President’s Perspective

Elissa Brown
President, ANACalifornia

Greetings,

Spring is coming... new beginnings... the time when we will continue to help others, and renew ourselves.

And, Happy Nurses Week—coming in May. The 2012 theme is “Nurses—Advocating, Leading, Caring.” In today’s political and healthcare climate, we face many challenges while trying to advocate, lead, and care; some ongoing, some new.

In keeping with that theme, here we are in the midst of a major election year. How wonderful that we live in a country where we have the right to vote; to participate in elections and decision making on local, state and national levels. Moreover, consider that it is a duty, an obligation, as well, and whatever your political leanings, do exercise that right to vote. Learn about the topics of concern, the varying sides of discussions, the candidates and their views, and the possible issues and outcomes at stake.

These are exciting times, with so many avenues for communication—TV, radio, social media—that we cannot miss being informed. Like it to evidence-based practice; base your thinking and decisions on the evidence, the knowledge you gain. We need to respect one another and differing viewpoints and to agree to disagree.

We also have the ability to be involved in decision making in all places of work. The same principles should be at play. With the focus on self-governance at all levels, everyone may have a role in deciding how to provide the best environment for staff to provide the best care for patients and families. Encourage your colleagues to get involved in constructive activities. Ask to be on those committees that are of interest to you, and will afford an opportunity to play a role in improving the quality of care. Become familiar with strategic planning, and how the goals of your workplace relate to everyday practice. Know and feel that you can make a positive difference—in the care you deliver, in teaching and sharing information, and in the improving the overall picture.

Being involved strengthens our nursing voice. As I have noted before: with over 360,000 nurses in California—Nurses are a strong and caring force in healthcare and in the local, state, national and international communities. The Board of Registered Nursing has the power to help shape the healthcare of our state. Nurses are a part of every aspect of the system of care. Join ANAC today and be involved in making our communities stronger and why you live.

It is a duty to vote,

Elissa Brown
President, ANACalifornia

We Almost Lost the Board of Registered Nursing!!!

Honorable Tricia Hunter, RN, MN

At regular intervals, every Board, Bureau, and Commission has to go through a sunset review process to establish that they still are relevant and meeting their mission. Over the years, the process has been used to force boards to make changes that the Associations may not have supported. Because the bills required to sunset the Board had to be passed, issues were frequently pushed in the legislation that were controversial.

The sunset review is the process of re-establishing a Board, Bureau, or Commission. The process takes two years. In the first year, a report is written based on questions asked by the Assembly and Senate Business and Professions Committees and then a hearing is held to review the report and allow the committee members to ask questions. The Assembly and Senate Business and Professions Committees alter the responsibility of the Sunset Review process. If everything goes correctly, the Committee will recommend the Board, Bureau, or Commission continue functioning and a bill is introduced in the following year from the Business and Professions Committee Chairperson.

Sunrise is the process of establishing a new Board, Commission or Bureau. It is a very detailed report required by the Business and Professions Committee that describes the public need and purpose for the Board, Bureau, or Commission. Each entity must also be financially independent of the state budget.

Governor Brown had several Sunset Bills sent to his desk this year. A number of these bills had language in them that had nothing to do with the Board being “sunseted” or had new requirements for the Board. Governor Brown does not believe policy bills should be in the same bill that determines whether or not a Board, Bureau, or Commission should continue. If the Governor doesn’t like the language, his only option is to sunset a board that he may believe should continue. Before 2011, a Board would have become a Bureau if the Governor vetoed the bill. The Bureau would have all the authority of the Board. The Governor now has the authority to enforce the laws of the Board. In 2011, legislation was passed that eliminated the creation of the Bureau. Now, if the Governor sunsets a Board, the laws stay on the book, but nobody can enforce them!

The Governor had discussions with the Legislative Leadership about his vision for the sunset of a Board, Bureau, or Commission. When the BRN Sunset Bill was going through the process, the Governor’s office notified the author and the Senate Business Professor’s Committee that they had concerns about language in the bill and wanted it removed. The language had to do with allowing six boards, under Title 16, to hire sworn and non-sworn officers. The Board of Registered Nursing has the
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• 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 appear.

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2. Photographs should be of clear quality. 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 c/o ANA\CALIFORNIA 1221 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 ANA\C shall be The Nursing Voice. The purpose of this publication shall be to support the mission of ANA\C 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 opinion or views of ANA\C, its staff, the Board of Directors, our Affiliates 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 every January, April, July and October and is complimentary to ANA\C members, schools of 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.

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Inside this issue:

Article Submittal to ‘The Nursing Voice’

ANA\C California accepts and encourages manuscripts and editorials 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, ANA\C 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 ANA\C, its membership, the board of directors or its staff.

ANA\C California’s official publication, ‘The Nursing Voice’ editorial guidelines and due dates for article submission is as follows.

1. Manuscripts should be word processed and double-spaced on one side of 8 ½ x 11 inch white paper. Manuscripts should be emailed to Editor at TheNursingVoice@yahoo.com

2. Photographs should be of clear quality. 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 c/o ANA\CALIFORNIA 1221 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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In June of this year, the American Nurses Association (ANA) of Delegates and convention will be in the Washington, D.C. area. Our elected delegates from California will be there, and will bring knowledge from our members and other Nurses as we address the issues at hand, and engage in the business of the association. After we return, we shall include reports and articles about the happenings at the ANA House, to keep California Nurses informed.

Issues: Health Care Reform: continues to be in the news; check the American Nurses Association website and the American Nurses Association website: www.nursingworld.org, for the latest information about healthcare reform, health care issues and nursing issues; also a video link to: ‘Nurses Have Power: Let’s Use It for Change.’ Also see on the nursingworld.org link to the “Key Provisions Related to Nursing and Health Care Reform.” Nurses continue to be a significant “caring” force in healthcare reform, through their work, community and political involvement at local, state and national levels.

Thank you to our ANACalifornia Board members who continue to work hard, to promote quality healthcare for the public, participate in healthcare reform and support the Nursing profession.

ANACalifornia wants to hear from our members about what you more would like to see in the way of programs, outreach, and opportunities for involvement.

Please keep your membership in ANA or join if you have not done so. ANA is the professional nurses association in California open for all RNs. I encourage you as always to join your professional nursing associations; to join at least two associations: your professional general organization, ANA California, and your specialty organization; the networking opportunities alone are worth it.

Reminder: ANA has 4 officers with clear responsibilities, and four Board Directors, each with a specific focus, i.e., Practice, Education, Legislation and Membership. Board members work together, making for a strong association dedicated to nursing. Nurses can be involved either on committees with the Directors or at least on their mail groups. Some groups have only ANAAC members, others include nonmember nurses; however those who vote must be ANAAC members.

Contact us at ANAAC, about how you would like to be involved in ANAAC activities.

A Future of Nursing Update: Members of ANAAC and other nurses are involved with the California Action Coalition—the Statewide CAC and local groups, continue working together to address nursing’s future in California. As mentioned before in the Nursing Voice, ANAACalifornia is quite involved on committees and coalitions, and has strong representative leadership in the CACs, regionally and statewide. As the regional Co-Leader for the Los Angeles area, along with Dr. Rosie Curtis, we are working on activities in the L.A. area. Please check our website for updated information, links and opportunities to become active participants. (Reference: The Future of Nursing: Leading Change, Advancing Health, by the Committee on the Robert Wood Johnson Foundation Initiative on the Future of Nursing, at the Institute of Medicine; (2010).)

Other issues: BRN updates; ongoing issues, state and national, continue with Health Care Reform; with bills related to nursing practice, and more. See our website for more information. ANAAC will keep you updated.

Visit the American Nurses Association website: www.nursingworld.org for the latest information about healthcare issues, health care reform and professional nursing issues on a national level. Registered Nurses are a trusted “caring” power in healthcare. Please take advantage of the opportunities to get more involved through work, professional associations and the community—at local, state, national and international levels.

Ongoing national: many healthcare reform issues continue being discussed; including the future of nursing initiatives. I continue vice Chairperson of the Executive Committee of the ANA Constituent Assembly (CA; the group of the Presidents and Executive Directors of all of the states plus a number of other constituents). I shall share with you any updates on the issues. We have regular calls with the ANA President, and with regional groups.

My continuing appreciation to our current and future members, to our reliable, diligent ANAACalifornia Board members, who give their volunteer time and to staff—who all promote quality healthcare for the public, participate in future of nursing programs, support the nursing profession, ANAACalifornia and ANAAC.

And thank you to all nurses for what you do. Be kind to each other.

Comments, questions and suggestions are welcome.

“When you learn, teach, when you get, give.”

Maya Angelou

Celebrate National Nurses Week with the ANA Every year from May 6 to 12, the ANA celebrates National Nurses Week. The 2012 theme is “Nurses—Advocating, Leading, Caring.” ANAAC offers a full line of products with the new theme and logo that can be purchased throughout the year. Celebrate your nurses by purchasing the official National Nurses Week products at www.nurseweekgifts.com.

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*Celebrate National Nurses Week with the ANA” text is redacted.
New Report on the Distribution of APRN Practice Location Zip Codes

The American Nurses Association and the Rural Health Research Center (RHRCC) at the University of Washington have issued a report, “Understanding Advanced Practice Registered Nurse Distribution in Urban and Rural Areas of the United States Using National Provider Identifier Data.” The study focused on NPs and CRNAs (because there were relatively few CNM and CNS observations.) The study found that in States that granted more practice autonomy, NPs were more likely to practice in rural locations. In addition, male NPs and CNMs were more likely than females to be in rural locations. Efforts to encourage more men to choose careers as NPs or CRNAs could likely benefit rural communities.

The analysis was conducted using data distilled by ANA from the National Provider Identifier (NPI) data to identify the location of individual APRNs who had been issued an NPI as of March 2010. There were 152,185 individual APRNs in these data. Under contract to ANA the RHRCC matched the zip code recorded for the APRN’s practice location with a code from the set of rural commuting area (RUCA) codes, a location taxonomy that breaks urban-rural distinctions into 33 different categories ranging from urban core areas to isolated rural ones. For both NPs and CRNAs, 15.2% of APRNs had a practice location that was in a rural area. For CRNAs, 7.3% of the rural practices were in isolated rural areas; for NPs the comparable statistic was 16.4%.

The national ratio of rural NPs was 2.8 per 10,000 population compared to the urban ratio of 3.6 NPs per 10,000. At the state level, those states with the highest rural ratio of NPs were N.P. per capita ratios were generally found in New England, the Northwest, and the South Central portions of the United States and the lowest ratios in the Southwest, and the South East. States with the lowest rural NP ratios were Nevada, Utah, and Texas. Those having the highest ratios were New Hampshire and Alaska. Three states (New Hampshire, New Jersey, and Illinois) had the same or greater rural than urban per capita NPs with NPs.

The national ratio of rural CRNAs was 0.9 per 10,000 population while the urban ratio was 1.2 CRNAs per 10,000. More states with high rural population ratios were found in the Midwest than other regions of the country, with the lowest ratio found in the West. NPs and CRNAs were generally found in New England, the Northwest, and the South Central portions of the United States. At the state level, the highest CRNA ratios were in Kansas and New Hampshire. The states with the lowest rural CRNA ratios were Nevada, Utah, and Texas.

The study examined the relationship between state and individual-level characteristics and the probability of rural practice for NPs and CRNAs. The factors associated with practice autonomy or autonomous practice included: (1) characteristics of the state like a rural or urban designation; (2) collaboration or supervision; (3) delegation or autonomous practice; (4) autonomy of practice by state; and (5) policy variables. Autonomous practice states had the highest CRNA ratios and the lowest rural NPs ratios. The factors included state population size, the presence of advanced practice RNs, and the availability of CRNAs. The study found that the states that did not allow autonomous practice for APRNs had lower ratios of CRNAs and NPs.

The study found that states with the highest rural NP ratios were those with autonomous practice for APRNs. The states with the lowest rural NP ratios were those with a policy of supervision or collaborative practice. The study found that states with the highest rural CRNA ratios were those with autonomous practice for APRNs. The states with the lowest rural CRNA ratios were those with a policy of supervision or collaborative practice. The study found that states with the highest rural NP ratios were those with autonomous practice for APRNs. The states with the lowest rural NP ratios were those with a policy of supervision or collaborative practice.

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In order to understand the future of nursing, specifically the Doctorate of Nursing Practice (DNP) study, ANA/CA decided to interview someone who is currently in the midst of this study. We chose our ANA/Advocacy Institute grant winner, Candace (Candy) Campbell, MSN-HCSM, RN, who is currently enrolled at the University of San Francisco DNP program in the Clinical Nurse Leadership (CNL) track. Here’s what we learned.

ANA/CA: “What in your prior professional life inspired you to take on yet another degree?”

CC: My passion in nursing has been twofold: to advance nursing as a profession, and to improve nursing practice in the areas of maternal-child health. As a student nurse, I already had earned a B.A. in Speech Communication/Theatre, which was a great help personally and professionally. I served as President of my local chapter of CSNA (then known as SNAC), and on the State Board as Editor of the bi-monthly newspaper, Range of Motion for a two-year term. That experience helped establish an interest in nursing public policy, and how it relates to the field of Communication on the local and state level. (Hopefully, nursing students who read this will make it their business to think outside the school, and get involved in statewide nursing issues!)

Scroll ahead several years after (three children were nearly grown), when concerns about the problems nurses face (specifically HMOs, burnout, single parenting, and moral distress) became two-one-person shows around the themes of nursing and healthcare. Both creative pieces were attempts to facilitate change by heightening awareness, through art. The first, Whatever Happened to My Parachute? was performed for a total of 16 months in San Francisco, in 1998. This show generated media attention and added to the public debate, which led to several speaking engagements and media appearances to discuss healthcare problems.

Meanwhile, in the mid-90s, on the clinical side, new studies emerged on the behavioral and developmental health of the premature infants we cared for in the NICU. My curiosity was piqued. That curiosity became a five-year qualitative research project around the question: How does a premature birth impact the family? In 2003, the film Hypoparachute Babies: How Low Can You Go? (based on the research), won an award from the prestigious International Medical Media. The award helped garner educational distribution, and the film found it’s way to universities, libraries and individuals on four continents.

Some valuable learning took place during this time, which impacted my nursing philosophy and practice. I realized that, (a) one determined person can actually complete research without a PhD, and (b) achievement within the nursing community is rarely recognized without at least three letters following one’s name. With an eye towards more effective implementation of change, I determined to continue my education with a master’s in nursing.

In the interim, my practice work led to an administrative post as Program Nurse for the Northern California Region of the state Newborn Hearing Screening Program. I was fortunate to share the experience of building the program from the ground up (literally, as we functioned without furniture for three weeks) with two Audiologists. This was a great experience utilizing the nursing process in a non-clinical environment. I was responsible for the education and certification of 120 hospitals, tracking NICU patients in all of Northern CA, and case-managing a portion of the out-patient population. Communication skills proved helpful during these times. My MSN in Healthcare Systems Management culminated in four months spent under the watchful wings of Myrna Allen, MSN, RN and the Honorable Tricia Hunter, MN, RN, our ANA/CA advocates, in Sacramento. You two helped me learn so much about the political process, healthcare coalitions, and how to advocate for the nursing profession. It was a life-changing experience, and I recommend it to anyone who wants to learn more about healthcare advocacy!

ANA/CA: “Tell us which part of the fundamentals of the DNP caused you to continue your studies?”


ANA/CA: Would you elaborate on that?

CC: When you think of healthcare policy in general, it sounds a bit abstract. But you need to think of the bit about how healthcare relates to nursing advocacy, it really lit a fire under me.

Our modern world is so complex. In terms of health-related issues, the US budget strains with the weight of carrying an incoherent national public health policy. There are so many looming socio-behavioral problems, including: infectious diseases, and chronic conditions (smoking, obesity, risky sexual practices, etc.), human trafficking, to name a few. Add to the list the elderly population surge (that’s many of us!), and we’ve got problems according to the Government Accounting Office (GAO), increased fiscal requirements “will increase in coming decades as more members of the baby-boom generation retire and become eligible for federal programs.”

By nature of our training and experience, the DNP prepared nurse already possesses useful skills to help solve problems of this magnitude. We do not focus on conducting scientific research, but the application of it. We have the ability to analyze health policy from the perspectives of health care providers, and consumer advocates. (AACN, 2006). We are all part of the change-making process, and influence decision-makers from the local to the national level. We are also trained to evaluate the efficacy of existing systems of healthcare delivery, and to generate and work to resolve ethical and legal issues that arise (AACN, 2006).

Ask yourself: Who already enjoys the highest public trust? Nurses. Which has been voted the most ethical of all professions for nine consecutive years? Nursing (Gallop polls, 2011). In fact, since legislators and lobbyists once turned to nurses to consult when making policy, nurses don’t focus on conducting scientific research, but the application of it. We have the ability to analyze health policy from the perspectives of health care providers, and consumer advocates. (AACN, 2006). We are all part of the change-making process, and influence decision-makers from the local to the national level. We are also trained to evaluate the efficacy of existing systems of healthcare delivery, and to generate and work to resolve ethical and legal issues that arise (AACN, 2006).

ANA/CA: And the second point?

CC: In the public arena, DNP graduates are trained to unpack problems and analyze trends, and utilize information from epidemiology, biostatistics, occupational, environmental, health you name it (AACN, 2006). We bring value by communicating closely with the evolving person, as well as the bigger players. This ability to bridge two worlds qualifies us to develop programs, and to advocate for the future. Our unique learning provides us an integrated view of possible solutions within the arena of public health that focuses on preventative teaching, and holistic management of chronic illness here, and abroad. The opportunities are limitless.

We’ve all heard of the studies which indicate that patient outcomes and satisfaction with DNP nurses is statistically the same as the same with the care given by medical doctors (Elwell & White, 2011; Kuehn, 2009). This is really a green-light for nurses. Doctorally prepared nurses are well-suited to open patient-friendly healthcare clinics, and provide a level of primary health service. Our advanced practice status is applicable to remote/isolated settings (Kuehn, 2009) where medical doctors are scarce, as well as urban areas, where the DNP can help fill the supply of medical doctors (Elwell & White, 2011).

ANA/CA: So where do you see yourself in 5 years?

CC: Of course, I’m not sure about that, but as a probationary doctoral student, I have already received offers for advancement. The first was the opportunity to teach master’s level students at USF, to which I gladly agreed. (I love teaching. For me, it seems like the perfect combination of Theatre and Nursing.) Another was the grant given me by the ANA Advocacy Institute, to under the tutelage of nurse-policy experts in Washington D.C. for a year. This has been such fun and so invigorating! What a responsibility, to advocate on the national level for nurses. I am honored and humbled by this ongoing experience.
In less than five years, I may apply for a gubernatorial appointment. And there’s also the possibility of running for public office. We’ll see. Although advanced education is not a pre-requisite for those positions, I want to complete the degree first. One thing is for sure: There are so many opportunities for nurses to help mold public policy. (It is worth mentioning that presently, we have a CA legislature with elected representatives, which includes no nurses. Considering California registered nurses number > 300,000, we could easily elect nurse-candidates, if more nurses would run for office!)

Clinically, my dream of opening a women and children’s health clinic was the catalyst for my entrance into a doctoral program. In five years, I hope to be helping other nurses open similar clinics.

All in all, despite the grueling work/study schedule, I feel blessed beyond measure to be in the DNP program, and am eager to absorb as much as possible. I want to encourage other nurses who are also over age 50 to consider the DNP, because they understand the concept of finishing well by making a difference. This has become very important to me. I feel guided by the spiritual concept of serving humanity in every possible endeavor. This was the mission to which Florence Nightingale called nurses (Christian Heroes, 2011).

Simply put, the DNP will help us help more people.

References
Reliving the Legacy of Margaret Sanger, RN

Angela Schwab, BSN, PHN, RN

Presidential election years are extremely crucial to our democratic process. ANA and nurses are at the heart of the concern for women’s health that occupied a century ago. She was a nurse who stepped up in an era of paternalism and fought for the public health of the world by making sure women had reproductive and personal health choices. Her impact led to political change and gave women the right to take control over their own healthcare through the commencement of Planned Parenthood. She brought about education and changed the ways nurses counseled patients on what some deemed controversial women’s health issues such as birth control, pregnancy, abortion, and sexually transmitted diseases. She had an enormous impact on women’s ability to control their own healthcare. Thanks to Sanger’s defining actions, nurses today know that it would be extremely negligent to recommend the rhythm method of birth control to a pregnant or breastfeeding woman for that matter. It is hard to imagine a day when nurses had to contemplates potential legal ramifications if they distributed educational materials or contraceptives. Planned Parenthood gave nurses and women an opportunity to seek counsel, educational materials, contraceptives, and sensitive procedures that previously carried the treat of the law. As someone who has been on both sides of the nurse patient relationship, I am extremely thankful that as a nurse I can educate my patients and assist them with the implementation of their healthcare decisions. As a patient, I am beyond appreciative that at the end of the day I have the ability to make the decisions about my body autonomously.

Undoubtedly, Margaret Sanger’s legacy inspires the nurses of today to stay strong in their battles to protect the integrity of healthcare. It is truly unfortunate that healthcare and patient’s rights remain in debate. I believe that nurses have an important opportunity this year to make sure our voices are heard. More people are watching and participating in the discourse, and we need to be part of the conversation. The dedicated nursing community has worked hard educating our patients to take responsibility for their health to allow Planned Parenthood to come under attack. Defending an organization like Planned Parenthood is more than a political statement it is a direct attack on the autonomy of women, and the importance of listening to nurses not the least of which is Sanger. Every day nurses hold the hands of women suffering through heart disease, breast cancer, gynecologic issues, fertility issues, to name a few. Nurses understand that women’s health requires different assessment skills. Sadly, this truth gets lost in the current political debate. Instead of putting the protection of healthcare at the center of the table, money has become the driving force of politics. It is unfortunate that power and money from a few are impacting legislation in an unproportionate way. Lobbying does not need to be a scandalous affair. It can impact change that greatly affects nurses at the bedside. In order for nurses to make this kind of impact we must join together and make sure our voice is not ignored. ANA is working hard and fighting to make sure the knowledge of nursing is not disregarded. We are not “just nurses,” we are the men and women that (among other things) educate the public on health and wellness. We are fighting to make sure patient’s rights are upheld. There is a reason we are the most trusted profession, and have been for quite some time. That is because the voices of our profession speak the truth.

Important changes should be about numbers and knowledge, not money that comes from few large donors. Representing seventy percent of the healthcare workforce, nurses as a group are united, knowledgeable, and are becoming a voice in this political time. We urge nurses to join ANA so that in unity we can protect what Margaret Sanger put in place. Now is the time to make sure that nurses have a seat at the table, where do we start? Together, we can assure that the future of healthcare is based on policy not politics. Heath care is changing and nurses should be guiding the discussion.

How Value-Based Purchasing is Changing Nursing

Rebecca Hendren, for HealthLeadersMedia, June 14, 2011

The advent of value-based purchasing has thrown everyone into a mad scramble. You can’t stand in a group of nurse executives without hearing someone ask about how others are improving their patient satisfaction or shifting to accountable care organizations (ACO). It’s not just talk. “Value-based purchasing is a game changer,” says Lillie Gelin, MSN, RN, FAAN, vice president and chief nursing officer at VHA Inc.

On a long-term scale, it has everyone wondering how on earth they will achieve so much—from improved patient experience to sustainable quality outcomes—in such a short time. As hospitals plan how to best operate in this new world, it’s worthwhile taking the time to reevaluate who should be working on what.

Porter-O’Grady recently presided over a meeting of 100 VHA CNOs and says it was one of the most successful CNO meetings VHA has ever held because rather than focusing on a specific topic, such as value-based purchasing, the group focused on innovation and how to develop strategies that will help organizations achieve transformation.

One of the meeting’s “a-ha!” moments came when Speaker Tim Porter-O’Grady shared a conversation he had with a CEO. The CEO was talking about his passion for patient care and how he was working on improving it. Porter-O’Grady responded that CEOs should not be concerned with things with which they have no competency. The importance of organizations ensuring proper role delineations is critical. Geriatric CNOs, Gelin says it’s important that people who are competent to do so are responsible for the right things. The C-suite should be responsible for the context of care, while front line direct caregivers must be responsible for the content of care. Confusion over these two only results in inertia and everyone trying to do everything.

“The context of the organization is owned by the c-suite. You (CNO) are responsible for the context of care, meaning the environment, the culture, the behavioral standards, the organization’s mission. The content of care is owned by the caregivers. When it comes to transforming care at the bedside, taking waste out of work, that’s what caregivers have to do and that’s the context through which you’re involved in provision of care decisions as akin to a radiologist trying to do heart surgery. What is far more important is what leaders do to empower their leadership, cultural change, transformation, ensuring the organization enforces standards of behavior and codes of conduct, and that the values of the organization are in alignment with its mission.”

“The hammer has fallen,” says Gelin. “First we had the tsunami of value-based purchasing and the realization...
The initial part of this century’s first decade exhibited national health expenditures increased by $258 per year. Have increased by roughly $100 million per year. Per capita of a steady state. On average, national health expenditures accelerated from the prior year; other cases exhibited expenditures increased. In some cases growth had coverage, etc. However, the data with respect to 2010 sources of funds, differences in spending between expenditures reached $2.6 trillion, which translates to of the National Health Expenditure Accounts. Total health Team.

The report, as always, goes into a great deal of detail we have not only different types of health care services: sources of funds, differences in spending between government programs and privately insured health coverage, etc. However, the data with respect to 2010 for the most part were unremarkable compared to the prior year and the year before that. Growth continued; expenditures increased. In some cases growth had accelerated from the prior year; other cases exhibited deceleration. In no case reported in the CMS highlights did any expenditure category exhibit absolutely lower expenditures.

The U.S. from 2007-2010 appears to be in somewhat of a steady state. On average, national health expenditures have increased by roughly $100 million per year. Per capita national health expenditures increased by $258 per year. The initial part of this century’s first decade exhibited somewhat higher increases: $134 million per year and approximately $400 per year, respectively.

“Social Media can be a powerful tool, one with the potential to enhance or undermine not only the individual nurse’s career, but also the nursing profession,” said ANA President Karla D. Auley, PhD, RN, FNP, FAAN. “ANA hopes these principles provide a framework for all nurses to maintain professional standards in a world where communication is ever-changing.”

ANA’s e-publication, “ANA’s Principles for Social Networking and the Nurse,” provides guidance to registered nurses on using social networking media in a way that protects patients’ confidentiality and inherent dignity. This publication is available as a downloadable, searchable PDF, which is compatible with most e-readers. It is free to ANA members on the Members-Only Section of www.nursingworld.org. Non-members may order the publication at www.nursebooks.org. ANA also provides additional resources at its Social Networking Principles Toolkit page.

NCSBN’s white paper “A Nurse’s Guide to the Use of Social Media” can be downloaded free of charge at https://www.ncsbn.org/Social_Media.pdf. NCSBN is also developing an electronic version of its popular Social Media Guidelines for Use for Social Media, on Oct. 25 featuring Nancy Spector, PhD, RN, director, Regulatory Innovations, NCSBN and Jennifer Mensik, PhD, RN, NEA-BC, ANA board member and administrator for Nursing and Patient Care Services at St. Luke’s Health System in Boise, Idaho.
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C/o ANA
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