NBNA Special Edition on Aging
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A Message from the President

Is nursing ready for the post Patient Protection and Affordable Care Act (ACA) and its emerging marketplace? Discussions have occurred regarding how nursing roles will change since the passage of the ACA. The nursing profession represents a critical portion of health practitioners in meeting the demands of the new health care system. The Institute of Medicine (IOM) stated that The United States has the opportunity to transform its health care system, and nurses can and should play a fundamental role in this transformation. However, the power to improve the current regulatory, business, and organizational conditions does not rest solely with nurses; government, businesses, health care organizations, professional associations, and the insurance industry all must play a role. Working together, these many diverse parties can help ensure that the health care system provides seamless, affordable, quality care that is accessible to all and leads to improved health outcomes. (Academies, 2010)

Access to healthcare is an important pre-requisite to obtaining quality care. ACA is an important milestone in addressing the issue of the uninsured, pre-existing health conditions, and health insurance for the nation’s children. As NBNA continues to advocate for solutions for the underserved and unserved, we must continue to educate consumers to be in charge of their health care. We have an important role to advocate and ensure that there is not only access to care but recognize that high quality care is a universal issue. It is equally imperative that while health cost rise there is an increased focus on prevention and wellness.

In 2008, the World Health Organization Commission on the Social Determinants of Health presented a 3-year investigation in a report titled, “Closing the Gap in a Generation: Health Equity through Action of the Social Determinants of Health.” The report noted that health inequalities were found all around the world, not just the poorest countries; even in wealthy nations such as the UK. (Shah, 2006).

What is the status of health disparities? We know that we continue to have disparities in diabetes, high blood pressure, cancer and other diseases and conditions such as mental health. Another disparity that we need to address is related to adult vaccination disparities. Influenza and pneumococcal immunization rates among all adults are significantly below the health people goals of 90% for each vaccine. However, immunization rates among African Americans and Hispanics are substantially below those of their white counterparts. There are major adolescent and adult immunization disparities in Hepatitis B, influenza and pneumococcal rates. While influenza and pneumococcal disease rates have improved during the past decade, large racial and ethnic gaps still persist among people 65 and older. (Megan Multack, 2012)

Success in providing vaccines to minority patients has its challenges and is twofold. Education of health care providers and the public is the cornerstone of an effective vaccination strategy – the second is educating patients in culturally competent, linguistically appropriate ways about the benefits of vaccination so they can engage in responsible disease prevention. (Megan Multack, 2012)

Lastly, faith based approaches have a significant impact – the power of the pulpit and parish health ministries. Research has demonstrated that a multicomponent approach is well suited to identifying barriers to and facilitators of adult immunizations among a variety of populations, including the disadvantages. (Zimmerman RK, 2001)

NBNA will continue its legacy in making an impact in communities across the nation. As an organization, our focus will remain on influencing diversity through education, policy, practice, research, practice, and leadership. NBNA has been guided by the principle that African American nurses have the understanding, knowledge, interest, and expertise to make a significant difference in the health care status of African American communities across the nation throughout history. Together, we are making a difference.

Deidre Walton, JD, MSN, RN
President

Dr. Deidre Walton, President
National Black Nurses Association

REFERENCES


This winter edition comes to you at a time when the snow has stopped falling, the ice has melted, and most people are out enjoying the springtime weather. I slightly delayed this publication because of the need to provide a platform to recognize Older Americans Month. This recognition dates back to 1963, when President John F. Kennedy designated May as Senior Citizens Month. It was later renamed Older Americans Month, honoring older Americans and celebrating their contributions to our communities and our nation. NBNA is utilizing this platform to inform nurses, policy makers, and community leaders about the importance and impact that aging has on healthcare across this country.

The Administration for Community Living (ACL) is part of the U.S. Department of Health and Human Services. ACL was created in order to achieve several important objectives: to reduce the fragmentation that currently exists in Federal programs addressing the community living service and support needs of both the aging and disability populations; to enhance access to quality health care and long-term services and supports for all individuals; to promote consistency in community living policy across other areas of the Federal government; and to complement the community infrastructure, as supported by both Medicaid and other Federal programs, in order to better respond to the full spectrum of needs of seniors and persons with disabilities. ACL reports that the older population—persons 65 years or older—numbered 39.6 million in 2009 (the latest year for which data is available). Older adults represented 12.9% of the U.S. population, about one in every eight Americans. In 2012, The Federal Interagency Forum on Aging reported that the oldest-old population (those age 85 and over) grew from just over 100,000 in 1900 to 5.5 million in 2010. Blacks made up about 9% of the older population. By 2030, we are projected to have about 72.1 million older persons, more than twice their number in 2000. People 65 years and older represented 12.4% of the population in the year 2000 but are expected to grow to be 19% of the population by 2030.

Dr. Paula Dobriansky, Under Secretary, Democracy and Global Affairs, Department of State, wrote that people are living longer and, in some parts of the world, healthier lives. This represents one of the crowning achievements of the last century but also a significant challenge. Longer lives must be planned for. Societal aging may affect economic growth and many other issues, including the sustainability of families, the ability of states and communities to provide resources for older citizens, and international relations. The Global Burden of Disease, a study conducted by the World Health Organization and the World Bank, with partial support from the U.S. National Institute on Aging, predicts a very large increase in disability caused by increases in age-related chronic disease in all regions of the world. In a few decades, the loss of health and life worldwide will be greater from noncommunicable or chronic diseases (e.g., cardiovascular disease, dementia and Alzheimer’s disease, cancer, arthritis, and diabetes) than from infectious and childhood diseases, and accidents. Dr. Dobriansky further articulated that despite the weight of scientific evidence, the significance of population aging and its global implications have yet to be fully appreciated. There is a need to raise awareness about not only global aging issues but also the importance of rigorous cross-national scientific research and policy dialogue that will help us address the challenges and opportunities of an aging world. Preparing financially for longer lives and finding ways to reduce aging-related disability should become national and global priorities. Experience shows that for nations, as for individuals, it is critical to address problems sooner rather than later. Waiting significantly increases the costs and difficulties of addressing these challenges.

Our NBNA Leaders and colleagues, from across the country, have provided articles in this edition that provide a wide-range of knowledge about aging and Older Americans. I hope that you enjoy the topics and as always looking forward to your commentary.

I recommend several resources to a community wanting to learn more about older adults and again.

1. Please review a complete review of Older Americans and Key Indicators of Well-Being at http://www.agingstats.gov/Agingstatsdotnet/Main_Site/default.aspx
2. For more information on ACL and programs, go to http://www.acl.gov.

Best,
Dr. Ronnie Ursin
Editor-in-Chief, NBNA News
African-Americans and All Americans Must Have Affordable, Quality Healthcare

Rep. Jan Schakowsky

This year is important and exciting for all of us who believe every person deserves affordable access to quality health and long-term care.

It’s important because 2015 is a big anniversary year. Medicare and Medicaid turn 50. The Affordable Care Act (which I proudly call Obamacare) celebrates its fifth year. Together, they greatly improve Americans’ health and well-being. As the co-chair of the House Democratic Caucus Seniors Task Force, I’m especially proud of the many benefits they bring to older Americans.

It’s also an exciting year because the White House Conference on Aging provides the opportunity to come together to discuss how to build on what has already been achieved. We must work both to implement and to improve what is already in place so that no one—regardless of age, race, gender, health status or geography—goes without the care they need.

The first step is universal coverage. We see evidence every day that being insured matters. Here’s one example. In states that took advantage of Medicaid expansion under Obamacare, diabetes diagnoses increased by 23%, compared to a 0.4% increase in non-expansion states. The reason: newly-insured individuals could seek medical care. Early diagnosis lets us catch problems early so they don’t grow in severity and cost; healthier children and adults lead to healthier seniors.

The second step is to build a robust workforce. Having an insurance card doesn’t matter much if you can’t find a medical professional to take it. Every person who wants to be a nurse, doctor or lab tech should be able to get the education they need. Students—as well as medical schools—need support. That is why I’m a big fan of the Title VIII Nurse Education and Training Act and the National Health Service Corps. We need more nurses and to ensure that Advanced Practice Nurses can practice to the full scope of their licensure. Each day, 10,000 Americans turn 65, and I’m focused on making sure that we have the geriatric workforce in place to respond to a growing senior population, including expansion of the Title VIII Geriatrics Workforce Enhancement Program.

Beyond medical education and training, action is needed to place adequate numbers of trained and committed health care professionals in every community and every facility. I believe—and study after study demonstrates—that nurses are essential to providing quality, timely care. A nurse at the bedside and in the neighborhood is vital to improving health outcomes. Since coming to Congress, I’ve worked with nursing organizations to solve the extremely serious problem of understaffing and the toll it takes on patient safety and nurse retention. Along with Senator Boxer, I introduced the Nurse Staffing Standards for Patient Safety and Quality Care Act, to require safe nurse staffing levels in hospitals.

I have also sponsored legislation to address the need for more nurses in nursing homes. Nursing home residents are more medically complex than ever, yet federal law only requires that a registered nurse be present 8 hours a day. RNs are essential for conducting medical assessments and responding to medical problems—but they can be absent 16 hours out of every day. My bill, the Put a Registered Nurse in the Nursing Home Act, would make sure an RN is onsite 24 hours, 7 days a week.

These improvements will help reduce the chronic problem of health disparities in health care and long-term services and supports. Once again, the evidence of the problem is clear. Recent research reports conclude:

- Medicare patients are consistently less likely to have their high blood pressure, cholesterol and diabetes under control;
- Older African-American women were less likely to receive comprehensive postsurgical treatment of early-stage breast cancer;
- People of color are more likely to live with undiagnosed chronic diseases; and
- Majority-Latino nursing home facilities and majority-African-American homes had RN care levels 60% and 34% below those in majority-white nursing homes.

In 1965, Medicare not only expanded access to care but helped to reduce disparities by refusing to make payments to segregated hospitals. During Black History Month, I talked with Congressional Black Caucus Chairman G.K. Butterfield about his personal memories of how Medicare was live-changing for African-Americans seeking quality hospital care.

Today, our goal must be to eliminate health disparities altogether by expanding medical education opportunities for students of color, requiring adequate staffing levels in all communities, providing universal health care and, yes, creating a strategy for universal, affordable access to the full-range of long-term care services and supports.

Congresswoman Jan Schakowsky has been a lifelong consumer advocate and a champion for what she sees as the disappearing middle class. She is in her ninth term, and currently serves in the House Democratic leadership as a Chief Deputy Whip and as a member of the Steering and Policy Committee. The Congresswoman is a member of the Energy and Commerce Committee, where she is the Ranking Democrat on the Commerce, Manufacturing and Trade Subcommittee. She is also co-chair of the Congressional Seniors Task Force and a member for the Democratic Policy and Communications Committee. For decades, she identified her top priority as winning affordable, quality health care for all Americans.
The use of technology among older Americans (aged >65 years) is at an unprecedented high. Today over 84% of U.S. households have a computer and the majority of these households also have access to the internet.\[1\] In addition, approximately, ninety-one percent of U.S. adults use cell phones and over half of these users own smartphones.\[2\] While expanded access to cellular phones has slightly narrowed the digital divide that has historically existed between Whites and individuals from under-represented minority groups (i.e., African Americans and Hispanics),\[3,4\] some stark inequities in technology access and adoption exist among older and often less educated African Americans.\[5\]

A recent national study conducted by the Pew Trust, an independent nonprofit organization elucidated the incongruencies in broadband access among older African Americans who have not attended college as compared to whites with a similar demographic profile.\[5\] Also, less than half of older African Americans surveyed regularly accessed the internet and less than one-third reported having broadband internet access, which is significantly lower adoption rates when compared to older whites (63% go online and 51% had broadband access).\[5\] A lack of access to the internet is compounded by the fact that older blacks are also less likely to own a smartphones or computers when compared to all of other age cohorts of blacks and whites.\[5\]

A persistent and pervasive digital divide, socioeconomic inequality in access to and use of information and communication technology, among older African Americans poses a significant public health concern as several federal organizations set agenda that include the delivery of healthcare resources electronically. For instance, Healthy People 2020 has multiple aims related to both increasing access to internet and increasing the proportion of that use the internet for management of their personal health information such as exam results and medical appointments.\[6\] In addition, the Obama administration has put forth a statements that advancements in technology, such as “high-speed broadband internet access” and “new health care information technology”, are necessary for “long-term prosperity and competitiveness” Of Americans.\[7\]

The need to bridge the technology gap is especially urgent in respect to supporting the milestone healthcare legislation (Affordable Care Act) passed by the Obama administration in 2010 which requires that all Americans have access to healthcare.\[8\] The law also had tremendous implications for health technology including those related to provision of services, management of healthcare data, and customer facing webpages like the healthcare insurance market place. Therefore, we pose the following overarching question to guide our synoptic overview of barriers and solutions to merging the gap between older African Americans and whites: Does the persistent digital divide among aging African Americans represents a contemporary issue of the have and the have-nots or an issue of diffusion of innovation?

**Recommendations to Enhance Access and Adoption of Technology**

The identification of new solutions to provide free or low cost internet access to low income and older adult communities is needed to help diminish health inequities. We offer to stakeholders the proposition of a tiered municipal internet network. This innovative telecommunication reform offers an opportunity to overcome the socioeconomic impediment that plagues a significant proportion of older African Americans from accessing the internet and publically available resources. The Obama administration has begun to support municipal networks in attempt to create faster internet for cities. Access to free or low cost internet coupled with discounts on technology—computers or cellular phones with internet accessibility—coupled with free community-based technology training could ameliorate the digital divide between older African Americans and their white counterparts.

To overcome physical and attitude-related barriers to technology adoption, we propose that computer manufacturers consider how they can partner with assistive technology, and human computer interaction experts to create and evaluate products with inclusive (add-on) features (e.g., voice recognition) that will eliminate obstacles connected with technology use among those with physical disabilities. These add-on features should be subsidized through special government programs so that older adults (particularly those with low incomes) are not paying substantially more for the assistive features to be added to their computer system. In addition, these design and development processes should include older adults through forums where they can provide verbal input and or be involved in the pre-testing of these systems.\[16\] The improved usability of technology systems that can result through a participatory design process may also improve older adult’s attitudes toward technology use and ultimately lead to higher system adoption if other barriers are overcome (e.g., cost).\[13, 16, 17\]

**References**


**Continued on Page 5**
Closing the Digital Divide... CONTINUED FROM PAGE 4


Dr. Ronald Hickman is an assistant professor and a Robert Wood Johnson Foundation (RWJF) Nurse Faculty Scholar at the Frances Payne Bolton School of Nursing, Case Western Reserve University in Cleveland, Ohio. His research focuses on developing and testing electronic health (eHealth) technologies to improve the health and healthcare decision-making of older adults living with chronic illness.

Dr. Otis L. Owens is an assistant professor in the College of Social Work and Director of the Healthy Aging Research and Technology Lab at the University of South Carolina. His research focuses on the community-driven development of products, technologies, and services to help older adults age in place.

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Telehealth and Remote Monitoring in Support of the Elderly

Sheila Haley, PhD, RN
Mari Tietze, PhD, RN-BC, FHIMSS

Telecommunication technologies are changing ways of thinking, acting, and communicating throughout the world. It is bringing new generation of information scientists together with the hardware and software technologies they generate. In terms of the financial future of telemedicine, one industry expert predicts that the U.S. telehealth market will grow to $1.9 billion in 2018 from $240 million today, an annual compounded growth rate of 56 percent (Wood, 2013).

Telecommunication reaches out to the previously unreachable rural areas of our country (Darkins & Cary, 2000). This is in contrast to care delivery in the direct vicinity of the patient. It is about the use of telemetry technology that transmits digital components about the patient’s physical, physiological and psychological status. It allows for benefits to the elderly population as they can be managed remotely while they stay in their own homes.

The term “telehealth” generally encompasses three broad method of digital care delivery that is “away” from the patient: 1) telemedicine (stationary scheduled remote diagnostics of health status), 2) remote management/monitoring/coaching (stationary home or facility based with scheduled and as needed remote transmission of health status); and 3) mobile health “community” groups/social media (wearable mobile patient generated health data with scheduled and as needed remote transmission of health status).

Characteristics that may by typical to these digital methods of care delivery relate to: 1) the mode of technology transmission, 2) the type of reporting and to whom, 3) approach for patient engagement, and 4) outcome measures. All of these telehealth characteristics can be deemed to improve the care delivery for the elderly patient who prefers to remain in the home as long as possible.

Telehealth nurses can provide nursing care to the elderly by: 1) using clinical algorithms, protocols, or guidelines to systematically assess patient needs and symptoms; 2) prioritizing the urgency of patient needs; 3) collaborating and developing a plan of care with the patient and supportive disciplines, which may include recommendations for care, call back instructions, and education; and 4) evaluating outcomes (Stokowski, 2008).

Telehealth nurses are special in that they correspond with patients about healthcare needs over the telephone. What could be easier than talking to patients on the phone all day? No 12-hour shifts on your feet, no lifting heavy patients, no answering call lights. Telehealth nursing does have its advantages however, it is not as cut and dry as it appears. Imagine if you had to assess your patients with your eyes closed and without using your hands and you will get an idea of the difficulty that telehealth nurses must overcome with every patient encounter. Telehealth nurses must maintain the same quality of care, but without the advantage of visual and other sensory assessments. Telehealth nurses are usually limited to the information they receive from patient reports, tone of voice, and responses to questions. From this, they must develop and communicate a plan of care, immediately (Stokowski, 2008).

According to Fairchild, Elfrink and Deickman, (2008). The research related to telehealth and telenursing practice has shown great benefits related to diagnosis and consultations, monitoring and surveillance of patients, clinical and health services outcomes, and technology advancement. Each of these areas have important patient safety concerns, and while not studied as a unique entity, patient safety themes have emerged throughout the literature. Telehealth is a unique field that uses innovative technologies to improve patient care and thereby improve safety. These technologies range from the telephone to ubiquitous computing and only promise more in the future. Special concerns related to patient safety emerge with each of these methods of health care delivery.

The different platforms for telehealth are diverse, yet all increase the ability of telenurses to communicate with and receive data about their patients. Regardless of the specific telehealth technology utilized, the reliability and validity of data transmission is essential to the safety of patients. Further, accepted and proven nursing practice must not be compromised. It is imperative for nurses to see the telehealth technology as a medium for care, and not a tool to replace high-quality nursing practice. Patient safety will be maintained with telenurses who are able to focus on patient care and not the technology itself (2008).

REFERENCES


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Dr. Sheila Haley is an Assistant Clinical Professor at Texas Woman’s University. Prior to her pursuing a career in education she was a Captain in the U.S. Army Nurse Core. Sheila has been a member of the NBNA since 1983 when she was an undergrad student a Chicago State University.
As a Licensed Vocational Nurse who specializes in Home Health Nursing in the Greater Houston, Texas area, I want to share what I have learned about the salient role that a group of lay community workers provide on a daily basis to vulnerable elders aging in place.

The landmark law, the Older American Act passed in 1965, and renewed repeatedly guarantees one hot meal a day to those persons aged 65 plus or in some cases younger regardless of income. Besides going to a nutrition site, elders who are home-bound can get this meal delivered to their home. Drivers of the meals on wheels program play a significant role in the lives of this group of elders, an invisible key role. These drivers get to know the normal behaviors of their homebound elders. Drivers can note if the elder’s speech is slurred, if their mobility is impaired, and if they are ‘still alive.’

The Meals on Wheels is a social model not a medical model, therefore, the supervisors of the drivers are social workers not registered nurses or physicians.

I interviewed Andrea Fineman, Communications Manager, Interfaith Ministries for Greater Houston, A United Way Agency, on March 2, 2015. Ms. Fineman stated that their program serves 1.5 million meals a month to homebound elders aged 60 and older. The most vulnerable age group are those aged 85 plus.

She described the process used by the social workers in their agency to educate and do on-the-job-training to drivers of the traditional meals on wheels program. On a monthly basis, the Director of the program holds a seminar with the drivers. In these seminars drivers get educated and trained on what changes in elders behaviors is due to normal aging what changes are due to disease at a paraprofessional or as a lay community health worker.

Often drivers are the only ones who can verify that at the particular time they made their daily drop-off that the elder was ‘still alive.’ Frequently, these homebound elders are isolated, depressed, afraid they will fall, have few or no next-to-kin, are physically unable to shop for groceries, and self-report to be in poor health.

Given this new information as a LVN Home Health Worker, I have a newly found respect for drivers of traditional meals on wheels programs. Perhaps you do, too.

REFERENCES
1 www.imgh.org
2 http://www.mealsonwheelsamerica.org/theissue/facts-resources/more-than-a-meal

Melba Lee-Hosey, BS, AAS, AA, LVN, is known as the Gifted Hands Nurse. Lee-Hosey, has been a nurse over forty years. Member, NBNA Board of Directors.

“It was only when I practiced in the care of the elderly, in their homes I saw how vulnerable our elderly are. After reading the article I hope you will all take extra care and find out what resources are available to our aged and disable clients... And share it!”
Healthy Seniors Know How to ROCK Steady!

Sandra M. Webb-Booker

Healthy, non-sedentary, tenacious and engaging seniors choose to spend the day and portions of the evening, at their local Parks! I have been an active member of Foster Park, one of the parks in the City of Chicago’s Park District, for several years now, and am presently serving as the President of the Seniors’ Association. I have relinquished my athletic and health club memberships for membership at the Chicago Park District.

Many senior activities are free or reasonably priced, and the instructors are not only qualified but are caring and resourceful too! Aquatic instructors also have a variety of assistive devices to aid seniors with special needs who request or have been prescribed aqua-aerobics. I join 20 to 40+ seniors ranging in age from 60 to 93 years, at the pool from 9am to 10am daily for aqua-aerobics. Exercising in the pool minimizes the arthritic pains and stiffness, increases the mobility of the limbs and joints and strengthens muscle tone. Enjoy the exercises and note the harmonious and synchronous motions of the body, when the music of song artists like James Brown, Isaac Hayes, Patty La Belle and Aretha Franklin are played. CAUTION, you are still in the pool, do not transition to an earlier time period or the CLUB!

After drying off, you can mosey on down to the gym and join another group of 20 to 40+ seniors’ for line dancing. The doctors and nurse specialists at Rush University in Chicago have provided classes to our seniors on memory and Alzheimer’s, some seniors have signed up to participate in their research studies. We have come to know, that memory can be facilitated/enhanced by learning and executing the various line dances. Personally, most seniors have NO PROBLEM adhering to this prescription, they still love to DANCE!

After line dancing, try spending another 20–30mins doing chair exercises. I employ you to oxygenate and stimulate your body, mind and spirit, by attempting a vigorous march while seated in a chair. Be certain to add some hip and shoulder motion, along with 1-2 pounds of hand weights for each hand.

Caution, you might need a towel during this process or a shower shortly thereafter!

The personal trainer comes twice a week. This physical fitness workout includes walking a couple of laps around the track or the gym depending on the weather, using the pulleys to exercise arms and shoulders, throwing a 2- to 5-pound beach ball on the wall 10 to 15 times, walking between cones that are strategically placed on the floor, doing some push-ups on the wall or on the floor and step aerobics.

Here comes Evelyn Collier-Dixon, RN of Chicago Chapter NBNA, it’s time for active seniors to renew their CPR cards! Active seniors know, despite our age we are not barred from childcare or from volunteering to assist with after-school athletic programs for children or from babysitting our own grandchildren!

Other senior activities might include belly dancing, ceramics, woodshop or sewing classes. You might enjoy the quarterly midday luncheons or social outings to the “Seniors Prom” (you do need to be DRESSED to impress). How about some entertainment: Anyone interested in a little jazz or some blues? What about the movies or a play? This summer Foster Park Seniors’ Association is taking a weeklong trip via bus to Martha’s Vineyard.

Investigate your park district activities and related associations for seniors. You might be pleasantly surprised at what you might find! Again, I personally enjoy my membership with the Chicago Park District. I invite you to view our video clipping on YouTube. Type in Chicago@Play Foster Park.

Dr./COL (RET) Sandra Webb-Booker, AN, USAR, Past Chief Nurse 330th Med Bde, Past Coordinator, Chicago Public Schools Practical Nursing Program current Advisory Board member for Foster Park of the Chicago Park District. Past Chief Nurse, 330th Medical Brigade; Past Coordinator, Chicago Public Schools Practical Nursing Program; current Advisory Board Member for Foster Park of the Chicago Park District; Member, NBNA Board of Directors.
The Primary Care Provider views their patient from a holistic perspective. There should be insight into physical health, mental health and sexual health as they each have an integral role in the patient’s perceptions of their self-worth. Often this comprehensive approach is not completed as sexual health is not routinely discussed among patients and providers. The potential for this to be more disparaging is among the aging where as many as one half of men and women between the ages of 57-85 report at least one sexual problem, but as few as 38% of men and 22% of women beyond age 50 have discussed sex with a physician (Lindau, 2007), and as few as 23% of nurse practitioners admit to never or seldom conducting sexual history (Maes, 2011).

The PCP should be tuned into the importance of sexual health among their patients of the silver age. Furthermore, there should be discussions regarding the relationship between physical health, sexual health, and mental health. Knowing such information opens opportunities of education for both the patient and the provider. A survey found that those who were less likely to be sexually active were also those who viewed their health as being poor and reported sexual problems (Lindau, 2007). Many patients may not be aware that the presence of sexual problems may be a sign of a more serious underlying medical condition. PCPs who fail to acknowledge the significance of a patient’s sexual health problem may eventually find themselves treating depression, social withdrawal and/or bargaining with a loosely adherent patient.

There should not be an assumption that due to sexual problems, sexual activity may be tremendously decreased among the aging demographics because that is far accurate. Despite erectile dysfunction, decreased libido and the multitude of other problems, older patients still engage in some form of sexual activity or intimacy. In fact, the prevalence of sexual activity among this cohort remains above 50% until age 74 (Lindau, 2007). Of even greater concern, is the incidence of sexually transmitted infections, including HIV/AIDS, which is growing faster among the over 50 cohort than any other age group (Buttar, 2014). This alone warrants the necessity for PCPs to initiate discussions about sexual activity with their older patients.

Various reasons have been cited for the avoidance of discussing sexual activity and sexual problems with the aging patients. The lack of knowledge and skills has been commonly cited as there has been little investigation into the sexual behaviors and sexual functions of older people (Maes, 2011). Additionally, the unwillingness of patients and providers to initiate discussions, age and sex differences among patients and providers, negative societal attitudes about women’s sexuality and sexuality at older ages have posed obstacles (Lindau, 2007). Some of these reasons are easier than others to address and resolve. As certified healthcare professionals, lack of knowledge and skill is easily modifiable in the age of the internet and virtual continuing education opportunities. Taking advantage of these opportunities in combination with the growing diversity of healthcare may be a resolve to the discomforts of initiating these discussions. However, the evolution of society will take some time and more frequent depictions of sex in the silver age on television may be an indication of some progress.

As we approach the midpoint of the 21st century, age gaps will continue to grow as life expectancies will continue to lengthen. It is projected that the portion of the US population over age 65 will increase from 13.3% to 21% by the year 2040 (DHHS, 2012). This will create an ever greater need for the understanding of sexuality and the significance of sex in the silver age. It will become ever more imperative for PCPs to establish trusting relationship with their patients and provide comprehensive care throughout their lifespan. And while the discussion of sex may not be held at the first visit, it should eventually become a part of the routine assessment by the primary care provider as there will never be that “perfect time”

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Kendrick Clack is a lifetime member of the National Black Nurses Association and a board member of the Fort Bend County Black Nurses Association. He completed undergraduate and graduate studies at Texas Woman’s University in Houston, TX, and is a veteran of the United States Navy Nurse Corps. Currently, he is completing a Family Nurse Practitioner residency in community health and plans to complete a terminal degree to further advance in nursing leadership and become involved with the development of healthcare policy.
NORMAL AGING INVOLVES some physical manifestations that do not necessarily impair the efficiency of the body of the body or lead to disease or death. They merely may bring about modifications.

The elderly are living longer than their parents and grandparents. There is good news since these citizens are living longer why not live one’s life to the fullest?

Harvard University, David Cutler, the Otto Eckstein Professor of Applied Economics stated, “There is some reason to be optimistic about our longevity.” The period which we’re in poor health is being compressed until just before the end of life. Where we use to see people who are very, very, sick for the final six or seven years of their life, that’s far less common. People are living longer and healthier, adding healthy years, not debilitated ones. (Sifferlin, 2013).

The elderly are seeing their Primary Care Physician (PCP) more often and therefore are being treated for various illnesses such as-Hypertension, Congested Heart Failure and Diabetes sooner including follow-up care. The patients are being seen at state supported Longevity Clinics. Those seniors that aren’t able to be seen in the clinic can be seen by the House Calls physician. That physician take care of the patient with the assistance of an APRN. The patient is seen by the physician or APRN every 2-3 months, or according to the particular patients need.

Home Health agency is available to provide care if the patient need more frequent visits such as wound care or ongoing education by the skilled nurses. Home Health agencies can provide skilled nurses, physical therapist, occupational therapist, social worker, speech therapist and home health aides. When patients are cared for in their home this method is usually the best option and help to keep healthcare cost down.

A study conducted by Paul Recer, (ABC News) state, “there are approximately 35 million people in the United States age 65 or older which account for 13% of the population.” This older generation is more ethnically and racially diverse. Those age 65 or older, about 84% are non-Hispanic whites (Recer, 2006).

The burden of aging, bring a challenge. There is a burden regarding insurance payment to cover the baby boomers as they take advantage of the advancements in medicines and behavioral health in keeping our population as healthy as possible. We want to continue to make care accessible with healthcare providers available in all areas of the state. Societies viewpoint need altering in regard to the aging population. Making sure all are integrated into our community.

Policies are needed to address the services needed by the elderly, covering all aspects of their lives. Continuation of health care to all citizens regardless of their ability to pay. We see so often economic burdens such as social security payment, medical insurance and medical expenses increasing, services needed that will not be covered by insurance.

CONCLUSION

We have physicians that have a specialty in their particular field allowing the elderly to obtain better treatments for their particular illness. Our seniors have more energy, have fewer impairments and are walking more than a generation ago. Because of the improvements in healthcare a 65 year old will gain 1.7 quality years; a 14% increase over a generation ago. Those findings can be related to the improvements in health care. (Griffen, 2013).

As caregivers/healthcare providers we have a responsibility to provide optimal care for our seniors. We must never forget every individual is different, therefore our assessment findings must be individualized to meet the needs of our seniors.

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Yvonne L. Sims, MSN, RN, has a background in cardiac nursing for 30 years including four years as nurse educator. Sims is currently nurse case manager for a home health agency.
E merging payment and delivery reforms (often called alternative payment models or value-based payment designs) hold promise in advancing efficient delivery of high-quality, personalized care for Medicare and Medicaid beneficiaries. At the same time, value-based payment systems hold significant implications for the physician-patient relationship, patient access to care, and continued medical progress.

Policymakers, private health systems, and payers, including the Centers for Medicare & Medicaid Services (CMS) are experimenting with a variety of payment and delivery system reforms with the goal of moving to payment systems that seek to pay for performance based on measures of cost and quality. One catalyst in generating these reforms has been CMS’s Center for Medicare and Medicaid Innovation, authorized under the Affordable Care Act to develop and test new payment models in Medicare and Medicaid. These payment and delivery reforms may have significant impact for beneficiaries receiving care from practices participating in these new models, yet, the patient voice is often not well-represented in the discussions.

While alternative payment models show potential to improve the quality of care, they must be carefully structured to preserve the existing beneficiary protections in the Medicare and Medicaid programs and ensure that beneficiaries continue to have meaningful choices about their care. For example, as medicine moves toward more personalized treatments based on the molecular fingerprints of diseases, payment reforms should recognize the unique nature of the individual patient to advance high-quality, personalized care.

The President recently proposed a Precision Medicine initiative to accelerate biomedical discoveries and support clinicians in selecting which treatments will work best for which patients. As part of the launch, the administration noted “Most medical treatments have been designed for the average patient. As a result of this one-size-fits-all approach, treatments can be very successful for some patients but not for others.” The initiative recognizes the importance of taking into account individual patient differences that impact the efficacy of therapies. The Food and Drug Administration’s Patient-Focused Drug Development Initiative, authorized during the fifth Prescription Drug User Fee Act (PDUFA V) in 2012, has similar goals to gather information and perspective from patients on their diseases in order to better assess risk/benefit of new therapies.

As science and innovation move toward considering individual patient factors earlier in the research process, it is important that changes in provider payment support access to these advances. In other words, as CMS seeks to pay providers based on value, new payment and delivery models must recognize that the road to value may differ on a patient-by-patient basis. Payment reforms should support patient access to the full range of treatment options and medical advances and include mechanisms to recognize new tests and treatments. Clinicians should have the flexibility to treat based on the individualized aspects of a patient’s disease. This is particularly important throughout the aging process, as the complexity of many chronic diseases warrant an individualized approach. Payment reforms that lack this flexibility risk imposing one-size-fits-all treatments in an era of increasing advances in the field of precision medicine.

Nurses play an important role as advocates for their patients. As CMS explores new ways of paying for care, the conversation should not simply be between payers and providers. Instead, putting the patient at the center will ensure the treatments and care that we deliver appropriately meet their needs.

Michael Ybarra, M.D. is a board-certified emergency physician and Senior Director of Alliance Development at PhRMA. In his capacity at PhRMA, Dr. Ybarra leads alliance outreach to provider, multicultural, and LGBT organizations. His issue areas include communications with health care professionals and delivery reform. In addition to his work at PhRMA, Dr. Ybarra works clinically in the Emergency Department at MedStar Georgetown University Hospital.
Frailty is defined as being in a state of increased susceptibility from age-associated decline in reserve and function resulting in reduced capacity to cope with commonplace or acute stressors. (Lee, Heckman, & Molnar, 2015) The frail older adult is at a higher risk of adverse health outcomes. Lee, Heckman, and Molnar (2015) state that frailty is associated with functional impairment, hospitalizations, and mortality. It is known that frailty is a more accurate indicator of individual mortality than chronological age. It is also a strong predictor of emergency department visits, hospitalizations, hospital readmissions, and mortality while in the hospital. (Lee et al., 2015) Patients who are frail preoperatively are at greater risk of postoperative complications and mortality, discharge to somewhere other than home, and reduced survival. (Hubbard & Story, 2014) In addition, frail individuals are at higher risk of fractures, falls, and disability. Approximately 82% of older adults have at least one chronic disease. (Heuberger, 2011) This is important when assessing for frailty. We know that the majority of frail people also have at least one chronic condition. (Lee et al., 2015) Some chronic diseases that have been linked to frailty include hypertension, cardiovascular disease, chronic kidney disease, diabetes mellitus, cancer, HIV disease, cognitive impairment, Parkinson disease, and depression. (Heuberger, 2011)

The recognition and management of frailty will become even more important as the population ages. According to projection by the US Census Bureau, the population of adults age 65 and older will more than double between 2000 and 2030. The over-85 age group is the fastest growing with an expected five-fold increase by 2050. (Brown-O’Hara, 2014) There have been several scales and tools developed that may be used to assessed the older adult for frailty. Most clinicians agree that indicators of frailty include slowed walking speed, low physical activity, unintentional weight loss of ten pounds or more in a year, low energy, and low grip strength. The individual with three of five indicators present is said to be frail. Those with one to two indicators are said to be pre-frail. (Lee et al., 2015) Along with the indicators mentioned previously, another fundamental component of frailty is sarcopenia, which is age-related loss of lean body mass. (Heuberger, 2011)

Prevention is more cost-effective than treatment and should be the first line of defense. Implementing appropriate interventions is key. Both malnutrition and immobility contribute to frailty. Older adults are at risk for malnutrition due to decrements in metabolic rate, lean body mass, gastrointestinal function, sensory perception, and fluid/electrolyte homeostasis. An older adult’s nutritional health may also be impacted by poor oral health, chronic disease, polypharmacy, social isolation, hospitalization, cognitive impairment, and pain. (Heuberger, 2011) Declining physical function is a risk factor for morbidity, disability, and mortality in older adults. The weakness of frailty, along with decreasing grip strength, gait speed, and physical activity is related to the nutritional, sarcopenic, and/or cachectic nature of frailty in adults. (Heuberger, 2011; Lee et al., 2015) The dysregulation of multiple chronic diseases that are common in the older adult often induce frailty.

How do we prevent or stop frailty from progressing? Ensuring that individuals participate in consistent physical activity throughout their life provides protection. Several large epidemiological studies have shown that older adults who participate in physical activity that included resistance training more than three times per week for at least six months along with increasing their intake of high quality dietary protein and micronutrients positively impacts the beginning and advancement of frailty. (Heuberger, 2011) Providing education regarding the importance of physical activity is a key nursing intervention and should include not only implications for current health, but future as well. Interventions for malnutrition may include the use of supplements, community resources such as Meals on Wheels, flavor intensification, assisting with feeding, and environmental enhancements during mealtime. (Heuberger, 2011) As nurses, we can provide information related to community resources and nutrition along with consulting dieticians who can make recommendations and also assist with providing education. We can also utilize volunteers to provide companionship, assistance, and encouragement for ambulation and range of motion as well as during meals. The Hospital Elder Life Program, or HELP, is one example of how volunteers can be utilized in this manner. The purpose of HELP is to prevent delirium in older adults while in the hospital. Two of the program’s interventions, physical activity and mealtime assistance, would also be beneficial in prevention and treatment of frailty.

As nurses, we play an important role in providing education and support that can lead to improved outcomes for the older adult. By developing and participating in research studies related to frailty, we can add to what we already know regarding frailty.

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Wendy Lundregan, MSN, RN, OCN, is a Nurse Specialist and the NICHE Coordinator at Reading Hospital. She has oversight of and mentors the Geriatric Resource Nurses throughout the hospital along with co-leading the NICHE Leadership Team. She is a member of National Association of Clinical Nurse Specialists, Gerontological Advanced Practice Nurses Association, and Oncology Nursing Society.
When it’s time to focus on you, and not your illness… It’s time to call Hospice

Peggy Pettit

When a person is coping with a serious illness, it can be difficult to find the right kind of care and support. Too often the quality of life deteriorates as treatments and side effects escalate. Are you or a loved one:

• Rushing to the emergency room in the middle of the night?
• Calling the doctor repeatedly with symptoms and questions?
• Being admitted to the hospital or ICU—again?
• In pain or frightened?

IT’S TIME FOR A TRANSITION

Despite your best efforts, you may no longer be getting the help you need. What you need is a calm and thoughtful approach to care and a plan to address concerns before they become crises—before another trip to the ER. This is when hospice care can do the most good.

When your doctor says, “Hospice,” it’s because the care you’re getting is no longer the care you need. Hospice controls pain and manages symptoms. Hospice makes sure you are calm, comfortable, and at home. You have a whole hospice team scheduled to visit you. Teamwork makes the difference.

Your team will answer your questions or make a house call, any time, day or night. They want to know if you’re feeling frightened in the middle of the night, or you are having difficulty breathing, or you’ve run out of your medicine. When you feel the need to go to the emergency room, they want to know that too. The goal of your hospice team is to make you feel better and to make your life better while helping you remain at home.

If your health declines and you need more or different care, hospice addresses those needs with gradual, non-crisis transitions. Instead of trauma in the middle of the night, there is time to talk with your team and your family, time to try treatments and make adjustments to assure that you are comfortable. You are at home and your health is under control with hospice.

DON’T WAIT TO CALL HOSPICE

Most people with serious illness wish to be comfortable and at home, doing what they like to do, able to see family and friends. That’s the goal of hospice. What’s more, evidence indicates that, given enough time, hospice care can greatly improve the quality of life of the patient and his or her family:

• According to a Gallup poll, nine out of 10 Americans say that if they knew they had just six months to live, they would prefer to be cared for in their own home or a family member’s home.1
• Research published in the Journal of Pain and Symptom Management found that Medicare beneficiaries who chose hospice care lived, on average, 29 days longer than similar patients who did not take advantage of hospice.2
• VITAS® Healthcare patient surveys indicate that 99 percent of families wish they had known about hospice sooner.3

Experts agree that hospice care is most beneficial when it is provided for months, rather than weeks or days. Get the information you need now, so that when you need additional support in order to remain comfortably at home, you’ll be ready to make the transition to hospice.

Your doctor can help determine when the time is right, but here are some symptoms to watch for:

• Repeat trips to the emergency room or hospital admissions
• Unrelieved pain
• Frequent infections
• Weight loss/difficulty swallowing
• Inability to move about on your own
• Nausea/vomiting
• Shortness of breath/oxygen dependence
• The burden of treatment outweighs the benefits

When you have any of these symptoms in conjunction with a life-limiting illness, consider the transition to hospice.

WHAT DOES VITAS DO?

VITAS® Healthcare brings hospice to your home. We control your symptoms and preserve your dignity. We help you transition from curative care to hospice care, or from hospital to home. We help your family make the transition too, to focus on you, the patient—not your illness.

Your VITAS team will include:

• Physician
• Registered nurse
• Social worker
• Hospice aide
• Chaplain
• Community volunteer
• Bereavement specialist

Although a hospice physician is part of the VITAS team, your personal doctor can continue to be involved in your care. In fact, we welcome the participation of your primary care physician in managing your care.

VITAS provides all four levels of hospice care, as defined by Medicare. You may receive one level or several, depending on your needs.

• Routine home care
• Intensive Comfort Care® when the patient at home needs acute symptom management up to 24 hours per day when medically appropriate
• Inpatient care when care cannot be managed at home
• Respite care for the patient when the family caregiver must be away

There is no need to defer hospice care due to financial concerns. The Medicare Hospice Benefit covers 100 percent of the cost of care related to the terminal illness. In most states, Medicaid (Medi-Cal in California) also provides hospice coverage, as do most private insurance plans. Coverage includes everything involved in hospice care, from nurse and physician visits to therapy, medication, equipment and supplies related to the terminal illness.

CONTINUED ON PAGE 15
AGING IS ONE OF the few guarantees in life. As we age, our bodies and our minds change in many important ways. For example, we lose muscle mass and bone density, our eyesight and hearing is often compromised and we can experience difficulties with balance, increasing our risk for falls. One of the other important organs that changes as we age is our brains.

The human brain shrinks on average five percent per decade after the age of 40 (Svennerholm, 1997). Aging research consistently reports deterioration of the prefrontal cortex (think the “CEO” part of the brain) in older adults. We often experience memory and cognition changes - yes, there is a reason why it’s difficult to remember where you put your keys! Finally, it becomes even more difficult to deal with distractions as we get older as we are less able to suppress distractors when engaged in specific tasks (Hasher and Zacks, 1988; Gazzaley et. al. 2005).

As life expectancy in our country continues to rise, it is crucial that we find ways to stay healthy and active to maintain and enjoy the highest quality of life possible. This includes eating well, getting regular exercise, limiting alcohol, avoiding tobacco use and working out the brain. There is increasing evidence to suggest that training the brain through mindfulness meditation may in fact be the ticket to maintaining optimal physical and cognitive functioning, while at the same time, enhancing our social connections.

Mindfulness is a form of self-awareness often described as the ability to be fully present in each moment with openness, acceptance and non-judgment. It is a quality that helps us show up fully in our lives instead of operating in autopilot, so that we can engage and experience life completely instead of being caught up in the past or the future—where we often spend a lot of our time.

As a long-term meditator, I can personally attest to the health and well-being benefits of mindfulness. I entered into mindfulness practice during a time in my life when I was quite stressed and experiencing a number of personal and professional challenges. The immediate benefits that I experienced included reduced anxiety and improved sleep. As I continued with my meditation practice, I found that I began to show up differently in life. I became less reactive, improved my relationships and became a better leader.

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Rigorous scientific studies over the past 25 years have demonstrated the positive impact mindfulness has on healthy aging. Brain scans show that meditators’ brains—even among older adults—are different: their cerebral cortex is thicker and there is more gray matter—evidence of increased blood flow in this part of the brain (Luders, 2012). Meditators also exhibit chromosomal differences consistent with someone younger. Meditators show less decline in telomeres (the cap at the tips of our chromosomes) and the enzyme telomerase. Shorter telomere length serves as a biomarker for accelerated aging and short telomeres are linked to chronic stress (Epp, 2009, 2010 and 2013; Hoge, 2013).

Meditators also demonstrate enhanced performance on “executive-functioning” tasks such as memory, attention and processing speed (Prakash, 2012). In one study, a group of meditators with an average age of 50 years performed as well as 24-year-olds on an attention-related test (Van Leeuwen, 2009). And there is strong evidence suggesting that mindfulness improves the quality and duration of sleep in older adults, reduces the intensity and severity of chronic pain, reduces inflammation and may even ward off the risk factors of loneliness—which alone carries high risk for morbidity and mortality (Black, 2015; Grossman, 2004; Kaliman, 2014; Cresswell, 2012).

So, how to get started with a mindfulness meditation practice? Mindfulness is simple to do and yet not so easy. It is unnatural for us to sit quietly and do nothing! The practice involves using the breath or the body as an anchor; a place to focus one’s attention into the present moment. And by doing so, we can begin to calm the mind and relax the body. And then, noticing when the attention is pulled away; just noticing where it has gone and what it is preoccupied with. The moment of noticing is a moment of awareness and the instruction is to just begin again by focusing on the breath.

Set aside some time each day and find a space in your home or office that is conducive to relaxation, with minimal disruptions. Begin with just a few minutes each morning by simply directing your attention to the sensations of breathing or to the physical sensations in your body.

There are a number of excellent books, applications and even great Ted Talks that one may access to support the initiation of a mindfulness practice. Some of my favorite books include any of the works of Jon Kabat-Zinn, the Founder of the Stress Reduction Clinic and the Center for Mindfulness in Medicine, Health Care, and Society at the University of Massachusetts Medical School. Kabat-Zinn is attributed with bringing mindfulness in its secular form into our country.

If you are interested in this topic, I invite you to join me during Nurses Week on May 11 for a 90-minute webinar focused on mindfulness, where I will be speaking about the health benefits and leading participants through a handful of meditation practices. You can register online at www.nbna.org and nursing CE is available. Also, watch for programming planned for the NBNA 43rd Annual Institute and Conference held in Atlanta, GA, July 29-August 2, 2015. I will be offering a half-day session entitled: The Mindful Nurse Leader: Strategies for Bringing Mindfulness into Nursing Practice, on Saturday, August 1.

While it is a given that each day we get older and may experience the joys and sometimes the pains of aging, finding ways to age “mindfully” is an option for each of us. Just as the health benefits of regular exercise and healthy eating are demonstrated for heart and bone health, we can also keep our brains healthy and “fit” through the practice of mindfulness meditation. I invite you to give it a try and hope to see you at one of my upcoming programs.
Mindfulness... CONTINUED FROM PAGE 14

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Dawn Bazarko, DNP, MPH, RN, FAAN and Certified Mindfulness Facilitator is the founder and senior vice president of a new UnitedHealth Group business called Moment Health, which is focused on bringing mindfulness solutions to the work place, to health care workers and into health care delivery to improve the care experience. Over the past 6 years, she has been a driving force behind cultivating mindfulness practices in the workplace; offering a number of mindfulness meditation and mindfulness based stress reduction programs to employees of major organizations including in-person, telephonic and drop-in formats.

Her research with UnitedHealth Group nurses involving tele-health mindfulness delivery was published in the Journal of Workplace Behavioral Health. She is increasingly seen as an expert in the science of the mindfulness and methods of bringing mindfulness practices into corporate environments and into health care.

Dr. Bazarko is a highly sought speaker nationally and internationally on the topics of mindfulness, the nursing workforce and creation of healthy work environments, which are also the foci of her published research. As a long term meditation, Dr. Bazarko has studied with Jon Kabat-Zinn, Rebecca Bradshaw, Diana Winston, Marvin Belzer, and many others. She received her certification as a mindfulness facilitator from the Mindful Awareness Research Center, University of California, Los Angeles.

Dr. Bazarko is a registered nurse and holds a Master’s in Public Health, specializing in environmental and occupational health, and a Doctor of Nursing Practice, both from the University of Minnesota. She was recently inducted as a Nurse Fellow in the American Academy of Nursing, an honor bestowed on a select group of nurses who have made a major impact on the field of nursing. In May, she will receive the Leadership Award from the Women’s Health Leadership TRUST for exemplifying excellence in health care leadership.

Prior to founding Moment Health, Dr. Bazarko, was the founder and senior vice president of UnitedHealth Group’s Center for Nursing Advancement. Established in 2008, the Center was created to support the personal and professional development and health and well-being of more than 23,000 company nurses globally as well as influence the profession and health care as a whole.

She serves on numerous boards, including the American Nurses Foundation Board of Trustees, the University of Minnesota Nursing Foundation Board and is the community voice for the Gerontological Advanced Practice Nursing Association Foundation Board.

Peggy Pettit has over 30 years experience in hospice management and nursing. Currently the Chair Elect of the Community Home Accreditation Partners (CHAP) Board, she is also a Council member of the Health Sector Advisory Council at the Duke University Fuqua School of Business, a member of the NBNA Corporate Roundtable, Steering Committee co-chair with Alabama Health Action Coalition, and a member of the National Hospice and Palliative Care Organization.
Malnutrition Screening and Intervention are Vital for Quality Nursing Care of Older Adults

Mary Beth Arensberg, PhD, RDN, LD, FAND

The critical ingredient lacking in malnutrition care today is engagement by the broader healthcare establishment. Systematic malnutrition screening and appropriate interventions for older adults are not in place, yet are vital. Malnutrition screening and intervention need to be part of quality initiatives, transition of care models, and national health goals. Malnutrition screening and intervention also need to be included in the core curriculum and training for nurses and other healthcare professionals.

The White House Conference on Aging is held every decade and is an excellent opportunity to increase awareness and bring forward a call to action on malnutrition. This can be accomplished in part through information shared at its regional forums and open channels for public comment. A recent National Listening Session on Nutrition featured the 2015 White House Conference on Aging and the session is now available for nursing continuing education. The 2015 White House Conference on Aging is a national-level forum for nursing to discuss age-related policies, influence decision makers at the state and federal levels, and guide the public and private sectors in how they can best contribute to the well-being of older adults in the future. The recommendation that nutrition be viewed as a vital sign for the health and well-being of older adults is an important potential outcome of the 2015 White House Conference on Aging.

RESOURCES

NBNA Malnutrition Resolution:
http://www.africanamerican.com/folder14/alot%20more%20of%20african%20&%20african%20american%20history8/leaders/NBNA+News+Fall+2012.pdf (Page 34)

The Alliance to Advance Patient Nutrition:
http://malnutrition.com/getinvolved/hospitalnutritiontoolkit

Sarcopenia Infographic:

What’s Hot? Aging Policy: Preventing, Treating Malnutrition to Improve Health and Reduce Costs Newsletter download:

Employer Elder Care Toolkit:
http://familiesandwork.fmmedia.com/

Malnutrition Quality Initiative:

White House Conference on Aging:
http://whitehouseconferenceonaging.gov/

Archived White House Conference on Aging National Listening Session, Nutrition = Solutions to Healthy Aging and Long-Term Services and Supports, is available for nursing CEU at:
http://anhi.org/courses/B059B13F0E44C8AA7324652409B344A
Malnutrition Screening... CONTINUED FROM PAGE 16

REFERENCES


SOCIAL MEDIA

Facebook:
Malnutrition affects 1 in 3 patients entering the hospital, 1 in 3 patients during their hospital stay, and costs the U.S. $156.7 billion per year. Find out what nurses can do to become more active in identifying and intervening with patients at risk for malnutrition by making nutrition a vital sign for older adults. [Insert Link to Article]

Nurses are critical for taking vital signs and are on the frontline for improving nutrition intake. Learn why making nutrition a vital sign for older adults could help improve patient health outcomes and save the U.S. billions! [Insert Link to Article]

The White House Conference on Aging recognizes the importance of older adult nutrition! Check out this listening session for the upcoming 2015 White House Conference on Aging and earn 1.5 Free Nursing CE credits. [Insert Link to Webinar]

Twitter:
Malnutrition Affects 1 in 3 Patients, Costs $156.7 Billion per Year. Learn about making nutrition a vital sign for older adults #NBNA15 [Insert Link to Article]

How malnutrition screening/intervention can improve patient health outcomes and save the U.S. billions! #NBNA15 [Insert Link to Article]

2015 White House Conference on Aging listening session on value of older adult nutrition now available for free nursing CEUs! #NBNA15 [Insert Link to Webinar]

Mary Beth Arensberg is director of health policies and programs at Abbott Nutrition. Her recent publications include co-authoring the article “Nutrition as a Vital Sign: Progress Since the 1990 Multidisciplinary Nutrition Screening Initiative and Opportunities for Nursing,” published in the open-access Journal of Nursing and Care.

This year marks the 30th Anniversary of the Report of the Secretary’s Task Force on Black and Minority Health, released in 1985 under the leadership of former HHS Secretary Margaret Heckler. This landmark report marked the first convening of a group of health experts by the U.S. government to conduct a comprehensive study of racial and ethnic minority health and elevated minority health to a national stage.

This milestone anniversary serves as a paramount opportunity to highlight national and local efforts towards eliminating health disparities and advancing health equity, including legislative policy and actions such as the Affordable Care Act, the HHS Action Plan to Reduce Racial and Ethnic Health Disparities, and the National Partnership for Action to End Health Disparities.
THE ALLIANCE FOR Balanced Pain Management (AfBPM) is pleased and honored to welcome the National Black Nurses Association (NBNA) as a valuable new member of our organization. AfBPM is a diverse collective of health care advocacy groups, patient organizations, industry representatives and other stakeholders with a mission to support appropriate access to integrated pain management and responsible use of prescription pain medicines with an aim to reduce abuse. AfBPM works collaboratively to educate, support and advocate on behalf of people affected by pain, both acute and chronic.

Members of the AfBPM Steering Committee include the American Cancer Society, the Gerontological Society of America, Partnership for Drug-Free Kids, American Chronic Pain Association, Alliance for Patient Access and Mallinckrodt Pharmaceuticals. All of our member organizations, who share a strong concern with balanced pain management, can be found at www.Alliancebpm.org.

AfBPM defines balanced pain management as a comprehensive approach to diagnosing, treating and controlling pain. In a balanced approach to pain management people with pain, along with family members and caregivers, learn to manage their pain in safe, effective, responsible and healthy ways to improve or maintain their overall well-being. The goal is a multi-faceted and individualized treatment plan to coordinate safe and effective options addressing pain on physical, emotional, social and psychological levels. When medications are necessary, it’s important for patients to be given an understanding of potential side effects and appropriate management of the medications, and commit to safely use, store and dispose of such medications.

NBNA brings to AfBPM a strong history of advocating for improved health services on behalf of the African American community. We know that NBNA leadership and each and every nurse will bring knowledge, experience, compassion and a voice that will contribute enormously toward achieving our goal of access to balanced pain management for Americans in need.

This need for access to adequate pain management is especially relevant for minority communities. Research shows—and many of you may have seen firsthand—that racial and ethnic minorities “consistently receive less adequate treatment for acute and chronic pain than non-Hispanic whites, even after controlling for age, gender, and pain intensity.” The research also reveals that whether in the emergency room, long-term care or while dealing with cancer pain, Hispanic and African American patients were less likely than whites to receive appropriate analgesia.*

Overall, an estimated 100 million Americans are affected by chronic pain, while a great number of people are affected by acute pain. But according to a recent report issued by the National Institutes of Health, 40 percent to 70 percent of people with chronic pain are not receiving proper medical treatment, which can include physical therapy and rehabilitation, psychological counseling, social support, medication and other complementary approaches. At the same time, the need to keep supporting efforts at preventing misuse, abuse and diversion of prescription pain medicines is ongoing.

AfBPM was officially launched in November 2014. Already we have made progress toward educating the public about the critical need for balanced pain management. We’ve launched a website—alliancebpm.org—that will continue to evolve and grow with useful resources, including steps that can be taken by people in pain and people who care for and about them. We are working on developing tools that will provide more insights about the barriers and needs faced by people with pain and health providers to adequate pain management. We also are developing simple ways to educate people about the importance of protecting themselves, their families and communities from prescription pain medicine abuse, misuse and diversion. And, as part of every effort, we are encouraging dialogue and raising the level of attention and awareness for balanced pain management. We do all of this as a team, and we are thrilled that NBNA will be an integral part of this process and this journey with AfBPM.

Defining Racial and Ethnic Disparities in Pain Management
http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3111792/

Bruce E. Becker, M.D., M.S., Steering Committee Liaison member from the American Academy of Physical Medicine & Rehabilitation, and Clinical Professor is a University of Washington School of Medicine is a graduate of Tulane University School of Medicine. Dr. Becker completed his residency training in Physical Medicine and Rehabilitation at the University of Washington. He directed the Oregon Rehabilitation Center in Eugene, OR for nearly 17 years before moving to Detroit, MI where he served as Vice President of Medical Affairs for the Rehabilitation Institute of Michigan from January, 1992 until June, 1998. He was an Associate Professor at Wayne State University School of Medicine as well as Residency Program Director for the Department of Physical Medicine and Rehabilitation of Wayne State University School of Medicine. He moved to Spokane to serve as Medical Director of St. Luke’s Rehabilitation Institute from June 1998 until January 2006. Since 2007, he has been a Research Professor at Washington State University, and also a Clinical Professor at the University of Washington, within the Department of Rehabilitation Medicine. Throughout his career Dr. Becker has focused his clinical practice on the rehabilitation of spinal injury, chronic pain, and the rehabilitation of workplace injuries.
TODAY, AGING AND LIVING longer lives is considered the norm. According to 2013 Census data, individuals over 65 years of age account for 14.1% of the US population (US Census Bureau, 2013). As preventative screenings are able to identify conditions earlier, practitioners are able to recommend and initiate treatment options earlier as well. In general, more Americans are making better lifestyle choices related to diet and exercise as our nation changes its healthcare focus.

Many believe that as individuals age, their sexual desire decreases. For some, this is true due to advancing chronic diseases and the loss of significant others/spouses, for others, this idea is furthest from the truth! With less work, child care responsibilities, and/or unintended pregnancy concerns, some aging Americans are finding much excitement in their “new” intimate life. This new sexual excitement is prompted by longer lives, remarrying after spouses become deceased, and gaining access to new partners via social organizations, support groups and nursing homes.

Advanced technology and new advances are aiding aging Americans in their sexual relationships. Pre and early menopausal women in good health with no known risk factors may be candidates for hormone replacement agents. Women on these agents may experience decreased vaginal symptoms of menopause, prevention of osteoporosis, decreased hot flashes, night sweats and increased libido (Mayo Clinic, 2012). Male sexual enhancement medications and testosterone replacement are assisting aging males with maintaining sexual relationships. Men on testosterone replacement agents commonly report increased muscle mass, enhanced cognitive skills, improved libido and energy levels (Mayo Clinic, 2014).

Being on the frontline of healthcare, it is imperative that nurses educate our aging population on the risks associated with sexual engagement. According to the CDC, “persons aged 55 and older accounted for 19% of the individuals living with HIV infection in the United States in 2010” (CDC, 2013). Another report indicated “from 2005 to 2009, the number of reported cases of syphilis and chlamydia among those 55 and older increased 43 percent” (Jameson, 2011).

Many nurses fail to acknowledge that aging adults are still sexually active but patients need to know if they are even healthy enough for sexual activity. Like many other cardiac exercises, the average person who engages in moderate to intense sexual activity will notice an increased heart rate, blood pressure (BP) and cardiac output. Uncontrolled chronic diseases such as hypertension, hyperlipidemia, and diabetes can place patients at an increased risk for myocardial infarctions (MIs) and strokes during sexual activity.

It is also important that individuals know their status before engaging in intercourse with new partners. Nurses often stress this with their younger clients, but this should also be addressed with older patients that are looking to begin new sexual relationships. Testing for viral and bacterial STIs, such as chlamydia, gonorrhea, and HIV is ideal BEFORE beginning new sexual relationships. Additionally, these diseases should be screened for routinely throughout the relationship. Urine screening for chlamydia and gonorrhea or cheek swabbing for HIV is convenient and less invasive than traditional serum testing options.

Lastly, aging patients need to be reminded of the importance of practicing safe sex. Barrier protection, such as the male condom, is effective against contracting most STIs. Introducing alternative barrier protection options to your aging population is important as well. Use of a product such as the female condom has been associated with protection against STIs and increase user freedom. Female condoms can be inserted up to 8 hours before planned intercourse (MedlinePlus, 2014).

As our population is living longer and healthier lives, they are also enjoying continued or new sexual relationships. Our jobs as nurses includes educating our patients about the potential risks as they enjoy the benefits of getting it on.

REFERENCES


AGING IS MORE THAN becoming older and developing wrinkles, it has a profound effect on the individuals psyche and physical status. One of the most crucial decisions we must make is where the aging person live, with relatives or an outside facility. Sometimes this decision may immediately stem from a tragic incident or a fall that the aging relative may have had. (Coleen Choisser & John Choisser, How To Modify A Home For Senior Living, 2014.) Many older adults often find aging a time where their bodies are more susceptible to varied physical changes and illnesses. As we age it is wise to make the necessary changes to ensure that one's health is closely monitored by a healthcare professional, especially if there are chronic health concerns involved. Questions arise in one's mind regarding the outcome of their future in the aspect of aging; “Will I have family around to help me?”, “Will I be healthy”, “Will I be able to afford healthcare costs?” These are all questions that one may come across.

The outwardly physical changes that are expected while aging may not be as traumatic as the psychological changes that are experienced. Physical changes experienced may not be linked to declining health or a chronic disease but more of a delay. Slowed reaction is a normal part of the changes that are involved in aging. The individual has to schedule more time throughout their day to accommodate this change so that stress won’t become a hindrance. Asking for help from available relatives and or neighbors and friends is also a good idea, along with keeping a log of emergency contacts and transportation resources for appointments and/or errands.

Physical incapacities can be limited with an intake of a healthy diet and physical exercise. These two aspects are extremely critical to how one's body reacts to the aging process, and will allow a smoother transition. (Kristy Clark, The Secrets to Healthy Aging and Making the Best of Your Golden Years, 2015.) A healthy, balanced diet and drinking at least eight eight-ounce glasses of water daily will help prevent many disease processes from occurring. An individual could walk a few blocks a day in their neighborhood to improve one's overall health. This physical activity will lower your body fat and decrease the risk of heart disease, diabetes and other. The overall health of your mind, body and spirit is very important. Senescence or the progressive deterioration of the mind and body's normal functioning can be delayed or experience radical improvement of those who apply these health related practices earlier in life.

Physiological changes experienced during the aging process may highly depend on the individual's social support system. Family members, neighbors and friends who are local that may be of any assistance; physical or social networking that may also be helpful in improving or maintaining the health status of chronic conditions. It is crucial that the aging person’s support system is easily accessible to help prevent any additional stress that may arise during times of crisis or daily living.

Overall, preparing for the time of aging is a significant task that is wise to handle before we become of age to help prevent any additional hardship for ourselves and our family members. There are an abundance of community resources available including specialists on aging, attorneys’, and physicians. Take advantage of resources present and reach out to those in your community who may be of assistance. Remember that aging is a process that we all must encumber and that it doesn’t have to be a dreadful time, it can be the best years to come.

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As the month of February brings forth awareness of heart disease, research continues to dictate the prevalence of cardiovascular disease in many populations. In fact, heart disease is the leading cause of death and disability for women in the United States (U.S.). Many cardiovascular deaths in women are from coronary heart disease (CHD). Despite these facts, practitioners and their female patients continue to believe that women have least cardiovascular risk than men (AHA, 2003). According to the United States Department of Health and Human Services (USDHHs, 2000) physical inactivity is one of the greatest risk factors of CHD associated with hypertension, smoking, and high cholesterol. Research has shown that regularly moderate-intensity exercise for at least 1.5 to 3 hours a day is a well-documented health benefit to all women with heart disease. Women continue to fail at carrying out these recommendations for several reasons, such as day to day routines related work and family obligations (Manson et al. 2002). There are barriers that exist in all primary care settings when it comes to counseling and advising patients on the benefits of an exercise regimen.

Nurse practitioners (NPs) are in a great position to motivate women to engage in healthy lifestyle interventions. The NPs role in practice is to search for solutions (Perry & Bennett, 2006). The use of Motivational Interviewing (MI) is an approach NPs are using in practice today to increase women’s participation in physical activity. Unlike providing advice, which is often seen as one sided conversation from the patient’s perspective. NPs that utilize MI are aware that the interventional approach allows the patient to give their input about exercise based on their own beliefs and values. Let’s face it, regardless of what the practitioner believes about exercise the patient needs to formulate their own personal frame of reference. Patients can achieve this by reflecting on their capabilities of finding solutions that can lead them to participate in a daily exercise program (Perry & Bennett, 2006).

Background of Motivation Interviewing

The history of MI was initiated for use in substance abuse counseling (Burke, Arkowitz & Menchola, 2003) but has proven to be a reliable tool for NPs choosing to help women participate in physical activity for cardiovascular benefits. MI begins with the NP asking the patient about their thoughts and beliefs in regards to participating in a daily exercise regimen. Therapeutically the NP can continue the conversation with the patient over several appointments. MI is meant to be patient-centered and involves several principles such as: expressing empathy, developing discrepancy, rolling with resistance, and supporting self-efficacy (Jansink et al. 2009).

Expressing empathy includes reflective listening, recognizing and accepting where the women are in their thoughts and actions about participating in an exercise program. It also allows for viewing ambivalence, as well as seeing reluctance to change as a normal process (Mosca et al. 2004). Developing discrepancy involves increasing the patient’s awareness of the differences between current behavior, core values, exploring ambivalence for change and having the patient express the importance of increasing exercise. Rolling with resistance involves accepting a patient’s resistance or reluctance to change. The goal of rolling with resistance is for the patient to argue for the change by eliciting “change talk” which is accomplished through reflective listening and summarizing the patient’s main points and placing emphasis on reasons to increase their physical activity (Perry & Bennett, 2006).

In order for patients to participate in an exercise program they must first develop a high degree of self-confidence, by reviewing past successes and discussing personal strengths and resources to enhance their self-efficacy. NPs must be careful as to not slip back into giving advice to the patient or telling them that they need to change. As NPs become more sufficient at MI their interaction with the patient will be mostly listening while the patient talks (Peterson, 2007).

Stages of Readiness

It is important that the NP have an understanding of the stage the patient is in from the moment the first conversation about an exercise program is initiated in practice. The stages are as follows: 1) precontemplation, 2) contemplation, 3) preparation, 4) action, and 5) maintenance. Each stage is meaningful because it provides the NP insight to the patient’s corresponding actions and responses about participating in an exercise regimen. Regardless of the stage, the NP should recognize and except the stage that the patient is currently experiencing during the motivational interviewing process. The NP should further the discussion around exercise each visit. Overtime this will allow the NP to see a change in the patient’s perceptions and behaviors (Van Nes & Sawatskey, 2009).

Perspectives for NPs on Key Components

There are some important points that the NP must keep in mind when implementing MI with patients, particularly women. First, NPs should understand that the desire and readiness to change is not stagnant, but is a movable state. Second, the interaction between the NP and their female patients should be viewed as a partnership not seen as one of an expert and patient. Thirdly, it is the women’s responsibility to voice her desire to exercise or not and to decide on her own strategies to develop an exercise routine. The NPs job is to assist by directing the conversation, however the NP must avoid giving advice and trying to solve problems expressed by the women (Perry & Bennett, 2006).

Fourth, the NP must understand that accepting a person position does not mean agreeing with the position. Fifth, the NP should have a thorough understanding that the assessment of the level of importance and level of confidence both need to be high before the women is ready to make the change. To end, it may take several visits for a women to solve her ambivalence about exercising and make a commitment to change. The NP begins the process of change by raising awareness, providing support and empathy. The MI strategies are not difficult and far outweigh the outcomes of women with heart disease who decide not to participate in an exercise regimen. The overall goal for the

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Colorectal Cancer Screening with sDNA: Cologuard®

Barry M. Berger, MD FCAP

OLORECTAL CANCER IS the nation’s second leading cause of cancer-related death, but it is also among the most preventable. A key reason colorectal cancer remains so prevalent is non-compliance with routine screening guidelines. According to the American Cancer Society, African Americans have the highest colorectal cancer incidence and mortality rates of all racial groups in the United States. Despite this, according to the National Cancer Institute, African Americans are less likely to be screened for colorectal cancer than whites. Causes for non-compliance with medical guidelines can be many and varied—in the case of colonoscopy, at least one reason may be fear of the test experience itself.

In August of 2014, a new option became available in the quest to encourage patients to be screened for colon cancer, with FDA approval of the first stool DNA (sDNA) test. Cologuard®, approved for colorectal cancer screening of typical, asymptomatic average risk individuals age 50 years and older, detects DNA and blood in the stool. Cologuard is a noninvasive option that allows the patient to collect a sample of their stool in the privacy of their home, then send to a lab for testing through a pre-paid mailer. There is no medication, dietary restriction or bowel preparation required. A negative test result means that the test did not detect abnormal DNA and/or blood in the sample. A positive result indicates the test detected abnormal DNA and/or blood that could be caused by cancer or precancerous polyps in the colon or rectum, and should be followed by a diagnostic colonoscopy.

The test is highly accurate in detecting early stage curable colorectal cancer. Data published in the New England Journal of Medicine in April 2014 from a 10,000 patient, 90 site, cross-sectional, pivotal study with colonoscopy on all patients as the reference method, showed that multi-target sDNA identified 92 % of CRC (Stage I-IV) and 94% of CRC Stage I-II, and 69 % of precancers with high-grade dysplasia at 87% specificity compared to 74%, 70%, 46% detection by fecal occult hemoglobin alone respectively (OC FIT CHEK, Polymedco) at 95% specificity. All difference were significant. At matched specificity of 87%, fecal hemoglobin alone detected only 76% of cancers. (Imperiale et al, NEJM April 3, 2014).

In October 2014, Centers for Medicare & Medicaid Services (CMS) approved on-label coverage for Cologuard for all Medicare beneficiaries age 50 – 85 every three years, independently of the use of any other CRC screening test. The test is available through prescription only.

Cologuard is not a replacement for diagnostic or surveillance colonoscopy. However, sDNA presents an important new opportunity for healthcare providers to encourage colorectal cancer screening among those patients who are not compliant with traditional screening recommendations.

Additional information is available at www.cologuardtest.com

Cardiovascular Care... CONTINUED FROM PAGE 21

NP is to avoid increasing further resistance toward participating in an exercise regimen. The support and listening components are instrumental in assisting NPs to develop therapeutic relationships with their female patients (Perry & Bennett, 2006).

REFERENCES


Dr. JoAnna Fairley is currently employed as a Professor at Capella University in the College of Nursing and School of Health Sciences where she mentors doctoral students and teaches in the graduate program. Dr. Fairley is a nurse consultant for Health care auditors and serves as a subject Matter Expert for test writing items. Dr. Fairley is a member of the National Black Nurses Association and serves as Vice President for the Mississippi Black Nurses Association. Dr. Fairley’s research interest includes but is not limited to gerontology, leadership, adult education, heart disease, online learning, and mentorship. Dr. Fairley is also a candidate for the Adult-Primary Gerontology Nurse Practitioner Certification.
Patients with heart failure (HF) have high rates of emergency department (ED) use that has been found to be preventable. They have heavy symptom burdens and complex care needs that are not adequately supported during frequent care transitions from hospital to home, making them vulnerable to poor outcomes. A quarter of HF patients were readmitted, primarily by the ED, within the first 30 days following hospital discharge (Go et al., 2013). However, half of those readmissions are preventable with optimal self-care (Braunstein et al., 2003) and symptomatic HF patients who practiced above average self-care had event-free survival similar to that of symptom-free HF patients (Lee, Moser, Lennie & Reigel, 2011). Yet HF patients are inadequately prepared to perform self-care after hospital discharge.

Heart Failure Symptom Burden and Self-Care

Heart failure affects all ages but 78% of patients are over 60 years with equal frequency in men and women but African-Americans are 1.5 times more likely to develop HF than Caucasians. The provider-based gauge of HF symptom severity, New York Heart Association classification (NYHA class I-IV) predicts likelihood of mortality where Class I patients with no symptoms have risks similar to the general population but 1-year mortality rates of 5-10% are associated with mild symptoms (NYHA Class II), 10-15% with moderate symptoms (Class III) and 30-40% with severe symptoms (Class IV) (Reisfield & Wilson, 2005). In an integrative literature review, Falk and colleagues (2013) found that HF patients have poor health-related quality of life, experience severe shortness of breath and fatigue and the majority show poor health literacy about their condition. Increased health literacy may not correspond to improved self-care performance. A correlational longitudinal study (N=81) suggested that although high health literacy correlated with knowledge acquisition, it did not correlate with self-care performance efficacy. HF self-care improves quality of life, reduces ED visits, hospitalizations and mortality (Vellone et al., 2013) but the treatments are complex. Therapies rely heavily on concomitant use of multiple drugs (beta-blockers, angiotensin converting enzyme inhibitors, aldosterone antagonists, diuretics, anti-arrhythmic and other vasoactive agents), daily adherence to varied dosing schedules, measuring blood pressure and urine output, watching for and reporting side effects, eating salt and fluid restricted diets, managing symptoms of shortness of breath, fatigue and dizziness and deciding when to seek emergent medical help (Heart Failure Society of America [HFSA] 2010).

Readmission and Patient Characteristics

In a survey by Kociol and colleagues (2012), of 100 randomly selected hospitals participating in the AHA Get With the Guidelines-Heart Failure Registry, only 20% of the facilities provided patient instructions about worsening HF symptom recognition and in 91% of the hospitals, care transition education was provided mainly on the day of discharge. However, the impact of care transition varies according to certain patient characteristics. In a cross-sectional study of 212 lower-income, urban dwelling HF adults, using multivariate analysis, Clark and colleagues (2003) found that quality of life scores of black participants (N=112) were significantly higher than scores of non-Hispanic whites (N=100); men comprising 32% of the sample reported more symptoms of fatigue; and there was no significant correlations between illness severity, social support and satisfaction with income. While Sin (2012) in prospective correlation study (N=87) using telephone interview found that in Hispanic HF elders, perceived low social support combined with greater symptom severity (NYHA class III-IV) were associated with higher incidences of depression and poorer health outcomes.

Summary

Patients with HF face frequent readmissions, complex care plans and are inadequately prepared to perform self-care leaving them vulnerable to lapses in management after care transitions from hospital to home (Stamp et al., 2013). Evidence suggests that in order to promote successful HF care transitions, care providers need to consider multiple factors including patient characteristics. Furthermore, there is a need for additional data to support clinical decision making about how to best support HF patients following transition to home.

Valrie Reid, MSN, ARNP is a cardiology nurse practitioner specializing in heart failure care since 1999 and is a PhD in nursing student at Florida International University with interests in transitional care and cross-cultural research.
African Americans Experiencing health disparities is not new. In fact, according to former Surgeon General of the United States Dr. David Satcher, race-based health disparities are both “pervasive and persistent”, costing the nation millions of dollars in medical costs, lost productivity and at least 80,000 lives each year. What is new is the recognition that Alzheimer’s disease is a substantial, but often underappreciated health disparity for older African Americans - exacting an unsupportable cost and burden on an already vulnerable community and their families.

African Americans are at least twice as likely to develop Alzheimer’s as non-Hispanic white Americans and are unlikely to receive a timely diagnosis which impedes access to symptomatic treatments. While Alzheimer’s is the 6th leading cause of death for all Americans, it is the 4th leading cause of death for older African Americans. Nationally, estimates show that the economic burden of Alzheimer’s is comparable to those of heart disease, cancer and diabetes. Yet, Alzheimer’s research is extremely underfunded by comparison.

Alzheimer’s has major economic and health implications for African Americans, especially with regard to care-giving which increasingly falls on the family, and medicine adherence needed to maintain other comorbidities like diabetes and heart disease. Researchers from Johns Hopkins University found that African Americans accounted for one-third or 30 percent of the cost of Alzheimer’s despite being less than 14 percent of the population. According to Hopkins, as this population ages we may in fact see one in two older African Americans with cognitive impairment, making Alzheimer’s one of the greatest public health challenges facing the United States and especially minority communities.

“The African American community has the power and responsibility to ‘Stand Up and Speak Out’ to compel political, industry, and scientific leaders to come together to devote the necessary resources for research and to change the systems that slow the development and availability of promising treatments,” says Stephanie Monroe, Director of the African American Network. “We recognize the challenging fiscal pressures facing Washington, but believe the moral imperative to finding an effective treatment or cure for Alzheimer’s must take precedence.”

It is well known that African Americans have a profound mistrust of scientists and as a result participate in clinical trials at far lower rates than other ethnic groups—often representing fewer than 2 percent of research participants. This under-participation makes it difficult to assess how new drugs will affect African American patients and ultimately, makes it harder to resolve disparities in health. Achieving the goal of increased minority participation in research will require engagement of many, but none more important than doctors and nurses who patients trust and often turn to for advice and look to for solutions that clinical research can provide.

Researchers believe it is possible to find more effective treatments or cures for Alzheimer’s with needed investments in research and corresponding increase in patients willing to participate in clinical trials. Unfortunately, studies have shown that many patients, especially minority patients aren’t informed about the availability of research that could help them as well the broader community at large. A recent Research America study found that 80% of individuals said they would participate in clinical research if asked. Unfortunately, most are not asked. We need to change this!

The African American Network Against Alzheimer’s is the first national network created specifically to respond to Alzheimer’s disease and its disparate impact on African Americans. By working nationally, locally and through strategic partnerships, the AAN is advocating in Washington for additional research investments, working in communities to encourage early diagnosis of the disease, and seeking to increase participation in clinical trials by under-represented minorities to find more effective treatments and cures.

To join or learn more, please visit: www.AfricanAmericansAgainstAlzheimers.org

Stephanie J. Monroe, J.D. is Director of African Americans Against Alzheimer’s whose mission is to engage African Americans and others in the fight to find a cure or effective treatment for Alzheimer’s by 2020. The African American Network is part of USAgainstAlzheimer’s, a national non-profit advocacy organization in Washington, DC. Stephanie brings to this issue over 25 years of service in the United States Senate and three years of Executive branch experience, serving most recently as Assistant Secretary for Civil Rights at the U.S. Department of Education. She is regarded as a veteran political strategist and an expert on a variety of health and education policy issues.
OPPORTUNITIES FOR THE nursing profession abound as we position ourselves to provide expanded access to care to older adults who are the fastest growing segment of our population. Atul Gawande (2014) in his recent book, Being Mortal writes eloquently about the challenges and opportunities that exist in caring for the aging population. As a surgeon who has witnessed unnecessary prolongation of life without sufficient attention to educating patients about the realities of their choices, Gawande advocates for more attention to assisting patients and families to carefully consider the range of health care choices associated with acute and chronic illness. His also discusses the importance of supporting alternative perspectives about how best to live in old age with more attention to fostering important relationships and living in settings that promote more focus on being engaged in meaningful life activities.

Nursing already has a long and proud tradition of providing care to the elders with a focus on attention to quality of life and assisting patients to maintain their dignity and wellbeing as they age. We need to leverage this rich history and expand our thinking on leading efforts to create more accessible and patient centered care. Our preparation in health promotion and chronic illness management coupled with our perspectives about promoting optimal function position us to create a more patient and family focused health care delivery system.

Health promoting education is essential at all stages of adult development and Valliant (2002) in his book Aging Well highlights many of the lifestyle choices made by adults in their fifties can remain positive influences on overall health and wellbeing even into old age. Regular exercise, the absence of alcohol abuse, normal weight and mature defenses were among the variables reported in studies Valliant reviews that when present in adults in their fifties continued to influence the positive health of older adults in their eighties. Nurses in all settings have an important role in providing, monitoring and supporting this range of health promotion activities in older adults.

Nurses often provide care for patients in settings where patients prefer to be such as home and assisted living. This dimension of our practice assists with the provision of access to health care for vulnerable patients. When elders require long term care placement, the continued need for access to compassionate and competent care is equally essential. Jackson, Dederian, White et al (2012) report that access to the ongoing primary care provider, nursing communication through their process of dying and the presence of advanced directives all positively affected the quality of the end of life experience for families. Nursing’s tradition of bringing care to where people require and prefer care has never been more needed.

Nurses and advanced practice nurses are the majority providers to older adults in all settings and taking leadership in entrepreneurial efforts to enhance quality of life, dignity in the face of functional change and loss, and ongoing access to quality care at the end of life is one of nursing professions’ most compelling challenges. A focus on an enhanced community based system of provision of care where nurses are able to practice to the full extent of their preparation will be essential in these efforts. Nursing educators along with nurses in the practice arena need to continue to lead our nation in this noble endeavor of providing improved health care our elders.

REFERENCES

Patricia White PhD, ANP-BC, is a Professor of Practice and has been teaching in the Nursing Programs at Simmons College since 1987. She received her B.S. and M.S. in Nursing from Boston College and received her Ph.D in Nursing at the University of Rhode Island. Dr. White was the Co coordinator of the Adult and Geriatric Nurse Practitioner Program for 25 years. She is currently the Director of the DNP program. She has an ongoing clinical practice since 1983 and currently practices in primary care and geriatrics. Her research interests include nurse practitioner practice, ethics, end of life care and educational research for accelerated NP students.
PEOPLE ARE LIVING longer than ever, and with an estimated 10,000 people expected to turn 65 every day through 2030, we all have a responsibility to rethink how we want to get old. However, perceptions of getting old haven’t changed. Younger adults in particular hold negative views, with many fearing loss of memory, sexual ability, and general physical abilities more than those over age 65. Complicating this sentiment is the reluctance of many to discuss aging, constraining our ability as a society to take actions that can help increase the likelihood of a long, active life.

For 165 years Pfizer has been working to help people live longer, healthier lives – and as one of the oldest pharmaceutical companies it knows and respects the challenges and opportunities that experience can bring.

Pfizer started Get Old to challenge misperceptions of aging and drive new conversations that inspire people of all ages to take action on their own health. Since 2012, Get Old has brought together a community of experts and leading partner organizations to share new insights on a diverse range of aging topics, from new research on chronic conditions to lifestyle changes that help people age well.

The third annual Get Old survey revealed that 87% of Americans have at least one fear related to aging. Last summer, we relaunched Get Old to challenge people to address their “Fear of Getting Old” – or #FOGO – head-on. Specifically, 23% fear physical decline, 15% fear memory loss, 12% fear chronic disease, 12% fear running out of money, and 10% fear death.

Our focus remains on education and awareness – but through a mix of wit and wisdom that aims to help people fight the fear of getting old in new, engaging ways. We understand getting old isn’t always fantastic, but it sure beats the alternative. After all, aging is a privilege denied to many. Visit getOld.com, where we have a host of digital and physical activities to help demonstrate how you can take actions today to fear less, live longer, and Get Old.

Many of your patients are likely facing their own fears of aging, and we encourage you to visit GetOld.com to learn more about the aging process – and how to have candid discussions with patients in your community to dispel commonly held fears about aging. GetOld.com is also a great resource for patients themselves. Adults exposed to GetOld.com report that they have changed their habits as a result of interacting with the site. Forty percent changed their eating habits for the better, 42% made changes in their lives to be healthier, and 35% started or changed an exercise routine.

For your patients who may have difficulty accessing their medicines, Pfizer’s patient assistance program, Pfizer RxPathways, helps eligible patients get access to their Pfizer medicines by offering a range of support services, including insurance counseling, co-pay help, providing Pfizer medicines for free or at a savings, and more. We are proud that we have been able to help nearly 2.5 million patients get access to more than 30 million Pfizer prescriptions in the past five years alone (2010-2014).

Aging continues to be a critical issue facing our communities, and nurses experience issues relating to aging almost every day! We hope you’ll use GetOld.com as a resource for your patients, and for yourself. We believe your later years should be celebrated.

Melissa Bishop-Murphy is Senior Director of National Government Relations and Multicultural Affairs for Pfizer, Inc. She is responsible for regulatory, legislative and public policy matters at Pfizer, Inc. Ms. Bishop-Murphy has extensive work experience throughout the Southeast, Washington, D.C., and Delaware. She serves as Chair of the Corporate Roundtable of the National Black Caucus of State Legislators. She is also a member of the National Hispanic Caucus of State Legislators Business Roundtable. She has previously served on a number of other state legislative organizations’ committees.

SOCIAL MEDIA POSTS

1. Facebook: Pfizer started @GetOld (https://www.facebook.com/GetOld) to challenge misperceptions of aging and drive new conversations that inspire people of all ages to take action on their own health. Since 2012, Get Old has brought together a community of experts and leading partner organizations to share new insights on a diverse range of aging topics, from new research on chronic conditions to lifestyle changes that help people age well. Visit getOld.com to learn more about healthy aging: https://www.getold.com/

2. Twitter: Pfizer started @GetOld to inspire people to take action on their own health. Learn more about healthy aging: https://www.getold.com/


Harris Poll Research 2014 commissioned by Pfizer’s Get Old
WHEN MILLCENT GORHAM wrote to me and asked me if I would write an article on Aging I was a bit distraught. After all, I may be a registered nurse but by no means an expert on aging; so I wasn’t sure what was expected of me. At first I went into some sort of a spin and then it came to me; an epiphany. I should write about my mother and her living legacy and connection to the current project I am associated with which is, “Movement is Life”.

My mother, Epifania Olivieri Gonzalez was born and raised on the island of Puerto Rico and came to the mainland in her 20’s. She was an independent woman and a woman of great faith, who raised four daughters in the South Bronx. She lived to be 100 years old, before she transitioned to be with the Lord at the end of November 2012.

Actually my family and I were all taken by surprise when she left this earth because she was always such an active individual, a woman with a can do attitude, who refused to define her age with just a number. She was so lucid and active till the very end that in many ways she lured us to into believing that she was almost immortal and many of my family members could not even fathom a world and life without her living breathing presence. There were days and times were we could not understand how she had the energy to continue and therefore, we frequently pushed our “younger” selves to keep up with her. In addition to her strong faith and commitment to family, she had a desire to give back to her community, still visiting individuals in the nursing home until age 99. She firmly believed and practiced that you could not spend all day seated in one place and really inculcated that behavior within us. That is, she valued the need to keep moving and served as a living example of its benefits.

It is often said that the lack of physical activity can accelerate death. In fact, limited mobility and sedentary lifestyles are the triggers for poor health and perhaps an even poorer quality of life. After living with my mom for several years I realized that it was her movement, her inability to sit still and her strong need to be active and engaged, which prolonged her life. Till the end, she climbed stairs in a three-story town home and cooked, did laundry and continued her favorite hobby, which was gardening. All that movement kept her strong and agile and an active member of our family and society. In many respects she is why I’m so committed to the work of Movement is Life.

Movement is Life is a multi-disciplinary, action-oriented group that has maintained a central mission of decreasing musculoskeletal health disparities among racial/ethnic minorities and women. Our goal is “To be a catalyst for change by energizing multi-disciplinary work groups to develop measurable short-term action plans.” Our group has developed pilot programs through an incubator thought process, based on grassroots input. Most recently, we created a nurse continuing education module, which provides an overview of gender and racial/ethnic musculoskeletal disparities and the relationship between immobility, obesity, osteoarthritis, and other co-morbidities.

Last year at the August 2014 NBNA Conference we actually hosted a focus group, made up of NBNA members from across the county, to secure feedback and input on this module. This year we are hosting a workshop to provide an overview of this initiative as well as provide the results of that focus group feedback with a goal of educating and engaging other nurses to help us spread the word. I hope you will join me and colleague, Julia, Kneedler RN, MS, EdD, CCM, EP, at this workshop on July 31, 11:00 – 11:45 AM. Remember, aging is a state of mind and not simply a number. My mother was an example of that. In order to beat the numbers game, movement and physical activity is key. So join us and learn how Movement is Life can be a step in the right direction to healthy aging.

Rose Iris Gonzalez, PhD, MPS, RN, is a Nuyorican from the South Bronx and served as the Director of Government Affairs for the American Nurses Association for almost 14 years. She now serves on the Steering Committee of Movement is Life.

TWEETS
Check out our latest documentary at www.startmovingstartliving.com
Sound the alarm on a sedentary lifestyle. Visit us at www.startmoving-startliving.com
Leg ulcer complication in people with sickle cell anemia is a relatively common occurrence. Leg ulcers are a painful and often disabling complication of SCD. Sickle cell associated leg ulcers are often resistant to treatment and recurrent in nature. Moreover, evidence suggests that patients with SCD associated leg ulcers may also be at an increased risk for the development of other, much more serious SCD complications like pulmonary hypertension.  

The development of leg ulcers happen more often in males than in females and may appear from 10 through 50 years of age. The etiology of SCD leg ulcer formation is unclear. However, research suggests a combination of factors including trauma, infection, inflammation, and interruption of the circulation in the smallest blood vessels of the leg may be major contributors to ulcer formation among individuals with SCD.

INSIGHTS is a clinical study currently sponsored by the National Human Genome Research Institute. The major aims of the study are to: (1) to understand the role of the skin microbiome in formation and delay in the healing of leg ulcers in sickle cell disease, and (2) understand genomic, environmental, and social factors that may increase the likelihood of developing this complication. The principal investigator for the INSIGHTS study is Vence L. Bonham, Jr., J.D. Mr. Bonham has worked vigorously with the National Black Nurses Association (NBNA) to disseminate knowledge about genetics and the importance of participation in genetics research.

Similar to disease prevalence disparities documented in the scientific literature, genetic research participation disparities exist among minority population groups. When comparing the significant disparities associated with African American health, and the representation of African Americans in the general population, it is clear that much of the publicly funded research in genetics and genomics has been conducted with suboptimal representations of African Americans. However, the need for sufficient participation of individuals from underserved and/or underrepresented ethnic minority populations in genetic studies is critical to improving the health care delivery system and aid the eradication of health disparities.

The NBNA membership is in a unique position to progress African American participation in genetics research. Data suggest that the majority of NBNA members recognize the importance of genetics studies such as INSIGHTS, and are eager to get involved and help spread the word about the importance of participation. Information regarding all aspects of the study including eligibility and inclusion criteria may be found at: https://clinicaltrials.gov/ct2/show/NCT02156102 or by contacting Mr. Bonham at bonhamv@nhgri.nih.gov

REFERENCES


Dr. Powell-Young, PhD, PCNS-BC serves as Dean at Alcorn State University. Dr. Powell-Young’s research focuses on topics in obesity and genetics among vulnerable populations.

Dr. Ida J. Spruill, PhD, RN, LISW, FAAN is an associate professor and diversity officer in the College of Nursing at Medical University of South Carolina. Dr. Spruill’s research focuses on ethnic cultural barriers to health literacy and disease management.
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Welcome!

27th Annual
National Black Nurses Day
on Capitol Hill
CDC recommends HIV screening for all patients ages 13 to 64

HIV crosses the boundaries of sexual orientation, gender, age, and ethnicity.

- More than 1.1 million people in the United States now have HIV, and nearly 1 in 5 (18.1%) are unaware of their infection.
- Hispanics/Latinos account for 16% of the U.S. population but for 21% of HIV diagnoses.
- Unless the course of the epidemic changes, an estimated 1 in 50 Hispanics/Latinos will be diagnosed with HIV infection at some point in their lifetime.

For free materials to incorporate HIV screening into your practice, visit: www.cdc.gov/actagainstaids/tlc

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- Milwaukee BNA (21)........................Sharron Coffie........Milwaukee, WI
- Racine-Kenosha BNA (50)..................Gwen Perry-Brye........Racine, WI

## DIRECT MEMBER (55)
*If There Is No Chapter In Your Area*
Dear NBNA Members:

I write to inform you that the conference registration area to pick up your program and bag, the education program and the exhibit hall for the 43rd NBNA Annual Institute and Conference will take place at the Atlanta Hilton Hotel. The Atlanta Marriott Marquis is attached to the Hilton via Sky Bridge from the Marquis level of the Marriott. The Atlanta Marriott Marquis has taken full responsibility for this situation and is assisting us to ensure that there will be a smooth transition. A brief overview of the conference agenda is listed below.

If you are an NBNA member and an exhibitor, NBNA will send the Hilton Exhibit Hall floor plan in the order that your original contract was received. Please provide three options. You will receive confirmation of your new booth assignment within 7 days. If you are not planning to ship your booth materials through GES, please ship them directly to the Atlanta Hilton.

There is a city-wide convention which overlaps with the NBNA Conference and the hotel has begun renovations on sleeping rooms. Thus, some of you may not have been able to book rooms in the host hotel. We have made arrangements with two other hotels for additional rooms. Please do not delay in reserving a room. (See page 41.)

THE FOLLOWING EVENTS WILL TAKE PLACE AT THE ATLANTA HILTON HOTEL

**TUESDAY, JULY 28**
3:00 pm – 7:00 pm  Registration

**WEDNESDAY, JULY 29**
7:00 am – 5:00 pm  Registration
8:00 am – 6:00 pm  All Meeting, Workshops & Events

**THURSDAY, JULY 30**
7:00 am – 5:00 pm  Registration
8:00 am – 5:00 pm  All Meeting, Workshops & Events
1:00 pm – 5:00 pm  Exhibit Hall Opens
6:00 pm – 8:00 pm  Opening Ceremony

**FRIDAY, JULY 31**
6:00 am – 6:00 pm  All Meetings, Workshops & Events
11:00 am – 3:00 pm  Career Fair/ Exhibit Hall
6:30 pm – 10:00 pm  Fundraiser Fashion Show

**SATURDAY, AUGUST 1**
6:00 am – 6:00 pm  All Meetings, Workshops & Events
11:00 am – 1:00 pm  Exhibit Hall
7:00 pm – 11:00 pm  President’s Gala

THE FOLLOWING EVENTS WILL TAKE PLACE AT THE ATLANTA MARRIOTT MARQUIS

**SUNDAY, AUGUST 2**
8:00 am – 9:30 am  Ecumenical Service
10:00 am – 12:00 pm  Brunch and Closing Session
Dear National Black Nurses Association Attendee,

The Atlanta Marriott Marquis is looking forward to hosting you brilliantly for the 2015 National Black Nurses Association Conference.

As much as we look forward to your arrival, unfortunately we have to inform you that the function space for the meeting will be located at the Hilton Atlanta. The Atlanta Marriott Marquis is attached to the hotel via Sky Bridge from the Marquis Level. When coming off the elevator bank on Marquis Level from your guestroom, walk south towards the sky bridge. There will be signage as well as our Hosts available to guide you.

Please know that the Atlanta Marriott Marquis accepts full responsibility for not being able to accommodate the program inside the hotel. We cannot adequately express how deeply we regret this situation.

The City of Atlanta cannot wait to show off our beautiful city with award winning chefs, restaurants, shopping, and rich history combined with inspiration-inducing attractions to create a city with Southern charm and world-class sophistication. Atlanta is going through a transformation, and we cannot wait to show you why Atlanta is one of the most popular destinations to visit.

While the city is transforming, the Atlanta Marriott Marquis is also going through a change. Every hotel from time to time finds it necessary to undergo renovations. In order to provide excellent physical facilities, the Atlanta Marriott Marquis will go through this improvement process in 2015 that will include the dates of your program, during which guest rooms will be undergoing renovation. We will make every effort to make sure this renovation does not affect your experience while in our hotel.

We are very appreciative of your loyalty to Marriott and consider National Black Nurses Association one of our most valued customers.

On behalf of the entire staff of the Atlanta Marriott Marquis, thank you for your business. We do hope that your time in Atlanta is memorable in every way, and we look forward to serving you for many years to come.

Sincerely,

[Signature]

Meinrad Lang III
Director of Sales and Marketing
Date: May 8, 2015
To: NBNA Conference Attendees
From: Dianne Mance, Conference Services Manager
Subject: Overflow Hotels

It appears that we are experiencing an outstanding turnout for the NBNA Annual Conference in Atlanta. We have sold out of our room block at the Marriott Marquis and do to a City Wide convention that precedes our meeting, we are unable to add additional rooms. The following options are currently available:

**Marriott Residence Inn** (4 blocks from the Marriott Marquis)
134 Peachtree Street • Atlanta, GA 30303
404-522-0950

- Dates: Tuesday, July 28 thru Sunday, August 2
- Rate: $179 per night
- Room Type: Queen Rooms Only
- Reservation: 800-321-2211 or 404-522-0950
- Cutoff date: 5 pm, July 7, 2015
- Valet Parking: $28 Daily

All reservations must be accompanied by a first night room deposit and guaranteed with a major credit card. The Hotel will not hold any reservation unless secured by a major credit card. **The deposit will be refunded only if the reservation is cancelled at least 72 hours prior to arrival date.** If guest does not cancel prior to the 72 hours, the one night advance payment of room and tax will be non-refundable.

**COURTYARD by Marriott** (4 blocks from the Marriott Marquis)
133 Carnegie Way • Atlanta, GA 30303
404-222-2416

- Dates: Tuesday, July 28 thru Sunday, August 2
- Rate: $179 per night
- Room Type: King Rooms Only
- Reservations: 800-321-2211 or 404-222-2416
- Cutoff date: 5 pm, July 7, 2015
- Valet parking: $25 Daily
- Offsite parking: $3 Hourly: $25 Daily

All reservations must be accompanied by a first night room deposit and guaranteed with a major credit card. The Hotel will not hold any reservation unless secured by a major credit card. **The deposit will be refunded only if the reservation is cancelled at least 24 hours prior to arrival date.** If guest does not cancel prior to the 24 hours, the one night advance payment of room and tax will be non-refundable.

**NOTE:** Call the Marriott Marquis periodically to see if they have cancelations in the room blocks reserved for the NBNA; the cutoff date is July 12, 2015.

Thank you for your patience.
**2015 CONFERENCE SCHEDULE AT-A-GLANCE**

**SUNDAY, JULY 26**
- 2:00 pm - 5:00 pm  Bag Stuffing

**TUESDAY, JULY 28**
- 9:00 am - 1:00 pm  Local Chapter Health Fair
- 2:00 pm - 4:00 pm  Board of Directors Meeting
- 3:00 pm - 7:00 pm  Registration
- 4:30 pm - 5:30 pm  Moderators/Monitors Workshop

**WEDNESDAY, JULY 29**
- 7:00 am - 5:00 pm  Registration
- 8:00 am - 12.00 pm  American Red Cross Workshop
- 8:00 am - 2:00 pm  Wound Care Workshop (5 CEUs)
- 8:00 am - 3:00 pm  Presidents’ Leadership Institute (CEUs TBD)
- 8:00 am - 6:00 pm  ElnEC Pediatric Palliative Care - Part 1 (8 CEUs)
- 8:00 am - 6:00 pm  Adult Mental Health First Aid USA (8 CEUs)
- 1:00 pm - 5:00 pm  Caribbean Exploratory Research Workshop (4 CEUs)
- 3:30 pm - 4:30 pm  Credentialing
- 3:30 pm - 4:30 pm  New Members/First time attendees Workshop
- 3:30 pm - 5:00 pm  Chapter development Workshop
- 4:30 pm - 5:30 pm  Moderators / Monitors Workshop
- 5:00 pm - 6:00 pm  New Members/First Time Attendees Workshop

**THURSDAY, JULY 30**
- 6:00 am - 7:00 am  Exercise Class
- 7:00 am - 5:00 pm  Registration
- 8:00 am - 10:00 am  Business Meeting (Chartering of new Chapters)
- 7:30 am - 4:30 pm  ElnEC Pediatric Palliative Care - Part 2 (8 CEUs)
- 7:30 am - 4:30 pm  Mental Health First Aid for Higher Education (8 CEUs)
- 10:30 am - 12:30 pm  Plenary Session (2 CEUs)
- 1:00 pm - 5:00 pm  Exhibit Hall Grand Opening, Refreshment served
- 3:00 pm - 5:00 pm  LPN FORUM
- 5:30 pm - 6:00 pm  Chapter Line-Up
- 6:00 pm - 8:00 pm  Opening Ceremony

**FRIDAY, JULY 31**
- 6:00 am - 7:00 am  Exercise Class
- 6:30 am - 7:45 am  Breakfast (2 sessions; CEUs to be determined)
- 7:00 am - 5:00 pm  Registration
- 8:00 am - 12:00 pm  Institutes (Select one of six sessions; 4 CEUs)
- 8:00 am - 4:00 pm  NBNA Summer Youth Enrichment Institute
- 11:00 am - 3:00 pm  Career Fair
- 11:00 am - 3:00 pm  Exhibit Hall, raffle and refreshments
- 12:30 pm - 3:00 pm  NBNA Nursing Innovations Theater (CEUs TBD)
- 12:30 pm - 2:30 pm  Institute of Excellence Awards and Luncheon
- 3:30 pm - 4:30 pm  Plenary Session (1 CEU)
- 4:30 pm - 6:00 pm  Under Forty Forum
- 5:00 pm - 7:00 pm  NBNA Choir Rehearsal

**SATURDAY, AUGUST 1**
- 6:00 am - 7:00 am  Exercise Class
- 6:30 am - 7:45 am  Breakfast Sessions (2 sessions, CEUs TBD)
- 8:00 am - 10:00 am  Business Meeting (chapter awards)
- 10:00 am - 10:30 am  Candidates forum
- 10:30 am - 11:00 am  Members Speaks
- 11:00 am - 1:00 pm  Exhibit Hall
- 11:00 am - 12:00 pm  NBNA Nursing Innovations Theater (CEUs TBD)
- 12:00 pm  Passport Raffle
- 12:30 pm  Grand Raffle
- 1:00 pm - 3:00 pm  Workshops (select one of sessions; (2 CEUs)
- 1:00 pm - 4:00 pm  Breast Cancer Screening Practicum
- 3:30 pm - 4:30 pm  NBNA Choir Rehearsal
- 6:00 pm - 7:00 pm  Board and Lifetime Member Photo
- 7:00 pm - 11:00 pm  President’s Gala

**SUNDAY, AUGUST 2**
- 8:00 am - 9:30 am  Ecumenical Service
- 10:00 am - 12:00 pm  Brunch and Closing Session (1 CEU)

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**THERE ARE THREE WAYS TO REGISTER:**
1. **FAX** your completed form with credit card information to: 301.589.3223
2. **ON-LINE** AT www.NBNA.org
3. **MAIL** your completed form with payment to:
   NBNA / Registration • 8630 Fenton Street, Suite 330 • Silver Spring, MD 20910

*(Please allow two weeks for check processing)*
2015 Conference Highlights

TUESDAY, JULY 28

9:00 am - 1:00 pm
Local Chapter Health Fair (TBD)

4:30 pm - 5:30 pm
Moderator/Monitor Workshop

WEDNESDAY, JULY 29

8:00 am - 12:00 pm
American Red Cross Workshop

8:00 am - 2:00 pm
Wound Care Workshop (pre-registration preferred)

Lower Extremities: A Foundation of Excellence in Wound Care and Treatment

At the conclusion of the program, nurse participants will be able to:
• Describe a comprehensive assessment of lower extremities.
• Identify parameters for compromised circulation in the lower extremities.
• Provide a return demonstration of lower extremities compression wraps.
• List contraindications for lower extremity compression.
• Discuss effective dressings for the management of lower extremity wounds.
• Differentiate methods of offloading pressure from lower extremities.

8:00 am - 6:00 pm

ELNEC PEDIATRIC PALLIATIVE CARE
(Train-the-Trainer Program)

“Caring for patients with complex, chronic conditions or at end of life can be very challenging. This is especially true when the patient is an infant or child or if the patient is an expectant mother of a child with special needs. Skills required for this special population are easily transferrable across the life spectrum. The ability to clearly communicate difficult information, recognize and alleviate symptoms of suffering, coordinate care with an interdisciplinary team and provide grief/bereavement support is essential in caring for patients in today’s complex healthcare system. This conference will increase participant’s readiness in caring for the patients of the future while also assuring the application of self-care principles.” Leading national pediatric specialists will serve as faculty for this Train-the-Trainer Program.

THURSDAY, JULY 30

7:30 am - 4:30 pm
ELNEC PEDIATRIC PALLIATIVE CARE (Part 2)

7:30 am - 4:30 pm
Higher Education Mental Health First Aid USA Pre-Registration is required.

Mental illnesses and substance use challenges often present during adolescence and young adulthood, when many individuals are students at colleges and universities. College and university faculty, staff, and students can learn how to help each other within a framework of their unique culture and set of resources.

Certification will require completion of the pre- and post-session on line surveys. Class size is limited to 40 nurses, there will be a waiting list. Please do not register for this class if you have received the certification at previous conferences.

8:00 am - 12:00 pm
NBNA Emerging Leaders Forum

Students must be registered for the conference to attend this session.

8:00 am - 4:00 pm
NBNA Summer Youth Enrichment Institute

Open to children ages 8 to 18. Each participant will receive a backpack and a certificate of completion. Please register your child on the attached form. Consent forms will be sent with your registration confirmation letter.
REGISTRATION FORM PAGE 1

NAME: ___________________________ PHONE: ___________________________

1. REGISTRATION INFORMATION (SPEAKERS, EXHIBITORS & SPONSORS DO NOT USE THIS FORM)
   PLEASE PRINT CLEARLY OR TYPE. ONE REGISTRATION PER FORM. COPY FORM FOR MULTIPLE REGISTRATIONS.

NAME ___________________________________________ CREDENTIALS _______________________________

ADDRESS _________________________________________________________________________________________

CITY ___________________________________________________________________ STATE ___________ ZIP ________________________________

WORK PHONE (_______) _________________________________ HOME PHONE (_______) _____________________________________________

FAX __________________________________________________ E-MAIL _________________________________

NBNA ID # ______________________________________ RN/LPN/LVN LIC. NO. ___________________________________________

NAME OF CHAPTER (REQUIRED INFO): _______________________________________________________________

EMERGENCY CONTACT: ___________________________________ PHONE _________________________________

☐ I AM A DIRECT MEMBER (do not belong to a chapter)

☐ ARE YOU UNDER AGE 40? ○ YES ○ NO

☐ ARE YOU A NURSE PRACTITIONER? ○ YES ○ NO

☐ NUMBER OF VEGETARIAN MEAL REQUIRED: __________

2. REGISTRATION FEES (PLEASE CIRCLE THE APPROPRIATE FEES)

MEMBER EARLY BIRD PRE-CON ON SITE NON-MEMBER EARLY BIRD PRE-CON ON SITE

RN/LPN/LVN

$375

$450

$575

$550

$625

$775

Student (NON-Licensed)

$230

$280

$405

$305

$355

$505

Retired

$300

$375

$500

$375

$470

$550

INCLUDES (1) Gala ticket (1) brunch & closing session ticket (1) general raffle ticket

INCLUDES (1) Gala ticket (1) brunch & closing session ticket (1) general raffle ticket

(1) CEU program, business meeting (MEMBERS ONLY) (1) Passport raffle ticket

(1) CEU program (1) Passport raffle ticket

☐ I AM A NEW MEMBER

☐ This is my first NBNA Conference

SUB-TOTAL $_____________

SUB-TOTAL $_____________

3. INSTITUTE REGISTRATION (ONLINE REGISTRATION NOT ACCEPTED AFTER JULY 17, 2015)

To receive the full compliment of Continuing Education Units, you MUST attend the institute and/or workshop of your choice IN ITS ENTIRETY. Institutes will be held on FRIDAY, JULY 31. NOTE: topics subject to change. Please choose ONE of the following: ☐ Cardiovascular Disease

☐ Cancer ☐ Children’s Health ☐ Diabetes ☐ Women’s Health ☐ Obesity ☐ Diversity ☐ Health Policy ☐ Founders Leadership

☐ ELNEC Pediatric Palliative Care - 2-Day Session (Pre-registration required) PART I: Wednesday July 29 / 8:00 am - 6:00 pm

PART II: Thursday July 30 / 8:00 am - 5:00 pm

☐ Adult Mental Health First Aid USA (Pre-registration required) Wednesday July 29 / 8:00 am - 6:00 pm

☐ Mental Health First Aid for Higher Education USA (Pre-registration required) Thursday July 30 / 7:30 am - 4:30 pm

☐ Presidents’ Leadership Institute (Chapter presidents, vice presidents or designated delegate ONLY) Wednesday July 29 / 8:00 am - 3:00 pm

☐ Lower Extremities Foundation of Excellence in Wound Care Workshop Wednesday July 29 / 8:00 am - noon

☐ Caribbean Research Exploratory Workshop Wednesday July 29 / 1:00 pm - 5:00 pm

☐ American Red Cross Workshop Wednesday July 29 / 8:00 am - noon

☐ Breast Cancer Screening Practicum Saturday Aug 1 / 1:00 pm - 4:00 pm

☐ NBNA Summer Youth Enrichment Institute (consent forms sent with registration confirmation) Friday July 31 / 8:00 am - 4:00 pm

Register my: ___________________________

RELATIONSHIP TO ATTENDEE ___________________________ CHILD’S NAME ___________________________ AGE OF CHILD ___________________________ GENDER ___________________________

☐ I will attend the Chapter Development Workshop

☐ I will attend the Emerging Leaders Forum

☐ I am a LPN/LVN and will attend the LPN/LVN Workshop

☐ I will attend the Under Forty Forum

☐ I want to volunteer: ☐ Registration ☐ Workshop Monitor

☐ Moderator ☐ Exhibit Hall (Friday)
REGISTRATION FORM PAGE 2

4. GUEST REGISTRATION*

NON-NURSE ADULTS:_____________________________________________________

_____________________________________________________

Address: _____________________________________________________________

(IF DIFFERENT FROM REGISTRANT’S)

_____________________________________________________

CHILDREN:

_____________________________________________________

_____________________________________________________

_____________________________________________________

_____________________________________________________

# OF GUESTS: _______ X $275 = ______ SUB-TOTAL

* NON-NURSE GUEST(S) REGISTRATION (ADULTS OR CHILDREN) $275 EACH.

REGISTRATION INCLUDES: EDUCATIONAL SESSIONS OPEN TO THE PUBLIC, EXHIBIT AREA, PRESIDENT’S BANQUET, AND SUNDAY BRUNCH.

5. PURCHASE ADDITIONAL BANQUET, BRUNCH OR INSTITUTE OF EXCELLENCE CEREMONY AND LUNCHEON TICKETS

Banquet & Brunch tickets are NOT refundable after JULY 1, 2015.

☐ NBNA INSTITUTE OF EXCELLENCE LUNCHEON 7/31/15 $75 ea X No. of tickets _____ SUB-TOTAL $________

☐ PRESIDENT’S GALA & BANQUET 8/1/15 $85 ea X No. of tickets _____ SUB-TOTAL $________

☐ BRUNCH & CLOSING SESSION 8/2/15 $50 ea X No. of tickets _____ SUB-TOTAL $________

6. PAYMENT INFORMATION (NBNA ACCEPTS ONLY MASTERCARD AND VISA CREDIT CARDS.)

☐ Check Enclosed ☐ Check has been requested/ PO# _____________ ☐ Money Order ☐ MasterCard ☐ VISA

AMOUNT ENCLOSED $_________________ (SUB-TOTALS FROM 2, 4 & 5)

Credit Card # ____________________________________________ Exp. Date: __________ Sec. Code: __________

Cardholder Name (please type or print):

_______________________________

Signature _____________________________________________

(ALLOW 2 WEEKS PROCESSING TIME IF PAYING BY CHECK)

NO REQUEST FOR REFUNDS WILL BE GRANTED AFTER JUNE 19, 2015.

THERE ARE THREE WAYS TO REGISTER:

1. FAX your completed form with credit card information to: 301.589.3223

2. ON-LINE @ www.NBNA.org

3. MAIL your completed form with payment to:

   NBNA
   8630 Fenton Street, Suite 330
   Silver Spring, MD 20910

JOIN NOW AT www.NBNA.org