza-related respiratory illness, complications, physician visits, hospitalization, and death among people at high risk.

While antiviral drugs have been developed to reduce the symptoms and complications of the disease, different strains of influenza virus have different degrees of resistance to the drugs, and the effectiveness of these drugs is limited. For this reason, vaccination is a far more effective way to control influenza.

The Biology of Influenza

The influenza virus is a RNA virus of the family Orthomyxoviridae (the influenza viruses). Two types of influenza viruses cause human disease: Influenza A and B. Influenza A viruses are categorized into subtypes on the basis of antigenic properties of viral hemagglutinin (H) and neuraminidase (N). Antigens are the body recognizes as foreign; as a result, the body reacts with antibodies to these antigens. Influenza B viruses do not have identified subtype categories.

The influenza A and B viruses are further separated into groups on the basis of antigenic (immune response) characteristics. Influenza virus variants result from frequent antigenic drift. Antigenic drift is the tendency of a virus to alter its genetic makeup over time. This process can produce a strain that can combat the altered virus. When this occurs, a new vaccine is required. As a consequence, people need repeated vaccinations to protect them from the altered viruses. Influenza B viruses undergo antigenic drift less rapidly than influenza A viruses. A person’s immunity to the surface antigens, hemagglutinin, reduces the likelihood of infection and severity of the disease if infection occurs. An antibody against one influenza virus type or subtype confers little or no protection against another influenza virus type or subtype. Frequent development of antigenic variants through antigenic drift is the virologic basis for seasonal epidemics and the reason that each year the new strains must be included in the latest influenza vaccine.

Signs and Symptoms

Uncomplicated influenza illness is characterized by the abrupt onset of nasal congestion and respiratory signs such as fever, muscle pain headache, malaise, nonproductive cough, sore throat, and rhinitis. Among children, nausea, vomiting, and otitis media are commonly reported symptoms. Adults with symptoms alone, respiratory illness caused by influenza is difficult to distinguish from illness caused by other respiratory pathogens.

Among certain individuals, influenza can exacerbate underlying medical conditions such as pulmonary or cardiac disease, lead to secondary bacterial pulmonary or primary influenza viral pneumonia, or occur as part of a co-infection with other viral or bacterial pathogens. Young children with influenza infection can have high fever, tachycardia, and respiratory distress declines during the first week of symptoms alone, respiratory illness caused by influenza is difficult to distinguish from illness caused by other respiratory pathogens.

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Effectiveness of TIV

Over time, the effectiveness of TIV has been amply demonstrated. Multiple studies have established that high vaccination for children and adults can reduce the severity of illness from influenza. Influenza vaccination helps reduce influenza-related respiratory illness, complications, physician visits, hospitalization, and death among people at high risk.

Influenza vaccines contain killed viruses, and thus cannot produce signs or symptoms of influenza infection. TIV is approved for use among individuals over 6 months of age. The vaccine is safe and well tolerated, and one that is recommended for the current season. TIV contains killed viruses and has a potential to produce mild symptoms related to influenza infection. It is FDA-approved only for use on healthy individuals ages 5 to 49 years of age and is administered intranasally by spray.

Influenza Vaccines

Two types of vaccine are available in the United States: Tetivalent inactivated vaccine (TIV) and live attenuated influenza vaccine (LAIV). Tetivalent inactivated vaccine (TIV) contains hemagglutinin (H) and neuraminidase (N) antigens from influenza A(H1N1) virus, one A(H3N2) virus, and one B virus. Each year, based on global surveillance for influenza viruses and the emergence and spread of new strains, one or more virus strains might be included. Viruses grown in eggs. The vaccines differ in several aspects. TIV [tetravalent inactive vaccine] contains killed viruses, and thus cannot produce signs or symptoms of influenza infection. TIV is approved for use among individuals over 6 months of age and is safer among those with underlying health conditions. TIV contains killed viruses, and thus cannot produce signs or symptoms of influenza infection. TIV is approved for use among individuals over 6 months of age and is safer among those with underlying health conditions.

LAIV [live attenuated influenza vaccine] contains live, attenuated viruses and has a potential to produce mild symptoms related to influenza infection. It is FDA-approved only for use on healthy individuals ages 5 to 49 years of age and is administered intranasally by spray.

Dosage recommendations vary according to age group. Annual vaccination is recommended among young children by approximately 30%.

The immunity provided by LAIV has been assessed in multiple studies. The LAIV vaccine strain replicates primarily in the cells of the nasopharynx. Its protective mechanisms are not completely understood but they appear to be effective.
to involve antibodies in both serum and nasal secretions. In studies, LAIV demonstrated up to 92% efficacy in preventing influenza in healthy children. It was also associated with reductions in otitis media (ear infections).

In a controlled study of both LAIV and TIV among 92 healthy adults, the overall efficacy against all three influenza strains combined was between 85% and 71%. The difference between the two vaccines was not statistically significant.

Multiple studies have demonstrated the ability of LAIV to stimulate an immune response (immunogenicity). LAIV is an option for vaccination of healthy, nonpregnant individuals aged 5 to 49 years who want to avoid influenza, and those who might be in close contact with others at high risk for severe complications, including healthcare workers.

LAIV can be administered to clients with minor acute illnesses (e.g., diarrhea or mild upper respiratory tract infection with or without fever). However, if clinical judgment indicates nasal congestion is present that might impede delivery of the vaccine to the nasopharyngeal mucosa, deferral of administration should be considered until resolution of the illness.

The following populations should not be vaccinated with LAIV:

- People under 5 years or over 50 years of age
- People with asthma, reactive airways disease, or other chronic disorders of the pulmonary or cardiovascular systems; people with other underlying medical conditions including metabolic diseases as diabetes, renal dysfunction, and hemoglobinopathies; or people with known or suspected immunodeficiency diseases or who are receiving immunosuppressive therapies
- Children or adolescents receiving aspirin or other salicylates (because of the association of Reye syndrome with wild-type influenza virus infection);
- People with a history of group-B strep (GBS)
- Pregnant women
- People with a history of hypersensitivity, including anaphylaxis, to any of the components of LAIV or to egg

The safety and effectiveness of LAIV co-administration with influenza antiviral medications has not been studied. However, because these antivirals reduce replication of influenza virus, LAIV should not be administered until 48 hours after cessation of influenza antivirals, and however, because these antivirals reduce replication of influenza virus, LAIV should not be administered until 48 hours after cessation of influenza antivirals, and

VACCINATION PROTOCOLS

Vaccination efficacy depends primarily on the age and immune status of the recipient, whether the viruses in the vaccine match the viruses in circulation, and the outcome being measured. Individuals with moderate-to-severe febrile illness should not be vaccinated until their symptoms abate. However, minor illnesses with or without fever do not contraindicate use of influenza vaccine, particularly among children with mild upper-respiratory tract infection. During periods of influenza activity, only two classes of anti-viral drugs are available in the United States: neuraminidase inhibitors and M2 inhibitors (adaminante derivatives).

Neuraminidase Inhibitors

Neuraminidase inhibitors are antiviral drugs such as oseltamivir (Tamiflu) and zanamivir (Relenza). They are designed to block a viral enzyme (neuraminidase) present in the influenza virus that helps the virus escape from infected cells. These drugs are sometimes effective against influenza A and B and have been found to reduce symptoms and complications. Because different strains of influenza viruses have differing degrees of resistance to these antivirals, they may not be effective in a future pandemic.

M2 Inhibitors

M2 inhibitors are antiviral drugs such as amantadine and rimantadine. They are designed to block a viral enzyme (M2) present in the influenza virus that helps the virus escape from infected cells. These drugs are sometimes effective against influenza A and B and have been found to reduce symptoms and complications. Because different strains of influenza viruses have differing degrees of resistance to these antivirals, they may not be effective in a future pandemic.

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POST TEST

1. Influenza is a contagious respiratory illness that causes mild to severe illness but is never fatal.
   a. True
   b. False

2. Which of the following symptoms are commonly associated with influenza in adults?
   a. Sudden onset of fever with diarrhea and vomiting
   b. Sudden onset of fever with headache and diarrhea
   c. Sudden onset of fever, headache, tiredness, cough, sore throat, runny nose, and body aches
   d. Gradual onset of fever with headache, cough, and sore throat

3. Influenza is spread through direct and indirect contact with virus-laden droplets.
   a. True
   b. False

4. The primary method for preventing influenza and its severe complications is:
   a. Vaccination.
   b. Antiviral medications.
   c. Handwashing.
   d. Isolation.

5. Influenza A viruses are categorized into subtypes on the basis of their:
   a. Effects on specific age groups.
   b. Surface antigens.
   c. Presence in certain geographical regions.
   d. Mortality rates.

6. Antigenic drift is:
   a. Immunocompromise due to poor health habits.
   b. Poor immune response to established viruses.
   c. Alteration of the genetic makeup of a virus.
   d. Movement of viruses globally in a pandemic.

7. Healthy adults who have influenza may be able to Infect others:
   a. One day before getting symptoms and up to 5 days after getting sick.
   b. One week before getting symptoms and up to 2 weeks after getting sick.
   c. Only after they are symptomatic.
   d. Only before they are symptomatic.

8. The risks for complications of influenza are spread equally across all age groups.
   a. True
   b. False

9. Live attenuated influenza vaccine (LAIV) may cause mild, flu-like symptoms because:
   a. It contains live virus.
   b. It is given in two doses.
   c. It is more potent and also more effective.
   d. Attenuated strains have greater virulence.

10. Trivalent inactivated vaccine (TIV) contains dead viruses and is approved for administration to anyone over six months of age.
    a. True
    b. False

11. Live attenuated influenza vaccine (LAIV) is administered:
    a. Intranasally to infants under 6 months of age.
    b. Intranasally to people aged 5 to 49 years.
    c. Intranasally to adults over age 50.
    d. Intramuscularly to children under age 5.

12. Improved antibody response is apparent when:
    a. Adults receive two vaccine doses in the same season.
    b. Children receive two vaccine doses approximately four weeks apart.
    c. Children with mild febrile illness are vaccinated after their symptoms have abated.
    d. Children receive a priming dose in the spring, followed by a second dose after the onset of flu season.

13. When used to inoculate healthy adults, TIV and LAIV are equally effective.
    a. True
    b. False

14. LAIV must be stored:
    a. In a refrigerator.
    b. In a freezer box within a standard freezer.
    c. At 0°C.
    d. In a frost-free freezer.

15. Antiviral drugs such as zanamivir and oseltamivir can be given as a substitute for the influenza vaccination.
    a. True
    b. False

Registration Information for Influenza Update 2008

To receive contact hours and a certificate of completion for this module, complete the post test and send it along with the completed registration form and a $10.00 check to: Wild Iris Medical Education, PO Box 257, Comptche, CA 95427. If your score is below 70%. A new copy of the post test will be sent to you at no additional charge.

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Select one answer for each question.

1. This course covered the objectives.
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2. This course took 60 minutes per contact hour to complete.
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3. This offering met my professional and educational learning needs.
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4. The manner in which this material was presented was effective.
   Agree______ Somewhat agree______ Neutral______ Somewhat disagree______ Disagree______

5. The course material was presented in an understandable manner.
   Agree______ Somewhat agree______ Neutral______ Somewhat disagree______ Disagree______

6. The course was accurate and current.
   Agree______ Somewhat agree______ Neutral______ Somewhat disagree______ Disagree______

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For questions or more information please call ANA/C at 916-447-0225. Members will receive instructions for parking and entry into the office building at that time. Thank you.

December 31, 2008—Golden State Nursing Foundation deadline for the Tony Leone and Catherine Dodd Scholarship applications—Completed applications must be post-marked and/or received in the ANA/C California offices no later than this date. Should you have questions or would like more information please feel free to give a call to 916-447-0225.

January 1—Ballot and Bylaws Mailed

February 1—Ballot must be postmarked to office

February 9—Newsletter deadline for articles

February 20—BVNPT Board Meeting in San Diego

March 1 and 8—ANA/C Board Meeting and New Member Orientation Sacramento

April 26 and 27—RN Lobby Days

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RN Lobby Days 2009
Sunday, April 26, 2009 & Monday, April 27, 2009

See page 7 for more information
American Nurses Association \ California
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