ONE STRONG VOICE FOR MISSOURI NURSES

THE MISSOURI NURSE

APRIL 2010
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POSTMASTER: SEND ADDRESS CHANGES TO: THE MISSOURI NURSE, P.O. BOX 105228, JEFFERSON CITY, MO 65110
The nursing profession is one of the most respected, vital and challenging fields today. Nursing is serious work and requires constant self-examination and close appreciation to the heart of the profession, which is true and unwavering compassion and concern for humankind.

This year, the American Nurses Association (ANA) has selected “Nurses: Caring Today for a Healthier Tomorrow” as the 2010 theme. Annually, National Nurses Week begins on May 6, marked as RN Recognition Day, and ends on May 12, the birthday of Florence Nightingale. The Missouri Nurses Association (MONA) is joining ANA in celebrating and honoring National Nurses Week. The purpose of Caring Today for a Healthier Tomorrow is to raise awareness of the value of nursing and help educate the public about the role nurses play in meeting the health care needs of the American people.

In honor of the dedication, commitment, and tireless effort of the nearly 2.9 million registered nurses nationwide, promoting and maintaining the health of this nation, the ANA and MONA are proud to recognize registered nurses everywhere for the quality work they provide seven days a week, 365 days a year.

Traditionally, National Nurses Week is devoted to highlighting the diverse ways in which registered nurses, the largest health care profession, are working to improve health care. From bedside nursing in hospitals and long-term care facilities to the halls of research institutions, state legislatures, and Congress, the depth and breadth of the nursing profession is meeting the expanding health care needs of American society.

On May 6, 2010, in honor of Nurses: Caring Today for a Healthier Tomorrow, all registered nurses in America are encouraged to proudly wear the official ANA “RN” pin or any other pin that clearly identifies them as registered nurses.

May 12, 2010, is also marked as International Nurses Day. The International Council of Nurses (ICN) has celebrated International Nurses Day since 1965.

The 2010 International Year of the Nurse (IYNurse) is the centennial year of the death of the founder of modern nursing, Florence Nightingale (1820-1910). Developed from four years of discussions, planning, meetings and conferences around the world, the idea for celebrating this year came from an in-depth review of the life and work of Florence Nightingale. Her name has been revered and respected across the world for more than a century. To celebrate this historic milestone, the 2010 IYNurse was established to actively involve the world’s nurses, estimated to be more than 15 million, in a celebration of commitment to bring health to their communities, locally and worldwide.

The 2010 IYNurse will provide nurses with innovative opportunities to:
1. Broaden the scope of their health education and health promotion practices
2. Bring their trusted global voices to express their concerns and to establish significant and effective global platforms for their advocacy.

2010 IYNurse seeks to recognize the contributions of nurses globally and to engage nurses in the promotion of world health, including the United Nations Millennium Development Goals (UN MDGs). In collaboration with other global citizens, nurses will demonstrate, throughout 2010 IYNurse, how nurses advocate for the achievement of these goals globally.

We honor the legacy of Florence Nightingale and other nurses, midwives and healthcare workers of the past and present, who have shown how personal actions can make a world of difference. Even today, Nightingale’s contributions to nursing theory, education, practice, research, statistics, public health and healthcare reform are foundational and inspirational and her contributions to human health still continue to be revealed.

2010 IYNurse is a “Celebration of Commitment” creating opportunities for nurses to showcase their unique contributions toward the achievement of health and well-being for everyone. All events, celebrations and activities for 2010 IYNurse are intended to be inclusive and collaborative.

For additional information visit the MONA website www.missourinurses.org.
## MONA Calendar

### APRIL
- **14th**  APRN-SIG Dinner/Meeting, Columbia, MO (6-9 p.m.)
- **15-16th**  20th Annual APRN Conference, Holiday Inn Select Executive Center, Columbia, MO
- **22nd**  Government Affairs Conference Call (12 p.m.)
- **28th**  E&GW Cabinet Meeting, MONA Office (5:30 p.m.)

### MAY
- **6th**  Membership Committee Conference Call (12 p.m.)
- **7th**  Holiday (Office Closed)
- **12th**  District President’s Conference Call (12 p.m.)
- **12th**  Nursing Practice Committee Conference Call (1 p.m.)
- **21st**  2nd Annual Nursing Practice Update, Warrensburg, MO
- **31st**  Holiday (Office Closed)

### JUNE
- **25th**  2nd Annual Nursing Practice Update, Cape Girardeau, MO

### JULY
- **1st**  Membership Committee Conference Call (12 p.m.)
- **1st**  Missouri Nurse Deadline for Submissions
- **5th**  Holiday (Office Closed)
- **14th**  District President’s Conference Call (12 p.m.)
- **14th**  Nursing Practice Committee Conference Call (1 p.m.)
- **22nd**  Missouri Nurses Foundation Conference Call (3 p.m.)
- **30th**  2nd Annual Nursing Practice Update, Hannibal, MO

### AUGUST
- **5th**  Finance Committee Meeting, MONA Office (1-4 p.m.)
- **5th**  Executive Committee Meeting, MONA Office (4-5 p.m.)
- **6th**  MONA Board Meeting, MONA Office (8:30 a.m. - 4:30 p.m.)
- **12th**  APRN-SIG Lunch/Meeting (12-3:30 p.m.)
- **20th**  2nd Annual Nursing Practice Update, Springfield, MO

### SEPTEMBER
- **2nd**  Membership Committee Conference Call (12 p.m.)
- **6th**  Holiday (Office Closed)
- **8th**  District President’s Conference Call (12 p.m.)
- **8th**  Nursing Practice Committee Conference Call (1 p.m.)
- **23rd**  Missouri Nurses Foundation Conference Call (3 p.m.)

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**MONA Benefits**

For additional benefit info visit our website
www.missourinurses.org

1. **Bank of America**
   Special rates on credit card services
2. **Assurant Health Insurance**
   Health Insurance for Individuals/Families
3. **Unitrin**
   Home and Auto Insurance Discounts
4. **John Hancock**
   Long Term Care Insurance
5. **Nu Dimensions Scrubs**
   MONA members receive 20% discount
6. **Drury Hotels**
   MONA members receive 10% discount
7. **Drive America Auto Club**
   Roadside assistance and much more
8. **CEUlCectures.org**
   Online lectures for health professionals
9. **CEU4U**
   Online Continuing Education
10. **Benefit Toolbar**
    Downloadable MONA toolbar
11. **MARSH**
    Liability Insurance
12. **Dell Computers**
    MONA/ANA members receive 12% discount
13. **Wyndham Hotels**
    MONA/ANA members receive 10% discount
14. **Choice Hotels**
    MONA/ANA members receive 15% discount
15. **Land’s End**
    MONA/ANA members receive 10% discount
16. **AVIS and Budget**
    Discounts for MONA/ANA members

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**Network with nurses from across the state by becoming a fan of MONA on Facebook!**
Nurses have recently received attention for their efforts in leading the way in progressive change and reform. Nurses around the country have taken an active role in discussions regarding health care reform as they advocate for their patients. In the wake of the disaster in Haiti, many nurses volunteered their services to assist the victims affected by the devastating earthquakes.

Missouri nurses have also shown leadership initiative through their commitment and dedicated work as members of MONA. Nurse Advocacy Day (NAD), held every February, is an example of what can be accomplished when nurses become actively involved in their professional association. NAD is an exciting event that provides nurses the opportunity to expand their knowledge of advocacy for the patients they care for and for the practice of nursing. Many nurses and nursing students from across the state made the trip to the Capitol to take part in this leadership opportunity.

Nurses attending Nurse Advocacy Day learned about MONA’s 2010 legislative priorities:
- House Bill 1449 - Allows physical therapists to accept orders from APRNs
- House Bill 1498 and SB636 - “Prompt pay” legislation which changes the laws regarding the requirements for reimbursing health insurance claims
- House Bill 1456 and SB742 - Modifies the membership of the MO Healthnet Oversight Committee

Nurses are an important part of Missouri's healthcare system. We can have a significant influence if we work together to advocate for our patients and practice. You can get involved by contacting your legislators and asking them to support these bills.

If you have made the choice to be active in the Missouri Nurses Association, I would like to thank you. Thank you for your dedication to the profession, and thank you for your choice to promote the progress of nursing. If you are not a MONA member, I invite and encourage you to become one. We need you! Together we can be “One Strong Voice” for Missouri nurses.

MONA Board Meeting Highlights

December

Board approved the development of a task force to draft a position statement regarding the future/professionalism of nursing and nursing education.

Government Affairs committee was given a directive by the board to develop a strategy for a “BSN in 10” initiative.

Board voted to discontinue the MetLife contract and approved Unitrin as the new company to offer discount home and auto insurance to MONA members.

Board approved the draft H1N1 position statement.

MONA board revisited the need for a new strategic plan and each committee will bring forth ideas at the March board meeting.

Approved MOCAP (Missouri Council on Advanced Practice) as an organizational unit of MONA.

Approved the Drive America Auto Club as a member benefit (Currently being implemented).

Appointed Sharon Shepherd as the MONA representative for the MO Patient Safety Advisory Panel.

Revised the regional map by moving a few counties into other regions for greater conformity.

Jan Polizzi was appointed to the MONA Executive Committee.

MOANA did not renew their contract with MONA.

Approved Benefit Toolbar as a member benefit (Currently being implemented).

Received board commendation on the financial status of MONA.
Casa de Salud opened its doors to interprofessional healthcare services on January 18, 2010, to fill the void in care for the Hispanic population when La Clinica and Acción de Social could no longer operate due to insufficient financial support in the Spring of 2009. The mission of Casa de Salud is to provide high quality basic health services to the uninsured and underinsured, especially to Hispanic immigrants, newly arrived in the region.

Casa de Salud represents a new model of immigrant healthcare delivery services championed by: Lawrence Biondi, S.J., President of Saint Louis University, Bob Fox and Maxine Clark, philanthropists and community activists; and, the Hispanic community and its leadership. This model

- Provides basic, episodic medical services
- Facilitates entry into patient centered medical homes, principally the federally qualified and full service community health centers.
- Reaches out to the community with disease prevention and health promotion activities.

Basic, Episodic Medical Services

Basic health services include the diagnosis and treatment of self-limited acute illness or injury and the initial diagnosis and control of chronic conditions among adults. Referrals to permanent medical homes, complete with navigators to help with the transition, are made primarily to the federally qualified health centers (FQHC). Because pediatric services are not provided, children are assured same day care, if needed, through collaborative relationships with local pediatric hospitals. Collaboration with FQHCs insures that children who require next day or within-week care and children who require routine pediatric care are provided with appointments. Family counseling services are incorporated as an essential aspect of basic health services.

Facilitating Entry to Patient Centered Medical Home

The region served by Casa de Salud extends from rural Washington County, in the foothills of the Ozarks, to the plains of Clinton County, Illinois. It covers eight Missouri and eight Illinois counties. In Missouri, they are St. Louis City, St. Louis County, and Jefferson, Washington, Franklin, Warren, St. Charles and Lincoln counties. In Illinois, they include Monroe, St. Clair, Madison, Jersey, Calhoun, Macoupin, Bond, and Clinton counties. This bi-state land mass alone is, in square miles, larger than the Commonwealth of Massachusetts.

To serve as a successful entry portal into established medical homes within this region, Casa de Salud collaborates with federally qualified and other community health centers. This requires considerable coordination, sociocultural understanding of and outreach to the client’s county health care services, assessment of client expectations, and personalized education about the importance of preventive medical services.

Entry into the larger system is made easier by a pre-arranged, mutually agreed upon standard operating procedure, which includes identifying a Casa de Salud appointment liaison, insuring that translator services are available, and providing for a Casa de Salud navigator to meet the client at the facility to help the patient register and negotiate the system the first time. Call back phone calls to the patient after the experience assist in working out any miscommunication and support program evaluation efforts.

Community Outreach

Welcoming immigrants is important, regionally. The Hispanic community contributes strong family and work values that enrich the diverse culture of the region and are essential to business growth. Because Casa de Salud represents a model of healthcare that extends beyond the treatment of disease to a vision of health dedicated to the thriving of the whole person, family, and region, it can play a crucial role in the welcoming process.

At the present time, outreach consists of informing the community about our presence. Health fairs are being planned as are focus groups. Health promotion is the primary objective of health fairs. The objective of calling together focus groups is to insure community ideas and priorities help shape the programs, events, and discussion topics that Casa de Salud sponsors. Given appropriate funding, it is hoped that community health workers or promotores de salud will play a central role in this outreach function. The promotores model of outreach has demonstrated excellent health outcomes and efficiencies in other communities across Missouri and the United States.
**Support Foundation**

Leadership, operational support, and the establishment of functional community/university partnerships could not be conducted without the early and continued interprofessional support of:

- Saint Louis University faculty and students from the School of Medicine, School of Nursing, Doisy College of Health Sciences, School of Public Health, College of Arts and Sciences, Public Policy, and the University’s Interprofessional Education Program
- Washington University faculty and students from the School of Medicine, George Warren Brown School of Social Work, and Arts and Sciences and such programs as Engineers without Borders
- Cardinal Glennon Children’s Hospital
- St. Louis Children’s Hospital
- Goldfarb School of Nursing
- St. John’s Mercy Health Care System and Neighborhood Ministry
- Community-based physicians/specialists/dentists

In summary, Casa de Salud is committed to welcoming the immigrant community in St. Louis, helping them become members of the existing and larger preventive health and primary care medical home services, and empowering their successful establishment within the region.

Mary Ann Lavin is an Associate Professor at Saint Louis University School of Nursing, and Casa de Salud Director of Clinical Services in addition to serving as a member of MONA’s Nursing Practice Committee.

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**Welcome to the New MONA Website**

As of January 1, 2010, the MONA website has a new look! We have rolled out our new, improved website. There are a few sections that are still under construction, but we believe the new site has much more to offer and will continue to improve as additional information is added.

**Website highlights include:**

- Legislative Bulletins
- Bill Status Reports
- Events/Calendar
- Updated CE Information
- New MONA Bylaws
- Regional Restructuring Information
- Consent to Serve Forms
- Last Issue of *The Missouri Nurse*

**Member Input**

Now MONA would like to ask for your help. We want to know what we can do to make the website a more useful tool for our members.

- What would you like to see more of on the website?
- What additional functionality would you like to see?

Please complete the **website survey** on the MONA homepage www.missourinurses.org or contact Krista Lepper, Office Services Coordinator, at the MONA office with your ideas and thoughts by email at krista@missourinurses.org or by phone at 573-636-4623, x226.

**Make your voice heard! Help us make the MONA website a valuable member benefit.**
Basing the Timeliness of Prenatal Care in Prison Populations on the Evidence

Leann E. Williams, RN, BSN; Janice Putnam, RN, PhD; Jo Riggs, RN PhD - University of Central Missouri

Introduction

Nearly a third of the half million women and girls held in prison globally are in the United States (International Centre for Prison Studies, 2006). This problem is growing as the number of incarcerated women in the United States has increased 757% between 1977 and 2004 (Institute on Women and Criminal Justice, 2006). While as many as 25 percent of women in federal and state prisons are pregnant when entering the prison system, and many are incarcerated in order to protect fetal health, the quality of health care services provided to pregnant women in prisons is poor. Prison healthcare consistently falls below federal and professional standards due to failure to address inmates' specific pregnancy needs, as well as substance abuse, abuse by corrections officers, and HIV/AIDs (Hannaher, 2007).

Incarcerated women are typically poor, uneducated, with limited job skills, and many are involved with drugs. Drug treatment and reproductive health services for women in prisons are inadequate, if available at all, and many prisons lack prenatal care (Ferst & Erickson-Owens, 2008). Incarcerated women are especially at risk for reproductive health problems and pregnant prisoners have limited access to healthcare, resulting in high rates of perinatal morbidity and mortality (National Council on Crime and Delinquency, 2006). Studies of prisoner pregnancy outcomes have demonstrated the need for intensive prenatal education, chemical dependency treatment programs, and psychological needs interventions, specifically designed for incarcerated women (Fogel, 1993).

Nursing Role and EBP

The role of the Advanced Practice Nurse (APN) is key to the establishment of evidence-based practices that reflect a scholarly, thorough review of current research, which promote quality health for patients, and establish the APN as the professional leader in healthcare. Evidence-based practice (EBP) is a clinical problem-solving process that integrates the best available evidence with clinical expertise, existing resources, and patient input, in order to solve healthcare problems and make patient care decisions based on improving the quality of care (Mantzoukas, 2008). Nurses, as professionals, have a responsibility to remain current on the latest research findings and the newest recommendations related to nursing practice. EBP can provide an essential bridge between research and practice (Polit & Beck, 2004).

Research utilization and evidence-based practice models have been developed in an effort to use research evidence to improve nursing practice. The Iowa Model of Evidence-Based Practice to Promote Quality Care outlines steps for identifying problems and systematically researching and forming conclusions or suggestions to improve nursing practice quality. The Iowa Model begins with the identification of practice questions, triggered through the identification of a problem or through new knowledge. A trigger stimulates the formation of questions and research ideas regarding evidence-based practices, giving an incentive to investigate possible changes to practice (Polit & Beck, 2004). There must be sufficient evidence from the practice field that improvements and changes to current practice are warranted (Polit & Beck, 2004).

One Midwestern Department of Correction (DOC), in an effort to standardize and improve the healthcare needs of its prisoners, utilizes the Iowa Model as a guide for clinical decision-making, practice guideline development, and continuous monitoring of outcomes (Stone, et. al., 2006). The DOC also utilizes a quality indicator matrix which is based on information used by civilian health systems. The purpose of the matrix is to evaluate the process and outcomes of select areas, compare to benchmarks and accepted standards, in order to improve the effectiveness of delivery and the management of health risks, diseases, and conditions within the DOC (Stone, et. al., 2006). The quality indicators for timeliness of prenatal care currently reports the percentage of pregnant offenders who received a prenatal care visit in either the first trimester or within 42 days of incarceration.

Review of Literature

In a review of literature, practice guidelines from the American Academy of Family Physicians (AAFP) provided general evidence-based prenatal care guidelines for the first trimester, which focused on counseling issues concerning dietary needs, avoidance of teratogens, genetics counseling, and prenatal parameters according to gestational age. Evidence-based guidelines of prenatal care for the third trimester from the AAFP further delineated gestational age practice parameters as well as a focus on prevention of infectious diseases (Kirkham & Harris, 2005). Healthcare guidelines (from the American College of Obstetricians and Gynecologists (ACOG) outlined recommendations for routine, uncomplicated prenatal care for the general pregnant population, which correlated with the AAFP's recommendations (Akkerman, et. al., 2008). The National Institute for Health and Clinical Excellence (2008) established best practice guidelines for prenatal care of healthy women with uncomplicated pregnancies based on evidence-based information. These practice guidelines formed the basis of the AAFP and ACOG guidelines and identified causes, diagnostic procedures, lifestyle changes, and follow-up care needed at each gestational age. These practice guidelines also established a basis for prenatal care of complicated pregnancies, as often encountered in prison populations.

A majority of research located through this review of literature focused on the fact that a substantial number
of incarcerated women only recently had attention paid to pregnancy outcome. A majority of integrative reviews revealed that the physical demands of pregnancy were exacerbated by the physical conditions of incarceration, and resulted in increased rates of or incidences of perinatal mortality and morbidity. Documented problems included high rates of fetal and neonatal death, intrapartum growth retardation, preterm labor and delivery, and other conditions causing neonatal intensive care admissions (Sakala & Corry, 2008). An integrative review of national policy, quality, and maternity care leaders indicated that providing efficient prenatal care visits resulted in fewer, more concise visits, and fewer sonograms, achieving positive pregnancy outcomes for both mother and infant as well as cost effectiveness (Budenholzer, 1999). Several studies validated the necessity of special prenatal care considerations and the necessity for further research of the growing adolescent incarcerated populations, utilizing a multidisciplinary approach with more intensive interventions (Bruener & Farrow, 1995).

In an attempt to meet the prenatal needs of incarcerated women, experimental community-based programs formed, which focused on health promotion of those with drug abuse (Barkauskas, et. al., 2002). These prenatal programs included a comprehensive, gender responsive program involving multiple treatment plans, and resulted in positive outcomes for both mother and infant (Knight & Plugge, 2005). Based on the positive findings of these experiments, a model residential care program was proposed with nurse midwives providing prenatal care through childbirth, social services consults, and the provision of job-training programs (Moses & Potter, 2008). The program was highly successful and provided an effective model approach for the future. However, it was discontinued because of financial constraints (Siefert & Pimlott, 2001).

Infant birth weights do not differ significantly among incarcerated and non-incarcerated women; however, appear to be positively influenced by the length of time in prison (Holland, 1997). Progressive increases in infant birth weights correlated with increases in prenatal care visits between incarcerated mothers with monitored prenatal care versus those without specific, monitored prenatal care (Howard, et. al., 2008). Analyses revealed that certain aspects of the prison environment, such as food, shelter, and limited access to drugs, may be health promoting for high-risk pregnant women (Martin, et. al., 1997).

Healthcare services available in most prisons were inadequate to meet the educational and support needs of pregnant inmates who were both pregnant and drug dependent (Ferszt & Erickson-Owens, 2008). In several non-experimental studies comparing birth outcomes in incarcerated women with a recent history of drug use to those of non-incarcerated women in a methadone maintenance program, it was noted that drug dependent women without access to safe, detoxifying treatment were more likely to continue to use drugs, leading to devastating effects on pregnancy (Key-Aboagey, et. al., 2000). Fogel (1993) also supported the need for intensive prenatal education and chemical dependency treatment programs designed specifically for incarcerated women that provided interventions for psychological needs. Hanaher (2007) reports that incarcerated women have limited access to healthcare or programs with specific treatment protocols specific to women offenders in general.

The National Council on Crime and Delinquency (2006) reported that incarcerated women are at risk for reproductive health problems, not only from previous histories of sexual abuse and high rates of sex work, but also from prior limited access to healthcare services and education. Expert opinions revealed that prison healthcare policies consistently fell below federal and professional standards, leading to violations of reproductive and parental rights (Vainik, 2008). Additional information from expert opinions revealed that incarcerated mothers and infants born in prisons may be separated, which violates civil rights, and causes harm to both mother and infant (Flores, 2008). A qualitative study provided research recommendations concerning the long term effect of separation on the maternal-child relationship, which needs to be included in pregnant inmate healthcare planning (Johnson, 1991).

Conclusions
This literature review supports the DOC quality indicator related to the timeliness of prenatal care, and indicates the importance of programs focused on the special needs of pregnant inmates. The correctional healthcare system must be proactive in providing access to early prenatal care, intensive prenatal education, chemical dependency treatment programs, and psychological needs interventions to ensure positive outcomes, and support the rights of both mother and infant. Guidelines issued by the American College of Obstetricians and Gynecologists provide best practices for prenatal care for the general obstetric population. Adaptation of these guidelines by incorporating needs of incarcerated women and incarcerated adolescents should be implemented to ensure the best possible outcome for this patient population.

References Available Upon Request
Saint Louis winters are cold. Due to the high humidity, winter becomes bone chilling. When the temperature lingers at twenty-degrees, then drops to zero and below, the chill becomes downright painful. During the seasons in between, we locals have amnesia to zero and below, the chill becomes downright painful.

During the seasons in between, we locals have amnesia to zero and below, the chill becomes downright painful. During the winter, we are surprised when the oppressive cold returns.

I walk the dog, little Zôë, at five in the morning. We are the first in the family to discover just how cold it is on any given day. While our neighbors sleep, Zôë and I gingerly step outside of the house and into the elements in the dark morning. I look for the newspaper on the lawn, so I don’t have to retrieve it later.

I will be on the windy train platform in two hours, waiting for the eastbound Metro train to carry me to my job. Although it is later in the morning, it seems colder there on the platform. I try to use the shelter as a windbreak, but it doesn’t help. Standing on the train platform is usually the coldest experience of my day.

My Metro station is one of the nicer ones. Its bus depot is covered and protected from the elements. There are modern sculptures suspended from the ceiling. It is located in an upscale part of town with an expensive parking garage. Nearby are county government buildings, the executive building, the courts, police and jail.

I purchased ear warmers to help me endure the cold wait on the windy train platform. On Sunday I accompanied my brother, Steve, to the football stadium so he wouldn’t have to travel through the city by himself. The city always feels colder to me; therefore, I wore my ear warmers. Walking back to the train alone, I passed numerous panhandlers lining the sidewalk. One woman, a regular, who sits on the sidewalk huddled under a blanket, held up her cardboard sign that reads, “Homeless, please help.” She tells anyone who will give her money, “Thank you. God bless you.” I was conflicted to pass her by, but I did so. I hoped that the person wearing them needed them more than I did.

When I saw ear warmers on sale in a catalog, I called to order a replacement pair. They were sold out of ear warmers in the sale colors, but more expensive ear warmers in popular colors were available. I purchased the expensive ear warmers for their utility, rather than their stylishness. However, when the new ear warmers arrived, in the expensive color of black, they were size large for men. My head is not large.

Today was ordinary enough to begin. I walked Zôë at five, read the newspaper, ate breakfast, showered, and left for work wearing the men’s ear warmers. I huddled on the cold, windy platform awaiting the eastbound train to carry me to my job. I wore my winter coat that confounds me with its straitjacket snug lining. The lining catches on my sleeves, bunching up and trapping my arms. Its double-zipper is an aggravation to zip.

Suddenly I was no longer alone in the cold on the dark platform. A young man of about twenty appeared beside me wearing a thin, short-sleeved baseball shirt, baggy blue jeans, and sneakers. To conserve his body heat, he had pulled his arms inside his shirt. “Is this the Metro?” he asked me, shivering and shaking from the cold.

“Yes, it is,” I answered.

“Does the train go to Grand Station?” he asked.

“Yes, it goes to the Grand Station,” I replied.

He looked in bewilderment at both sides of the train platform. “Which one?” he asked.

“The eastbound train goes to the Grand Station,” I explained.

“Which side?” he asked, his voice nearly frantic, as he looked back and forth.

“The eastbound train will arrive on this side. The side where we are standing,” I explained further.

Now the young man’s entire body was quaking. “Do I need a ticket?” he asked me.

It occurred to me that the young man had never ridden a Metro train. He had no idea how to do it. “You need to buy a ticket to ride the train,” I told him. I quickly assessed my own financial situation. All I had in my pocket was four dimes. I hoped he had the two dollars for a ticket.

“Where do I buy a ticket?” he asked. I pointed up toward the ticket machines located by the nearby parking garage. “How do I get there from here?” he asked.

I gestured up, answering, “You have to climb those stairs, take the bridge over the street, and buy a ticket from the machine. You’ll need two dollars. Do you have to be at the Grand Station at a certain time?”

“Seven-thirty,” he told me. “Can I get there by seven-thirty?” His body was jumping.

I quickly calculated. “I think so, but the next eastbound train will be here in a few minutes. I don’t think you have time to buy a ticket and make your train.”

“Do I have to have a ticket?” he asked.

“Well, if you cannot show a ticket, you will have to pay a fifty dollar fine. At this time of day, there will probably not be anyone checking tickets, but it is a risk.” I did not want to advise him to ride without a ticket. He was having more than his share of troubles.
He stammered rapidly, “Well, I can tell them, I just got out of jail. I didn’t know. If I tell them I just got out of jail, and I didn’t know, then they will let me go, won’t they? They won’t make me pay fifty dollars, will they?”

I couldn’t give him the answer he wanted. “If they check for tickets, and you don’t have one, it is a fifty-dollar fine. I doubt that anyone will be checking on the train this early, but it is a possibility.” I looked at him shivering, and thought, he could go into shock in this weather. “You need a coat,” I told him wittily.

“I had one when I went to jail, but they told me it must have been lost. I couldn’t find my coat.” He pulled his hands out through the neck in his collarless shirt to cover his ears.

His ears were cold, of course. I was wearing ear warmers. I was wearing brand-new, expensive-colored men’s ear warmers… and a lined coat… and gloves. “Take my ear warmers.” I passed them to him. “They are men’s ear warmers, so they will fit you.”

He took them eagerly and put them on his ears. “Thank you. God bless you.” was his response. He was quiet for a moment, and then asked, “Does the train have heat?”

“Yes, the train has heat.” I felt so guilty, so privileged, to feel warmer than he felt. “Take my gloves,” I told him, desperate to help him. I felt cruel not to have thought to help him sooner. What is wrong with me? I wondered to myself why I had not seen how cold he was, and why I did not immediately offer him the ear warmers when he first approached me in the cold predawn. Am I heartless?

“I don’t need your gloves,” he answered proudly, pulling his hands back inside his shirt.

He was too large to fit into my coat. I can barely get into my coat with the strangulating lining and Houdini-proof zippers. I considered putting my arms around him until the train arrived, but I decided not to try. He was shivering less, since donning the ear warmers. The eastbound train arrived. On the train, I pointed out to him grand stations. “Look, we are in Washington.”

At the end of the workday, I phoned home and told my husband Roger what time I would be at the metro station. He said, “I’ll bet you are glad you wore the ear warmers today. It is really cold out there.”

“About the ear warmers,” I began. I told him the story of why I no longer had the ear warmers. He didn’t scold me about giving away the extravagant ear warmers. I should have known he wouldn’t have balked at their cost, or that I had them on only once.

As I was leaving the lab, Mo, the cardiologist came back looking for his coat. “Did you see my coat?” he asked me.

“I gave it away to a homeless person,” I joked wryly, remembering the cold young man.

“No one would steal it,” he smiled. “It is a Louis Vuitton, very ugly. Who would want it?”

A person who was cold would want it, I thought. I hope whoever is wearing the ugly coat right now feels warmer inside it.

There will always be people who have less and those who have more. But it is wrong for those of us who have chosen a life in a helping profession to simply accept that there are people close enough to touch, close enough to see, who do not have food, water, clothing, shelter or health care. On a cold January Monday, I saw the invisible at last.

Mimi Signor, RN, MSN, a hospital staff nurse, has been a member of MONA since 1989.
The way that nurses provide care is rapidly changing due to technology and the quantity of new knowledge available to health care providers and consumers. One of the most significant changes in technology is the use of electronic systems to communicate, share electronic health records (EHR) among providers and facilities, and access evidence-based decision support. Some advantages to the change from paper to electronic health records are that they:

- Reduce preventable transcription errors when medications and tests are ordered,
- Eliminate the unnecessary redundancy of duplicate tests, treatments, and procedures done when providers do not have timely access to test results,
- Give more complete, accurate, and timely clinical information,
- Track clinical care to improve coordination of care,
- Make health information portable so that consumers have intact health information when switching providers or when geographically away from usual providers,
- Increase the quality of evidence-based decision making, and
- Improve privacy by restricting protected health information to only providers who consumers’ allow to view their health records.

To support national adoption of health information technology (HIT), the Office of the National Coordinator for Health Information Technology (ONC) was created by the American Recovery and Reinvestment Act (ARRA) of 2009. Meaningful use of HIT is described as basic or full depending on the adoption of 24 functions. ONC surveys of hospitals and physician offices have found little meaningful use of HIT and variation of use by geographic area or within health systems. The ONC reports that in 2009, 20.5% of office-based physicians used basic HIT systems and 6.3% used fully functional systems. According to the Missouri Department of Social Services, three of 151 Missouri hospitals meet the ONC definition of basic adoption and 11 hospitals meet the definition of full adoption.

Although the comprehensive use of HIT is in the early stages across the nation, efforts are underway in Missouri to build a statewide infrastructure for health information exchange (HIE) by 2011. The ARRA provided nearly $14 million to Missouri to plan, design, and implement a state-wide HIE to encourage adoption and use of electronic health records in all health care settings. The Missouri Office of Health Information Technology (MO-HITECH) was created in September, 2009, by executive order of Governor Jay Nixon. MO-HITECH is within the Missouri Department of Social Services and is coordinated by DSS Director Ron Levy. The objectives of MO-HITECH are to:

- Improve the quality of medical decision-making and the coordination of care;
- Provide accountability in safeguarding the privacy and security of medical information;
- Reduce preventable medical errors and avoid duplication of treatment;
- Improve the public health;
- Enhance the affordability and value of health care; and,
- Empower Missourians to take a more active role in their own health care.

Following ONC criteria, MO-HITECH has initiated the process to create Strategic and Operational Plans for creating the necessary infrastructure to support statewide HIE. A 20-member Board of Advisors has been tasked to develop the Plans. The Advisory Board is composed of a diverse group who represent health care consumers, providers, insurers, privacy experts, and state government. The six duties of the Advisory Board are to recommend methods to achieve 1) sustainable financing, 2) transparent governance, 3) privacy protection and compliance with state and federal laws, 4) consumer engagement, 5) business and technical operations supporting adoption and use, and 6) technical infrastructure to support statewide health information exchange.

Six workgroups, corresponding to each of the six duties of the Advisory Board, were created to develop and vet recommendations to the Advisory Board. The workgroups are open to the public and are attended by a variety of stakeholders and subject matter experts. The workgroups are staffed by the Missouri DSS to provide consistency and coordination of efforts. Meetings are held in Jefferson City every other week from December, 2009, through May, 2010. Workgroup meeting times and locations can be found at the MO-HITECH web site (http://www.dss.mo.gov/hie/index.shtml). The Strategic Plan outlining MO-HITECH efforts is available online and was submitted to the ONC in mid March, 2010. An Operational Plan including sustainability of the infrastruc-
tute will be submitted to ONC at the end of May, 2010. Proceedings of the meetings and the Strategic and Operational Plans also are available on the MO-HITECH web site.

Implementation of the MO-HITECH Strategic and Operational Plans will affect the care provided by every Missouri nurse. CMS incentive payments to advance practice nurses who provide care to Medicare and Medicaid beneficiaries will be dependent on meaningful use of certified EHR technology beginning 2011. The workgroup meetings are an opportunity for open dialogue among health care stakeholders and benefit from the perspective of nurses in identifying the technology needs of providers and in advocating for consumers as full partners in their own health care. Nurses do not need to attend all workgroup meetings and can attend as many or as few as their schedules allow.

Other funds to support adoption of HIT are an estimated $34 billion for subsidies for the purchase of electronic health record systems by hospitals and office-based physicians. The money to providers is available through the Medicare and Medicaid programs through 2015. An estimated $2.8 billion will flow to Medicaid providers from 2010 to 2015. The remaining $31 billion will support Medicare providers from 2011 to 2015 with statewide adoption of electronic health records expected by 2015. Providers who have not responded to the incentives to adopt electronic medical records by 2015 will be subject to penalties. In addition, increased matching funds to cover states’ administration costs will be available for Medicaid, with $142.3 million available for Broadband and telehealth development, and grants to provide workforce development.

Citations available upon request.

BEHIND THE BOOK

Heroic Acts in Humble Shoes
America’s Nurses Tell Their Stories

Irene Stemler, RN, BSN

They are compassionate voices, they are dedicated professionals, they are critical players in the health care system with worn pairs of shoes that have miles of stories to tell. They are America’s nurses.

Heroic Acts in Humble Shoes: America’s Nurses Tell Their Stories is more than just a quick glance into the trials, tribulations, joys and rewards of nursing. It is a gateway to understanding what today’s nurses are challenged with everyday.

Irene Stemler, RN, BSN, goes beyond the research and gives a voice to the millions of nurses who directly or indirectly make a difference in the lives of patients. Each story opens with a photograph of the nurse’s shoes and offers a unique, passionate, personal, and sometimes controversial perspective on nursing in today’s health care environment.

Author Bio

Irene Stemler is a registered nurse and holds a Bachelor of Science degree in Nursing from Rush University in Chicago. She has over 22 years of health care experience in nursing management, education, advocacy and consulting. Irene had been working on a federally funded nurse retention grant at the University of Illinois, and most recently has been focusing on nurse recruitment strategies for the federal government. She is a former vice president of clinical services for a national assisted living company where she co-developed the corporation’s signature health and wellness program.

She has been collecting well worn nursing shoes and the stories behind them in response to this country’s impending nursing shortage. (By the year 2020, the projected RN shortage will be 800,000.)

Nearly two years after she began collecting nurses’ shoes and their stories, she stumbled across a family story that gave greater meaning to her work. She was told that her grandfather, a man she had never met and who died in WWII, was a shoemaker. She realized then that a pair of worn nurses’ shoes was the perfect symbol for a profession that needed mending….and that a shoemaker’s granddaughter might be the ideal person to take up the cause.

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www.slackbook.com/stemler
The Unbreakable Bonds of Nursing

Georgene Bosaw, CCRN, CRNA, MS in Nurse Anesthesia

Two thousand ten is a precarious time to be a nurse. Health care reform is imminent. We can pretend it won’t happen, but it will despite our best efforts to prevent it. All I can say is, it’s about time...To fix a health care system that I love, but realize needs to change in order to suit the needs of the patients and their families. I was taught the focus must always be on the patient and the patient’s family.

Our current health care system is too expensive for the value it provides. Now is the time to brainstorm on how to provide quality with getting the best “bang for our buck” or in economist terms, to be cost effective without sacrificing the quality of care. This is where we need to tread lightly. A pure economist might tell us the most cost effective way to take care of a patient is to kill him humanely and I have actually heard an economist say that in jest. These kinds of comments have people fearing “death camps,” euthanasia and all kinds of morally repugnant ideas that keep people fearing ANY kind of change in health care. Change will occur whether we like it or not. The cost of health care continues to skyrocket, while the cost of living wages dwindle, as unemployment continues to rise. Money is running out, so where will the money come from? I do not pretend to know all of the answers. All I do know is that nursing must be sitting at the table to discuss the big changes with our legislators and leaders, probably more so than any other group, because we are the proclaimed patient advocates. Our valuable history will attest to that fact.

Nurses have existed in some form for centuries, as have physicians, and pharmacists. Florence Nightingale is lauded as our famous nurse leader, the pioneer of modern nursing. She was a feminist, statistician, hospital administrator, and a woman ahead of her time. 2010 is a great time to be a nurse. It happens to be the International Year of the Nurse, commemorating the centennial of Nightingale’s death. The United Nations Decade for a Healthy World is 2010 to 2020. Nightingale focused on prevention and holistic care, which is the cornerstone of nursing today. How appropriate that her centennial coincides with the Decade for a Healthy World.

Nightingale was inspired by what she took as a Christian divine calling to become a nurse in 1837, at the tender age of 17. She made the decision to enter nursing in 1845, despite the anger and distress of her family, her mother in particular. She rebelled against the expected role for a woman of her high economic status to become a wife and mother. Instead, Nightingale cared for people in poverty, and was active in the reform of the Poor Laws in Great Britain.

Florence Nightingale’s most famous contribution came during the Crimean War. In 1854, she and a staff of 38 women volunteer nurses, who were trained by Nightingale, tended to British troops in what is now modern day Istanbul. She and her nurses found wounded soldier being poorly cared for by overworked medical staff in the face of official indifference. Medicines were in short supply, hygiene was neglected, and mass infections were common. Most of the soldiers died from typhus, typhoid, cholera and dysentery rather than from battle wounds. Conditions were fatal because of overcrowding, defective sewer systems, and lack of ventilation in the military hospitals. Within six months of Nightingale’s arrival, death rates were reduced from 42% to 2% by simple improvements of hygiene and sanitation. Initially she thought the high death rates were due to poor nutrition, limited supplies, and overworking of the soldiers. The statistician in her led to her later conclusion that the sanitary conditions were what made the critical difference in survival rates.

Remember that Florence was a nurse, so the human touch and connection were also of great importance in the healing process. “The Lady with the Lamp” was the phrase that a report in THE TIMES stated: She is a “ministering angel” without any exaggeration in these hospitals, and as her slender form glides quietly along each corridor, every poor fellow’s face softens with gratitude at the sight of her. When all the medical officers have retired for the night and silence and darkness have settled down upon those miles of prostrate sick, she may be observed alone, with a little lamp in her hand, making her solitary rounds.

“Nightingale’s achievements are all the more impressive when they are gauged against the background of social restraints on women in Victorian England. Her father, William Edward Nightingale, was an extremely wealthy landowner, and the family moved in the highest circles of English society. In those days, women of Nightingale’s class did not attend universities and did not pursue professional careers; their purpose in life was to marry and bear children. Nightingale was fortunate. Her father believed that women should be educated, and he personally taught her Italian, Latin, Greek, philosophy, history, and more unusual of all for women of the time, writing and mathematics.” Nightingale wrote Notes on Nursing, published in 1859. Every day sanitary knowledge, or the knowledge of nursing, of how to put the constitution in such a state as that it will have no disease, or that it can recover from disease, takes a higher place. It is recognized as the knowledge which every one ought to have distinct from medical knowledge, which only a profession can have. That profession is nursing, one that focuses on the well-being of patients, not merely the absence of disease, the holistic aspects of nursing. In my opinion, any nurse who focuses merely on the physical aspects of patient care is missing a critical
piece in the healing equation. Nurses need to harness whatever power lies within a patient and his or her family to help in the healing process. Whatever you wish to call it, it does exist and begs to be used by all of our patients. Most patients wish to be healed and much of that power lies within them. Nurse just need to analyze how to best channel that power, or have the patient “heal himself.” Nurses support patients on their journey of healing.

Nightingale started her own nursing program, now called the Florence Nightingale School of Nursing and Midwifery in 1860. She trained Linda Richards, “America’s first trained nurse” in the 1870s. Linda Richards went on to become a great nursing pioneer in the United States and Japan. What a splendid history nursing has!

Numerous studies in our profession have proven that when nurse to patient ratios are too great, morbidity, mortality, and infection rates increase. Can many other professions make that claim? Nurses have been the “ whistleblowers” of health care corruption and report those who do harm to patients. Nurses are consistently voted among the most trusted of health care professionals in survey after survey.

Nurses historically were the ones who cleaned the patient rooms and linens, stoked the fires, fed the sick from meals the nurses had prepared, gave the patients medications, helped with patient exercise, and performed respiratory percussion to loosen secretions. Before the specialties of dietary, nutritionists, physical therapists, occupational therapists, music therapists, and respiratory therapists, came into being, there were nurses. We are the profession that treats every aspect of the entire patient, the one body with many parts and a soul, a soul that can often soar when the body has already shut down. We as nurses witness those born into this world and those who exit it. We help regardless of where our patients are on their journey. It is our great honor to witness all of this, or at least as much as we can handle.

So the rich history of nursing blends with that of nurse anesthesia. Nurses were the first professional group to provide anesthesia services in the US. Established in the late 1800s as the first clinical nursing specialty, nurse anesthesia was developed in response to the growing need surgeons had for specially trained anesthetists. The profession continued developing in the early 1900s through the efforts of Dr. William Mayo and the mother of anesthesia, Alice Magaw, at the facility later known as the Mayo Clinic.

World War I increased the demand for nurse anesthetists and as a result, the training of nurses for this field escalated. Existing nurse anesthetists trained both physicians and nurses to provide anesthesia services at home and abroad. The formalization of physician education in the field of anesthesia did not become prevalent until after World War II. Only seven anesthesiology residencies for physicians of at least one year of specialty training were in existence at the outbreak of World War II. Since World War I, nurse anesthetists have been the principal anesthesia providers in combat areas in every war in which the United States has been engaged. During World War II, there were seventeen nurse anesthetists to every one physician anesthetist. In Vietnam, the ratio of CRNAs to physician anesthetists was approximately 3:1. During the Panama strike authorized in 1989, only CRNAs were sent with the fighting forces.

Nurse anesthetists have been pioneers in anesthesia for specialty surgery, particularly lung and heart surgery. They are also involved in the development of anesthesia equipment for utilizing certain anesthesia techniques.

CRNAs were the first specialty nursing group to receive direct Medicare Part B reimbursement under the Omnibus Budget Reconciliation Act of 1986.

**Missouri’s Unique Contributions to AANA and CRNA History**

The Missouri Association of Nurse Anesthetists (MoANA) was founded in 1935 by fifteen charter members, including Helen Lamb, of St. Louis. Helen Lamb was the first president of the Missouri Association of Nurse Anesthetists (MoANA) and later served as president of the American Association of Nurse Anesthetists (AANA). Helen was the director of one of the first schools of nurse anesthesia, begun in 1929 at Barnes Hospital in St. Louis. The Barnes/Washington University Nurse Anesthesia Program graduated its last official class in August of 1994. The program is now called the Goldfarb School Nursing Anesthesia Program at Barnes-Jewish College in St. Louis. The college reopened its door again in 2005, and is directed by Bernadette Henrichs, CRNA, PhD, and Vicki Coopmans, CRNA, PhD.

**Who Are Nurse Anesthetists?**

A Certified Registered Nurse Anesthetist (CRNA) is an advanced practice nurse who administers anesthesia. CRNAs are anesthesia professionals who safely administer approximately 32 million anesthetics to patients.
ANESTHESIA COVERAGE IN MISSOURI

CRNA only - 38 Counties
CRNA and Anesthesiologist - 33 Counties
No Surgical Services - 44 Counties

UPDATED 01/10

each year in the United States, according to the American Association of Nurse Anesthetists (AANA) 2008 Practice Profile Survey.

CRNAs are the sole anesthesia providers in nearly 70 percent of all rural hospitals, affording these medical facilities obstetrical, surgical, and trauma stabilization capabilities. They work in every setting in which anesthesia is delivered, including hospital surgical suites and obstetrical delivery rooms, ambulatory surgical centers, and the offices of dentists, podiatrists, and plastic surgeons.

Scope of Practice
All 50 states and the District of Columbia recognize CRNAs as qualified anesthesia providers who administer all types of anesthesia (local, regional and general) at the request of surgeons, dentists, ophthalmologists and podiatrists.

Education and Experience
For those applying to a nurse anesthesia program, the minimum requirements include:
- Bachelor of Science in Nursing or other appropriate baccalaureate degree.
- License as a registered nurse.
- Minimum of one year of experience in an acute care nursing setting.
- Graduation from an accredited school of nurse anesthesia program at least two years in length. These programs offer a graduate degree and include clinical training in university based or large community hospitals.
- Passing a national certification exam following graduation, and completing a continuing education and recertification program every two years thereafter.

Due to the American Association of Colleges of Nursing (AACN) changes, all Master Degrees awarded in Nursing Schools will be lengthened to doctoral degrees (DNP or PhD or both) by the year 2015.

By 2025, the Council on Accreditation (accredits nurse anesthesia programs) is requesting that all programs be converted to a doctoral program. This means all CRNAs will graduate with a DNP or PhD or similar doctoral degree. Many programs are making that change, starting in 2010. All programs are currently transitioning their educational programs to grant doctoral degrees with the deadline of 2025.

Accredited Nurse Anesthesia Programs in Missouri
Goldfarb School of Nursing at Barnes-Jewish College--Nurse Anesthesia Program
Provides an MSN in Nursing with a specialization in Nurse Anesthesia. Program is 28 months in length.

St. John's School of Nurse Anesthesia at Missouri State University
Provides a MS in Nurse Anesthesia. Program is 30 months in length.

Truman Medical Center School of Nurse Anesthesia
Provides an MA in Biology. Program is 36 months in length.

Webster University
Provides an MS in Nurse Anesthesia. Program is 30 months in length.

Missouri Association of Nurse Anesthetists (MoANA)
The Missouri Association of Nurse Anesthetists (MoANA) is the professional association of Missouri Anesthetists. MoANA strives to ensure patient safety in anesthesia and access to excellent anesthesia care for all Missouri citizens – rural and urban. MoANA represents over 900 CRNAs in our state.

MoANA is currently in legal arbitration with the Board of Healing Arts regarding the ability and rights of nurse anesthetists to perform pain management on patients with
chronic pain. Blocks such as lumbar epidural, thoracic epidural and cervical facet blocks, are often performed with the use of fluoroscopy. The Board of Healing Arts has now stated this is outside of the scope of practice of nurse anesthetists and the practice of medicine. As of yet, there has not been a decision made. MoANA still has a case before the Administrative Hearing Commission on whether MoANA can join a suit before the Board of Healing Arts regarding one CRNA in the state of Missouri who was practicing with an anesthesiologist in a chronic pain setting.

The chronic pain issue and issues regarding supervision requirements by physicians in the Missouri Nurse Practice Act continue to be an ongoing stressor between MoANA and the Missouri Society of Anesthesiologists. Advanced practice nurses in Missouri practice in collaborative practice agreements with physicians and nurse anesthetists practice differently.

CRNAs practice under the supervision of a surgeon, dentist, ophthalmologist, or podiatrist. CRNAs in Missouri are licensed registered nurses and hold a Certificate of Recognition for Advanced Practice under the Board of Nursing. Anesthesia given by a CRNA is the practice of nursing. In fact, over 53% of Missouri’s counties with hospitals providing anesthesia services are covered solely by CRNAs. These CRNAs provide anesthesia to many patients who would have to drive an inordinate number of miles to receive anesthesia services if sole provider CRNAs did not exist in Missouri. Less than 47% of Missouri’s counties with hospitals providing surgical services have anesthesiologists, whereas 100% of Missouri’s counties with hospitals providing surgical services have CRNAs.

Managed care plans recognize CRNAs for providing high-quality anesthesia care with reduced expense to patients and insurance companies. The cost-efficiency of CRNAs help to control escalating health care costs. Studies that compare morbidity, mortality and infection rates between CRNAs and anesthesiologists have found no statistically significant differences. One of these studies was done by a cardiologist, Dr. Pine, who probably provided the least biased study of the many performed.

In May, we celebrate Nurses Week 2010. I hope this year is our banner year. I consider myself fortunate to be a nurse, to have a job in this trying economy, and to serve my patients and their families, and my fellow nurses. Nightingale had it right. We are here to serve, educate, and protect, our patients and each other. It is our calling as it was hers. It is an honor to be a nurse in 2010, the International Year of the Nurse. We should never forget our unbreakable bonds.

References available upon request.
Overview of the Nurse Staffing Requirements that Resulted from the Work of the Technical Advisory Committee and The Missouri Nurses Association

The Technical Advisory Committee on the Quality of Patient Care and Nursing Practices (TAC) was established during the 2000 legislative session as Senate Bill 788 was passed and signed into law effective August 28, 2000. Members were appointed by the director of the Department of Health and Senior Services (DHSS) and include:

a. One representative from the Department of Health and Senior Services;

b. Three registered nurses from nominations made by the Missouri Nurse’s Association;

c. One physician nominated by the Missouri State Medical Association;

d. Two members nominated by Missouri Hospital Association;

e. One member representing licensed practical nurses; and

f. One public member.

The committee was initiated to work with hospitals, nurses, physicians, state agencies, community groups and academic researchers to develop recommendations for improving the quality of patient care and ensuring the safe, efficient, and professional employment of nurses in hospitals and ambulatory surgical centers. Originally, the committee was to sunset in December of 2006, but the committee members requested an extension due to the fact that completion of several key patient safety issues had not been finalized. The extension was granted for an additional five years. The committee is now scheduled to sunset on December 31, 2011.

One major accomplishment recently was the development and finalization of Safe Staffing regulations. The TAC on the Quality of Nursing Care and Patient Services recommended rule changes to bridge a gap between mandated staffing ratios and staff participation in determining nurse staffing models and workload. These regulations provide guidelines for hospitals related to developing safe staffing patterns on nursing units. The committee developed a collaborative model which involves staff nurses in decision making.

In December 2008, the DHSS published amendments to the hospital nursing services rule that outlined new requirements for nurse staffing requirements in hospitals. The rule, found in portions of 19 CSR 30-20.096, became effective Tuesday, June 30, 2009, and applies to hospitals licensed by the DHSS, including critical access hospitals.

There are several key elements of the new regulations that apply to units organized as part of the hospital’s nursing service.

- Maintain a list of nursing staff who may be called when additional staff is needed per the hospital’s developed policy.
- Develop a hospital-wide staffing plan and submit a copy of the plan to the DHSS annually at the beginning of the hospital’s fiscal year.
- Document actual staffing levels by unit on a per-shift basis.
- Monitor staffing plan effectiveness with a minimum of three nursing sensitive indicators.
- Make the staffing plan available to patients or their authorized representatives.
- Seek input from direct care nursing staff in developing the staffing plan.

For your convenience, the entire Nursing Service regulation has been reprinted on the following pages.

New language is in bold-face, blue type.
The Missouri Nurse standards:

1. The nursing service shall be integrated and identified within the total hospital organizational structure.
2. The nursing service shall have a written organizational structure that indicates lines of authority, accountability, and communication.
3. The organization of the nursing service shall conform to the variety of patient care services offered and the range of nursing care activities.
4. Nursing policies and standards of practice describing patient care shall be in writing and be kept current.
5. Policies shall provide for the collaboration of nursing personnel with members of the medical staff and other health care disciplines regarding patient care issues.
6. Nursing service policies shall establish an appropriate committee structure to oversee and assist in the provision of quality nursing care. The purpose and function of each committee shall be defined and a record of its activities shall be maintained.
7. Policies shall make provision for nursing personnel to be participants of hospital committees concerned with patient care activities.
8. Policies shall be developed regarding the use of overtime. The policies shall be based on the following standards:
   (A) Overtime shall not be mandated for any licensed nursing personnel except when an unexpected nursing staff shortage arises that involves a substantial risk to patient safety, in which case a reasonable effort must be applied to secure safe staffing before requiring the on-duty licensed nursing personnel to work overtime. Reasonable efforts undertaken shall be verified by the hospital. Reasonable efforts shall include pursuing all of the following:
      1. Reassigning on-duty staff;
      2. Seeking volunteers to work extra time from all available qualified nursing staff who are presently working;
      3. Contacting qualified off-duty employees who have made themselves available to work extra time, per diem staff, float pool and flex team nurses; and
      4. Seeking personnel from a contracted temporary agency or agencies when such staffing is permitted by law or an applicable collective bargaining agreement and when the employer regularly uses the contracted temporary agency or agencies;
   (B) In the absence of nurse volunteers, float pool nurses, flex team nurses or contracted temporary agency staff secured by the reasonable efforts as described in subsection (8)(A) and if qualified reassignments cannot be made, the hospital may require the nurse currently providing the patient care to fulfill his or her obligations based on the Missouri Nurse Practice Act by performing the patient care which is required;
   (C) The prohibition of mandatory overtime does not apply to overtime work that occurs because of an unforeseeable emergency or when a hospital and a subsection of nurses commit, in writing, to a set, predetermined staffing schedule or prescheduled on-call time. An unforeseeable emergency is defined as a period of unusual, unpredictable or unforeseeable circumstances such as, but not limited to, an act of terrorism, a disease outbreak, adverse weather conditions, or natural disasters which impact patient care and which prevent replacement staff from reporting for duty;
   (D) The facility is prohibited from requiring a nurse to work additional consecutive hours and from taking action against a nurse on the grounds that a nurse failed to work the additional hours or when a nurse declines to work additional consecutive hours beyond the nurse's predetermined schedule of hours because doing so may, in the nurse's judgment, jeopardize patient safety;
   (E) Subsection (8)(D) is not applicable if overtime is permitted under subsections (8)(A), (B), and (C);
   (F) Nurses required to work more than twelve (12) consecutive hours under subsections (8)(A), (B), or (C) shall be provided the option to have at least ten (10) consecutive hours of uninterrupted off-duty time immediately following the worked time; and
   (G) The nursing service shall maintain and make available upon request to the department a list of qualified nurses, nurse registries, and per diem nurses that may be called upon to provide replacement staff in the event of sickness, vacations, vacancies, disasters, and other absences of direct care nursing staff.
9. The nursing service shall be administered and directed by a qualified registered professional nurse with appropriate education, experience and demonstrated ability in nursing practice and management.
10. The nursing service administrator shall be responsible to the chief executive officer or chief operating officer.
11. The nursing service administrator shall be a full-time employee and shall have the authority and be accountable for assuring the provision of quality nursing care for those patient areas delineated in the organizational structure.
12. The nursing service administrator shall participate in the formulation of hospital policies and the development of long-range plans relating to patient care.
13. The nursing service administrator, or designee, shall represent nursing at all appropriate meetings of the medical staff and governing board of the hospital.
14. The nursing service administrator shall be accountable for the selection, promotion and termination of all nursing personnel under the authority of nursing service.
15. The nursing service administrator shall have sufficient time to perform the necessary managerial duties and functions of the position.
16. A qualified registered professional nurse shall be designated and authorized to act in the absence of the nursing service administrator.
17. Nursing personnel shall hold a valid and current license in accordance with sections 335.011–335.096, RSMo.
18. There shall be a job description for each classification of nursing personnel which delineates the specific qualifications, licensure, certification, authority, responsibilities, functions and performance standards for that classification. Job descriptions shall be reviewed annu-
ally and revised as necessary to reflect current job requirements.
(19) There shall be scheduled annual evaluations of job performance for all classifications of nursing personnel.
(20) All nursing personnel shall be oriented to the hospital, nursing services, their position classification, the use of overtime, and the nursing service regulation 19 CSR 30-20.096. The orientation shall be of sufficient length and content to prepare nursing personnel for their specified duties and responsibilities. Competency shall be validated prior to assuming independent performance in actual patient situation.
(21) For specialized nursing units and those units providing specific clinical services, written policies and procedures, including standards of practice, shall be available and current.
(22) Nursing personnel meetings shall be conducted at intervals necessary for leadership and to communicate management information. Separate meetings for the various job classifications of personnel may be conducted. Minutes of all meetings shall be maintained and reflect attendance, scope of discussion and action(s) taken. The minutes shall be filed according to hospital policy.
(23) Every hospital shall develop, implement, and submit to the department by April 1, 2009, and annually thereafter at the start of the hospital's fiscal year, a written hospital-wide staffing plan for nursing services. Every hospital shall have a process that ensures the consideration of input from direct care nursing staff from each unit within the hospital.
(24) The hospital-wide staffing plan for nursing services shall:

(A) Include the number, skill mix, and qualifications of direct care nursing staff needed for each unit of the hospital;
(B) Be based on the expected nursing care required by the unit population and individual needs of each patient. The expected unit population and individual nursing care needs of each patient shall be the major consideration in determining the number and skill mix of direct care nursing staff needed; 
(C) Identify relevant factors in each hospital unit including, but not limited to, the number of patients in a unit; intensity of care required; skill and experience of care givers including registered nurses, licensed practical nurses, ancillary personnel, and other members of the patient care team consistent with the level of authority and responsibility delegated under state licensure; admission, discharge, and transfers; nonpatient care duties; geography of a unit; and the availability of technological support; and
(D) Provide for documentation of the actual staffing plan.
(25) Every hospital shall establish nursing sensitive indicators and monitor outcomes of these indicators to evaluate the adequacy of the hospital-wide staffing plan for nursing services. At least one (1) of each of the following three (3) types of outcomes shall be used to evaluate the adequacy of the staffing plan:
(A) Patient outcomes such as patient falls, adverse drug events, injuries to patients, skin breakdown, infection rates, length of stay, or patient readmissions;
(B) Operational outcomes such as work-related injury or illness, vacancy and turnover rates, nursing care hours per patient day, on-call use, or overtime rates; and
(C) Validated patient complaints related to staffing levels.
(26) The hospital shall, in consultation with its direct care nursing staff, monitor and evaluate the hospital-wide staffing plan and nursing sensitive outcomes for effectiveness on a continual basis and revise the plan annually and as necessary.
(27) Each facility shall develop and utilize a methodology which ensures it is staffed with sufficient numbers and skill mix of appropriately qualified direct care nursing staff in each unit to meet the unit population and individualized care needs of the patients. Each unit shall document actual staffing and patient census during every shift.
(28) At a minimum, there shall be a sufficient number of registered professional nurses on duty at all times to provide patient care requiring the judgment and skills of a registered professional nurse and to supervise the activities of all nursing personnel.
(29) There shall be sufficient licensed and ancillary nursing personnel on duty on each nursing unit to meet the needs of each patient in accordance with accepted standards of nursing practice.
(30) Each nursing unit shall post in a visible location on the nursing unit or make available to the patient(s) or patient’s authorized representative a copy of the unit’s hospital-wide staffing plan for nursing services and documentation of actual daily staffing levels.
(31) Patient care assignments shall be consistent with the qualifications of the nursing personnel and the identified patient needs. Nurses included in the count of direct care nursing staff in a unit of a hospital for purposes of compliance with the hospital-wide staffing plan shall have appropriate licensing, training, and orientation to ensure that the nurses are capable of providing competent nursing care to the patients in the unit. Hospitals shall also verify that nurses included in the count are capable of providing competent nursing care to the patients in the unit. Nurses included in the count shall spend a minimum of seventy-five percent (75%) of their time providing direct patient care.
(32) Documentation in the patient’s medical record shall reflect use of the nursing process in the delivery of care throughout the patient’s hospitalization.
(33) A registered professional nurse shall assess the patient’s needs for nursing care in all settings where nursing care is provided. A nursing assessment shall be completed within twenty-four (24) hours of admission as an inpatient. The registered professional nurse may be assisted in the process by other qualified nursing staff members.
(34) Patient education and discharge needs shall be addressed and appropriately documented in the medical records.
(35) The necessary types and quantities of supplies and equipment shall be available to meet the current needs of each patient. Reference materials pertinent to patient care shall be readily accessible.
MONA ANNOUNCES
7th Edition Continuing Education Excellence in Missouri Manuals for Provider and Education Activity Approval

The Missouri Nurses Association (MONA) presents the Continuing Education Excellence in Missouri Manuals for Provider Approval and Education Activity Approval, 7th edition. To be in compliance with the American Nurses Credentialing Center’s Commission on Accreditation (ANCC COA), the members of the MONA CE Approver Unit Committee have reviewed the new ANCC COA criteria, developed new applications and sample forms for applicants, and revised & published the 7th edition of the CE Manuals for Provider and Education Activity Approval. While change is challenging for everyone involved, MONA believes that through continued improvement of the ANCC COA criteria, we can offer nurses enhanced continuing education activities while streamlining the approval process for applicants.

To facilitate the application process, we strongly encourage providers to purchase the new manual. A variety of sample responses have been provided for each statement of required evidence to assist you as you complete the application process. All applications and sample forms are available to download from our website at www.missourinurses.org.

ORDER TODAY
ONLINE: www.missourinurses.org
EMAIL: sara@missourinurses.org
PHONE: 573-636-4623, x224

Thank You for a great conference!

See you next year
Tuesday, February 22, 2011
Health Reform? Listen up for a Different Perspective
Your Wellness is Under Your Control!

With the health care industry now in the national spotlight, many of us are questioning the current systems in place for diagnosis, treatment and reimbursement for delivery of services. There are growing concerns for those with chronic disease and the cost of care needed to support, obesity, diabetes, heart disease, etc. This is just not a concern for adults but for our children too, who are now being diagnosed with Type 2 or Adult Onset Diabetes. Many of us are looking for alternative options, hence all the media focus on wellness and prevention. What many of us fail to realize is that the absence of disease does not necessarily mean we are well. We are sometimes in a state of pre disease with no symptoms, with some diseases having long latency periods. We also fail to realize that we have lost our nutrition to processed foods and are reaping the undesirable effects - obesity. Obesity is linked to several medical conditions including heart disease and diabetes is out of control.

So, what can we do to stay healthy and realize a better quality of life? What can we do to stay energized and not feel tired and lethargic all the time? We can stay informed, eat healthier and exercise daily. This can lead to staying well. Being educated on lifestyle and diet and how they can positively or negatively affect your health is crucial. Lifestyle is connected to wellness and is in our control. We need to assume this accountability to stay well and keep down the cost of health care. Did you know that by exercising five times per week there is a likelihood you can reduce the risk of colon and lung cancer by 50%. WOW!

Diet and exercise play a huge role in our overall well-being and many common illnesses and issues could be reduced by up to 80% by a change in lifestyle and diet. Commit to taking charge of your health and the health of your loved ones now. Let’s take part in our own health reform agenda and realize a better future for ourselves and the ones we care for.

Be watching for more articles and information on obesity, exercise, stress, weight gain, and changing body composition using the low glycemic index theory of eating and healthier lifestyles.

Julie J. Leibold RN, MONA Member, Independent Wellness Consultant.

NCLEX Joins Facebook and Twitter

The National Council of State Boards of Nursing (NCSBN) NCLEX Examinations have joined the social networking sites Facebook and Twitter to enable individuals who are interested in learning more about these exams to receive the most up to date information quickly and easily.

NCSBN develops and administers the NCLEX-RN Examination for registered nurses and the NCLEX-PN Examination for licensed practical/vocational nurses. NCLEX Facebook updates and Twitter tweets will focus on sharing critical information about these examinations with the public and serving as an informational hub for all things NCLEX.

Facebook users can become fans of NCLEX by joining the official NCSBN NCLEX-RN and NCLEX-PN Examinations Facebook page at http://bit.ly/a4hPg; Twitter users can follow NCLEXInfo tweets at www.twitter.com/NCLEXInfo.

NCSBN’s NNAAP and MACE Examinations Department have also launched their own Facebook pages, providing information about the National Nurse Aide Assessment Program (NNAAP) and the Medication Aide Certification Examination (MACE).

The National Council of State Boards of Nursing (NCSBN) is a not-for-profit organization whose members include the boards of nursing in the 50 states, the District of Columbia and four U.S. territories — American Samoa, Guam, Northern Mariana Islands and the Virgin Islands. There are also four associate members.

Mission: The National Council of State Boards of Nursing (NCSBN), composed of Member Boards, provides leadership to advance regulatory excellence for public protection.
Credit Tips - Use Credit Wisely

In order to buy a home, get a loan, deal with emergencies, shop online, or do most traveling, you must have a credit card. By using credit wisely, you can make the most of having it and limit the risks. Having good credit makes accomplishing your financial and personal goals much easier. You will be free to pursue short-term term plans while saving for the future!

Using credit wisely will help you:

- Build wealth instead of pay debts
- Get better loan terms
- Enjoy financial freedom
- Plan a successful future

Knowing your credit history is essential. Your credit report documents your financial behavior: how much credit you have, how long you’ve had it, and how well you have handled it. If you identify any problems, you will be able to take action to improve your score.

Understanding the terms and policies of your creditors is critical in building and maintaining strong credit history. Knowing the interest rate, grace periods, and fee policies on each account is the first step in preventing problems. A record of paying bills on time is a primary factor in demonstrating good credit management.

Inspect your credit report once a year to ensure all of the information is accurate. If you identify any errors, work directly with creditors and provide supporting documentation to have them corrected.

With a credit card, you can buy things right away, even if you do not have the money, and repay the amount you spend — usually with interest — over time. This makes credit cards a good way to deal with unexpected expenses, but beware of impulse buying.

Credit cards are a convenient way to shop: you do not have to carry cash, it is easier than writing checks, and it helps consolidate your spending into one payment. But if you pay only the minimum due each month, interest charges can add up fast. Make a plan to repay balances quickly, and keep in mind that debt should never exceed 20% of your income. Knowing your limit and understanding what you can afford is the key to using credit wisely.

Wisdom and Wealth

The Missouri Nurses Association (MONA) and Women’s Institute for a Secure Retirement (WISER) have teamed together to provide a NurseWise seminar focusing on retirement issues for women. This three-hour seminar covers all aspects of planning including insurance, investments, retirement, budgeting, social security and much more. Lisa DeSha, Director of Association Operations, has been trained to present the program to nurses around the state. If your facility, clinic, school or healthcare setting is interested in this presentation, please contact Lisa DeSha at 573-636-4623, ext. 223 or lisa@missourinurses.org.

Check out upcoming issues for the Wisdom and Wealth column pertaining to money management.
Terry Reese, MSN, FNP-BC

Terry Reese, a Nurse Practitioner in Poplar Bluff, MO, has been a member of the Missouri Nurses Association for sixteen years.

He was elected to the position of state director and took office at last year’s MONA Biennial Convention. He also serves on the MONA Bylaws and Government Affairs Committees.

Terry believes challenges facing nursing today include: advancing the profession with BSN in ten, improving conditions for patients on a continual basis, getting more nurses involved in the legislative process, and staying in tune to the health care reform debate and taking advantage of the opportunities that arise.

As a long term goal for his career, he would like to obtain a doctorate degree and become an associate director in the VA. He has also considered starting a Nurse Practitioner group practice.

Terry and his wife, Carla, are the proud parents and grandparents to four children and four grandchildren.

Terry sees the importance of MONA as the only collective voice for the nursing profession at the State Capitol, which is where our livelihood is managed legislatively. It is also important that MONA has a professional lobbyist that monitors legislation affecting nursing. This allows for quick action by MONA on the Missouri nursing profession’s behalf. Terry feels as licensed professionals, nurses have an obligation to the profession to be involved in professional organizations to promote and protect our profession, our work place and our patients.

MONA Member
Appointed to ANCC Board of Directors

Michael L. Evans, PhD, RN, FAAN, the Maxine Clark and Bob Fox Dean and Professor of the Goldfarb School of Nursing at Barnes-Jewish College, has been appointed to the Board of Directors of the American Nurses Credentialing Center (ANCC). Dr. Evans was nominated for this appointment by the Missouri Nurses Association and the Texas Nurses Association. The appointment was made by the Board of Directors of the American Nurses Association.

The ANCC Board consists of ten members. ANCC’s internationally renowned credentialing programs certify nurses in specialty practice areas, recognize healthcare organizations for nursing excellence through the Magnet Recognition Program®, and accredit providers of continuing nursing education.

Michael is a MONA member and also serves as treasurer of the Missouri Nurses Foundation.

MONA would like to say farewell and thank you to Rachel Carr who provided administrative support to the MONA office and membership for many years.

She has been accepted into the nursing program at Lincoln University and is currently serving as a Unit Clerk/Patient Care Tech in the Intensive Care Unit for Capital Region Medical Center in Jefferson City. Please join us in congratulating her on this new position as well as her acceptance into the nursing program.

Rachel will be missed by many but hopefully we will see her back soon as a MONA member!!
Georgene Bosaw, RN, BSN, CCRN, CRNA, MS in Nurse Anesthesia

Georgene Bosaw from Des Peres, MO, has been a member of the Missouri Nurses Association for twenty years.

Georgene believes the greatest challenge of nurses today are the barriers to care placed by a health care system which no longer considers the patient and family first. She thinks the patient and family must always come first, or the health care system is doomed to fail. She also believes health care reform is inevitable because our current system is broken. She sees medical care costs continuing to skyrocket disproportionately with inflation and outcomes on long term morbidity, mortality and infections rates are dismal when compared to other industrialized countries. Georgene does not believe our health care system is broken beyond repair, but she does think it requires a major overhaul. She thinks it will take the talents and efforts of many nurses to repair much of it, because nurses, more than any other health care professional, affects patients’ outcomes. She believes the behavioral health physicians, pharmacists, and therapists have the most amount of work to perform in order to save our health care system and our country. The rates of addiction and obesity in our children and young adults appear to be at an all time high, while the resources are stretched too thin. She observes prevention as the first place health care reform needs to begin as prevention of illness has always been the nursing profession’s mantra and it rings true even more today.

As a long term goal for her career, she would like to become more active in the education of nurses and nurse anesthetists. She plans to continue to network with nurses and legislators to affect change in the political arena. She would also like to enhance changes in nursing practice by research at the doctorate level.

Georgene and her husband, Scott, are the proud parents and grandparents to a daughter, son, and one granddaughter.

Georgene sees the importance of MONA because it gives nurses a voice and power to change our health care system, to promote healthy behaviors in nurses, and to make America a healthier country. She believes it is in our power to do this.

She believes that certified registered nurse anesthetists (CRNA) have a nonbreakable tie with MONA and all Missouri nurses and sees it as a strong point that neither group should ever forget. Our strength is in our numbers and in our ability to vote. Our strength is also in our intellect and passion to serve our common goal; to best care for patients and families in Missouri and neighboring states.

Georgene encourages all nurses to take the time to view and search the MONA website, which she believes to be fantastic!

Lucy Brenner, MEd, BSN, RN

Lucy Brenner, MEd, BSN, RN, MONA member, was recognized in the March 1, 2010, Active Times edition of the Jefferson City News Tribune for her parish nursing accomplishments in Osage County, MO. To access the entire article, please visit “What’s New” on the MONA web-site homepage at www.missourinurses.org.

Congratulations, Lucy, we are so proud of you!

Thank You
MONA PAC Contributors!

Nancy Barr
Sue Beckering
Laurie Beach
Dolores Drury

Corinne Fessenden
Sherri Hedges
Janice Jones
Dianne Schmidt

Thank You
MNF Contributors!

Nancy Barr
Laurie Beach
Maryann Coletti

Corinne Fessenden
MCNAP

12/01/09-2/28/10
District 3 & 15 Becomes Chapters

The former District 15, which included the counties of St. Charles, Lincoln, Franklin, Jefferson, and Warren, met February 22, 2010, and voted to become Chapter 15 under the new restructuring of MONA. The former District 3, which was comprised of St. Louis County, met February 6, 2010, and voted to become Chapter 3 Work is being done to update the bylaws to reflect the change in circumstances. The official change has been sent by fax to the MONA office.

On January 28, 2010, representatives from the former District 15 and District 3 met to begin the organization of the East Central Region.

District 10 Becomes Chapter

The former District 10, which included Lafayette, Saline, Johnson, Pettis, Henry, and Benton, met January 12, 2010, and voted to become a chapter of the West Central Region under the new restructuring of MONA. The official change has been sent by fax to the MONA office.

Blessing-Rieman College of Nursing Nurse Advocacy Day Highlights

Blessing-Rieman College of Nursing was one of sixteen schools of nursing that attended the 24th Annual MONA Nurse Advocacy Day which was held February 24, 2010, in Jefferson City, Missouri.

Attendees learned how RNs protect their patients and practice by educating state and federal legislators, how advocacy is significant in shaping health care and public policy, and how grassroots lobbying can be used as a means of advocating.

The day also included a trip to the Capitol to visit with legislators and see the legislative process at work.
The Missouri Nurses Foundation Board of Directors held a Strategic Planning Retreat on February 26, 2010, at the MONA Office. Several board members attended, as well as Carolyn Sullivan, the group facilitator from New Chapter Coaching, LLC, in Columbia, MO.

The entire focus of the meeting was to revisit the mission statement, review survey results and discuss strategic implications, define priority areas, including the purpose and goals of the organization, and to identify key outcomes. MNF board members focused on the benefits of planning including:

- Building consensus about where the organization needs to go and how it will get there.
- Establishing realistic goals and objectives based on the resources and capacity for implementation.
- Ensuring effective use is made of organization’s resources.
- Providing a basis for measuring performance.
- Providing a board recruitment tool.
- Providing a fundraising tool.
- Helping to strengthen MONA.

While considering the future plans of MNF, members completed a survey on the goals and mission of the organization, and also conducted a SWOT analysis. The following areas were noted:

**Strengths**
- Staff
- Board, and adding non-nurse members
- Planning
- Programs

**Weaknesses**
- Mission/vision/planning
- Leadership/Management
- Funding/Diversification
- Visibility

**Opportunities**
- Publicity/Visibility
- Grants/Funding – MFH
- Strategic planning
- Health care reform
- Promotion of nursing
- Health promotion

**Threats**
- Economy
- Performance
- Staff Size

In addition to conducting a SWOT analysis, the members also considered the differences between MONA and the MNF, the reasons for the existence of MNF, MNF’s constituents and beneficiaries, outcomes and results wanting to be achieved, fund development objectives and core methodology. Following the meeting, the members will meet again to revise the mission statement, and drafts goals for programs, governance, visibility and fund development.

A special thank you goes to the MNF board members for taking on this monumental task. We truly appreciate your work and dedication!

MONA PAC and the Missouri Nurses Foundation now accept donations through pledges. A pledge is a weekly, monthly, or annual donation using your debit or credit card. Everything is set up electronically... no mailing, no writing checks, no worries. Any amount, no matter how big or small, will be put toward bettering the profession of nursing in Missouri.

For more information on donations and pledges, please contact the MONA office 573-636-4623.
MONA Partners with Drury Hotels

MONA has partnered with Drury Hotels to give its members a 10% discount on any stay at any Drury Hotel. Whether you’re traveling on business or taking your family on vacation, if you stay at any of the 140+ Drury Hotels across the United States, members of MONA will receive a 10% discount.

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2nd Annual
Nursing Practice Update
What Nurses Need to Know

Too busy to keep up with the latest trends and current events?
- Half day - (12:30 - 4:30 p.m.)
- Four locations
- A maximum of 3.5 nursing contact hours
- Everything you need to know!

Catch up on current issues and trends affecting your nursing practice in Missouri.

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<thead>
<tr>
<th>Location</th>
<th>Date</th>
<th>Location Details</th>
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<tr>
<td>Warrensburg</td>
<td>May 21, 2010</td>
<td>University of Central Missouri</td>
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<td>Cape Girardeau</td>
<td>June 25, 2010</td>
<td>Southeast Missouri Hospital</td>
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<td>Hannibal</td>
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<td>Hannibal Regional Medical Center</td>
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<td>Springfield</td>
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Agenda
School Nurses Experience with H1N1
Future of Nursing & Healthcare Reform
MoANA & Board of Healing Arts
Practical Applications of EHR
Legislative Activities & the Political Process
State Board of Nursing
- Compact Licensure
- SB 724
- General Info & Discipline Issues
Disaster Preparedness - Protection for Actively Licensed RNs

Purpose
This activity is designed to provide nurses updates on current issues and trends affecting nursing practice in Missouri.

Audience
This activity is appropriate for, but not limited to staff nurses, nurse educators, managers and new nursing graduates who desire updated information on nursing practice issues and trends.

Accreditation
The Missouri Nurses Association is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center’s Commission on Accreditation.

Accreditation as a provider refers only to the recognition of continuing education activities and does not imply Missouri Nurses Association or ANCC Commission on Accreditation approval or endorsement of any commercial product.

Cancellation
We encourage you to send a qualified substitute if you cannot attend.

MONA reserves the right to cancel an activity if insufficient enrollment occurs. If cancellation of the activity is necessary for any reason, you will be notified by phone or mail and a full refund will be sent to you.

Registration fees, less 525 enrollment/processing fee, will be refunded to participants who cannot attend and notify the MONA office in writing of the cancellation no less than ten (10) business days prior to the date of the activity. No refunds will be made after that date. There will be no refunds due to inclement weather.

Register NOW!
Join MONA NOW and register for only $20!!
Contact the MONA office for details.
Call for Nominations for Regional Officers

The Nominations Committee would like to extend an invitation to all MONA members to submit your name as a regional candidate for the office of:

- Regional Vice Chair
- Regional Secretary/Treasurer
- Regional Member-at-Large (2)

These regional offices will be elected by a majority vote on the regional level following election of the regional chair. The term of office will begin January 1, 2011.

To submit your name as a candidate, please complete the Consent to Serve Regional Officer form which can be found on the MONA website www.missourinurses.org or contact the MONA office for a copy at 573-636-4623.

Thank you for your consideration!

Nominations Committee

MONA Regional Information

Do you need more information on your region?

Regional information is now available on the MONA website www.missourinurses.org. Under About MONA on the left hand side of the home page you will find Regions. From there you can locate the regional map as well as links to each individual region’s current officers.

For more information on regional meetings and events, please contact your regional officers or the MONA office at info@missourinurses.org or 573-636-4623.

Revised/Approved by MONA Board 12/11/09