The purpose of The Missouri Nurse, the official publication of the Missouri Nurses Association (MONA), is to disseminate information regarding policies, positions, and activities of the Association and to provide a forum for discussion of nursing issues relevant to its members.

The Missouri Nurse attempts to select authors who are knowledgeable in their fields. However, it does not warrant the expertise of any author, nor is it responsible for any statements made by any author. This publication is peer reviewed; however, Special Column sections are written by editorial invitation only and are not peer reviewed.

The Missouri Nurse encourages readers to submit articles and information for publication. Requirements, deadlines, and ad rates are available on the MONA website www.missourinurses.org or by emailing info@missourinurses.org. The Missouri Nurse reserves the right to edit manuscripts. MONA reserves the right to utilize published articles in a variety of formats and for the purpose of the organization.

The Missouri Nurses Association is accredited as an approver and provider of continuing nursing education by the American Nurses Credentialing Center’s Commission on Accreditation, for the periods of March 2013 – March 2017 (Approver) and April 2013 – July 2017 (Provider).
The first year of the Midwest Multistate Division (MSD) pilot ended on April 30, 2014. This is a two-year pilot and we are looking forward to continuing to build a strong MSD Continuing Education Unit, increasing membership and advocacy in year two of the pilot. The following states are currently included in the Midwest MSD: Iowa, Kansas, Michigan, Missouri, Nebraska, North Dakota, and Wisconsin. There are currently two additional Multistate Divisions being piloted which include the Northeast MSD (RI, NH, ME, CT and VT) and the West MSD (UT, CO, ID and AZ).

Through our due diligence processes we found several opportunities to increase operating efficiencies within the participating state nurses associations (SNAs). This included:

- Launching a call center within the MSD to enable all SNAs to have a phone number and have the phone answered by an attendant.
- Offering financial and accounting services within the MSD and reducing individual SNA expenditures for these services with other service providers.
- Providing common policies and procedure templates to support SNA operations.
- Identifying nurse planners to help plan events co-provided within the MSD.
- Instituting a weekly electronic Professional RN Update “Lighting the Way”.
- Implementing a Midwest MSD Continuing Education Accredited Approver and Provider Unit.

The Midwest MSD will continue to work on implementing a stream-lined business operations model that leverages common capabilities of the SNAs and ANA to enhance the multistate operations. Through this joint, collaborative effort the Midwest MSD will be more efficient and profitable, allow for more effective advocacy and membership recruitment, and retention efforts in the SNAs. The overarching goal is for the SNAs to grow and become more vital and visible in the future.

AMERICAN NURSES ASSOCIATION ELECTS PAMELA CIPRIANO AS PRESIDENT

On June 14, representatives at the American Nurses Association’s (ANA) Membership Assembly elected Pamela Cipriano, PhD, RN, NEA-BC, FAAN, of Charlottesville, Va., to serve as president of the professional association that represents the interests of the nation’s 3.1 million registered nurses (RNs).

The voting representatives of ANA’s Membership Assembly also elected three other members to serve as officers of the 10-member board of directors.

Cipriano, senior director at Galloway Consulting, which helps hospital groups, health care payers and providers improve their operations, outcomes and profits, succeeds Karen A. Daley, PhD, RN, FAAN. Cipriano, who is also a research associate professor at the University of Virginia School of Nursing, served as the inaugural editor-in-chief of ANA’s official journal, American Nurse Today, and is a member of the Virginia Nurses Association.

Cipriano oversaw more than 3,000 University of Virginia Health Systems employees as the chief clinical officer and chief nursing officer. She earned her doctorate in executive nursing administration from the University of Utah in 1992 and a master’s of science in physiological nursing from the University of Washington in 1981. She previously served two terms on the ANA Board of Directors, including one term as treasurer, and has served for more than 30 years on state and national committees for ANA and the American Academy of Nursing. From 2010 to 2011, Cipriano served as the Distinguished Nurse Scholar in Residence at the Institute of Medicine, where she helped study the safety of health information technology assisted care.

She currently chairs the Task Force on Care Coordination at the American Academy of Nursing.

“Godmother of the nursing profession, Dr. Bessie Cover, once said that God’s work is done by nurses,” Cipriano said. “As ANA’s 350 members and our 300,000 nurses, we are deeply honored to be called upon to serve in this capacity.”

“This is indeed the most impressive honor in my entire career. I look forward to working with you to serve nurses, improve the safety and quality of care for our patients, and continue to transform our nation’s health,” Cipriano told 350 nurses attending ANA’s annual Membership Assembly, the association’s governing body.

Elected as officers were Vice President Cindy R. Balkstra, MS, RN, ACNS-BC, Georgia Nurses Association; Secretary Patricia Travis, PhD, RN, CCRP, Maryland Nurses Association; and Treasurer Gingy Harshie-Meade, MSN, RN, CAE, NEA-BC, Ohio Nurses Association and Indiana State Nurses Association.

Jesse M. L. Kennedy, RN, Oregon Nurses Association, was elected to serve as a director-at-large, recent nursing school graduate.
Missouri Nurses Association welcomes new ANA President Pamela Cipriano, PhD, RN, NEA-BC, FAAN! Cipriano was elected at the ANA Membership Assembly on June 14 to a two-year term. Here is a little more about President Cipriano and her hopes for the future of ANA and the profession.

GETTING TO KNOW ANA’S NEW PRESIDENT
Prior to becoming ANA president, Cipriano served as senior director for health care management consulting at Galloway Advisory by iVantage. She also has held faculty and health system leadership positions at the University of Virginia (UVA) since 2000.

Cipriano is known nationally as a strong advocate for health care quality, and serves on a number of boards and committees for high-profile organizations, including the National Quality Forum and the Joint Commission. She was the 2010-11 Distinguished Nurse Scholar-in-Residence at the Institute of Medicine.

A longtime ANA member, Cipriano has served two terms on the ANA Board of Directors and was the recipient of the association’s 2008 Distinguished Membership Award. She acted as the inaugural editor-in-chief of American Nurse Today, ANA’s official journal, from 2006-14, and is currently a member of the Virginia Nurses Association.

VISION FOR THE FUTURE OF ANA
In a recent conversation with The American Nurse, Cipriano shared her vision for ANA by outlining three priorities for her presidency.

First, she will focus on ANA’s “core strengths,” which include: political advocacy, efforts around safe staffing and healthy work environments, and fighting for nurses’ rights to control their profession and practice to the full extent of their education and licensure.

Second, Dr. Cipriano will lead membership growth and retention. “I strongly believe in the old saying, ‘There’s strength in numbers,’” she said.

The third priority for her first term includes positioning nurses to exert greater influence in the transformation of health care. “It’s very important for ANA to make sure nurses are in prime positions and key decision-making groups so our voice is there at every turn,” she said.

Finally, what does President Cipriano want members around the country to keep in mind? Optimism. “We are making a number of strides,” she said. “We’re going to need all of our members...if we want to truly achieve a new direction in health care.”

To read more about President Cipriano, please visit: www.theamericannurse.org/index.php/2014/06/30/meet-anas-new-president/
More than 200 registered nurses met with congressional representatives June 12 to advocate for safer nurse staffing, expansion of safe patient handling and mobility programs, and removal of restrictions that prevent certain nurses from certifying patients for a home health benefit and ordering durable medical equipment.

The Capitol Hill visits were organized for the American Nurses Association’s (ANA) annual Lobby Day, which leads into the association’s two-day Membership Assembly, ANA’s governing body.

“If there’s one thing I know for certain, it’s that when nurses talk, Washington listens,” ANA President Karen A. Daley, PhD, RN, FAAN, told RNs from state nurses associations before they fanned out on Capitol Hill. “Whether you are advocating for legislation to advance safe staffing, or working to remove barriers that prevent consumers from benefitting from advanced practice registered nurses’ full scope of practice, be proud that we speak with one strong voice for nursing.”

Six RNs from ANA-New York briefed Sen. Chuck Schumer (D-NY). As the co-sponsor of The Home Health Care Planning Improvement Act (H.R. 2504/ S. 1332), Schumer said he would be “pushing the home health bill pretty hard” and looking for an opportunity to offer it as an amendment to another health care bill with a good chance to advance. That bill would allow nurse practitioners, clinical nurse specialists, certified nurse midwives and physician assistants to certify home health services for Medicare patients. Current law requires a physician to sign home care plans, which can cause delays in care and lead to hospital readmissions.

The nurses contended that it would be “nonsensical” to gain the authority to sign home health care plans and certify patients for the benefit, but be prohibited from ordering necessary equipment for those same patients. Schumer agreed he would work to move such a bill as a co-sponsor if nurses could secure a lead sponsor in the Senate.

Seven members of the Oregon Nurses Association urged a staff aide to Sen. Jeff Merkley (D-OR) to support the same issues, noting that in many rural areas of Oregon, there are no physicians and APRNs serve as primary care providers. They also commended Merkley for sponsoring the RN Safe Staffing Act of 2013 (H.R. 1821) and supporting The Nurse and Health Care Worker Protection Act of 2013 (H.R. 2480), which would require health care facilities to implement safe patient handling and mobility programs.

In association with Lobby Day, ANA also honored U.S. Sens. Susan Collins (R-ME) and Barbara Mikulski (D-MD) for their advocacy and work on behalf of issues important to nurses and the health care system.

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In August 2013 Missouri’s Governor signed a law authenticating the title Community Paramedic and providing the statutory authority for their ability to function in this state. This law legalizes the use of the title of Community Paramedic. It also allows Community Paramedics to provide services to those not eligible for home health care, or according to some paramedics, provides a mechanism for intercepting 30 day readmissions and thus preventing penalization of hospitals.

This effort originated through Representative Dave Hinson from the St. Louis area. He believed the bill would safeguard his practice as a paramedic because he believed he was performing at the community paramedic level with no safety net for his paramedic activities. He was able to move the bill in one legislative session, pre-filing his bill in 2012 and then amending it to any bill which seemed appropriate in order to get it passed in the spring of 2013 and signed into law summer of 2013.

Rules and regulations are being developed which include requirements for education, who is legally responsible for this service, and how the community paramedic will be operationalized in ambulance districts in the state. These rules may be finalized and in effect by January, 2015. The Bureau of Emergency Medical Services will be the state oversight authority.

Since this is now LAW, nurses must be aware of how and when the community paramedic is being utilized. The American Nurses Association (ANA) has published a document, ANA’s Essential Principles for Utilization of Community Paramedics, February 28, 2014, which is available on the MONA website at www.missourinurses.org. ANA has consistently advised “nurses must be at the table when operationalization of the community paramedic occurs.”

There is no question that this law will provide patients with access to care that they may not have had previously. HOWEVER, we need to be concerned with exactly how this law will be enacted. Questions of paramount importance are standardization of education for any paramedic in the State of Missouri to use the title community paramedic. The title can only be used if additional education is obtained by the paramedic (community paramedic is not an entry level position). Some paramedics identify the community paramedic as a “feeder” to Home Health or Primary Care Options. Some paramedics see the community paramedic as a revenue stream for an ambulance service.

As an advocate for our patients, we need to be concerned! There must be a standardized educational process!
- How and where will the instruction will be given?
- How will the education be tracked and monitored?
- What are the qualifications for the instructors? Much of the educational framework will be borrowed from and structured around community health nursing principles
- Will the community paramedic be eligible for a national certification process?
- Will the educational process be housed in an institution of higher learning?

There are 217/218 ambulatory districts in the state of Missouri! Nurses MUST be involved in the Rules and Regulations process for the well-being of our patients. Nurses MUST be a patient advocate to ensure they are getting the best care possible. Nurses MUST educate patients about who provides what kind of care and why.

This is a law so what can you do? Talk to paramedics: what do they think, are they involved, are they in favor, will they support education to use the title, do they feel using existing staff is an option to support this additional function? Talk to Emergency Nurses: get their opinion and ask them to be involved in their local ambulance district discussions regarding Community Paramedics. Volunteer to be on the board for the ambulance regions in the state, be vocal about the need for nurses’ involvement since the basic education for community paramedics is driven by knowledge nurses have developed. Contact the Missouri Nurses Association for further information or to volunteer to be a member of the Practice Committee (this MONA committee is the watchdog for direct care nurses and advance practice nurses).
Election for MONA officers will open September 1. The voting process will be held by electronic voting (eVoting). A link to the eVoting ballot will be available on the MONA website at www.missourinurses.org. If you do not have access to the internet, please contact the MONA office as soon as possible and a paper ballot will be mailed to you. To cast your vote, you will need to log in using the following:

USERNAME: “Your Last Name with First Letter Capitalized”
PASSWORD: “Your MONA Membership Number”

The eVoting services are being provided through a contract with an independent firm and all votes will remain anonymous.

The following is a list of candidates for each position. The candidates were asked their personal position regarding one or no more than two nursing issues, in relation to the leadership position you have chosen. Their position statement is included below their name. These positions are elected by MONA membership for a two year term (January 1, 2015 - December 31, 2016).

**PRACTICE DIRECTOR**
This position has a seat on the MONA Board of Directors and serves as Chair of the MONA Practice Committee. The Practice Director will influence nursing professional practice issues and nursing policy covering a broad range of health care settings, specialties, nursing roles and practice challenges. Must be able to commit annually to participate in 3 board meetings at the MONA office and 6-7 committee conference calls.

**CANDIDATES**

**Nancy Barr, MSN, BSN, RN**
Kansas City (WEST CENTRAL REGION)
I want to serve in the elected position of Practice Director to continue the work of the Committee on Nursing Practice, to develop new strategies for the practice of nursing and to forge partnerships with nurses and groups who are influential in strengthening the practice of nursing whether it be at the direct practice level or the advance practice level. The Practice of Nursing must be recognized for its ability to provide safe, documented care in any setting by the direct care nurse or the advance practice nurse level. The Practice Director must constantly scan the environment to determine how rules & regulations of others might influence, alter, limit or compete with nurses and nursing care. The Practice Director must be able to articulate the practice of nursing in an understandable and reliable way to influence the development of a health care system where direct care and advance practice nurses are considered experts in their field to provide direction for this much needed work.

**Stacey Morgan, MSN, APRN-PCNP**
Gobler (SOUTHEAST REGION)
The role of the practice director will require someone that stays up to date with current technology and trends affecting clinical practice and in so doing promote improved performance in the nursing profession. As practice director, I will commit to constantly improve the practice of nursing, thereby improving healthcare. I will work diligently researching the standards and priorities that are important to the nurses in the state of Missouri. By understanding these findings, I will be able to address practice concerns and promote policies that improve those concerns. I want to empower nurses to take an active role in implementing necessary improvements in their work environment and surrounding communities. My character is sincerity; my personal aspiration is to be a devoted Christ follower, wife and mother. My professional goal is to be humble and a valued nurse that uses evidence based practice, promotes life-long learning and adds value to the profession.

**Olivia Young, FPMHNP-BC, PhD**
Hazelwood (EAST CENTRAL REGION)
I strongly believe that the registered professional nurse’s first allegiance is to the health and safety of patients. I also strongly believe that current staffing patterns are usually inadequate for the acuity level of the patients they care for. I think it would be better for nurses and patients if registered nurses had to use a national identifier and were required to sign off on billing for the care they provide. Yet, I also believe nurses should be held accountable for that care. I also believe that active nurses should be required to complete mandatory continuing education annually covering Missouri’s Nurse Practice Act and 2-5 other practice areas. The program and testing should be provided by an organization other than the one where the RN is employed. I would also like to see facilities sponsor on site seminars about the duty to belong to professional associations and pay at least some of those dues as a benefit. I would also like to see MONA dues deducted from nurses’ paychecks, with the nurses’ approval, by approved organizations. I also believe MONA should support other nursing organizations whenever possible.
EDUCATION DIRECTOR

This position has a seat on the MONA Board of Directors and serves as the liaison between the MONA Board of Directors and the CE Approver and CE Provider Units. The Education Director should have education and/or experience in the field of education or adult learning with an interest in continuing nursing education and expertise with staff development and continuing education in a variety of practice settings. Knowledge of the ANCC Accreditation Program criteria is preferred. The Education Director must have a baccalaureate degree, or higher, in nursing (or international equivalent). Must be able to commit annually to participate in 3 Board meetings at the MONA office and 4 committee conference calls.

CANDIDATES

Lauren Royal, RN, MSN  
St. Peters (EAST CENTRAL REGION)
1. Nursing faculty shortage - I believe that action should be taken to encourage qualified nurses to serve as faculty members and work should be done to ensure that nursing faculty feel as valued in their role as they have in prior clinical roles. 2. Health literacy - Nurses must be educated on the barriers to health literacy that patients may have and utilize proven strategies including adult learning principles to help provide education in various formats to help ensure patient understanding of health information.

Cookie Stude, RN, BA, MC  
Wright City (EAST CENTRAL REGION)
1) Emergency night call: COPD individual, assessment indicated quick action with other symptoms sent to hospital Dx Aorta Tear. 2) Husband collapsed in my arms with a 100% blockage by blood clot able to stabilize with 911 Cardiac Team waiting @ hospital Stent inserted 3) Have started program of teaching everyone to have all medication medical information inserted behind name badges at conventions etc. and in an area in billfold for quick information by the medical team.

Ruth Yunker, RN, MA, MSN, EDSPEC. Doctoral Candidate  
Blue Springs (WEST CENTRAL REGION)
This is a time of great change throughout the health care system. Nurses are increasingly called upon to shoulder greater responsibility and do more with less. As the largest group of health care providers, registered nurses have a major role in promoting the health and well-being of America’s people. In doing so, they face many challenges including keeping abreast of new technology and medical advances. In addition, increased immigration and migration have resulted in a highly diverse society with thirty percent of the nation’s residents belonging to ethnic and minority groups. The 2013 Healthcare Disparities Report reveals that members of these groups, along with the poor, experience increased morbidity and mortality rates in comparison to the white population.

These are just a few examples of the challenges facing today’s nurses. In order to respond to these and other challenges requires continuing education. Nurses must be able to change their practice based on the most accurate and up-to-date information as it becomes available. In this way we become active agents in promoting quality health care for all.

REGIONAL CHAIR

This position is responsible for the business of the region including but not limited to organizing regional meetings, serving as the regional representative on the Nominations Committee, and acting as the liaison between the regional members and the Member Services Director. The Member Services Director shall be elected from the group of Regional Chairs to serve on the MONA Board. There are seven Regional Chair positions, one from each MONA region. You must be a member of the region in order to be considered for the position of Regional Chair. Must be able to commit annually to participate in 6-7 committee conference calls/meetings.

CENTRAL REGION CANDIDATE

Kristen Pringer, RN  
Jefferson City
I am committed to the growth of the nursing profession. In addition I am a strong advocate for the practice of nursing and improving the front line staff nurse representation within MONA.

EAST CENTRAL REGION CANDIDATES

Kathryn Steinman, RN, MSN, FNP  
St. Charles
I feel as nurses we need to step up and own our positions. We need to be more vocal in politics, group organizations, and we need more representation.

Danielle Bruce, RN  
St. Charles
1. I believe that in order to be a valuable voice within nursing it is important to educate, mentor and develop new and experienced nurses. 2. I believe that work culture and environment within healthcare must be one that is just, respectful and communication rich. In order to maintain patient excellence and safety.

Gail Esparaza, MSN, RN, JD, ESQ, CNOR  
St. Louis
Licensed Attorney, passionate about the ACA implementation at local, state and national levels
An important issue in nursing is using evidence to reinforce and support practice decisions. Evidence based practice (EBP) has become a prominent issue in healthcare. Due to increasing health care costs, as well as doing what is right for quality patient care, it is important for nurses to work at the top of their license and use the evidence to support our practice. We have to work more efficiently with less staff and focus on what is important to deliver quality care. We must define those practices that will support patient care and the best outcomes. I believe in a leadership position we must instill in other nurses that we have complex challenges and must find solutions to deal with these challenges we face. We must define best practices and promote the responsibility of the nurse to deliver care based on evidence.

Throughout my entire career as a nurse and nurse practitioner, I have worked in rural settings in Kansas and now here in Missouri. I have always had a passion for helping the underserved. As I began to consider my position on nursing issues; the practice of helping “People In Need” is one of the main foundations of my nursing practice. The Missouri Nurses Association (MONA) is also dedicated to, “promoting safe, high quality, accessible and affordable healthcare for all people in need…” (MONA Position Statement – “People In Need”). The only way that we can effectively help at risk populations is to be able to bring together the constituents of MONA. This will facilitate networking and brainstorming on topics like this. Therefore, as the regional chair for the Northeast region, I would promote continued interactions with others, in this region, to assist those in need of access to affordable healthcare.

Healthcare reform has presented both challenges and opportunities for nurse educators and clinicians. Now more than ever, it is important that nurses are involved in shaping the future of our profession! In the State of Missouri, we must continue to advocate for nurses to practice within the full scope of their education and training. We must also be diligent in preparing our future nurses to take on the demands of a rapidly changing practice environment while reducing barriers for those nurses who wish to continue their education. As nurses, we have great responsibility and power to impact change yet we must get involved in order to make a tangible impact. I am prepared to work hard in the NW Region to enhance awareness and provide education and advocacy regarding MONA initiatives.

My one issue I am most passionate about is having nurses work to their level of clinical preparation and expertise. Our field requires both technical and interpersonal skills. I think the challenge is to be experts in both. What I mean is that many nurses tend toward one or the other. We need nurses in Missouri and indeed in the US who know the science of nursing and are still able to console a suffering patient. Participation in any professional nursing organization gives that balanced, big picture view. Role modeling this behavior of dedication to professional growth is key, as well.

As I approach the end of my nursing career I see opportunities to share a vision with those newer to the profession. My vision is one of ongoing learning, evidence based practice, participation in MONA and other professional organizations, and of pooling resources/talents to influence policy makers, administrators, and even our patients. Nursing is a dynamic profession which will continue to move forward if our practicing clinicians and educators are willing to learn new techniques and practice in an evidence based manner.

Hello! My name is BJ Whiffen. I currently serve as SE Region Chair and would like to run for a second term. My first term as Chair has been quite an eye opener, and I have learned so much. One issue I have always been passionate about is removing practice barriers to care for APRN’s. I work as your MoCAP representative to ensure that our voice is heard in the legislature and I will continue to fight for barrier free care for Missouri citizens whether or not I am re-elected. I also care deeply about RN’s in Missouri strongly supporting their own organization and the rules and laws that govern that organization. As a nursing instructor, I pledge to get nursing students more involved in legislature that affects nursing issues. I truly appreciate your confidence in me.

Democracy cannot succeed unless those who express their choice are prepared to choose wisely. The real safeguard of democracy, therefore, is education.

— Franklin D. Roosevelt
SOuThwesT reGiOn canDiDaTe
Martha Baker, PhD, RN, CNE, CENP, ACNS-BC
Republic
One of the most pressing issues facing nursing is reducing barriers to practice, not only for advanced practice nurses but bedside nurses. Patient care coordination is dependent on the nurse and his/her expertise. The skill required for this demands the autonomy of the nurse be increased. Nurses need to be able to act and authorize the services needed by patients. This is particularly true when support services are needed in the home. Nursing does the best job of assessing the functional abilities and discharge needs. Some aspects of the affordable care act address this as well as the IOM report. MONA is in a unique position to advocate for Missouri nurses with the legislative process to improve nursing practice in the state. They have worked diligently to cultivate resources and connections that can assist nurses to increase autonomy and remove barriers to practice. I want to serve to assist in this valuable work. It will take all nurses working together to advance the profession in the State of Missouri.

WEsT cenTral reGiOn canDiDaTes:
Janet Clark, DNP, APRN, NP-C, CDE
Lee’s Summit
The people in the rural areas of MO often time must travel or go without health care due to no providers in the area. APRNs can help to remove those barriers to care. As MONA members it is our obligation to do everything we can to advocate for barrier free care for all residents in the state of MO. APRNs can help to remove those barriers if they are allowed to practice to the full extent of their license. I would like to submit my name as a candidate for West Central Region Chair.

Jeanne Helman, RN, BSN, CCM, MSESM
Raymore
One issue that will be facing Public Health nurses in Missouri is the Medicaid expansion bill that is currently being debated in the State Senate. The approval of $26.6 billion budgeted for the next fiscal year, which goes to the Senate shortly is not supported by several budget makers who disagree with Governor Nixon’s proposal for spending. The proposal does not include federal money for Medicaid expansion. This will tremendously impact community health nurses, APNs, LPNs, administrators and other professionals in their practices, and the care that is so important in rural and disadvantaged areas. Gov. Nixon is in West Plains today to discuss the General Assembly’s inaction and failure to strengthen the Medicaid program. Along with this, I would support any nursing issues involved in transitions toward improvement of care for older adults.

MARK YOUR CALENDAR!

MOña
ELECTION DEADLINES

9/01/2014            Polls Open - 12:00 a.m.
                    eVoting link on MONA website

9/30/2014            Polls Close - 11:59 p.m.

1/01/2015            Elected Members Assume Office

ONLINE VOTING OPENS SEPTEMBER 1
Missouri Nurses Association

POLITICAL ACTION COMMITTEE

The Missouri Nurses Association Political Action Committee (MONA PAC) is the only political action committee representing the interests of all professional nurses in Missouri. It was established to elect candidates that will advance MONA’s legislative and regulatory agendas.

MONA PAC was founded in 1985 and since that time has interviewed and endorsed hundreds of candidates for elected office in the Missouri legislative and executive branches.

GOALS

• Ensuring a majority of legislators are those endorsed by MONA PAC
• Advocating for all House and Senate committees impacting nursing to be chaired by a MONA PAC endorsed legislator
• Advocating for legislative leadership positions be held by MONA PAC endorsed persons who are successfully elected

MONA PAC activities build on non-partisan, criteria-based selection to:
• Promote and financially endorse candidates who support MONA’s legislative agenda
• Encourage grassroots involvement and nursing participation in the electoral process
• Establish a dynamic, ongoing communication process between MONA PAC, the MONA Board of Directors, regional chairs, and individual contributors

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Wanda Brown, Lincoln
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One Strong Voice

for Missouri Nurses

MONA PAC differs from the MONA Advocacy Committee in that MONA PAC endorses candidates that support MONA and its legislative and regulatory agenda. The Advocacy Committee works to monitor legislation and regulation that impacts nursing and develop a proactive agenda to support and direct nursing issues. MONA PAC is funded through individual contributions. MONA membership dues are not and cannot be used to endorse candidates.
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According to the U.S. Department of Health and Human Services (HHS), 16% of Missourians are uninsured (2013). Further data from HHS indicates that 799,255 Missourians, that have been uninsured, are now eligible for participation in the health care marketplace established under the Affordable Care Act (ACA) of 2010. This group joins an already aging baby boomer population as well as an obesity epidemic that has resulted in increasing rates of diabetes in the United States (Centers for Disease Control and Prevention, 2013). With this information, one can surmise that there will be increasing numbers of individuals seeking primary health care services.

The United States is predicted to experience a significant primary care physician shortage. Petterson, Liaw, Rabin, Robert wood Johnson foundation [RWJf], 2013). Studies have suggested that advanced practice registered nurses (APRN) would be a viable solution to meet the burgeoning numbers of physicians by the year 2025. The institute of Medicine (2011) advocated for the need to make important changes in nursing practice. The first major recommendation was for nurses to be able to practice to the “full extent of their education and training” (Institute of Medicine, 2011, p. 1-8). This report also recognized the important contribution that APRNs can make to the delivery of primary care. Since the publication of that report, both the National Governor’s Association and the American Hospital Association have released papers that also recognize how restrictive state laws and regulations impede the ability of APRNs, specifically nurse practitioners, to provide primary care to the full extent of their abilities (AHA Primary Care Workforce Roundtable, 2013; National Governor’s Association Center for Best Practices, 2012).

Despite the call for action from many groups to reduce regulatory barriers to APRN practice, organized medical groups still oppose changes in current practice. After the 2008 APRN Consensus Model was published, the American Medical Association (2009) published one of its Scope of Practice Data Series directed toward nurse practitioners. The stated purpose of this document was to “provide the background information necessary to challenge the state and national advocacy campaigns of limited licensure health care providers who seek unwarranted scope-of-practice expansions that may endanger the health and safety of patients” (American Medical Association, 2009, p. 4). Medical groups continue to use the argument of patient safety against regulatory change.

**EVIDENCE OF QUALITY – SYSTEMATIC REVIEWS**

Review of the total literature on the quality of APRN care is beyond the scope of this article; however, several systematic reviews in this body of literature are available. Two systematic reviews compared health outcomes and patient satisfaction between APRNs and physicians in primary care settings (Horrocks, Anderson, & Salisbury, 2002; Laurant et al., 2009). Though published later, Laurant et al. (2009) covered literature of a similar time period, studies published between 1966 and 2002. Both systematic reviews found that patient health outcomes were comparable whether treated by APRNs or physicians. In addition, both found that patient satisfaction was higher for those treated by APRNs.

Another systematic review by Newhouse et al. (2011) included more recent literature and excluded studies performed prior to 1990. This review also differed from the previous ones in that it reviewed only studies performed in the U.S. to reduce the heterogeneity of advanced practice nurse roles across different countries. One hundred seven studies were included compared to 34 studies in Horrock et al. (2002) and 16 studies in Laurant et al. (2009). Newhouse et al. separated and described quality outcomes for different APRN roles – nurse practitioners (NPs), certified nurse midwives (CNMs),
clinical nurse specialists (CNSs), and certified registered nurse anesthetists (CRNAs). When comparing NP, CNM, and CNS care with that of physicians, this review (Newhouse et al., 2011) found equivalent or better patient satisfaction and health care outcomes for the APRN groups. For CRNAs, the review found no studies whose outcomes met the review’s inclusion criteria (Newhouse et al., 2011).

EFFECT OF NURSE PRACTITIONER INDEPENDENCE ON OUTCOMES
Traczynski and Udalova (2013) examined the relationship of NP independence on a variety of patient outcomes. They used a large national database for health outcome and health care utilization data spanning the time period of 1996 to 2010. Repeated cross-sections of the data were taken for individuals by state. Traczynski and Udalova also retrieved data on state laws and regulations governing NP practice from state boards of nursing between 1970 and 2013 to determine whether or not NPs practiced independently and if they did, when independence was granted. To meet the definition of independent practice for this study, NPs must have had both independent practice authority and independent prescriptive authority. This study provided evidence that NP independence is positively related to both increased health care utilization and better health outcomes.

Three systematic reviews of literature ranging from 1966 to 2008 indicate that APRNs provide high quality health care (Horrocks, Anderson, & Salisbury, 2002; Laurant et al., 2009; Newhouse et al., 2011). They consistently showed that APRN care outcomes are equivalent to or in some cases better than physician outcomes. It is clear that the past and current evidence does not support organized medicine’s stated concern that removing regulatory barriers to APRN practice endangers patients. In fact, Traczynski and Udalova (2013) suggested that increasing practice authority for APRNs actually would improve both health care utilization and health outcomes.

RESEARCH QUESTIONS
This present study addressed two questions to note the influence of the type of APRN practice in each state on the rank of that state regarding health outcomes.

1. Do states that have independent APRN practice have better health outcomes, as evidenced by a higher rank, than states that do not have independent practice?
2. What effect does the type of APRN practice; whether full, reduced, or restricted; have on the national health outcomes state rankings?

METHOD
The health outcome rank for each of the fifty states was obtained from the 2012 report on America’s Health Rankings by the United Health Foundation in conjunction with the American Public Health Association and the Partnership for Prevention. Data collection for this edition was noted to be more accurate than in previous years due to the addition of
data from cell-phone only households. The health outcome data were compared to type of state regulatory practice noted from the American Association of Nurse Practitioners (AANP, 2013). AANP categorized APRN activities into full, reduced, or restricted practice. Full practice is considered to be independent practice overseen solely by a state board of nursing. Reduced practice requires a collaborative agreement between the APRN and a physician. Restricted practice requires “supervision, delegation, or team-management” by a physician for APRN care to be provided (AANP, 2013, ¶3). Table 1 identifies the data analyzed with the state rankings, states with and without APRN independent practice, and the type of APRN practice in each state (full, reduced, or major restricted).

**Table 1 - State Rankings Related to APRN Practice**

<table>
<thead>
<tr>
<th>Rank*</th>
<th>State</th>
<th>Independent #</th>
<th>Type ^</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Vermont</td>
<td>Y</td>
<td>F</td>
</tr>
<tr>
<td>2</td>
<td>Hawaii</td>
<td>Y</td>
<td>F</td>
</tr>
<tr>
<td>3</td>
<td>New Hampshire</td>
<td>Y</td>
<td>F</td>
</tr>
<tr>
<td>4</td>
<td>Massachusetts</td>
<td>N</td>
<td>M</td>
</tr>
<tr>
<td>5</td>
<td>Minnesota</td>
<td>N</td>
<td>R</td>
</tr>
<tr>
<td>6</td>
<td>Connecticut</td>
<td>N</td>
<td>R</td>
</tr>
<tr>
<td>7</td>
<td>Utah</td>
<td>N</td>
<td>R</td>
</tr>
<tr>
<td>8</td>
<td>New Jersey</td>
<td>N</td>
<td>R</td>
</tr>
<tr>
<td>9</td>
<td>Maine</td>
<td>Y</td>
<td>F</td>
</tr>
<tr>
<td>10</td>
<td>Rhode Island</td>
<td>Y</td>
<td>F</td>
</tr>
<tr>
<td>11</td>
<td>Colorado</td>
<td>Y</td>
<td>F</td>
</tr>
<tr>
<td>12</td>
<td>North Dakota</td>
<td>Y</td>
<td>F</td>
</tr>
<tr>
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<td>Oregon</td>
<td>Y</td>
<td>F</td>
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<tr>
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<td>Y</td>
<td>F</td>
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<td>Nebraska</td>
<td>N</td>
<td>R</td>
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<td>N</td>
<td>R</td>
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<tr>
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<td>Idaho</td>
<td>Y</td>
<td>F</td>
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<tr>
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<td>R</td>
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<td>R</td>
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<td>R</td>
</tr>
<tr>
<td>31</td>
<td>Delaware</td>
<td>N</td>
<td>R</td>
</tr>
</tbody>
</table>

* Data from America’s Health Rankings (2012)  
# Independent practice – yes or no  
^ Type of practice – full, reduced, or major restricted

**Results**

A two sample t-test performed on question 1 determined that states that have independent practice have statistically higher rankings in national health outcomes, at p = 0.0018, as noted in Table 2. One-way analysis of variance (Table 3) followed by Tukey's test for pairwise comparisons noted a statistical difference on state health outcome rankings between the three groups of full, reduced, and restricted APRN practice (p = 0.0048). The pairwise comparison indicated there was a significant difference between full independent practice and reduced practice (p=0.0059) as well as between full and restricted practice (p=0.024). No statistical difference was noted between reduced and restricted practice (p=0.0324).

**Table 2 - Independent Practice Outcomes**

<table>
<thead>
<tr>
<th>No-Independent Practice</th>
<th>Yes-Independent Practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>M (SD)</td>
</tr>
<tr>
<td>33</td>
<td>29.9 (14.3)</td>
</tr>
</tbody>
</table>

p=0.0018

**Table 3 - Practice Type Outcomes**

<table>
<thead>
<tr>
<th>Practice Type</th>
<th>N</th>
<th>M (SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full</td>
<td>17</td>
<td>16.82 (10.96)</td>
</tr>
<tr>
<td>Reduced</td>
<td>21</td>
<td>28.09 (15.47)</td>
</tr>
<tr>
<td>Restricted</td>
<td>12</td>
<td>33.08 (11.93)</td>
</tr>
</tbody>
</table>

p=0.0048
DISCUSSION

While causality cannot be elicited through this study, there is a distinct relationship between the health outcomes of a state and independent practice of advanced practice nurses. States that allow independent APRN practice have a healthier population than states that do not. State health outcomes are also higher with full APRN practice in comparison to reduced or restricted practice of APRNs. No difference in state health rankings is seen between reduced or restricted APRN practice; thus, showing any amount of barriers to APRN practice may reduce the health of a state population.

CONCLUSION

With the ACA layered over an incredibly complex pre-existing health care milieu, it becomes evident that as with a prism, we need to examine the issues from a number of different perspectives. This will challenge all members of the health care team to step outside of what has perhaps been a long held comfort zone and look at health care from a new and enlightened perspective. Are our beliefs truly based on fact or are they based on long held fears and turf wars? With the complexity of our health care system, one notion becomes clear, we are all needed and all have strengths to bring to the table, and we need to put those to our full advantage in order to maintain and improve health care outcomes.

REFERENCES


ACKNOWLEDGEMENT

The authors would like to thank Dr. Rose Porter, Associate Professor Emerita and Dean Emerita of Nursing, for her innovative ideas that initiated this research study.
Honor A Nurse

Nursing is a calling, a way of life. Nurses rely on each other for the synergistic effect of teamwork in our efforts of care giving. It is appropriate that we honor those colleagues that have made an impact in our lives and the lives of others. We honor...

Mary Ann Lavin, DSc, RN, APRN, ANP-BC, FAAN
In honor of her exceptional career in nursing.
Honored by Judy Collins, MA, RN, BSN, President - Iowa Nurses Association

IMPORTANT UPDATE
MISSOURI NURSES LONG-TERM CARE INSURANCE PROGRAM
BENEFITS AND NEW FEATURES

Great news for Missouri Nurses, regarding this serious subject of your Long-Term Care program! As the Advocate for the LTC program, I can tell you we have significant features of importance for the Nurses and their Families.

As we know so well, the need for Long-Term Care can come upon us at any time. We may think we are in good health today, but, an unexpected illness, accident, or the natural aging process can leave us unable to perform those everyday activities we take for granted. Every day we witness, Medical Science is “ramping up,” with one medical breakthrough after another, increasingly stabilizing us and extending us to an older age. It’s a strong likelihood you’ll live longer than previous generations in your family, but, is it a good bet that you’ll be able to afford those extra years?

We all insure our most valued assets: our homes, our cars, our lives. Then why not insure our retirement plans against the devastating costs of Long-Term Care needs? The likelihood of one of a couple having need for Long-Term Care services has increased to 90%*. Also, about 79% of women who have reached the age of 65 will need some Long-Term Care during their lifetime*. And these percentages continue to increase because of Medical Science. It’s human nature to avoid thinking about growing older, but, consider, 42% of the people receiving LTC services are under the age of 65.

Knowing that the likelihood of needing Long-Term Care is very high, it is natural for Nurses to want a comprehensive program that covers all levels of care, but to primarily want every opportunity to have Home Health care instead of Facility care.

It is important to note, with the Nurses primary LTC program, unlike other programs, you can choose your own Care-Giver and it may be a family member or friend. This is very significant, because it means the Home Health Care benefits can be paid directly to you in your home, in cash. This gives you the very best opportunity to stay in the comfort of your home, instead of a facility, by having the option to choose a family member, or friend, to be your Home Health Care Provider, or if you choose, an out-side professional service coming to your home.

With the recently proposed changes in Health Care and Medicare, both programs have become somewhat gray, in that, it’s difficult to know exactly what benefits they are going cover in the future. With the Nurses discounted Long-Term Care program, you and your family will know precisely the benefits that it will provide now and in the future.

For more information on the features and benefits of the discounted Long-Term Care Program for the Nurses and their Families, just call 888-825-0224 and a Long-Term Care Planning Nurses Advocate will be glad to answer all your questions on this serious subject.

L. Robert Wear, CLTC
Advocate for the MONA Long-Term Care Program

*1 National Clearinghouse for Long-Term Care Information Website, August 16, 2012
*2 AARP.ORG Website, August 16, 2012
Press Ganey Acquires National Database of Nursing Quality Indicators (NDNQI®)
Advances Press Ganey’s Commitment to Quality Improvement on Nursing-Sensitive Measures

Press Ganey announced June 10, 2014, the acquisition of the National Database of Nursing Quality Indicators (NDNQI®), the leading quality improvement and nurse engagement tool developed by the American Nurses Association (ANA) and managed by The University of Kansas School of Nursing. The acquisition strengthens Press Ganey’s ability to empower nurses and nursing leaders in their mission to reduce patient suffering and improve the patient experience.

“Press Ganey is privileged to carry on the quality improvement efforts designed by the ANA and looks forward to expanding the capabilities of this exceptional program,” said Pat Ryan, CEO, Press Ganey. “As we partner with providers to transform the health care system, we remain committed to the role of nursing in advancing the quality of the patient experience and achieving higher quality, more coordinated care.”

NDNQI was founded by ANA and since 2001, has been managed by The University of Kansas School of Nursing. NDNQI promotes nursing excellence through the most robust source of comparative norms in the industry and supports nurse retention through its leading RN survey tool. Used by 2,000 hospitals nationwide, it is the largest provider of unit-level performance data to hospitals. Coupled with Press Ganey’s deep benchmarking data, expansive engagement tools and advanced analytics, the addition of NDNQI will offer more targeted insights into nursing performance to improve the overall patient experience and outcomes.

“ANA has found a partner in Press Ganey that shares its mission of improving patient care through the power of nursing-sensitive data measurement, collection and comparison,” said ANA Chief Executive Officer Marla J. Weston, PhD, RN, FAAN. “This strategic alignment will enhance the power of nursing data, generate even better normative comparisons and allow for expanded linkages to outcomes.”

The NDNQI program is unique in its ability to provide unit-level reporting aligned to nursing-sensitive measures and in compliance with Magnet Recognition Program® requirements to help achieve the highest levels of performance. NDNQI tracks up to 19 nursing-sensitive quality measures, providing actionable insights based on structure, process and outcome data. Health care organizations can use the information to establish organizational goals for improvement, down to the unit level.

“At a time when the health care industry is moving from volume-based care to value-based care, the ability to understand nursing quality indicators and retain valued nursing staff has never been more critical,” said Christy Dempsey, CNO, Press Ganey. “We are pleased to announce the acquisition of NDNQI, as it is the gold standard for nursing quality data and a proven solution that addresses the vital role of nursing in coordinated models of care.”

About NDNQI
NDNQI® is the only national nursing quality measurement program that enables hospitals to compare measures of their nursing quality against national, regional and state norms for hospitals of the same type down to the unit level. Used by 2,000 hospitals nationwide, it is the largest provider of unit-level performance data to hospitals. NDNQI is a program of the American Nurses Association (ANA) and is administered on behalf of ANA by The University of Kansas School of Nursing. Visit the NDNQI website to learn more about the database and how it’s helping hospitals across the U.S. and around the world to track and improve on nursing-sensitive quality measures. For more information, visit, www.ndnqi.org.

Recognized as a leader in performance improvement for nearly 30 years, Press Ganey partners with more than 11,000 health care organizations worldwide to create and sustain high-performing organizations, and, ultimately, improve the overall health care experience. The company offers a comprehensive portfolio of solutions to help clients operate efficiently, improve quality, increase market share and optimize reimbursement. Press Ganey works with clients from across the continuum of care – hospitals, medical practices, home care agencies and other providers – including more than 50 percent of all U.S. hospitals. For more information, visit www.pressganey.com.
Nola Pender’s Health Promotion Model helps to explain how health promotion is so much more than education alone (Nola Pender – Nursing Theorist, http://www.nursing-theory.org/nursing-theorists/Nola-Pender.php). Until recently, my personal experience in health promotion has been in collaboration with individual clients to identify their goals, empower them with competencies related to those goals, and to tailor interventions using interpersonal influences to be successful. However, I have applied this framework of goal setting, empowerment and interpersonal influences to policy change and found it useful. The purpose of this article is to share some lessons learned about being a change agent and engaging faculty in tobacco policy activities.

The process to change the policy from a clean indoor air policy to a tobacco free campus began with an evidence-based approach to tobacco policy change. After the Faculty Senate and Student Government Association passed smoke-free resolutions in 2010-2011, the University president appointed a tobacco policy committee to review the current policy for its adequacy in meeting university needs. The committee worked with the president to appoint a very representative group of faculty, staff, and students. The intent was to have the campus constituency represented our committee, but also to have smokers, non-smokers and former smokers represented.

An assessment started with a campus survey. The committee wanted to find out what the campus thought, and over 2000 people responded to our survey. The majority of them wanted the University to be smoke-free inside and out. Next was a review of the economic, environmental, and health impacts of the current policy. The current policy had designated smoking areas outside of building entrances, and this is really problematic for non-smokers. It was also reported that there were a lot of smokers that were smoking in non-designated areas. It was reported that it took half of a full-time employee (.5FTE) to pick up butts on the campus every year. Although no figures were available for tobacco related insurance claims, the economic impact at state and national levels has been well documented.

Currently the number of colleges and universities that have smoke-free policies is well over 800, and this trend is growing. Assessments indicated that there’s a lot of industries and employers who also have a trend of going smoke-free. This includes healthcare systems, airports, and stadiums. Therefore, student success directed the committee to prepare students to anticipate smoke-free environments in the workplace. During this time, a nursing student requested smoking cessation counseling because he was unable to get a summer internship in St. Louis because of his smoking status. Lastly, the committee also considered some model policies such as those at the University of Kentucky and evidence-based smoking cessation approaches presented by the Department of Health and Human Services. Based on this assessment the committee recommended that the University go 100% tobacco-free, and presented an implementation plan, a timeline, and frequently asked questions.

So why even focus on engaging the faculty? The CDC recommends that when it comes to tobacco, the needs and interests of the stakeholders should be represented throughout the process (Evaluation Toolkit for Smoke Free Policies, http://www.cdc.gov/tobacco/basic_information/secondhand_smoke/evaluation_toolkit/pdfs/evaluation_toolkit.pdf). Faculty are valuable stakeholders. The reason that they are valuable is that they have a lot of key positions that can influence not only policy but also practices on campus. These can also be sustainable practices because of the nature of their work. Dr. Hovland works with those who are interested in communicating with policymakers (2007). She states that the primary reason to communicate is to inspire and to inform. This also creates spaces for voices to be heard, it fosters social awareness and change, it facilitates understanding, it contributes to evidence-based policy, and it promotes progress. It is known that good policies are owned by a broad range of stakeholders. Faculty are an important group; they are in large numbers and they should be considered in this process.

Faculty Forward is a medical college capacity building program run by the Association of American Medical Colleges (Retrieved from https://www.aamc.org/services/facultyforward/toolsandfacts/). This program includes an assessment of the workplace culture. Some of the questions asked in their survey are relevant to an assessment of the faculty. Over 10% of faculty members plan to retire in the next year or two, and nearly 20% are unsure if they are even going to be here in another year or two. So, over 30% of our faculty members may not be here in the next year or two. That’s really important. Are faculty members satisfied with their school? Thirty-five percent of faculty members feel they can speak freely in their work environment? Less than half feel that they can express their opinions about the school without the fear of retribution. Do faculty members participate in governance at your school? A quarter of the faculty members feel there is not sufficient opportunity for them to do this. The good news, comes with this question: Do your faculty members feel good about their day-to-day activities? Four out of five faculty members feel very good about their day-to-day activities. Do you know the future plans of your faculty members? This is a good place to start an assessment.

Another assessment is a faculty stakeholder analysis (Babou, S., 2008). This is an assessment of interested stakeholders. The purpose of this assessment is to help develop a cooperative relationship with the stakeholders. This analysis can either be done once in the beginning or several times through
the process; trending their attitudes throughout the process. There are three categories of stakeholders - the first one is the primary category consisting of those who may be affected either positively or negatively by your policy change. For example, smokers are a primary stakeholder group, but primary stakeholders could also be non-smokers with health problems. Those are the people who tend to be very adamant about changing policy. For primary stakeholders, you may consider the processes that faculty members are measured by in promotion and tenure. Typically a promotion and tenure process includes teaching, service, and scholarship. So as you’re looking at this primary group think about activities and think about how could that feed into teaching service and scholarship. Could they include this in their classes? In their curriculum? Could they include this in their research and the writings that they do? Or could they participate in service such as volunteering to do counseling at your smoking cessation center?

Secondary stakeholders are those that are indirectly affected. An example is non-smokers, maybe teachers that teach online, or even retired faculty. Lastly are our key stakeholders, and this is who you really want to focus on. These are people that have significant influence in your school. They can be your Faculty Senate representatives, activists or experts in policy, highly funded or senior faculty members, or even those with very high profiles.

Another technique that is useful in engaging faculty in tobacco change is mapping stakeholder importance and interest. Dr. Hovland reports that not all stakeholders are created equal (2007). Understanding their power and interest can help us to understand why people take certain positions and what we can do to bring them around. So there are two areas to look at. Power, which is defined as the degree that they can influence the change, and interest - what degree they are affected by the change. So the map is a 2x2 grid of power and interest. The objective is to identify those with high power and high interest. This is the target group. At our university, we were very fortunate that the President fell into this category. For people with high power and low interest, you just want to keep them informed. People with low power but high interest are people to assign activities to (because they tend to be very good at contributing). Low power and low interest is a group that you don’t want to target your activities because they are unlikely to do them. The benefits of this mapping activity is knowing the stakeholders interests, identifying mechanisms to enforce other stakeholders, identifying potential risks, identifying key people to inform about policymaking activities, and to know the negative stakeholders and what their adverse effects could be on your initiatives.

According to Dr. Glassman and colleagues (2011), gaining support involves generating a comprehensive rationale as to why change is important. It is important to be able to articulate the benefits associated with tobacco policy change. Rationales should be tailored to the concerns of faculty and will likely involve direct contact. Let me reinforce the idea that this will likely involve direct contact in order to adequately address any barriers or misconceptions.
According to Outten and colleagues (2003), faculty hold a more negative view of smokers. Faculty think that smokers are less intelligent, less creative, less independent, less conscientious, less ambitious, less considerate, have poor judgment and are viewed as being more hostile than non-smokers. This could be another piece of evidence tied into your strategies for changing a tobacco policy.

So there are assessment tools available, but assessment is not enough. Nurses should be tailoring change activities to the faculty. Assessment facilitates planning activities to reduce suspicion and fear. Suspicion and fear cause change agents to be ignored, criticized, resisted and can even end up with sabotage. Activities should increase awareness and commitment, allow for different perspectives, and allow for integration of the knowledge and experience of the faculty (CDC, 2001). Faculty are a valuable resource, so bring them in and access their knowledge. Perhaps there is a faculty who’s fabulous with statistics, or a faculty member who is an expert in cultural understandings. They can add support. Acting on the recommendations and having these faculty involved actually can lend credibility to the activities that you’re doing. And lastly, by doing this we acknowledge the unique situation that the faculty members are in.

Hovland (2007) has shared with us what she thinks are some of the top strategies to engage faculty. These include: 1. Checking faculty perceptions, and you should do this before you get started. 2. State your objectives and make sure that they’re clear, simple, and measurable. Be clear on your strategy, know what you will and you won’t do. An example of this in our experience was dealing with a powerful person who was adamant that we should have included obesity and nutrition because of the huge health issue. The committee agreed this was not something we were going to do during the tobacco initiative. Hovland recommends developing some simple messages in different contexts, ensure the messages are branded, frame the message so that it is useful, consider whether the message is coming from a health perspective (perhaps the same message could come from a curricular perspective or even a future employment of the students’ perspective). 3. Prioritize your faculty by power and interest, as discussed above. 4. Develop a project work plan. A work plan is critical, especially having timelines and knowing when you need to have activities completed. This helps with staying on track. Our policy took two-years to be approved by the Board of Governors. Our work plan was set up on six month increments, assuring that activities were completed. A work plan is important for doing that. Hovland also suggests estimating your time and cost. She recommended 5% of your total budget be put towards communication, and not to hesitate hiring experts in communication as consultants to help you. Build simple evaluation measures, and make sure, that this happens from the beginning. Evaluation measures are important to add into your work plan and objectives. I think that laying out what you want to do in writing will really be helpful.

The Foundation Coalition is an organization that is focused on helping campuses improve their learning environments and curriculum. From Getting Faculty to Change is it Possible or Not (2001), come some final words of wisdom. They recommend engaging faculty from the beginning. Make sure you assess them, but assessment’s not enough. We’ve talked about tailoring your activities. Successful change requires energy and time and maybe more energy and time than you even anticipate. Don’t be surprised or be defensive when resistance appears. I’d like to recommend that you take a look at some the techniques of motivational interviewing to improve response skills to resistance. Persevere through turmoil. This is an important piece. Zealous change champions cannot institutionalize the change by themselves. I think some of the characteristics that can help include tenacity, perseverance, and inclusiveness. Engage your faculty, articulate processes for the change, and watch it happen! 😊

REFERENCES


Getting Faculty to Change, Possible or Not? - Foundation Coalition. Retrieved from www.foundationcoalition.org/.../2001purduepresentationwatson.ppt


I will preface this column with a note that I am not a nurse. Is this a bad thing? Not necessarily. Do I care for nurses and respect the job they do? Definitely! I have had several nurses in my family and there are several MONA members that I consider friends. To write the following I am putting myself in a nurse’s shoes (shoes that may be big and clunky, but comfortable!). As the Director of State Affairs for MONA I must put myself in that position in order to possess the passion to drive the work of the association forward.

ONWARD AND UPWARD!! These are strong words but nurses are a strong group. In Missouri alone RNs number 96,000+!! Nurses are strong in numbers, but also strong in spirit! You care for every age, sex, race and show them all equal compassion and respect. You recognize the uniqueness of every individual and situation and treat them all with equal worth. You are committed to your patient’s health, safety, and rights. You are the person your patient feels most comfortable with because you work so closely with them. You take on the responsibility of advocating for your patient’s needs. So many times with all this responsibility and stress, this is where compliance with the Code of Ethics for Nurses ends; but there is so much more.

To preserve integrity and safety, you should maintain competence and continue personal and professional growth. Safe work environments, advancing the profession, promoting efforts to meet health needs... these are only a few of the efforts you should be involved in as professional nurses. Can you make a difference if you stand alone? Possibly. Can you make a difference if you stand together? DEFINITELY! To begin to improve the profession of nursing, you must come together as a “family”! You must treat your fellow nurses with as much respect and dignity as you show your patients. You all have different credentials, education, and experience. Is one better than the other? NO! ALL nurses serve a purpose for the patient. You are all needed and all equally important in the big picture of health care.

So why ONWARD AND UPWARD? If nurses are able to embrace the differences of fellow colleagues and work together, you can focus on making major changes and moving nursing forward in Missouri.

There is a lot of talk about the work MONA does for the APRNs. The APRNs have had many issues in the recent legislative sessions; however, APRNs are not the only focus for MONA. Over MONA’s entire legislative history we have had major accomplishments that have affected all registered nurses. In 1976, for example, MONA organized the first override in 112 years of the Governor’s veto related to the Nurse Practice Act! MONA members have a strength that many do not even realize and it’s time to flex our muscles!

Community Paramedics, Assistant Physicians, you may not know what these terms mean but rest assured, MONA does and we are working hard to protect the nursing profession against any threats. Whether you observe from the sidelines or actively participate in legislative issues, your voice is important! We need our members to be ready to respond when we send out a “Call to Action”.

As a MONA member, you already understand the importance of your association. SPREAD THE WORD! MONA gives you the chance to have your voice heard. We have a lobbyist at the Capitol working for nurses! Even if you are not a “political” person, this isn’t about politics. It is about protecting the nursing profession and making changes that will benefit you now and improve nursing in the future. MONA made history in 1976 and I am confident if we join together we will again be a force to be reckoned with!

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## MONA Calendar

### July
- **4th**: Holiday (Office Closed)
- **8th**: Regional Chair Meeting  
  MONA Office (10 a.m.-2 p.m.)
- **10th**: MOAC Exec Committee Meeting  
  MONA Office (1-3 p.m.)
- **21st**: Nursing Practice Committee Call (12 p.m.)
- **29th**: MNF Board Retreat  
  MONA Office (10 a.m.-3 p.m.)
- **31st**: Pharmacology Conference  
  Children’s Mercy - Kansas City

### August
- **1st**: Pharmacology Conference  
  Maryville University - St. Louis

### September (continued)
- **18th**: Nursing Practice Committee Call (12 p.m.)
- **22nd**: Approved Provider Training - Jefferson City
- **27th**: EC Region Program: “Affordable Care Act and Scope of Practice”  
  Missouri Baptist - St. Louis (8 a.m.-3 p.m.)

### October
- **13th**: Holiday (Office Closed)

### November
- **6th**: APRN-SIG/MOCAP Meeting  
  Jefferson City (11:30 a.m.-3 p.m.)
- **7th**: Nursing Practice Committee Call (12 p.m.)
- **11th**: Holiday (Office Closed)
- **13th**: MNF Board Conference Call (3 p.m.)
- **14th**: MONA Board Meeting  
  MONA Office (9 a.m.-3 p.m.)
- **27th**: Holiday (Office Closed)

### December
- **11th**: Advocacy Committee Call (7 p.m.)
- **24th-26th**: Holiday (Office Closed)

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