Hello Colleagues,

Well it has really happened—my term as ANA\C President was completed on March 6, 2015. In my last President’s Perspective I spoke about the three Cs—Collaboration, Coalition and Incivility: Advocacy for Election Results and the Capitol Registration of Ethics for Nurses 2015—Save the Date!

In December of 2014 I had the opportunity to attend the two day Second Annual ANA Immersion Conference for state Presidents and Executive Directors. Thirty-one (31) states were represented. The first Immersion Conference was for President’s only but the post-evaluations showed the Executive Directors needed to be added. Many topics were addressed. All included the theme of support and coordination of ANA organizational offerings and the states incorporation of these offerings into their operations. Here is an overview of the conference:

- Standards of Excellence for non-profit associations were presented.
- ANA’s Mission, Vision and Value statements were reviewed.
- The need for clear definitions of governance and operational duties was strongly suggested.
- The development of a strategic plan which then in turn can be used to assess the effectiveness of the Board of Directors was discussed at length. Those states that prepared operationally to fulfill the assessment of their Boards using the strategic plan as a measurement were few. It was suggested the strategic plan be developed midway through the Board term. This would allow the Board to come together and begin to function as a unit and subsequently better identify the directionality of the Association for the future.

- Finances – No organizational/operational conference goes without a portion of the agenda devoted to finances. ANA was one of very few states that had Quarterly Profit/Loss webinars. Assets, liabilities and equities along with reserve ratios were advised to be routinely included in the Profit/Loss webinars.

- State bylaws being in harmony with ANA bylaws – ANAC gets an A+ for this item. Thank you to our Bylaws Committee – Kathy Falco, RN and Susan Bowman, RN. Presently the Committee is in the process of preparing needed proposed ANAC bylaw changes which will be submitted to the ANA bylaw committee prior to the 2015 Membership Assembly, thereby assuring harmony between the ANA and ANAC bylaws.

- Membership numbers and data collection/retirement procedures need to be included in the strategic plan being programmed that will allow for monthly reporting including certain analyses. ANA is beginning to track new grad data but data is not available at the state level at this time.

This was an extremely informative program. It gave me time to review my term and compare it to the expectations identified by ANA of the state president’s role.

We were asked what our legacy will be at the end of one’s term. This gave me time to reflect. I had believed that two years was too short a period of time to develop let alone leave a legacy — then I made a list. I have identified my contributions:

- I established a Board of Directors calendar that was cast in stone. This allowed your Board to plan their calendars knowing the dates for the Board meetings would not change.
- As I said before the establishment of task forces utilizing Board and non-Board members allowed for more creativity, flexibility and openness of the Association. Task forces are short term and allowed the Association to complete an assignment and move on to another task at hand. Some of the task forces formed were the Magnet Status recognition process, the Association Awards procedure including documentation of past award recipients on the website under the leadership of Treasurer Donna Dolinar, RN, the General Assembly task force under the leadership of Vice-president Dianne Moore, the development of a Conflict Resolution process under the leadership of the Director of Practice Elissa Brown, the refinement of the ANAC exhibiting activity with other organizations under the leadership of Membership Director Phillip Bautista, RN.
- Policies/Procedures – the dreaded assignment we all still struggle with. Most of your Board thought they left the review/revise/archiving of policies/procedures in the direct patient care arena. Well your Board almost made it until a well hidden bylaw requiring biannual review of all of the ANAC policies/procedures was identified to me by the Bylaws Committee. I want to publicly acknowledge and thank the Board of Directors for a stellar job well done. I can say to you today – all the ANAC Board of Directors.

A Call for ANA\C Bylaw Proposals

Each year at the ANAC General Assembly, proposed amendments to the ANAC Bylaws are voted on by the membership. If you would like to have your idea put to a vote at the next General Assembly, please contact the Bylaws Committee Co-Chair, Kathy Falco at kfalco@anacalifornia.org. Kathy can help to guide you through the proposal process. We look forward to seeing you at the General Assembly in October!
1. Letters, Articles and Manuscripts should be word processed and double-spaced on one side of a 8 ½ x 11 inch white paper. Manuscripts should be emailed to Editor at TheNursingVoice@anacalifornia.org or mailed to: ANA\California 1121 L Street, Suite 508 Sacramento, CA 95814 Fax to: 916.442.4394

2. Photographs should be in jpeg format and emailed with the name of the Letter, Articles or Manuscript referenced in the subject line. Email to TheNursingVoice@anacalifornia.org Photographs should be of clear quality. Write the name(s) of the persons displayed in the photo in the order in which they appear in the body of the email.

3. E-mail all narrative to TheNursingVoice@anacalifornia.org

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Update on the New Code of Ethics for Nurses

Elissa Brown, ANA/C Director for Practice

Update: the recently revised Code of Ethics for Nurses is now available for purchase in print, and for viewing through ANA at nursingworld.org.

This article shares some of the words and wisdom from a recent ANA webinar: “Keeping the Code: Every Nurse’s Obligation.” The presenter, Marge Hegge, Chair of the Steering Committee for revising the Code, discussed some of the details about the revision process, changes and implications for nursing practice. Those who tuned in also participated in scenario discussions. Many thanks to the American Nurses Association (ANA) and Dr. Hegge for the information incorporated into this article.

It is important for nurses to remember that the Code of Ethics for Nurses is recognized as a “legal standard;” it is “integrated into nurse practice acts,” and can be and has been “used as evidence in competency hearings, disciplinary proceedings and malpractice cases.”

Some additional highlights from the webinar are:

1. This is an “inclusive code,” for all nurses in all roles in all settings, i.e., staff nurses, nurse directors, managers, educators, APRNs, researchers, regulators, students, unemployed RNs, Nurse volunteers in disasters, military nurses in any country.

2. With data from over 2700 responses to an online nursing survey, it was determined that the code needed updating. Reasons included the changes in healthcare delivery, technology, and public and global health.

The basic call to nurses is that they commit to the values and ideals of the code.

A steering Committee was established, plus a large Ethics Advisory Panel, to provide more input. Efforts were made to keep the document easier to navigate, use more clear, understandable, timeless language and to avoid divisive, controversial or political stances.

The new Code has an introduction, preface, and 9 provisions-with resources, an afterward and glossary.

The presenter noted two “radical declarations:”

Provision 8 which states that “Healthcare is a universal right”

Provision 1.4: Nurses may not act with intent to end life even though such actions may be motivated by compassion, respect for autonomy or quality of life considerations.”

Major changes in the new Code, for the “nurse” and in the areas of:

Research and evidence-informed practice, care coordination and advocacy, interdisciplinary collaboration, ethical practice environments, moral distress, incivility, bullying, end of life care and social media and genetics. Work environment is addressed, including responsibility of Administrative nurses to maintain ethical environments and support nurse autonomy; recognizing conscientious objection; whistle blowing without reprisal and addressing issues of incivility and bullying.

Changes for the nursing profession are in the areas of:

“the nurse’s voice in social justice and health policy,” nursing as a global united profession, and international collaboration to address: Climate destabilization, violence and terrorism, emerging epidemics, and other global threats to health.

The presenter, Dr. Hegge, stated the emphasis in the revised Code is on:

“inclusiveness of all nurses…, relationship with other caregivers, including unlicensed personnel, conscientious objection, increasing diversity…, nursing as a lifetime endeavor.”

Hopefully, all nurses will use the code, and learn how it can help them in their everyday practice.

ANA has designated the theme for this year as “Ethics.” The theme for National Nurses Week is: “Ethical Practice: Quality Care,” May 6-12.

Be looking for dates of future Webinars, to enable more nurses to participate and become familiar with the revised Code.

And a 2015 ANA Ethics Symposium designed to facilitate dialogue across the nursing spectrum, will be on June 4-5, 2015, in Baltimore.

The third National Nursing Ethics Conference in L.A. will have occurred before this newsletter is published. Please be looking for the next local Ethics of Caring Conference coming in March 2016.

The ANA Nursing Voice newsletter, the ANA website and the ANA website, will have additional ethics programs information.

Dr. Hegge ended her informative webinar with this interesting quote:

“Do the right thing. It will gratify some people and astonish the rest.” ~ Mark Twain
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ANA Urges Support for Bill to Increase Veterans’ Access to APRNs’ Services

SILVER SPRING, MD – The American Nurses Association (ANA) applauds Representatives Sam Graves (R-MO) and Jan Schakowsky (D-IL) for their leadership in introducing the “Improving Access to Care Act of 2015.” The bill, H.R. 1247, allows Advanced Practice Registered Nurses (APRNs) who work in Veterans Health Administration (VHA) facilities ‘full practice authority.’ Full practice authority means allowing APRNs to practice to the full extent of their education and training and provides a common-sense solution to the challenges associated with ensuring America’s veterans have access to high quality health care services.

“This legislation will make a big difference in meeting the health care needs of our nation’s veterans,” said ANA President Pamela Cipriano, PhD, RN, NEA-BC, FAAN. “As the VA works to address staff shortages that have contributed to delays in veterans’ access to care, an important first step is to remove barriers that prevent APRNs from providing a full range of services.”

APRNs are advanced practice registered nurses who have completed formal graduate education leading at least to a master’s degree in nursing, and increasingly to a doctor of nursing practice degree, in one of four APRN roles that provide primary, preventive and chronic care: nurse practitioners (NP), certified nurse-midwives (CNM), clinical nurse specialists (CNS) and certified registered nurse anesthetists (CRNA).

Currently, APRNs who work in VHA facilities are subject to the laws of the state in which they are licensed. While some states have removed restrictive practice regulations, in other states APRN faces regulations that limit their scope of practice, with veterans’ access to care suffering as a result.

By recognizing APRNs, this bill is consistent with the recommendations of the Institute of Medicine report The Future of Nursing: Leading Change, Advancing Health, and with proposals recently introduced in Congress.

Additionally, VHA recognition of APRN full practice authority would make the VHA consistent with the models already practiced by the U.S. Armed Forces, Indian Health Service and Public Health Service systems where veterans can now use their VHA health benefits under the Veterans Access Choice and Accountability Act of 2014 (P.L. 113-185).

ANA joins other national nursing organizations, representing more than 240,000 APRNs, in calling on Congress to support this legislation.

APRNs are playing an increasing role in American health care delivery. Passage of the Home Health Planning and Improvement Act will reduce Medicare spending. Medicare has recognized the independent practice of APRNs for nearly two decades, and these health care professionals now provide the majority of skilled care to home health patients. These delays in access to home health services inconvenience patients and their families and can result in increased costs when patients are unnecessarily left in more expensive institutional settings.

ANA Applauds Introduction of Bill Recognizing APRNs’ Ability to Sign Home Health Plans of Care for Medicare Patients

SILVER SPRING, MD – The American Nurses Association (ANA) applauds Senators Collins (R-ME) and Schumer (D-NY) for introducing S.578, the Home Health Care Planning and Improvement Act of 2015. This bill would amend a quirk in the Medicare law which has kept advanced practice registered nurses (APRNs), a group that includes nurse practitioners, clinical nurse specialists, and certified nurse midwives, from signing home health care plans and from certifying Medicare patients for the home health benefit. The bill is estimated to reduce Medicare spending by $1.5 billion over a decade.

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SILVER SPRING, MD – The American Nurses Association (ANA) is spearheading an initiative to reduce catheter-associated urinary tract infections (CAUTIs) — one of the most common and costly infections contracted by patients in hospitals — through an assessment and decision-making tool registered nurses (RNs) and other clinicians can use at the bedside to determine the best way to provide care.

The initiative to implement the streamlined, evidenced-based tool into nursing practice nationwide is aimed at decreasing CAUTIs, which cause serious harm and even deaths, and increases in costs. Federal figures show CAUTIs affect 560,000 patients per year, which account for about 30 percent of all infections acquired in a hospital. Research indicates that 70 percent of the urinary tract infections — 380,000 cases and 9,000 deaths — could be prevented through consistent application of infection-control best practices.

The CAUTI Tool, designed to prevent harm and save lives, incorporates best practices based on Centers for Disease Control and Prevention (CDC) guidelines. The CAUTI Tool is a one-page guidance to assist clinicians in determining whether a urinary catheter is appropriate to insert; recommending alternative treatments for urinary retention and incontinence; evaluating indicators for timely catheter removal to prevent harm; and following a checklist on catheter insertion and cues for essential maintenance and post-removal care.

“Nurses can have a big influence on reducing urinary tract infections, since they are continually assessing patients to minimize the use of urinary catheters, and have sharp assessment and decision-making skills that will be enhanced by this concise guidance,” said ANA President Pamela F. Cipriano, PhD, RN, NEA-BC, FAAN. “The CAUTI Tool is a great example of how nurses, physicians and other health care team members can collaborate on strategies that work best for patients.” The CAUTI Tool and effective implementation strategies will be introduced to nursing leaders across the country at ANA’s National Quality Conference Feb. 4-6. ANA also will disseminate the CAUTI Tool to the nation’s RNs, federal agencies and health care systems, geriatric and infection-prevention organizations, and other associations.

ANA, along with the Partnership for Patients (Partnership) and the CDC, convened a technical expert panel to develop the CAUTI Tool. The Partnership, which includes hospitals, health care professionals, patient advocates, employers and government, is seeking to reduce hospital readmissions and harm that occurs during hospital stays, such as infections. The Partnership reports significant reductions in several types of hospital-acquired conditions; however, CAUTI rates continue to increase, largely because many factors can contribute to CAUTI and no universally accepted tool exists among clinicians for CAUTI prevention. To fill this gap in infection-prevention, ANA developed the CAUTI Tool. Fourteen hospitals participated in the Partnership’s pilot program to test and refine the CAUTI-reduction approach, and reported positive results.

These ANA affiliates contributed to the development of the tool: Association of peri-Operative Registered Nurses; Academy of Medical-Surgical Nurses; Association of Rehabilitation Nurses; and Wound, Ostomy and Continence Nurses Society.

For more information: Preventing infections using the CAUTI Tool.

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

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The Year of Ethics Commences with First Revision of Code Since 2001 (1/6/15)

ANA Plans Ethics Educational Activities for 2015 to Highlight Importance in Nursing Practice

SILVER SPRING, MD – Making decisions based on a sound foundation of ethics is an essential part of nursing practice in all specialties and settings. In recognition of the impact ethical practice has on patient safety and the quality of care, the American Nurses Association (ANA) has designated 2015 as the “Year of Ethics” highlighted by the release of a revised code of ethics for the profession.

“...the actual and anticipated ethical actions and decisions experienced by nurses and the potential impact of those actions on patients and the community," said ANA President Pamela F. Cipriano, PhD, RN, NEA-BC, FAAN. “ANA believes it’s important that all nurses practice at the highest ethical level, and therefore, we will be offering a full range of activities to inform and support nurses to achieve that goal in a stressful and ever-changing health care environment.”

A December Gallup survey ranked nurses as the top profession for honesty and ethical standards for the 13th consecutive year.

The foundation of the 2015 ethics initiative is the revised Code of Ethics for Nurses with Interpretative Statements, which was released Jan. 1. Several thousand registered nurses submitted comments during a four-year revision process for the new Code of Ethics, which was last updated in 2001. The update ensures that the Code reflects modern clinical practice and evolving conditions, and fully addresses transformations in health care.

Activities emphasizing the importance of ethics in nursing practice include:

A Jan. 21 live webinar, “Keeping the Code: Every Nurse’s Ethical Obligation,” with other webinars planned throughout the year.

The National Nurses Week theme, “Ethical Practice. Quality Care,” May 6-12.

The 2015 ANA Ethics Symposium designed to facilitate dialogue across the nursing spectrum, June 4-5 in Baltimore.


In 2014, ANA participated as a strategic partner in the National Nursing Ethics Summit convened by the Johns Hopkins University’s Berman Institute of Bioethics and School of Nursing to strengthen ethics in the profession. The summit resulted in the Blueprint for 21st Century Nursing Ethics: Report of the National Nursing Summit. Summit leaders are encouraging individuals and organizations to adopt and implement the ethics blueprint to “create and support ethically principled, healthy, sustainable work environments; and contribute to the best possible patient, family and community outcomes.”

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Promoting RN Health, Safety, and Wellness

Are you a healthy nurse and a role model for wellness? Too often, RNs neglect their own care and health, forgetting to take the advice they give their patients. Stress, fatigue, poor diet, lack of exercise and time, as well as occupational health risks, threaten nurses’ health on a daily basis. RNs need to practice self-care to ensure they are at their optimal health level. The American Nurses Association (ANA) defines a healthy nurse “as one who actively focuses on creating and maintaining a balance and synergy of physical, intellectual, emotional, social, spiritual, personal and professional wellbeing. A healthy nurse lives life to the fullest capacity, across the wellness/illness continuum, as they become stronger role models, advocates, and educators, personally, for their families, their communities and work environments, and ultimately for their patients.”

Furthermore, ANA has developed the following HealthyNurse constructs:

Calling to Care
- Caring is the interpersonal, compassionate offering of self, as nurses build relationships with their patients and their families, while helping them meet their physical, emotional, and spiritual goals, for all ages, in all health care settings, across the care continuum.

Priority to Self-Care
- Self-care and supportive environments enable the nurse to increase the ability to effectively manage the physical and emotional stressors of the work and home environments.

Opportunity to Role Model
- The healthy nurse confidently recognizes and identifies personal health challenges in themselves and their patients; enabling them to help their patients to overcome the challenge in a collaborative, non- accusatory manner.

Responsibility to Educate
- Using non-judgmental approaches, considering adult learning patterns and readiness to change, nurses must empower others by sharing health and safety knowledge, skills, resources, and attitudes.

Authority to Advocate
- Nurses are empowered to advocate on numerous levels, including personally, interpersonally, within the work environment and the community, and at the local, state, and national levels in policy development and advocacy.

To assist RNs on their wellness journeys, ANA, in collaboration with Pfizer Inc, created a health risk appraisal (HRA). This HRA assists participants in identifying their health, safety, and wellness risks personally and professionally. The HRA is divided into three general categories: demographics, occupational health, and health/safety/wellness. Participants can compare their personal results against ideal standards and national averages. Participants can also access an interactive wellness portal for further resources. A heat graph allows participants to easily evaluate their results: red denotes high risk, yellow medium risk, and green low to no risk. It takes approximately twenty minutes to complete the HRA. Participation in the HRA will help to build a unique nurse-specific personal and occupational health-related aggregated data base. Secure and HIPAA-compliant, the HRA is free and available to all RNs and nursing students. Take the HRA today at www.anahra.org.
Legislative Orders Audit of Department of Consumer Affairs and the Board of Registered Nursing

Hon. Tricia Hunter, RN, MN

In 2013 the Department of Consumer Affairs launched an aggressive program to update the computer systems for the 43 Boards, Bureau’s, and Agencies. The implementation of this system has caused delays at the BRN to approve students to take the NCLEX, licensing renewals, licensing endorsements from other states and countries. The Board staff have shared reports of having to hand process applications as the BreEZe system is modified and corrected.

The BreEZe system was supposed to decrease processing time and therefore reduce staff. It was supposed to reduce costs. In fact it has done just the opposite. At this time the Board has 16 temporary staff helping them process license applications, endorsements and renewals.

The BRN staff has been working long hours including many Saturdays to try to catch up on the backlog. The legislature has held hearings, after getting calls from constituents, about not being able to get their license. A process that use to be completed in six weeks is taking 3 months.

The California Board of Nursing has 409,000 licenses. IT is a large enough board to have a computer system that is tailored to the unique needs to Registered Nurses. The Bureau of Automotive Repairs licensing issues are very different from the Board or Registered Nursing. The uniqueness of the Boards should be reflected in the systems they purchase. BreEZe has been a very expensive system, that we have had to pay for through our licensing fees.

If you want to see the full report there is a link on the BRN website www.rn.ca.gov or you can go to http://www.auditor.ca.gov/

California Department of Consumer Affairs’ BreEZe System:
Inadequate Planning and Oversight Led to Implementation at Far Fewer Regulatory Entities at a Significantly Higher Cost

HIGHLIGHTS
Our audit concerning the California Department of Consumer Affairs’ (Consumer Affairs) planning, development, and implementation of BreEZe—an information technology (IT) system envisioned to support all primary functions and responsibilities of its regulatory entities—revealed the following:

- Consumer Affairs failed to adequately plan, staff, and manage the project for developing BreEZe.
- It did not effectively assess the regulatory entities’ business needs to determine system requirements.
- Inadequate system requirements led to significant delays at key stages of the project.
- It relied on faulty assumptions in selecting a commercial “off-the-shelf” system as the foundation for BreEZe, which contributed to an increase in project costs—from $28 million in 2009 to $96 million as of January 2015 for half of the entities originally planned.
- It did not have adequate staffing to execute and implement BreEZe through critical project phases.
- Between December 2010 and September 2014, the California Department of Technology’s (CalTech) independent oversight raised nearly 180 significant project concerns, yet both CalTech and Consumer Affairs’ officials allowed the project to continue without significant intervention.
- Despite significant problems with the BreEZe project, CalTech approved additional funding for it.
- The California Department of General Services and Consumer Affairs revised the BreEZe contracts’ terms and conditions, at the request of the project vendor, in ways that significantly increased the financial risk to the State.
- As of January 2015, only 10 regulatory entities had transitioned to BreEZe, eight more intend to transition in March 2016, and it is unknown if the remaining 19 regulatory entities will implement BreEZe.
- Most executive officers of the 10 regulatory entities that had transitioned to BreEZe reported that it has decreased their regulatory entity’s operational efficiency.
- Due to lack of evidence, the Board of Registered Nursing’s claim that the implementation of BreEZe caused inefficiency in processing applications could not be substantiated.

RESULTS IN BRIEF

The California Department of Consumer Affairs (Consumer Affairs) encompasses 40 boards, bureaus, committees, and a commission (regulatory entities) that regulate and license professional and vocational occupations to protect the health, safety, and welfare of the people of California. Annually, these regulatory entities process more than 350,000 applications for professional licensure and an estimated 1.2 million license renewals. The regulatory entities establish the minimum qualifications and levels of competency for licensure, register or certify practitioners, investigate complaints, and discipline violators. Although these entities are responsible individually for activities related specifically to the professions they oversee and they are semiautonomous bodies whose members are appointed by the governor and the Legislature, Consumer Affairs establishes general administrative policies for them and provides them with administrative support.

Historically, the regulatory entities have used multiple computer systems to fulfill their required duties and meet their business needs. However, significant issues with these systems reportedly resulted in excessive turnaround times for licensing and enforcement activities, impeding the ability of the regulatory entities to meet their goals and objectives. In 2009, after undertaking several unsuccessful efforts to develop or procure an information technology (IT) system that would improve the capabilities of the regulatory entities it administratively supports, Consumer Affairs proposed, and the California Department of Technology (CalTech) approved, BreEZe—a system Consumer Affairs envisioned would support all of the primary functions and responsibilities of its regulatory entities. Unfortunately, this has not been the case.

The work Consumer Affairs undertook on the BreEZe project has lacked adequate planning. Although an up-to-date assessment of business needs is critical to the successful development of an IT project, Consumer Affairs failed to properly perform such an assessment for its regulatory entities when developing the system requirements, resulting in requirements that did not adequately reflect the individual needs. According to our IT expert, system requirements define a business problem to be solved and specify what the system should do. For example, a system requirement for a regulatory entity could be that the system allow the entity to record the date it receives an application. In planning the BreEZe system, Consumer Affairs should have taken steps to ensure that the system requirements were based on the current business needs of its regulatory entities, so that the resulting system would aid the entities in conducting their business operations and in fulfilling their regulatory responsibilities. Instead, when developing the requirements for BreEZe, Consumer Affairs relied on requirements for earlier projects that were abandoned.

Because Consumer Affairs did not properly determine the business needs of its regulatory entities, it incorrectly assumed, for example, that the entities could use similar business processes to process applications and issue licenses. This misconception, coupled with the fact that the Consumer Affairs IT project team did not effectively assess the regulatory entities’ business needs to determine system requirements, led to a significant increase in project costs—from $28 million in 2009 to $96 million as of January 2015 for half of the entities originally planned.

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Affairs wanted BreEZe to be developed quickly, informed Consumer Affairs’ decision to select an existing commercial “off-the-shelf,” or COTS, system as the foundation for BreEZe. Consumer Affairs believed that this type of product, rather than a custom-developed system, would require only moderate modifications and resources to implement. These faulty assumptions have led to significant project delays and a substantial increase in the estimated costs of the project, from $28 million in 2009 to $96 million as of January 2015, for implementation of a system that will include only half of the regulatory entities originally planned for BreEZe. Thus, it appears that Consumer Affairs’ selection of this COTS product may not have been the most appropriate and most cost-effective decision.

In part, because the foundation of BreEZe—its system requirements—was inadequately developed, the BreEZe project has experienced delays at key stages of the project. The most extreme delay involved the key milestone of user acceptance testing—testing that future users of the system conduct to confirm that the system operates as specified. User acceptance testing for the 10 regulatory entities included in the first implementation of BreEZe (phase 1) was originally planned to occur over an eight-week period, instead it spanned 11 months, from the end of November 2012 to October 2013, significantly exceeding the original time frame. This likely occurred in part because the BreEZe system had almost 1,700 unresolved system defects at the beginning of user acceptance testing. According to our IT expert, many of these defects were likely attributable to the poor development of the system requirements. Although user acceptance testing is one of the final and more critical procedures undertaken before system implementation to ensure that the system operates appropriately, in this case it morphed into a redesign of the requirements and a rework of the system. Specifically, in conducting the testing of the system, some of the 10 regulatory entities included in the first phase of implementation, as well as Consumer Affairs itself, learned that the system did not operate as they expected or needed. Had Consumer Affairs performed a complete, current assessment of the regulatory entities’ needs when determining the system requirements for BreEZe, some of the delays the project has experienced might have been avoided.

Further, although CalTech began providing independent oversight of the BreEZe project approximately one year after the project’s inception, neither CalTech nor Consumer Affairs responded appropriately to the significant and persistent concerns that the CalTech staff and consultants charged with overseeing the project were raising. In addition to having the statutory authority to suspend or terminate IT projects, state law assigns responsibility for IT project oversight to CalTech; this project oversight mainly consists of two types of independent oversight. Independent verification and validation (IV&V) is used to ensure that a system satisfies its intended use and user needs. Independent project oversight (IPO) is used to ensure that effective project management practices are in place and in use. In their reports from December 2010 through September 2014 on the BreEZe project, the CalTech IV&V consultant and the IPO specialist raised nearly 180 significant concerns relating to project management, staffing, system requirements, and vendor performance. According to our IT expert, the volume and significance of these concerns should have prompted both CalTech and Consumer Affairs to analyze fully the costs and benefits of suspending or terminating the project versus proceeding. However, although Consumer Affairs officials and CalTech management were fully aware of these concerns, neither group took sufficient action to ensure that these concerns were appropriately addressed; instead, they allowed the project to continue for more than three years without significant intervention.

Given CalTech’s authority and the numerous concerns the IV&V consultant and the IPO specialist raised about the project, we question why CalTech did not take steps to ensure that Consumer Affairs heeded its advice. For instance, CalTech could have formally warned Consumer Affairs that it would suspend the project if Consumer Affairs did not bring the project back into alignment with its planned scope, cost, and schedule. As an example, the estimated cost to complete the project had almost tripled to $78 million and the project had experienced significant delays in its schedule before completion of user acceptance testing. We believe these problems, along with the significant cost increases the project had already experienced, should have been enough to elicit CalTech’s greater involvement in the project. Instead, it approved Consumer Affairs’ Special Project Report (SPR) 2, which requested additional funding for the project, in October 2013.

Consumer Affairs submitted SPR 3 to CalTech in June 2013; in it, it requested additional funding and estimated the costs to complete the project through phase 2 at $118 million. However, it was not until after Consumer Affairs informedly estimated the cost of completing the project had risen to $300 million that same month that CalTech changed its oversight approach on the BreEZe project.1 Although CalTech approved SPR 3 in July 2014, according to the BreEZe project director, Consumer Affairs withdrew its submission of SPR 3 upon direction from CalTech and the California Department of Finance in September 2014.

As discussed previously, CalTech has the authority and responsibility to oversee IT projects. If CalTech had chosen to suspend the project, BreEZe development would have been paused temporarily, giving Consumer Affairs additional time to conduct a cost-benefit analysis and correct fundamental problems, such as requirements issues, that occurred during planning and development. However, in October 2014 the CalTech director—who has overseen the BreEZe project since Consumer Affairs executed its contracts with the project vendor, Accenture LLP (Accenture)—told us that CalTech has not halted BreEZe development.

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for several reasons: because BreEZe is moving in the right direction, because the system’s problems are not incurable, and because the system is working and functional. 1 However, Consumer Affairs’ SPR 3.1, which it submitted to CalTech in January 2015, indicates the project is not moving in the right direction and proposes a rescoping of the project because of significant concerns relating to staffing and increasing project costs, and because its contracts with Accenture are no longer financially feasible for Consumer Affairs. For these reasons, among others, the future implementation of BreEZe is uncertain at best and, as it relates to the regulatory entities originally included in the final phase (phase 3), likely unfeasible. As of January 2015, direction, because the system’s problems are not incurable, relates to the regulatory entities originally included in the implementation of BreEZe is uncertain at best and, as it

According to the director of Consumer Affairs’ director of Consumer Affairs, these 19 regulatory entities, and as of January 2015 lacked the funding to fill those positions. Additionally, it is unknown whether or when the remaining 19 phase 3 regulatory entities will implement BreEZe. Specifically, CalTech officials indicated that it completed renegotiating Consumer Affairs’ design contract with Accenture on December 1, 2014, and according to Consumer Affairs’ director, these 19 regulatory entities had been removed entirely from the project. Although the director of Consumer Affairs maintains that the department intends to implement BreEZe at those 19 regulatory entities, it lacks a plan to do so. In fact, SPR 3.1 indicates that the project will end after the phase 2 regulatory entities implement BreEZe, and only after its successful implementation of that phase will Consumer Affairs reassess the best implementation approach for the phase 3 regulatory entities. However, the director of Consumer Affairs acknowledged that the department has not assessed the extent to which the business needs of the 19 regulatory entities will require changes to the system. Moreover, Consumer Affairs has not conducted a formal cost-benefit analysis to determine whether BreEZe is the most cost-beneficial solution for meeting those needs. Additionally, the contracts Consumer Affairs executed with Accenture for developing BreEZe do not adequately protect the State. Consumer Affairs approved the BreEZe contracts with Accenture in September 2011, under the direction of the California Department of General Services (General Services). Although its role at that time was to administer state IT procurements and conserve the fiscal interests of the State, General Services and Consumer Affairs agreed to revise the contracts’ terms and conditions during the procurement process, at Accenture’s request, in ways that significantly increased risk to the State. During the request for proposal (RFP) bidding period (RFP phase), General Services provided every potential bidder with the opportunity to submit a protest for issues such as the selection of prequalified bidders or RFP requirements before submitting a bid and to have General Services review its concerns. During the RFP phase in the BreEZe procurement process in January 2011, only Accenture submitted a protest, in which it proposed modifications to the State’s standard IT general provisions and model contract language (standard IT contracts). Of the 44 modifications to the State’s standard IT contract that Accenture proposed, General Services accepted 18, proposed its own revisions to 19, and rejected just seven. Subsequently in April 2011, in accordance with state law, Consumer Affairs entered into a negotiation with Accenture during which further changes were made to the contract, with General Services’ approval. However, some of those accepted changes to the standard IT contract’s terms and conditions decrease Consumer Affairs’ ability to obtain rights to work product that Accenture builds if Consumer Affairs terminates the contracts early, and they reduce Consumer Affairs’ financial protections in the event of intellectual property rights violations. Although General Services cited reasons for approving the modified terms and conditions in the BreEZe contracts, we question the prudence of some of the decisions it and Consumer Affairs made, as they increased Consumer Affairs’ financial risks related to these contracts. CalTech’s current authority over procurements for IT projects, a role that was not in place at the time the BreEZe contracts were being negotiated, together with its authority for approving and overseeing IT projects, position it well to ensure that future IT procurements do not jeopardize the State’s financial interests. Healthcare laws and regulations affect the nursing profession and the nurses’ ability to provide quality care. Understanding and using this insight is vital and ANA/C plans to educate nurses’ how to set policy and influence nursing and health care legislation on Monday, April 13th 2015. Join ANA/C RN Day - A day at the Capitol a legislative program giving the nursing community a unique perspective on health care policy and advocacy. Nurses and students will be given the tools they need to enhance the nursing profession through legislation. Teaching all nurses the importance of their voice. Join us for this exciting ‘hands on’ event in Sacramento, CA.

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The agenda is subject to change due to the availability of political persons

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inforation prior to the program.

Audited by California Association of Schools and Colleges (CASAC)

General Services

Monday

April 13th, 2015

Registration begins at 8:00am.
Audit continued from page 10

decreased since implementing BreEZe, it has requested additional staff; it believes it needs to process applications within required time frames. However, this request is based on data from the two fiscal years preceding BRN’s implementation of BreEZe. Thus, because the analysis BRN used to support its need for the additional positions does not reflect its current workload and business processes since implementing the BreEZe system, the additional positions it requested are not adequately justified.

Most of the executive offices of the 10 phase 1 regulatory entities are generally dissatisfied with their BreEZe experience because it has not met their expectations. We interviewed the executive officers of each of the regulatory entities that have implemented the system regarding various aspects of their experience with the project, including their satisfaction with BreEZe and their overall experience with the system. Each regulatory entity reported experiencing issues with certain aspects of the BreEZe project. For example, the majority were unsatisfied with the testing they were able to conduct before implementing the system, and most found the training to be inadequate. In addition, all 10 of the executive officers indicated that BreEZe’s reporting capability was unsatisfactory. Of greater concern, most executive officers reported that BreEZe has decreased their regulatory entity’s operational efficiency.

RECOMMENDATIONS

CalTech

To help ensure the success of the BreEZe project going forward, CalTech should ensure that Consumer Affairs responds promptly to, and adequately addresses, the IPO specialist and the IV&V consultant raise.

If Consumer Affairs receives the necessary funding and resources to successfully implement BreEZe at the phase 2 regulatory entities and the project continues to face escalating costs, CalTech should require Consumer Affairs to analyze the costs and benefits of moving forward with the project as planned versus suspending or terminating the project.

To ensure that future IT project procurements do not jeopardize the State’s financial interests, CalTech should document its reasons for approving any deviations from standard contract language.

Consumer Affairs

Consumer Affairs should develop a process to ensure that it undertakes all required oversight activities with respect to BreEZe so that it can prevent or identify and monitor any problems as they arise. This includes taking steps to sufficiently respond to any concerns the IPO specialist and the IV&V consultant raise.

To ensure that BreEZe is a cost-effective solution to meet the business needs of the phase 3 regulatory entities, should it elect to pursue implementing BreEZe at these entities, Consumer Affairs should first complete a formalized cost-benefit analysis. This analysis should include an assessment of the potential changes those regulatory entities may require to be made to the BreEZe system and the associated costs.

Consumer Affairs should continue to work with the phase 1 regulatory entities to ensure that the issues they are facing with BreEZe are being resolved in a timely manner.

BRN

To ensure that it has adequate data to effectively use its resources and manage its workload, BRN should do the following:

Formally track and monitor the timeliness of its:

• processing of applications by type and track the cause of any delays.

• Formally track and monitor the applications pending its review by type and original receipt date.

Conduct an analysis no later than June 30, 2015, of its application processing since implementing BreEZe to identify its workload capability. To the extent that it determines additional resources are necessary, BRN should submit a request for these resources that is appropriately justified.

AGENCY COMMENTS

Consumer Affairs and BRN agreed with our recommendations and outlined the actions they plan to take to implement them. Although CalTech states that its report’s recommendations are for the most part appropriate and in line with actions the agency is already undertaking, it explained that it has general concerns with the report and did not indicate whether it agrees with our recommendations. Our comments on CalTech’s response begin on page 125.

1 Although Consumer Affairs consists of 40 regulatory entities, only 37 of these entities were originally scheduled to implement BreEZe. Specifically, the Bureau of Real Estate and the Bureau of Real Estate Appraisers were brought under Consumer Affairs as a result of the governor’s reorganization plan, effective July 2013, after the BreEZe project was approved and underway. According to Consumer Affairs, it planned to implement BreEZe at these regulatory entities once the system was fully implemented at the 37 regulatory entities. Another entity, the Arbitration and Certification Program, does not issue licenses and will not be included in BreEZe.

2 An SPR provides a summary of proposed changes to the original project cost, schedule, or scope. An SPR is generally required when the project costs or total program benefits deviate or are anticipated to deviate by 10 percent or more, or a major change occurs in project requirements or methodology.

3 The BreEZe project team developed the estimate informally and not in the same manner as an SPR requires.

4 There are three contracts related to the BreEZe project— one contract for design, development, and implementation; another contract for maintenance support; and a third contract for the system license. When we discuss a specific contract, we identify it as either the design, maintenance, or system license contract.

5 At the time of the BreEZe procurement, General Services had several models of standard contract language related to IT contracts.

2015 RN Day – A Day at the Capitol -- Additional Information

For a complete list, include in your packet basic information prior to registering. A complete registration packet will be sent upon completion of registration.

1. Participants should register at least two weeks prior to the event. Late registrants are not guaranteed a position.

2. Please be sure and complete the registration form in its entirety. An incomplete form could cause a delay and positions are not guaranteed.

3. Large groups or schools of nursing should notify ANA/C staff no later than April 1st 2015 for guaranteed positions.

4. Email confirmation will be sent upon the receipt of registration form, which will include, but is not limited to; travel suggestions; overnight accommodations; directions to and from event location; your local representatives information and contact worksheet, etc.

5. The agenda is subject to change up to the date of the event, so check web site often as date approaches www.anacalifornia.org

6. Participants will be touring the Capitol, speaking with their representatives and attending committee hearings so business attire should be worn.

7. It is highly encouraged that participants schedule a meet and greet (even if there is not an issue or bill to discuss) with their local representative while in attendance at this event. Participants will receive a worksheet and contact information for their local representative upon registration.

8. Sign-in begins at 8:05 am in the Capitol Cafeteria (sixth floor – elevators are near the east entrance across from the Governor’s office). Security can direct you if needed.

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Quality Healthcare • Quality Lifestyle
Every year the BRN contracts with the University of California, San Francisco to conduct a survey or nursing programs. The report this year was conducted by Renee Waneka, MPH, Timothy Bates, MPP, Joanne Speiz, PhD. The report is a public document and available on the BRN website at www.ca.gov.

The survey collects data about nursing programs and their students and faculty from August 1 through July 31. Annual data presented in this report represent August 1, 2013 through July 31, 2014. Demographic information and census data were requested for October 15, 2014.

RN Program Response Rate 1 In this 2014 report there are 131 schools in California that offer a pre-licensure nursing program. Some nursing schools offer more than one program, which is why the number of programs (n=141) is greater than the number of schools. In addition, some schools offer their programs at more than one campus. In the 2013-2014 survey, 131 nursing schools reported data for 141 pre-licensure programs at 162 different locations.

The share of nursing programs that partner with another nursing school that offers a higher degree has been increasing since 2007-2008. In 2013-2014, 49% of nursing programs (n=67) collaborated with another program that offered a higher degree than offered at their own program. Of nursing programs that had these collaborations in 2013-2014, 52% (n=35) had formal agreements and 69% (n=46) had informal agreements.

Admission Spaces and New Student Enrollments
The number of spaces available for new students in nursing programs reached a high of 12,812 in 2008-2009 and has shown an overall decline since then. In 2013-2014, there were 10,691 spaces available for new students and these spaces were filled with a total of 12,365 students. This year represents the fourth consecutive year in which new student enrollments declined, after having increased every year in the five years prior to the 2010-2011 academic year. The share of nursing programs that reported filling more admission spaces than were available decreased, from 48% (n=68) in 2011-2012 to 43% (n=60) in 2013-2014. The most frequently reported reason for doing so was to account for attrition.

Applications
Nursing programs continue to receive more applications requesting entrance into their programs than can be accommodated. The number of qualified applications received in 2013-2014 decreased 16% (n=5,472) over the previous year. In 2013-2014, 58% of the 29,569 qualified applications to California nursing education programs did not enroll. Since these data represent applications and an individual can apply to multiple nursing programs, the number of applications is likely greater than the number of individuals applying for admission to nursing programs in California.

Enrollment
New student enrollments have been decreasing since 2009-2010 and are currently below levels seen in 2006-2007. In 2013-2014, 12,365 new students enrolled in registered nursing programs. ADN programs had a similar number of new students enroll in those programs over the last two years, while both BSN and ELM programs had enrollment declines. Both public and private programs had declines in the number of new students enrolling in their programs over the last three years. Public programs have seen their enrollments decline by 20% (n=2,019) in the last seven years, while private programs had enrollment growth until 2011-2012, when enrollment declines were experienced in those programs as well.

Student Census Data
The total number of students enrolled in California nursing programs on October 15, 2014 decreased in comparison to the previous year and is lower than any year since 2008. All program types saw decreases during this time period. Of the total student body in California’s pre-licensure nursing programs at the time of the 2014 census, 49% (n=11,502) were in ADN programs, 45% (n=10,574) in BSN programs, and 6% (n=1,473) in ELM programs.

Education Programs continued on page 13
NCLEX Pass Rates
Over the last ten years, NCLEX pass rates have typically been higher for ELM graduates than for ADN or BSN program graduates. Improved pass rates for ADN and BSN graduates and lower pass rates for ELM students have narrowed this gap in recent years. In 2013-2014, the highest average NCLEX pass rate was 85% for ADN graduates. All program types had declines in their NCLEX pass rates in 2013-2014 in comparison to the previous year. The NCLEX passing standard was increased in April 2013, which may have impacted the NCLEX pass rates in 2012-2013 and 2013-2014.

NCLEX pass rates for students graduated from accelerated nursing programs are generally comparable to pass rates of students who completed traditional programs. While the pass rates for both types of programs have fluctuated over time, students who graduated from accelerated ADN programs had the lowest average pass rate in 2013-2014, while graduates of accelerated BSN programs had higher average pass rates than their traditional counterparts.

Employment of Recent Nursing Program Graduates
The largest share of RN program graduates work in hospitals, even though this share has been decreasing from a high of 68% in 2007-2008. In 2013-2014, programs reported that 56% of graduates employed in hospitals. The share of new graduates working in nursing in California had been declining, from a high of 92% in 2007-2008 to a low of 64% in 2013-2013. In 2013-2014, there was an increase in the share of graduates working in California, to 69%. Nursing programs reported that 14% of their 2013-2014 graduates had been unable to find employment by October 2014, which has declined slightly from that reported a year ago.

Clinical Space & Clinical Practice Restrictions
The number of California nursing programs reporting they were denied access to a clinical placement, unit or shift decreased to 81 programs, the lowest in four years. Just under half of all nursing programs in the state (43%, n=61) indicated they were denied access to clinical placements, while 40% (n=57) were denied access to clinical units and 24% (n=34) were denied access to a clinical shift during the 2013-2014 academic year. The clinical site offered fewer alternatives for lost placements and units in 2013-2014 than in the previous three years but offered about the same number of alternative shifts. Access to an alternative clinical site depended on the type of space denied. A quarter of programs denied clinical placement were offered an alternative, compared to 47% of programs denied a clinical unit, and 74% of programs denied a clinical shift. The lack of access to clinical space resulted in a loss of 293 clinical placements, 118 units and 48 shifts, which affected 2,195 students.

Faculty Census Data
The total number of nursing faculty continues to increase. On October 15, 2014, there were 4,204 total nursing faculty. Of these faculty, 36% (n=1,498) were full-time and 62% (n=2,610) were part-time. The need for faculty continues to outpace the number of active faculty. On October 15, 2014, schools reported 432 vacant faculty positions. These vacancies represent a 9.3% faculty vacancy rate overall (11.9% for full-time faculty and 8.1% for part-time faculty), which is the highest vacancy rate reported in ten years.

NCLEX Pass Rates
After 14 days, up to $350/line. Credit approval required. Early Termination Fee (sprint.com/etf): After 14 days, up to $350/line. SDP Discount: Avail. for eligible company employees or org. members (ongoing verification). Discount subject to change according to the company’s agreement with Sprint and is avail. upon request for select monthly svc charges. Discount only applies to Talk 450 and primary line on Talk Share 700; and data service for Sprint Family Share Pack. Sprint $60 Unlimited Plan and Unlimited, My Way plans. Not avail. with no credit check offers or Mobile Hotspot add-on.

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President Dianne S. Moore, PhD, MN, MPH, CNM, RN

With many years in ANA, ANAC, ACNM (American College of Nurse-Midwifery), along with the Public Health Association Dianne has learned much from colleagues. Her prior experience as an Advanced Practice RN, serving both as a CNS and CNM has laid a strong foundation for understanding of nursing, i.e., the art and science of caring. Dianne’s time as a researcher, entrepreneur, faculty and administrator within clinical and education settings as well as being on the Board of Directors of a major LA hospital has given her a broad and unique perspective of health care.

Given her diverse background Dianne has the ability to be a representative and spokesperson for ANAC while working in concert with the many other nursing organizations. Having served on the ANAC Board as a Director and Officer she is very familiar with the workings of the organization. During the past several years she has also been a part of ANAC as it has updated its structure and membership.

Dianne believes as President it is important to implement the bylaws of the association. She will insure the new Bylaws are implemented, ANAC continues to grow membership, and be part of other nursing and health care organizations to insure the profession of nursing is heard and grows appropriately. ANAC has also been active within the legislature process.

Diane was the Vice President ANAC: Director of Education, ANAC: Representative ANA GA Washington DC; President California Association of Colleges of Nursing; Vice President COADN; ACNM National Nominations Committee; Assistant Editor Journal of Nurse Midwifery; Member ACNM Division of Education.

She is a BSN graduate of Hunter College CUNY; she received her MN from UCLA; her Certified Nurse Midwife from Downstate Medical Center; her Phd from New York University; and a MPH from Columbia University.

Dianne has held a number of positions in Education including the Director of Nursing at Pasadena City College; she was the Founding Dean at West Coast University; Associate Provost West Coast University and the Director of Nursing at Fresno City College.

Vice President
Corinne MacEgan BSN, RN, CHPN*

Corinne was the Communications Director for the California Nursing Students’ Association (CNSA 2011-2012). She communicated with over 2,000 student nurses through newsletters, e-mails, and the website. Corinne believes spreading the word about the mission and vision of ANAC is essential, as nurses cannot participate in what we do not see.

Corinne believes her experience with the CNSA Board working on bylaw amendments was great preparation for the Vice President role. Keeping bylaws current is an important part of keeping an association functioning smoothly. Reviewing policies and procedures is also integral to the success of an association in elections, consistency, professionalism, and efficacy.

From various CNSA board experience, and leadership within the Navy Reserve, she is confident in her skills of communication and negotiation. Currently she chairs the patient satisfaction committee on her floor at Sharp Chula Vista Medical Center, and write the quarterly staff newsletter which brings together nurses, staff, and physicians to ensure consistent connection. She introduced an Employee-of-the-Month program which has inspired her staff to go above and beyond for their patients. She took part in a Frontline Leadership Project through the Advisory Board Committee, focusing on a positive admission experience for patients and staff. She am presently working on her Masters of Nursing Education, with expected graduation in April 2016. Throughout this journey, she is increasing her skills in communication, leadership, and transforming healthcare. With healthcare in the spotlight, having leaders with new insights and experiences will empower and inspire California nurses to find their voice.

Corinne received an AA from Cuyamaca College in Spanish, an AS of Exercise Science; a BSN from San Diego State University and is currently enrolled in an MSN/EdD program. She is a Clinical Nurse in Medical/Oncology at Sharp Chula Vista Medical Center.

Secretary
Anne Hughes, APRN, PhD, FAAN

Anne believes that nursing has given her, and so many nurses’ like her opportunities to help, to learn, to teach, to serve and to lead. As a staff nurse and as advance practice nurse (NP/CNS) she has practiced in medical surgical inpatient care, critical care, home care, palliative care and hospice settings, and in long term care. She witnessed the impact of our profession on the lives and communities we serve. Anne believes serving as Secretary of ANA California both an honor and responsibility. Fulfilling the responsibilities of the Secretary will allow her to work closely with other Board members, staff and most importantly members in order to document our association’s activities, support nurse’s practice in a variety of settings, and advance our profession through advocacy, education and research.

Anne graduated with an AA from Gwynedd Mercy College in Blue Bell, PA, a BS from Boston College, an MN from University of Washington, Seattle and a PhD from the University of California San Francisco. Anne is certified as a family nurse practitioner, AIDS certified RN and advanced practice nurse in hospice and palliative nursing.

Anne served as a board director and president of the Association of Nurses in AIDS Care. She is a member of the Expert Panel on Palliative and End of Life Care for the American Academy of Nursing.

Her current clinical role is as an Advanced Practice Nurse, Palliative Care, Pain Management and Ethics – Laguna Honda Hospital and Rehabilitation Center, San Francisco Department of Public Health where she coordinates a Pain and Healing Clinic and serves of Vice-chair of the Ethics Committee. Anne is a volunteer Clinical Professor of Nursing at UCSF.
Mary Ellen believes as the Nursing Practice Director that nursing research is most helpful when it is directly related to nursing practice issues, whether they are of a clinical, public policy, or organizational nature. Her education, academic and service experiences, and personal commitment to advancement of the discipline of nursing as an applied science provide evidence of my qualifications for this position. She has also taught at the University of Phoenix San Diego campus nursing program from 1994-2014. She believes that she is in a position to be aware of and advocate for issues that affect professional nursing in the clinical, educational, and public policy arenas.

Mary Ellen believes she is a direct, but friendly communicator and very much enjoy’s working with people as individuals or members of a group. She believes our lives are best spent in knowing ourselves as a means to be of service to others. Each of us brings a unique and valuable perspective to nursing practice and the discipline of nursing. The level of our education in nursing is simply not an issue for me when it comes to being a requirement for being in a position to make valuable contributions to nursing.

Mary Ellen received her BSN from UCLA School of Nursing; her MS from Rush University; and her PhD UCLA School of Nursing. For the past 5 years Mary Ellen has been employed at VA San Diego Healthcare System, San Diego, California as a Researcher and a Research Nurse Scientist (2012–present). Prior to taking the 2012 position, she was a Career Development Awardee at VA/SDHS. Although her primary focus is on research (nursing practice related to pressure ulcer prevention—evidence based practice and management, nursing home quality) she has spent approximately 50% of my time working on either national or local practice issues related to evidence based practice and pressure ulcer prevention. Research Nurse Scientist.

Legislative Director
Elizabeth O. Dietz, EdD, RN, CS-NP

Liz has assisted throughout the last 2 years as the Legislative Director of ANA/C. She is involved in the issues and work with our lobbyist and others to make sure that the ANA/C has the information to make good decisions on supporting appropriate legislation for the association.

Nationally Liz is on the Leadership council for the ANA PAC. She continues to work with the issues both locally, state, and nationally. This is an exciting and sometimes frightening times for legislation within our association. In her work with American Red Cross and her academic positions she is able to stay on top of the issues for our association.

Liz received BSN from Cornell, MSN from Boston University, & EdD from University of San Francisco. Liz is the lead for Service to Armed Forces Silicon Valley Chapter American Red Cross; Regional State Nurse Lead Silicon Valley Chapter American Red Cross; Lead Area Faculty at University of Phoenix and Substitute District School Nurse San Jose Unified School District.

Mary Ellen Dellefield, PhD, RN

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Eric J. Williams

Eric believes we face enormous challenges which impacts healthcare today. His experience will allow me to lead ANA/C with passion, purpose, and high professional standards. As a member of ANA for many years, he has heard the concerns of members and value each person’s experiences. Eric’s leadership skills will strengthen ANA/C’s infrastructure, and create new programs that will assist our communities to thrive. He has worked diligently to promote and accomplish the organization’s mission, philosophy, and goals. He has volunteered countless hours to eliminate health care disparities in New Orleans and Los Angeles. This is an important role that we lobby and work to eliminate these disparities. His ability to mentor students in unwavering, he is responsible for the mentoring program with the Council of Black Nurses, Los Angeles. The recruitment of nurses under the age of forty to ANA/C is needed to facilitate change. We will mentor them to become the next generation of nurse leaders. Growing ANA/C for the next generation will be a priority.

Eric graduated from William Carey University; the University of South Alabama; and Case Western Reserve University. Eric is a Professor of Nursing at Santa Monica College.
A major issue before the nursing profession, ANA/C and ballot committee relates closely with nursing education. With the advancements in healthcare there is a need for nurses that are highly educated with the right skills to provide safe care (The Robert Wood Johnson Foundation 2010). Nursing education must transform to meet the needs of the ever changing healthcare environment, to ensure nurses continue to obtain advance training to meet entry level nursing requirements. Over the past decade there has been nursing shortage, with the nursing population retiring and nursing faculty retiring, nurse educators are needed to meet the demand. Without trained nurse educators, at the Master’s and Doctoral level, the nursing profession will continue to see shortages of nurses as programs can only provide education to a number of students with a limited number of nurse educators that are available. The nurses that are educated in California will also be the nurse leaders in the future, it is important that they have the proper education to represent and advocate the profession.

Election Results continued from page 15

The Gallup completed a survey 5-8 December 2013 that found nurses as the number one profession for trust and ethical practice. This to me as a professional nurse speaks volumes to the integrity and honor of our profession. It not only makes me proud to say that I am a part of that personal experience that our community endorses but it charges me with great responsibility to hold myself and other accountable for our practice. It is for this reason that I wish to be a part of the ballot committee to ensure the integrity of our processes remains intact. I would assist in ensuring this process in keeping colleagues abreast of their ethical and legal obligation to standards. Reminding professionals of their duty, oath and service to their communities of practice in a loving, tactful way will, in my belief vector maintenance to standards. The key here is the way in which you deliver this information.

Some major issues influencing professional practice on an international, national and local level are that of scope, ethics and political impact. I am an advocate for change management and believe with interdisciplinary cross talk we can smooth the transition in entering the political arena, the provider work centers and finally, the policy of practice internationally. For my office locally, it has to start with who we elect to be our voice and advocate for the profession that we honor and have been engrained to transcend into our core being. I greatly desire to be a part of this organization to do exactly that. Alina graduated from the Chamberlain College of Nursing with a BSN, from Grand Canyon University with an MSN and Grand Canyon University with a DNP. Alina has 8 ½ years with the United States Air Force – ER, Psych, Case Management, Triage, Nursing Education.

Gloria believes it is important for her to actively participate and contribute to my profession. One way she can fulfill this obligation is serving the American Nurses Association of California. Her experiences in volunteering for community projects, faith-based organizations, and political clubs/activities provide a foundation for serving on the ballot committee. Gloria graduated from St. Joseph Mercy School of Nursing, RN Diploma in Nursing, and received a BSN and MSN/MHA EdD. Gloria is currently the Campus College Chair at the College of Health Sciences & Nursing. She has been a Palliative Care Nurse at John Muir Medical Center and Kaiser Permanente. She was also a Home Health Care & Hospice Coordinator at Sutter VNA & Hospice.

Lori has a BSN from California State University, Sacramento; a MSN-Ed, MLN from Walden University, RN DNP Student Walden University Masters.

Lori is a Staff Development Officer, Training Affiliation Agreement Program Manager, Student Site Coordinator. She has been a Nurse Manager as well as 673 MDG Family Practice Clinic and a Flight Commander Flight medicine Clinical Nurse, Infection Preventionist.

Gloria C. Lewis, EdD, MSN, MHA, RN, CCM

Alina V. Kendrick, MSN, RN, CCM

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Pushing Care Coordination

Katherine M. Falco, MSN, RN

Dr. Farbod Hagigi, PhD, MPH is an expert in care coordination and he skillfully broke it apart to the nurses and nursing students during his presentation at Ronald Reagan UCLA Medical Center on April 18, 2014.

Why care coordination? Care coordination is at the core of what nurses do. Nurses understand the small differences that can make greater change and know best what can work, or not work, in managing patient care. Dr. Hagigi spoke about the significance of care coordination improving patient results and called for nurses to take the lead.

He asked the audience to embrace the trust the public has in the nursing profession and use it to build relationships. He said that, “Relationships are key and should be built on shared goals, shared knowledge and mutual respect.”

Dr. Hagigi asks that, “Nurses keep pushing care coordination.”

Recognize and rethink care coordination. If you want to discover more about this topic, please go to www.nursingworld.org for ANA’s position statement and other information on care coordination.

Dr. Hagigi is the Founder and CEO of clinicabon, a company that builds evidence-based software for care coordination and patient engagement.

American Lung Association®

American Lung Association Gives California Failing Grades for Tobacco Control, Joins Fight for Higher Tobacco Taxes

On January 21, the American Lung Association (ALA) released its annual State of Tobacco Control 2015 report giving California low scores for lagging behind the rest of the nation in its tobacco control policies. California received a B grade for its smoke free air policies, but then dropped to an F grade for its low tobacco taxes and failing to sufficiently fund tobacco prevention and control programs. The report also gave the state a D for poor coverage of smoking cessation and treatment services.

These grades reflect the fact that while California was once a national leader in tobacco control policies, its current efforts in tobacco control are not enough. Exacerbating California’s weakened position on tobacco prevention is the fact that the state has not increased its cigarette tax since 1999 and now ranks 33rd in the country at 87 cents per pack. Texas, Oklahoma and Montana now have higher tobacco taxes than California.

The ALA also announced that it has joined the California Medical Association and the Save Lives California coalition in its effort to pass a lifesaving $2 per pack tobacco tax in California – either through the legislature or by ballot measure – by the end of 2016. The coalition believes that a tax increase on tobacco will not only save lives, but will also save California taxpayers billions in health care costs.

The ALA report looked at all 482 incorporated cities and towns in California and all 58 counties. Local grades were awarded in three categories: smokefree outdoor air, smokefree housing and reducing sales of tobacco products. http://www.statetobaccocontrol.org/state-grades/california/

Assemblyman Cooper (District 9) with ANAC Executive Director Tricia Hunter and members Marketa Houskova and Phillip Bautista at a California Allied for Patient Protection reception in Elkgrove, California.
Workplace Violence and Incivility: Advocacy for the Nursing Profession Through Change in Legislation

December Stroble, BSN, RN, RNC-MNN, PHN

I am a nurse and I have been a victim of assault by my patients. More than once. More than twice. For many times, I’ve lost count. And I am not alone with it.

In 2012, I experienced a verbal and physical assault at the hands of a female patient, who was my height and weight. The patient, who had been sleeping on a gurney in the Emergency Department, woke in a very agitated state. Initially, I attempted to de-escalate the situation by addressing her concerns. Listening intently to what she wanted, she offered several reasonable interventions. Refused and less than five seconds of my offer, the patient jumped off of the gurney and began charging towards me. With a wild look in her eyes, calling me every belligerent epithet known to man, I started to back away from her, but was unsuccessful. With a closed fist, she struck me in my clavicle, shoulder and chest, knocking me to the ground.

I stood up, as the patient cocked her arm back to swing at me a second time. As she did this, Jason, an ED Tech saw what was happening, and reached his arm across me, striking me in my clavicle, shoulder and chest, knocking me from her, but was unsuccessful. With a closed fist, she struck me in my clavicle, shoulder and chest, knocking me to the ground.

According to the U.S. Bureau of Labor Statistics, in 1999 there were, “2,637 nonfatal assaults on hospital workers,” and in 2010, an estimated 19% of workplace assaults occurred against nurses. This estimate is likely to be much higher, as “many more incidents probably go unreported.” and the actual reported rates have tripled within the last decade. “Of all non-fatal injuries in the private sector in 2007, approximately 9,953 (39%) occurred in the health care.”

Currently, the American Nurses Association (ANA) and Emergency Nurses Association (ENA), along with colleagues from the American Medical Association (AMA) and American College of Emergency Physicians (ACEP), are bringing awareness to the issue of workplace violence and incivility, and proposing actions for legislative changes to ensure safer work environments for healthcare providers.

Workplace Violence is defined by the Occupational Safety and Health Administration (OSHA) as “Violence or the threat of violence against workers. It can occur at or outside the workplace and can range from threats and verbal abuse to physical assaults and homicide.” As healthcare providers, our duty is to provide care to our patients under a myriad of circumstances. Violence and the threat of violence, however, should not be included or accepted as part of the job.

According to the U.S. Bureau of Labor Statistics, in 1999 there were, “2,637 nonfatal assaults on hospital workers,” and in 2010, an estimated 19% of workplace assaults occurred against nurses. This estimate is likely to be much higher, as “many more incidents probably go unreported.” and the actual reported rates have tripled within the last decade. “Of all non-fatal injuries in the private sector in 2007, approximately 9,953 (39%) occurred in the health care.”

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Workplace Violence continued on page 19
Wishing to seek treatment related to workplace violence, and prevention of hospitals taking punitive or retaliatory actions against providers subjected to violence who seek law enforcement or EMS assistance; requirements of hospitals to document and report to Cal OSHA all violent incidents against hospital employees and maintain those records for 5 years; and for all incidents to be available to the public, via the internet.

The California Emergency Nurses Association (CENA), following suit of nursing colleagues in 31 other states, has drafted a bill proposing violence against healthcare providers to be punishable as a felony, and is sponsored by Assemblyman, Freddie Rodriguez (D-Pamona). Rodriguez following suit of nursing colleagues in 31 other states, the internet.

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Physician groups, such as the American College of Emergency Physicians (ACEP) are also addressing issues related to Workplace Violence. In 2011, the Protection from Physical Violence in the Emergency Department, policy statement was adopted by ACEP, to encourage improvements for safety and security of ED staff, patients and visitors. This policy statement can be found at http://www.acep.org/Clinical---Practice-Management/Protection-from-Physical-Violence-in-the-Emergency-Department-Environment.

California ACEP has also committed to reducing ED workplace violence by assembling a subcommittee of ED doctors and key stakeholders dedicated to finding solutions to the problem. Dr. Kevin Jones, of Sutter Medical Center, Sacramento, Emergency Services, and Cal/ACEP Board Member, has proactively taken on the task of bringing awareness to doctors, nurses, and EMS colleagues by educating them with his lecture series and article Workplace Violence in the ED: A Disturbing Trend. http://californiaacep.org/wp-content/uploads/LifelineMagazine

FEB_2014_v2.FINAL.pdf. He is passionate about this topic and has worked directly with CENA to help advance legislation protecting healthcare workers.

As healthcare providers, our job is to give the very best care we can to our patients. In order to accomplish this, we must be able to do so in a safe environment. The actions of groups such as, ANA, ENA and ACEP have begun to address the issues of workplace violence and incivility. With support from our fellow nurses and physician colleagues, our voices are more likely to be heard and change can happen. Please contact your Assembly Person and Senator, and urge them to support healthcare providers in providing the best and safest care we can to our patients, by giving us safer workplaces. Encourage others to do the same.

In the words of Margaret Mead, “Never doubt that a small group of thoughtful, committed citizens can change the world; indeed it’s the only thing that ever has.”


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