NBNA/United Health Foundation SCHOLARS
In this Issue:

Linking Nursing Theory to Nursing Education ..............................................................3
The Sickle Cell Challenge ..............................................................................................5
A Call to Action ...........................................................................................................6
Integration of Leadership, Quality & Safety .................................................................7
STDs and HIV in the Older Adult Population .............................................................8
Addressing Smoking Cessation in Patients .................................................................9
African American Females and Cerebral Vascular Accident ..................................10
The Mass Incarceration and Mental Health-Care Justice ........................................11
Sharing Bad News .....................................................................................................12
A Nation Divided: Infant Mortality in Black America ...............................................14
Biosimilars: Another Untold Story of the Affordable Care Act .............................15
Reflections on the NBNA Conference .....................................................................17
Obstacles that May Impede the Success of Minority Nursing Students .............18
Incivility in Pre-licensure Nursing Education and the Impact on Client Safety ....20
NBNA Chapter News & Member on the Move ..........................................................21
NBNA Conference Photo Highlights ....................................................................28-34
NBNA 2015 Conference Registration & Information ................................................35-38
NBNA Chapter Presidents .......................................................................................39-40
NBNA Chapter Websites ........................................................................................41-42
Message from President

In its landmark report, *The Future of Nursing: Leading Change, Advancing Health*, the Institute of Medicine (IOM) emphasized the importance of nurse leadership in improving America’s health care system (Hassimiller, 2012). While nurses have leadership roles in many health care venues, they remain largely overlooked for the highest level of organizational leadership: board positions. The IOM report made specific recommendations to increase nursing’s role in the boardroom, calling for health care decision makers to ensure that leadership positions are available to, and filled by, nurses (Hassimiller).

Research on nonprofit governing boards indicates that only about two percent of their members are nurses. A 2009 Grant Thornton LLP study of governance in community health systems urged that “All boards should consider enriching their membership with greater racial and gender diversity; they should also consider the appointment of highly respected and experienced nurse leaders as voting members of the board to complement physician members and strengthen clinical input in board deliberations (Totten, 2014).

The National Black Nurses Association (NBNA) joined nurse leaders from 21 national nursing and other health-related organizations as they came together to change the composition of the boardroom. The nursing leaders launched the national Nurses on Boards Coalition, which has a goal to put 10,000 nurses on boards of corporate and nonprofit health care organizations by 2020 (Hassimiller & Reinhard, 2014).

NBNA will continue to prepare its membership to take leadership roles in the transformation of health care. It will also continue its focus on their involvement in their communities as well leaders in health care – from the bedside to the board room; practicing to the full extent of their skills and being viewed as equal partners in health care delivery. NBNA must take nurse leadership roles in health policy, planning, and provision. Hassimiller and Reinhard (2014) stated that the nation’s largest health care philanthropy, the Robert Wood Johnson Foundation (RWJF), and the 38 million-member AARP, believe nurses must have a voice in the boardrooms of the health care organizations we trust to care for us. Backed by RWJF and AARP, the Future of Nursing: Campaign for Action, is driven by the IOM’s evidence-based recommendations. Nurse representation is our best hope of truly achieving high-quality care that is accessible, affordable and compassionate (Hassimiller and Reinhard).

NBNA membership must also adopt a global perspective on evolving nursing roles for innovations in health care and implications for education, research, leadership and practice; working with stakeholders to identify and remove barriers to practice in order to increase consumers’ access to high-quality, patient-centered care; and increasing the diversity of the workforce to include men in nursing. As an organization, we will continue to take a leadership role as we come to the table as a participant and a change agent in health care in the United States and globally.

Deidre Walton, JD, MSN, RN
President

REFERENCES


Dear Members of the National Black Nurses Association,

As leaders in health care, you are among the most trusted sources of information about health care – not just to patients, but to the public as well. To that end, I am writing to ask that over the next two weeks you share important information with your patients, family members, and others in your community about the opportunity to obtain affordable, quality health insurance coverage through the Health Insurance Marketplace (www.HealthCare.gov) before the February 15, 2015 deadline.

For most people, access to health care services is predicated on access to health insurance. While over the past year we have seen a 26 percent drop in the number of uninsured in the nation – a remarkable achievement for each of those individuals and families – there are 32 million Americans without this security. Right now, however, they can obtain affordable coverage through www.HealthCare.gov.

For Marketplace materials relevant to clinicians and patients, please visit Marketplace.cms.gov. I encourage you to share these resources broadly with your networks.

Research findings indicate a clear relationship between health insurance coverage and health outcomes. From now through February 15, 2015, please take this opportunity to help ensure that those in your clinical settings and throughout your communities know about the availability of health insurance and why it’s so important to have it.

Additionally, to ensure patients have access to health care services, particularly in underserved areas, the Health Resources and Services Administration is also supporting the NHSC Loan Repayment Program, which is supported through funding made available in the Affordable Care Act, and the NURSE Corps Loan Repayment Program. These two programs are currently accepting applications from nurse practitioners interested in receiving help paying for the cost of education in exchange for practicing in underserved areas. I invite you to explore these opportunities by visiting www.NHSC.hrsa.gov and www.hrsa.gov/loanscholarships/nursecorps.

Nurses have a critical role in strengthening the health of the nation. This is an opportunity for all of us, regardless of where we live or where we work to help achieve that aim by helping others secure affordable, quality health insurance and access health care services. Thank you for your contribution to improving the health of individuals and families across the country.

Sincerely,

Mary Wakefield, Ph.D., R.N., FAAN
Administrator, Health Resources and Services Administration
U.S. Department of Health and Human Services
The Use of Nursing Theory is essential to providing the building blocks in which educational curriculum can be based. When nursing education programs integrate theory into nursing curriculum, the elements and foundation of theory become an essential component to professional nursing practice. Assimilating the fundamentals of nursing theory, science and research information into education will ultimately enhance not only scholarship, but also nurse practice. Having nursing education programs that commit to providing curriculum embedded with theory, will influence and demand a level of excellence that will require research as a basis for the standard of nursing practice (Simon, 1999).

Integration of Nursing Concepts

The integration of nursing concepts, science, research, and practice enhances the understanding and influence of the elements of nursing knowledge and nursing performance. Clark and Fawcett (2013) confirmed that the whole of nursing knowledge consists of the parts: nursing concepts, nursing philosophies, nursing theories, and research methods. Nursing science provides an ability to associate knowledge, beliefs, philosophies and theories to nursing practice (Fawcett, 2012). So, nursing science provides the method and emphasis as to how nurses will perform. The use of critical thinking skills, consequential to the implementation of nursing theory, involves reasonable and reflective thinking. The integration of nursing concepts provides educators with the tools to encourage students to think strategically while empowering and motivating them toward professional practice.

Clark and Fawcett (2013) believed that the assimilation of science and research put value on nursing knowledge with a purpose and impact on nursing practice. As such, there is a danger of obstacles occurring or existing as a consequence of the absence of nursing concepts that would impact nursing knowledge and practice (Lee and Fawcett, 2013).

Nursing Theory Influence on Nursing Education

The focus of nursing curriculum should be to educate future nurse leaders that comprise the elements of the nursing concepts, as the conceptual framework for nursing practice, while defining the philosophy of the school (Duffy, Foster, Kuiper, Long, and Robison, 1995). Because the relationship between nursing concepts and nursing practice is significant to the successful development of professional practice, it is critical that the incorporation of theory, science, and research be implemented into the coursework. The integration of nursing theory into nursing education programs, allows for effective professional development, and an enhanced level of critical thinking skills, while encouraging accountability and responsibility associated with professionalism. When the use of theory is modeled in the educational environment as a focus and guide to practice, life-long behaviors are developed which encourages continual professional development. Professional practice is dependent on critical thinking that is nurtured in nursing education that entails the ability to problem solve, and be effective decision makers.

Developing capabilities toward critical thinking enhances competence levels, personal empowerment, and the ability to develop skills associated with collaboration and the exchange of ideas with other disciplines and nursing professionals. Educational programs should be charged with developing curriculum that lead to nurses being effective leaders, through implementation of evidence-based practice approaches.

Conclusion

Nursing theory is crucial to laying the foundation for successful educational curriculum development. The integration of nursing concepts, as well as students’ ability to transition practical knowledge, to that of abstract thinking is essential to the success in nursing education programs. Lee and Fawcett (2012) believed that integrating nursing concepts into nursing practice through nursing education programs is essential for the continued growth and development of the nursing profession. Adding to the current body of knowledge is possible as a result of continued research and theory development, as well as students’ reflective practice, as an additional focus toward knowledge enhancement. So, as theories and research provide the basis for professional development in the educational process, the implementation of theory-based practice, perceptions of theory, and the application of information, goal achievement can occur (King, 1991). While looking toward the future of nursing, continuing professional development through education with the integration of science, research, theory and practice, nurses’ knowledge base will continue to advance health while positively impacting optimal patient outcomes.
REFERENCES


Evelyn “Lynn” Houston Bell, MSN, BA, RN, has been a practicing registered nurse for the past 17 years. Her clinical nursing experience includes psychiatry, postpartum/newborn nursery, rehabilitation, chronic disease management, legal nurse consulting, and adjunct faculty. She is an owner and operator of a legal nurse consulting business. She earned her Master of Science degree in nursing from the University of Phoenix. Evelyn is currently a PhD student at the University of Phoenix. She is a member of the Omicron Delta chapter of Sigma Theta Tau International Honor Society of Nursing and the Georgia Nurses Association.

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His past summer has brought together many people of all ages and cultures to raise awareness for Amyotrophic Lateral Sclerosis (ALS), also known as Lou Gehrig’s disease. ALS is a neurodegenerative disease found in the spinal nerve cells. It is a destructive disease that with gradual onset, leads to paralysis and death. It is an illness that takes away the quality of one’s livelihood. This disease is indeed saddening and if not discovered ahead of time, usually becomes extremely difficult for the person and their loved ones to manage. According to the Amyotrophic Lateral Sclerosis Association (ALSA) (2014), the incidence of ALS occurs in 2 per 100,000 people. Throughout this time, ALS and the events that have taken place this summer has been a symbol of inspiration which shows that the populace can come together for a definitive matter.

As a result of our generous hearts to the non-profit ALSA, the organization has raised over $100 million to help find a cure for ALS. This alone has granted many people a chance to believe that if this disease could exemplify how heartfelt we are to the cause that affects 2 in every 100,000, then there is a possibility that our hearts and generosity can raise awareness for the people diagnosed with sickle cell anemia; which occurs in 1 per 500 African American births, as stated by the Center of Disease and Control Prevention program.

Sickle cell disease is a form of anemia which is a crescent-shaped red blood cell that is irregular in its form. The structure of the blood cell contributes to the pain the person who has it may feel as it inadequately flows through their body and cause tissue and organ damage. Complications and symptoms start at birth and proceeds throughout life. Despite the fact that there is a 25% chance of a child acquiring it from their parents who must both be carriers of the disease, the predisposition of being one of the many that has it still remains.

For many survivors, sickle cell disease has been manageable, but for others it remains detrimental. Based on the accounts of people who have been in treatment for this disease, they would be the first to explain that receiving treatment is a painful procedure. Although there has been more fitting treatment practices designated for the disease, it still has its precedence. While the symptoms of the disease can easily be treatable for those who are insured and financially stable, there are those who do not have the economic means to pay for treatment. With further research and adequate funding, more can be done such as the course of better therapy that are not only cost effective but can also lessen the health disparity gap between those on corresponding sides.

With each disease that have been eradicated, it has only motivated society to raise inquiries that would yield treatments for other disorders and diseases. Hopefully, there will be a treatment such as a simple injection that will eliminate sickle cell anemia or lower the ratio of people from 1 in 500 to 1 in 100,000. The treatment may motivate our society in finding how to do away with cystic fibrosis, or better yet, find a cure for the different forms of dementia.

There is a never ending battle in finding new ways to curb the destruction of what diseases do to us and our loved ones, but stopping at ALS is not at all enough. Our marches, the bright colors we wear for breast cancer, and playful actions of pouring cold buckets of water on one another for ALS to name the least, is a note of what we can do when we come together for a meaningful purpose.

This battle against sickle cell anemia is not a fight for the next generation to carry on, but the actions we take now could help make the world a better place just as we have entered it and that is with one less affliction. The challenge that we partake in is not only to support our loved ones and to fight this ignored calamity, but it is for us to make our contribution to history and human prosperity. If we can find it in our heart to create our own sickle cell challenge that occurs within our household, a neighbor’s backyard or even our workplace, then we will inspire future generations to create a means of finding a cure for new diseases that may challenge their health.

REFERENCES

Chinedu Ezekwemba, SN, is a junior nursing student in the Bachelors of Science Nursing program at Oakland University, and is graduating in May, 2016. Chinedu is from Detroit, MI and is an active volunteer member of St. Joseph Mercy Oakland hospital.
A Call to Action

Darnell Caldwell, SN
Southern University School of Nursing
NBNA/United Health Foundation Scholar
Member, New Orleans Black Nurses Association

Growing up I was somewhat of a typical African American girl. I always felt like I was born to nurture and take care of people. I did not know nursing was my calling. However, in my community, I saw nurses who were among the most highly respected and regarded members as a professional group and role model. By the nature of their jobs, nurses shared a vision that was crucial to the health care of our family members and neighbors. These nurses believed in a better world that was also dependent upon improved healthcare for individuals who often did not have the financial means for regular doctor visits. Observing these nurses ignited a desire in me to pursue a dream in health care. I wanted to become a nurse and care for others.

At first, this dream appeared to be beyond my reach because some people told me that I was not smart enough to pursue nursing because I did not perform well academically. However, my heart and my mind were on a different level. I pushed my heart’s desire to becoming a nurse away and settled for jobs in the hospitality field like my mom, my grandmother and great grandmother. In my family, there were no nurses or anyone in the healthcare field. Therefore, I did not have a role model. Just waking up every day and putting pride with hard work in doing something that my heart was not into was a constant struggle. This struggle became my drive and determination to improve academically and pursue nursing. I knew that a better education was the foundation to getting into nursing school and becoming a professional nurse.

The art of nursing is the process of caring and the science of nursing the act of doing” or the actual providing of care. I knew I had the caring part, but needed the knowledge and skills to do what I wanted to do in life, serve others. My decision to become a nurse was not easy; I had to work thru what I felt were my own personal conflicts, insecurities and reservations. I was told I was making a monumental mistake that would not only affect me, but also my family. But, one day in May 2005, I can recall listening to Nelson Mandela’s speech “Our deepest fear” that was taken from the book “A Return to love” by Marianne Williamson. I repeated that poem to myself every day for a month, I believed in myself and conquered my fears, nursing school became my life, and I put my heart and soul in taking the biggest steps of my life to reach my calling. Today, I am living my dream as a student and learning from other nurses how to become a true professional.

It would be easy not to be involved in community service and just keep my head in my books. However, community involvement is my way of giving back and making a difference in my community. Between my family obligations and a part-time job, there is little time for an extra-curricular life, but I make time for community service and working with my local chapter. I want to tell my story to the kids who have the heart to make a difference in their community but do not know how, or they have had the same said to them that they cannot be or do want their heart desires. I want them to see that they can be the first in their family to follow their dreams. I want them to know that their current situation can change with time, effort and dedication. I am the first to sign up for donating blood and organs because it seems to be a stigma within the black community. I help sponsor food drives, where we showed people in the neighborhood how to eat healthy food and cook meals that are healthier. In addition to school and church activities, I am an advocate for programs where I speak on HIV/AIDS outreach, STD and sexual health education to adolescents because New Orleans and Baton Rouge have the highest new cases of HIV in the U.S.

I regard myself as a role model for my community that needs African American nurses to continue the work to alleviate all forms disparities that our race and ethnicity faces. I will continue to pay it forward to others because we are our brothers and sisters keeper. As Dr. Martin Luther King said, “The world is now a neighborhood and we must learn to live together as brothers or perish as fools.”

Darnell Caldwell is a native and current resident of New Orleans, Louisiana. Ms. Caldwell is a senior nursing student at Southern University A & M College School of Nursing and will graduate in May 2015. She is a graduate of Francis T. Nicholls High School and holds certifications as a phlebotomy technician (2003) and as an Emergency Medical Technician (2008). Mrs. Caldwell serves on Southern University’s BSN council as a Level III student representative. She is an active member of the Southern University Student Nurses Association and serves as the parliamentary. She is a member of the New Orleans Black Nurses Association, and participates on several committees. In 2013, she was elected as the Student representative to the National Black Nurses Association Board of Directors; she helped to coordinate the Student Forum and worked with the program committee, and members of the NBNA executive committee. In 2014, she was inducted into Sigma Theta Tau Nursing Honor Society.

In her free time, Darnell dedicates her time towards work and school sponsored blood drives, health fairs for the community, the Boys and Girls Club, HIV/AIDS outreach, sexual health education to adolescents and assisting with the rebuilding of homes in the New Orleans Ninth Ward. Helping others find physical and personal fulfillment is Darnell’s biggest goal and achievements.

Darnell is a wife, mother and a member of Spiritual Sunlight Baptist Church in New Orleans.
Integration of Leadership, Quality & Safety
A Perioperative Course in the Undergraduate Nursing Curriculum

Stephanie Doibo, RN
NBNA/United Health Foundation Scholar
Member, Cleveland Council of Black Nurses

If a registered nurse is looking for an exciting, dynamic, and high-energy nursing career, the operating room (OR) is a great choice. The OR is an exciting, challenging, fast-paced, and stressful environment. The integration of perioperative content into nursing school curriculum is both practical and beneficial for preparing students for a nursing career and future recruitment in the OR.

Perioperative nursing encompasses three phases of surgery: preoperative, intraoperative, and postoperative stages. Inside the OR, the intraoperative nurse may be a scrub nurse or a circulating nurse. A scrub works directly with the surgical team fulfilling several responsibilities all while providing safe care (Foti, 2014). The circulating nurse coordinates the overall care in the OR, ensuring to maintain a safe environment for both the patients and the surgical team. The nurse is also responsible for completing preoperative assessment, validating that patient consent occurred, taking crucial steps to prevent patient injury and limit healthcare acquired infection, ensuring the supplies, equipment, and instruments are in place while anticipating the surgical team needs for the surgical procedure (Foti).

Perioperative nursing requires a broad knowledge base, instant recall of nursing science, the intuitive ability to be guided by nursing experience, and diversity of thought and action, as well as great stamina and flexibility (Rothrock, 2011). Perioperative nursing is not offered in most nursing school curriculum; however, there is one school that has created a program to prepare nurses for this high-energy atmosphere.

The Frances Payne Bolton School of Nursing (FPB) at Case Western Reserve University (CWRU) introduced a mandatory perioperative nursing course to its undergraduate curriculum in 2011. This school is among the first schools in the country to offer this type of program. This course helps nursing students to improve their understanding of infection control, sterile techniques, teamwork, communication, quality and safety issues; which are all critical (Infection Control Today, 2011). Students are required to spend seven weeks in the OR during their junior year. Students are selecting the OR for their 336 hours senior practicum. There is a significant nursing staff shortage in the OR. While FPB’s undergraduate nursing program prepares nurses as generalists, this course has exposed them to the perioperative nursing role in the OR, acute care, surgical, and procedural centers. This meet a significant community need and is a great asset to the public (Infection Control Today, 2011). Their curriculum is based on six core Quality and Safety Education for Nurses (QSEN) competencies: patient-centered care, teamwork and collaboration, evidence based practice, quality improvement, safety, and informatics (Quality and Safety Education for Nurses [QSEN], 2014).

In the future, it would be advantageous for other nursing schools to offer a perioperative course within their curriculum. Perioperative nursing is a blend of technical and behavioral care which includes critical thinking based on the nursing process (Rothrock, 2011). Training is essential for such a highly specialized atmosphere. Nursing students who are prepared for this type of nursing will, most likely, have no difficulty securing a perioperative nursing position after graduation and will thrive in the OR.

References
SEXUALITY IS A KEY component to healthy living. Unfortunately for many, it is difficult to accept that older adults are sexually active. There is a common misconception that as adults age they forego sexual activity all together. In truth, older adults not only desire sex, many are engaging in sex (Stewart, 2013). According to the Centers for Disease Control (CDC), 40 to 65% of adults aged 60 and over in the United States report being sexually active (Fox-Seaman, 2005). One may wonder why does it matter and more importantly why should I care? Although adults aged 50 and older have many similar risk factors for HIV and sexually transmitted infections (STIs), little research has been done to examine sexual behavior in this population. Rates of STIs (gonorrhea, chlamydia, and herpes) had the largest increase in numbers per age groups (45-64) during 2000-2009, with Chlamydia in those aged 55 and older outpacing the national average for all other age groups during the same time period. (Somes, Donatelli, 2012). Adults aged 55 and older accounted for 19% of all new HIV infections in the United States in 2011 (CDC, 2013). Most alarming is the fact that one out of every four people living with HIV is over the age of 55. These sobering statistics indicate that STIs and HIV have become the latest silent epidemics within the older adult population. It is important to consider what factors have contributed to this very important issue in order to create solutions.

While there is not a generally agreed upon age to define older adult, for most of the developed world older adult consists of people aged 60 and older (World Health Organization, ND). People who are 60 or older now, were in their late teens or early 20’s during the sexual revolution. This is an important factor because the revolution promoted casual sex and freedom. STIs were considered mild problems easily treated with an injection or pill. Condoms were generally used to prevent pregnancy. Fast forward fifty years and the picture is quite different. Youth are inundated with safe sex messages, and casual sex carries dire consequences. Condoms are now viewed as an effective method to prevent HIV and STIs. One could conclude that the adults who were not given tools to protect themselves from HIV and STIs as teens and young adults, are the same older adults who are engaging in sexual activity without the tools needed to protect themselves today.

Another factor is stigma and shame related to discussing sex in this population. Older adults may have an easier time engaging in sex than discussing sex. Rather than talk about testing, condom use, and other partners, it is simpler to engage and hope for the best. Many do not believe themselves to be at risk, and therefore do not understand the importance of engaging in conversations regarding sex before taking part in the act. In addition, research has shown that older adults to not openly discuss sexual health with primary care providers. Health care providers do not routinely ask older adult patients about sexual behavior due to embarrassment and discomfort. Finally, as people age and suffer from other health issues they become more susceptible to contracting HIV and STIs. The potential ramifications for these issues are serious. Given that often HIV and common STIs are asymptomatic, it is imperative for discussions related to sexual activity to become common place between both potential partners and healthcare providers and patients.

Although HIV and STIs are having a huge impact on older adults, there are things that can be done to address the issue. First and foremost, more research must be conducted within this population. In addition, medical professionals must raise both awareness and acceptance of older adult sexuality. Finally, programs addressing safe sex in the older adult must be developed and implemented. Once these steps are taken, then and only then will the issues begin to be resolved.

REFERENCES


Terry Lee, MS, RN, BC, is currently a nursing instructor at Regis University. Terry is a 2nd-year PhD student at Saint Louis University. Her research focus is older adult sexuality. Terry is a 2014 Jonas Scholar. Her project is focused on mentoring for nursing students of color.
Addressing Smoking Cessation in Patients

Katheryne T. Amba, MSN, ACNP-BC, CCRN
NBNA/United Health Foundation Scholar
NBNA Direct Member

SMOKING IS A MAJOR health problem globally. It is a risk factor for cancer and cardio-vascular disease and other health complications. Smoking cessation is beneficial yet challenging for patients to follow through. Nurses have a role in assisting smokers to quit despite the challenges. According to Pender, Murdaugh and Parsons (2002), “the purest form of motivation for health promotion exists in childhood through young adulthood when energy, vitality, and vigor are important to attain but the threats of chronic illnesses seem remote.” Many resources can be incorporated by healthcare providers to change at risk behaviors. Initiating the resources at an early level may be instrumental to health promotion because once habits are formed; they may be challenging to revert later in life. It is also best to initiate change when the individuals are ready and committed to engage in positive change.

Addressing patient attitudes about quitting smoking is important in smoking cessation. Addressing smoking habits in the course of addiction treatment and offering interventions to increase readiness to quit can contribute to quit attempts in smokers (Rigotti, Munafò, & Stead, 2008). In my acute care practice, patients are assessed for willingness to quit with a time limit as to when they intend to do it along with the methods that would be used such as nicotine gums, patches or other methods. Allowing choices gives ownership and responsibility to the patients while clinicians may model as support champions promoting the healthy behaviors.

According to Westmass and Brandon (2004), health care practitioners should encourage all smokers to attempt cessation and emphasize pharmacotherapy as an important aid. Professionals who educate patients on the appropriate use of pharmacotherapy and follow-up on smokers’ attempts to quit can help reduce risks of smoking and the societal burden from smoking effects.

Effective interventions for quitting continue to be a combination of behavioral and pharmacologic approaches (Westmass and Brandon, 2004). Prescribing the right therapy for the patient with follow up visits to evaluate adherence can accentuate treatment measures to change and ameliorate at risk behaviors.

In a review of second hand smoking exposure (SHS), Menzies (2011) discussed its effects on morbidity and mortality in association to cardiovascular diseases on a global scale. Menzies (2011) recommended banning smoking in public places as an effective tool for reducing tobacco-related morbidity across a multiplicity of diseases. Menzies (2011) also reiterated the benefits of banning SHS and advocates for constituencies to introduce legislation that prohibits smoking in public places.

Smoke-free grounds, now implemented in most of U.S. hospital campuses may deliver a positive effect on smokers. Nurses may play a positive role by explaining the importance of smoke free environments through advocacy and discussing the details with patients. Nurses can also create an impact through advocacy and being active in the communities where smokers can be educated and encouraged to quit smoking. This can be enhanced through media broadcasts or school activities to reach out to at risk children and young adults.

In examining smoker’s behaviors, Uppal, Shahab, Britton and Ratschen (2013) explored smoker’s attitudes towards quitting. After interviewing 22 participants, Uppal et al. (2013) concluded that “continuing smokers’ attitudes towards smoking and quitting suggest that research and policy need to focus on increasing smokers’ implicit motivation to quit smoking.” The implication thus is for care providers to motivate the smokers during assessment and consultation interactions. Nurses are positioned to be effective healthy policy advocates (Chism, 2010) and changing at risk behaviors in smokers may be an opportunity to demonstrate positive action. Smoking poses major negative implications not only to the smokers but to society, and most importantly the US healthcare system.

REFERENCES


Katheryn Tifuh Amba is a Direct Member of the NBNA. Tifuh is employed as an Acute Care Nurse Practitioner at the University of Chicago Medical Center and currently pursuing doctoral studies in Nursing at Barnes Jewish College, Goldfarb school of Nursing in St. Louis MO.
African American Females and Cerebral Vascular Accident

Regenia Carter, BSN, RN
NBNA/United Health Foundation Scholar
Member, Little Rock Black Nurses Association

Recently, I took care of a 42-year-old African American female who had an emergent decompressive craniotomy after being found at home unable to speak or move her left side. As I began my assessment, my heart was heavy. Lying in front of me was a female that looked just like me and of the same age with a swollen face and flaccid extremities on the left side. The next week, I took care of a 55-year-old female with cerebral vascular accident (CVA) symptoms. Taking care of these women started me thinking about how, over the last couple of years, I have seen an increase of African American females being diagnosed with cerebral vascular accident (CVA) and transient ischemic accident. As care providers for our community, it is important that we arm ourselves with facts that affect this population so that we can educate them with the knowledge of prevention, early detection, and treatment.

Cerebral Vascular Accident is the fourth leading cause of death in the US, with one person dying every four minutes as a result. Approximately 800,000 people have a stroke each year; about one every four seconds (CDC, 2014). More than 100,000 women died from stroke last year. CVA has been shown to kill twice as many women as breast cancer every year. Cerebral Vascular Accident is a major cause of death and disability and African American females seems to be the raising new face of this disease.

African Americans are affected by stroke more than any other group. More than 30 percent of CVA occur in women before the age of 65. This rate is even higher in African American women, in fact it is almost twice that of Caucasian women. African American women also have a higher risk of dying from a stroke than Caucasian women. African Americans 35-54 years old have four times the relative risk for stroke.

According to an interim report from the African American Antiplatelet Stroke Prevention Study, stroke is the third leading cause of death in African American women. This report also showed some research reports rates of hypertension in the community and in stroke populations have been higher in African American women than in African American men.

The African American population also tends to have higher rates of obesity and diabetes, which puts them at greater risk for high blood pressure and heart disease. However, for many African American women, particularly those who consider themselves perfectly healthy, perception may not always equal reality. Researchers have found that there may be a gene that makes African Americans much more sensitive to the effects of salt, which in turn increases the risk for developing high blood pressure. In people who have this gene, as little as one extra gram (half a teaspoon) of salt could raise blood pressure by as much as five millimeters of mercury (mm Hg).

Another unique factor that affect African Americans’ stroke risk is sickle cell anemia, which is a genetic disorder that mainly affects African Americans. Sickle red blood cells are less able to carry oxygen to the body’s tissues and organs and tend to stick to blood vessel walls. This can block arteries to the brain and cause a stroke. Other risk factors affecting strokes in African American women is proportions of hypertension and diabetes are strikingly higher in women more than men. Also, women face particular stroke risks related to hormonal changes which are related to pregnancy, childbirth, and menopause.

It is important that as providers form partnerships with the American Heart Associations, churches, beauty and barber shops, sororities, and other community programs that can help this population and strengthen our community. There have been a few programs dedicated to this cause such as Go Red and Power Sunday, however many more programs and partnership are called for and need.

Research has shown that we loss more than 100,000 of women over last year, and at least more than half of them are African American. These are our sisters, mothers, daughters and friends. As providers for our community, it is important that we arm ourselves with the knowledge of factors that uniquely affect our community. Knowledge is power and power is what we need to keep our sisters alive.

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Regenia Carter, BSN, RN, is currently the Health care chairperson for Little Rock Black Nurses Association. She is currently pursuing a Masters with a focus as an FNP. Regenia has been a nurse for 15 years and a critical care nurse for 12 years.
The Mass Incarceration and Mental Health-Care Justice

Taylor Lauren Davis, SN
NBNA/United Health Foundation Scholar
Howard University

In Dorothea Dix’s riveting Memorial to the Legislature of Massachusetts address, Dix gives a chilling account of the “horrors” she witnessed while visiting American prisons and asylums. Her investigations of these institutions revealed the severe injustices that those afflicted with mental illnesses suffered. So greatly moved by the inhumane treatment of the patients and prisoners she observed, she began a noble movement to create reform in the mental health-care system. Dix’s reform was centered upon creating institutions specifically designed to cater and treat mental illnesses. Dix understood that “prisons are not constructed [to become] county hospitals,” realizing that the sickness would inevitably be inflamed in such environments. Through her tireless advocacy and effective lobbying, she influenced the government to produce 32 psychiatric mental institutions over the course of several decades. Her vision for these institutions focused on providing the highest level of care coupled with professional compassion. Her call for the preservation of patient’s humanity lead to a standard of evidence-based psychiatric and mental health practices that arguably become the catalyst for all future mental-health care reform in this country.

The next great paradigm shift in mental health care would come years later with the same taste of justice Dix undoubtedly had. In 1963, the Community Mental Health Act (Mental Retardation and Community Mental Health Centers Construction Act of 1963) was signed into law by President John F. Kennedy. The act sought to deinstitutionalize mental asylums and push for outpatient and community-based care, recognizing that this form of treatment was more beneficial and economical. Thankfully, the outpatient approach has become the norm for contemporary care.

The drastic changes that have taken place since Dix’s day have confirmed the idea that it is both absurd and beneath our call to punish and/or fail to provide health-care to those in need regardless of their illnesses. However, this conviction can easily be called into question when the American incarceration system is examined. It is alarming to note that most prisoners are incarcerated for non-violent drug offenses; even more disturbing is the fact that those prisoners are disproportionately African American. This disparity is difficult to accept as mere coincidence when according to article, “Ethnic Disparities in Unmet Need for Alcoholism Drug Abuse, and Mental Health Care,” whites are more likely than blacks to suffer from substance abuse.

As reported by Michelle Alexander in her book, The New Jim Crow: Mass Incarceration in the Age of Color Blindness, laws such as the 1994 Violent Crime Control and Law Enforcement Act, have worked to ensure that those with addictions are criminalized instead of rehabilitated. How is it that a nation that has passed legislation in support of mental health reform could also pass legislation that punishes its citizens for their mental illnesses? Certainly, it is a long cry from the passionate crusade Dix waged for the mentally ill.

As the privatization of prisons continues to increase the need for men and women to fill beds, it is imperative that nurses, specifically black nurses, lead the charge for radical reform to protect the basic rights of the marginalized and those suffering from drug addictions. Fortunately, the passage of the Affordable Care Act (ACA) has placed nurses in a unique position to create effective change in drug policy by “[setting] the stage for a new health-oriented policy framework to address substance abuse and mental health disorders.” The American Civil Liberties Union (ACLU) has taken an important step in drug reform by establishing their campaign, “Healthcare not Handcuffs,” which presents strategies to expand the ACA in ways that will benefit the mentally ill either at risk for and currently incarcerated. However, if such measures are to be successful, it is necessary that nurses, the leader and foundation of health-care join them and rise up “as the advocate[s] of the helpless [and] forgotten.”

REFERENCES

Taylor Lauren Davis is a senior nursing major at Howard University from Memphis, TN. Her love for advocacy influenced her decision to enter into the nursing profession. After obtaining her degree, she plans to continue unto law school and ultimately become a mental health-care advocate and policy maker.
Sharing Bad News

Marcia Lowe, MSN, RN-BC
NBNA/United Health Foundation Scholar
Advanced Nursing Coordinator, University of Alabama Hospital
Member, Birmingham BNA, Inc.

Sharing bad news is difficult and requires effective communication skills. Physicians usually deliver the initial bad news about a disease and/or prognosis, but patients and families rely on nurses to provide support after receiving the news. Because of their close association with patients and families, nurses are often called upon to answer questions regarding prognosis and treatment (Barclay, Blackhall & Tulsky, 2007).

Sharing bad news is very difficult for a number of reasons. In one study, nurses expressed cultural differences, heightened emotions of patients and families, communicating with physicians, and religious and spiritual issues as the most challenging (Malloy, Kelley, & Muné’var, 2010). Often, patients and families are from cultures that have diverse philosophies related to receiving unpleasant healthcare news. For example, in the Hispanic, Chinese, and Pakistani communities, family members actively protect terminally ill patients from knowledge of their condition (Searight & Gafford, 2005). Nurses are often uncomfortable when patients and families express heightened sadness because many have difficulty expressing their own emotions. In the past, it was considered unprofessional for nurses or other healthcare workers to cry with their patients. Now it is more acceptable for nurses to express their feelings. Communicating the concerns of patients and families to physicians can be emotional as well. Likewise, dealing with religious and spiritual issues may be distressing to both the nurse and patient/family. Many religious beliefs or preferences may not surface until bad news is brought forth.

Malloy et al., (2010), also discovered that nurses have their own, personal barriers to communicating bad news. Nurses fear causing more pain. Some nurses feel threatened by such discussions and fear their own mortality. Many novice nurses lack the knowledge or personal experience with death. And sometimes, nurses have unresolved grief.

Nurses can address their barriers to sharing bad news through effective communication skills, including listening, presence and re-phrasing (Malloy et al., 2010). When listening, be sure that you heard what the patient or family is saying to you. Presence, or “just being there” is often all that patients and families desire. Finally, re-phrasing or stating back to the patient what you understood them to say is important to be certain your understanding is accurate.

Here are a few tips when communicating bad news. Be prepared, show compassion, listen attentively, answer questions openly and honestly, be present, use eye contact if appropriate (many cultures find this offensive) and make supportive comments. According to Baer & Weinstein (2013), it is important to utilize questions or phrases that will help to explore a patient’s world. All of the phrases or questions convey empathy and are designed to help the patient or family open up.

- What is the toughest part of what is going on with you and your family?
- Tell me more.
- What troubles you the most?
- What is more important to you if your time is limited?
- When you think of the future, what worries you the most?
- How can we support you at this time?
- What are your biggest fears?
- Can you tell me how you are feeling?
- I wish the news was different.

It sounds like it’s been pretty rough. One tool nurses may find useful for presenting distressing information in an organized fashion is the SPIKES (Setting, Perception, Invitation, Knowledge, Emotions, Summary and Strategy) six step protocol. The goal of a conversation using the steps in SPIKES is to gather information, and support the patient and family. It is important to choose a setting that is private and without interruptions. Find out the patient’s perception of the information. What does the patient already know? Investigate how much information the patient would like to be given. In many cultures, the patient may not be the one making the healthcare decisions for them. When discussing knowledge, it is important to use non-technical terms. Such as for metastasized, use the word spread. Make sure that you are speaking on a level that the patient understands. If the patient becomes emotional, acknowledge their emotions. Allow the patient to cry, and it is acceptable if the nurse cries, but the family should not be consoling the nurse. Finally, understand the clear goals of the patient and family (Baer & Weinstein, 2013).

In conclusion, sharing bad news is not an easy task. It requires education and continuous training. One method is to offer on-going education to nurses to help in improvement of communication skills. The incorporation of communication skills within annual competency programs or continuing education and training programs is an important approach for keeping open channels of communication with patients and their families.

CONTINUED ON PAGE 13
REFERENCES


Marcia Lowe, MSN, RN-BC, employed at University of Alabama (UAB) Hospital in Birmingham, AL as an Advanced Nursing Coordinator in the Medical Nursing Division. Marcia is a 3rd year PhD student at the UAB School of Nursing with a research interest in predictors of burnout in the palliative care nurse. She is a certified gerontological nurse and very active in the Birmingham Black Nurses Association, Inc. Marcia served as a chapter president and currently on the membership committee. She is a past NBNA board member.

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A Nation Divided:
Infant Mortality in Black America

Toni K. N. King, RN SNM
NBNA/United Health Foundation Scholar
Member, BNA of Greater Cincinnati

Infant mortality is the death of a baby before his or her first birthday. The infant mortality rate or IMR, takes into account the number of those deaths per 1000 live births (Center for Disease Control [CDC], 2014; MacDorman, Hoyert, Mathews, 2013). Overall the United States has seen a decline in infant mortality rates from 2005-2011. In fact, non-Hispanic black women showed a decline of 16% overall in infant mortality (MacDorman et al., 2013). However, despite the decreasing trend, disparities among black and white infant mortality still persists. Infant mortality rates are so important because the rates are often used to gauge the overall health of a nation. It is well known that blacks are disproportionally affected by a number of other health issues such as heart disease, hypertension, and diabetes. According to the Center for Disease Control (CDC) (2014), health factors that have the potential to affect the health of an entire population can directly impact infant mortality rates. Currently African Americans make up roughly 13% of the US population, yet the infant mortality rate of non-Hispanic black infants is more than twice that of non-Hispanic white infants who are over three-fourths of the population (CDC, 2014; United States Census Bureau, 2014). With that being said, infant mortality for black America is still an issue and is not something that we as a nation can afford to ignore. Infant mortality rates give a glimpse of overall health and suggest that the health of Black America is still an issue regardless of a decline in the overall statistics.

Currently the targeted IMRs are guided by The Healthy People 2020 goal for overall infant mortality, with a goal of six deaths per 1000 live births (Healthy People, 2014). Despite the decline in overall rates previously mentioned, some states in the South and Midwest remain persistently high. As of 2010, 17 US states had black infant mortality rates greater than or equal to 12.0 per 1000 live births; that is double the target goal. The state with the highest rate of black infant death is Indiana with an infant mortality rate of 15.0 compared to the highest white non-Hispanic state of West Virginia with a rate of 7.6 per 1000 births (Mathews & MacDorman, 2013).

People often wonder why the huge difference across races and ethnicities. Unfortunately, there is no real explanation for the disparities because the problem is one that is complex and will require a multifaceted approach with multidisciplinary efforts. Nevertheless, if we begin to look at the main causes of infant mortality we can begin to see where to focus our efforts. The leading causes of infant mortality account for over half of all infant deaths and include prematurity, Sudden Infant Death Syndrome (SIDS), birth defects, maternal complications, and injuries such as suffocation (CDC, 2014). The causes of infant death are multidimensional and factors that affect birth outcomes include social, behavioral and health risk components. All aspects must be addressed in order to increase health equity across races and cultures. The underlying causes of racial, ethnic and socioeconomic disparities must be confronted as well; specifically poverty and racism which can affect psychosocial well-being and have been widely known to contribute to disparities in birth outcomes (Health Resources and Services Administration [HRSA], 2013).

The Secretary’s Advisory Committee on Infant Mortality suggests targeting high-risk areas and increasing access, opportunity and resources through community-based initiatives. They also recommend making an impact on poverty, specifically on families in their childbearing years. Such recommendations are made with an understanding and an emphasis on the multidimensional approach; noting such efforts as practice improvements, change in knowledge, attitudes and behaviors of both men and women of childbearing age, empowering communities and a serious commitment to the efforts by everyone involved (HRSA, 2013). Infant mortality is not going to turn around on its own; it is not something that will just go away. Every effort must be made to bring this issue to the forefront because it truly is a reflection of the overall health of a nation, in particular the sub-groups who are extremely affected by it. Bill Clinton said it best, at the end of the day, “Nowhere are the divisions of race and ethnicity more sharply drawn than in the health of our people… no matter what the reason, racial and ethnic disparities in health are unacceptable in a country that values equality and equal opportunity for all” (Brooks, 1998).

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Biosimilars: Another Untold Story of the Affordable Care Act

Congressman Bobby L. Rush, Illinois

With the 2014 Mid-Term elections over and the open enrollment period for the ACA approaching on November 15, the American public has been saturated by a flood of campaign advertisements and literature attacking and promoting the Affordable Care Act (ACA). Were it not the political lightning rod that it has become, many more Americans would have a much clearer understanding about the ACA’s wide breadth and how some of the law’s policy changes, which are not featured in those campaign ads, will benefit them and their loved ones. In addition, a good number of these changes will significantly advance healthcare quality and science in our country.

One sweeping policy and regulatory innovation under the ACA, of which most Americans are unaware, is the role that the Food and Drug Administration (FDA) now plays in the regulation and approval of biological medicines and their biosimilar counterparts. This past summer, the first biosimilar applications were submitted to FDA for approval. These pending applications mean that patients and prescribers will soon have access to even more treatment options, since biosimilars are not currently available in the U.S.

Over the last two decades, it has been astonishing to witness medical innovations made possible through the advancement of biologics, and soon biosimilars. These advances have exponentially expanded the therapies available to both patients and physicians. Biologics and biosimilars can serve as innovative treatments for life-altering and chronic diseases, such as cancer and AIDS. In addition, they can be used as preventive interventions for the onset of deadly and debilitating diseases such as Alzheimer’s, heart disease, Parkinson’s, multiple sclerosis and arthritis. Unlike their pharmaceutical counterparts, biologic drugs are made from living organisms, primarily administered by injection or infusion and derived from more complex manufacturing processes.

In the months ahead, state legislators and regulators across the country will have opportunities to create laws and rules relating to the dispensing of biologic and biosimilar drugs. This has led to an earnest debate, currently taking place both in Washington, DC and in state capitals across the country, about how laws governing pharmacy practices can be updated to expand access to these drugs. While the nuances of the legislation and rules considered in each state may vary, one underlying issue has been raised in every state discussion thus far: the need to ensure active pharmacist-prescriber communications when it comes to dispensed biologics and biosimilars.

Prescribing physicians need to know which biologic has been dispensed to support patient care in the event that a patient has an adverse response and has received multiple biologics. This is relevant not only to retail dispensed biological products, where a pharmacist and physician may not normally communicate about the history of a patient’s medicines, but also to mail-order prescriptions where the occurrence of pharmacist and prescriber communication is even less likely to take place.

Ensuring that patient safety and access to these medicines is my paramount concern, and that concern is also a top priority for many other federal and state legislators and regulators who are engaged on this issue. Fortunately, many major drug manufacturers, including manufacturers of both innovator and biosimilar drugs, understand the promise of biosimilars and the need to ensure patient safety as they come to market. In addition to investing in the development of new biologics and biosimilars a number of these manufacturers are partnering with patients and physician advocates across the country.

All Americans deserve to benefit from the hope and promise of biosimilars: whether or not they recognize that their ability to access these new drugs is a result of the Affordable Care Act. As biosimilars become available to patients throughout the nation, there is an exciting opportunity for patients to be at the forefront of both medical innovation and patient safety. Patients throughout the nation, along with their families and physicians, are counting on their legislators and regulators to put patient safety first, as they advance critical legislation and rules to expand access to biologics and biosimilars.


Toni King, RN, is a student nurse-midwife at Frontier Nursing University and is the 2014 United Healthcare Foundation Scholar and AAUW Career Development Grant recipient. She currently serves as secretary of the Black Nurses Association Greater Cincinnati Chapter. Toni’s interest includes infant mortality and progesterone and its effects on prematurity.
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FOR QUITE SOME TIME, the founding president of the Birmingham Black Nurses Association (BBNA) and this year’s trailblazer award winner, Mrs. Deborah Walker, has been telling me that I need to attend a National Black Nurses’ Association (NBNA) Conference. She said that it would be so inspiring and something that I would thoroughly enjoy. I have a lot of respect for Mrs. Walker and the local chapter members of the BBNA. Mrs. Deborah Walker, Mrs. Geneva Irby (another founding member), and other members of BBNA have been very supportive of me even before I became a member. They held health fairs at my church including blood pressure checks, diabetes management, and information on healthy eating and active lifestyles. They have been very active in the community and are truly legends in the field of nursing. I thought that all I really needed to do was to look at my local chapter to get all the inspiration I needed because the members are so dedicated and caring. They encourage each other and are very involved in the community and with the local schools of nursing to encourage young nurses.

This year, I finally had the opportunity to attend the NBNA conference in Philadelphia, PA. The opportunity came as a result of Deborah Thedford-Zimmerman’s vision to have a wound and ostomy care workshop at the pre-conference session. She said it had never been done at a NBNA conference before and it was definitely something that was needed. She paved the way so that three of us with an interest and certifications in wound, ostomy, and continence care from Birmingham, AL were able to provide the workshop. Deborah spoke on ostomies, Sharon White spoke on lower extremity wounds, and I spoke on pressure ulcers. This was followed by a hands on session that participants stated they really enjoyed and enhanced their knowledge of ostomy management. It was such an honor and privilege to be able to provide this lecture at the conference. Working with my colleagues made it an absolutely unforgettable experience.

I just don’t have the words to express how proud I felt at the opening ceremony. The Birmingham delegates marched in looking so beautiful with their white outfits and silver flowers. In fact, we had such a large presence that I was sitting in the audience with my white dress and silver flower along with several other members as we watched the delegates march in. I kept watching as each of the various chapter delegates were announced and came in with different outfits representing their areas. It was truly awesome. When the military nurses came in, there was an older nurse who still had that military step, marching with a straight back and a pep in her step that I felt overwhelming pride that I was among such proud Black Americans. As I continued to look and listen to the motivational messages from the speakers, to hear about the higher education, the vast experience, and the power available to these nurses while they remained so humble, my pride in being a member of this organization was just taken to another level! We can and do make a difference in providing optimal health care services and influencing diversity. Our NBNA president, Rev. Deidre Walton and RADM Sylvia Trent-Adams, the chief nursing officer, are truly inspirational leaders. Even the young student who was honored for her vision of the youth mentoring program did not forget where she came from. She brought her mother, a NBNA member, up to the platform to accept the award with her. We can’t forget where we came from as we strive to move forward in the healthcare arena.

All of the educational sessions I attended were very interesting and informative. The topics were pertinent and presented in a very organized manner. The two new graduate nurses from our chapter did an awesome job with their presentations! They were so poised and eloquent. It was a testament to the mentorship provided by the BBNA nurses. Of course, our BBNA chapter president, Jennifer Coleman along with Mary Williamson presented the diabetes prevention and wellness education community effort very professionally. Unfortunately, I was not able to attend all of the presentations by our chapter members, but had no doubt that they did a fine job. In this day and time, it is so wonderful to have young intelligent, dedicated, gentleman like Adam Smith, from the BBNA who represent the young Black male presence in nursing so well. Our future looks brighter with the young people in this organization. I also had the opportunity to network with nurses from several chapters including the Atlanta chapter who will be hosting next year’s conference. I definitely plan on attending next year!

Mrs. Deborah Walker was absolutely correct! Attending a National Black Nurses Association Conference was truly inspiring, motivating and something that I will never forget. Attending and speaking at the NBNA conference in Philadelphia is something that I would never have dreamed of growing up in a small town in Alabama. But, I do know that I can do all things through Christ who strengthens me. Just as He has done for nurses before me, those with me now, He will do for nurses in the future. My faith is my foundation in nursing and in life. I’m thankful to God for ordering my life, directing my footsteps, for having the BBNA available locally, and allowing me this wonderful opportunity to participate in the NBNA conference!
Successful completion of nursing school requires a fair amount of intelligence and family and community support. Some obstacles that may impede the successful completion of nursing school include lacks of adequate finances which may affect transportation, housing and childcare. Other factors include faculty discouragement, learning disabilities, insufficient technology access and poor family and peer support. According to the National League for Nursing (NLN) (2010) graduation rates from basic RN programs between 2006 and 2007 were approximately 60 percent for associate degree nursing programs and 37 percent for baccalaureate programs. The graduation rate for Blacks in that same period was 10.4 percent overall for both programs (Dapremont, 2011).

Dapremont (2011) reported that although Blacks comprise 12.3 percent of the United States population, they represent only 4.6 percent of registered nurses. Additionally, Blacks have the highest percentage of non-graduates among nursing students compared to other racial/ethnic groups. Nursing Statistics (accessed July 2012) reported that Hispanics comprise 14.8 percent of the population but only 1.7 percent is registered nurses. Bond et al. (2008) reported that Hispanic nurses have several factors associated with the decrease of nurse graduation which include inadequate finances, language barriers, lack of emotional and moral support, and professional socialization, insufficient mentoring, poor academic advising and insufficient technical support.

With a brewing national nursing shortage it is imperative for nursing programs to facilitate their students from admission to graduation to successful National Council Licensure Examination (NCLEX) passage. Therefore, this study was conducted to determine the obstacles that may impede the success of minority nursing students.

Review of Literature

Dapremont (2011) surveyed 18 Black nursing students (16 females and 2 males) who graduated from predominately White associate or baccalaureate degree nursing programs between 2000 and 2006 in the Mid-Southern United States to assess their view of obstacles. Eighty-nine percent (n=16) felt that peer support was very important. Black students reported that outside their ethnic background, peer groups were formed due to clinical group assignments initiated by faculty. Black students reported fearing negative reaction from their own race about their behavior if they mingled with White peers. Some participants didn’t want to offend other Black students by studying and interacting with White peers. While others felt White students had access to test material and other material that would be helpful for success and found it essential to develop relationships with their White peers. Eighty-three percent (n=15) stated family support was needed and necessary.

Seventy-eight percent (n=14) shared that they would have withdrawn from nursing school if it wasn’t for the encouragement of the faculty.

Rogers (2010) interviewed six seniors to determine factors that contributed to the successful completion and passage of NCLEX. The nursing program student population was predominantly White. The students were selected based on exemplary academic performance in the nursing program. Participants stated that many factors contributed to their success which included academic abilities such as critical thinking, test taking capability, study skills, organizational skills, prioritization of roles and responsibilities. In addition, the students felt the ability to manage life events such as extreme stress and health care issues such as poor nutrition and inadequate sleep influenced progression.

Bond, et al. (2008) surveyed 14 students ranging from age 21 to 42 with a median age range of 25.6 years. The participants self-identified themselves as Mexican Americans. Seven were married and 11 were the first in their families to attend college. Thirteen participants were employed and worked between 20 to 40 hours per week. Seven received financial support from scholarships and 11 had received loans.

Bond, et al. (2008) found that students that received financial assistant in the form of scholarships had financial needs that extended beyond tuition fees and books which included the costs of child care and transportation. The participants’ also identified that the lack of specific counseling or incorrect information at the high school level and or community college level was an obstacle to entrance and progression through nursing school. Gender stereotype or tension related family values also created some obstacles. In the Mexican culture males are priority when it comes to receiving education. Additionally, the students stated that scheduling conflicts prevented accessibility to mentoring programs, professional organizations and socialization groups thus impacting progression through their program of study.

McGregor (2007) interviewed nine nursing students three times throughout their academic year to determine obstacles to their progression. The participants were randomly selected with their academic standing being assessed by nursing faculty as strong, average and weak. The nursing students felt unfair faculty treatment was their greatest obstacles. Students felt that their clinical survival was contingent on the teachers’ appraisals with these appraisals being subjective. These students expressed feeling of vulnerability and fear of failing.
DATA COLLECTION

A survey questionnaire was constructed to measure the obstacles described by associate degree nursing students in successfully completing nursing school. The survey questionnaire was easily accessible through an electronic web site. The research pool consisted of a possible 175 participants between two campuses. Forty-seven participants completed the survey of which fifteen were described as minorities (African Americans, Asians, Hispanics or other). Since the participants were using a website to respond their participation was voluntary and confidential. The web-site prevented any identifier markers to be associated with the entry. Students were not compensated nor did they receive credit for participating.

RESEARCH FINDINGS

The responding population mix consisted of five first-semester students, twenty-eight second-semester, nine third-semester students, and five fourth-semester students. The majority, 46.8 percent (n=22) age ranged was from 18 to 25 with 68.1 percent (n=32) being Caucasian, 19 percent (n=9) African American, 4.32 were percent Asian (n=2) and 4.3 percent (n=2) as were Hispanic and 4.3 percent (n=2) identified themselves as other. The majority 25.8 percent (n=15) were minorities which reported little or no college while 24.8 percent (n=14) had prior college credits while 21.3 percent (n=10) had an associate degree. Relating to college entrance requirements 27.7 percent (n=13) scored greater than 25 on the American College Testing exam (ACT). While 48.9 percent (n=23) reported themselves as single, 55.3 percent (n=26) reported themselves as being unemployed. Of this number, 5.8 percent (n=8) were minorities. Although a noted percent was reported as unemployed, 61.7 percent (n=29) reported an income of $20,000 per year or greater. The participants reported no government assistant with childcare while 21.3 percent (n=10) reported paying out of pocket for childcare. The participants were asked to rank their support systems. With respect to support systems the participants reported that 93.6 percent (n=44) came from family, 76.6 percent (n=36) from friends, 36.2 percent (n=17) from the church and 23.4 percent (n=11) from neighbors. Of the 36.2 percent (n=17) that reported support from their church 29 percent (n=14) were minorities. Surprisingly, none of the participants reported their educators as part of their support system. The majority reported traveling less than 50 miles per day for school, while 17 percent (n=8) reported traveling greater than 75 miles. As far as documented disability, a majority 71.1 percent (n=32) reported having problems with anxiety while 11.1 percent (n=5) reported as being diagnosed with attention deficient hyperactive disorder. While the some minority students reported anxiety none reported being diagnosed with attention deficient hyperactive disorder.

CONCLUSION

Although the literature is limited in studies related to the obstacles impeding nursing students to successful completion, this study serves as a good jumping off point for future studies. Because this study presents such a small population and is limited to only one program, the results cannot be generalized. The study findings indicated that the highest percentage of participants were single Caucasians with no children and prior college credits, an American College Testing (ACT) of 25 or greater and unemployed with an income of 20,000 or greater per year. In contrast, 17 percent (n=8) of the participants had less than 12,000.00 dollars annual income. The study findings indicated that the minorities, African Americans, Hispanics, and Asians 25.8 percent (n=15), may need additional assistance and mentoring to be successful. The study suggests that although the family was found to be the primary support system, it would be imperative for colleges to create other support systems for minority students. A mentoring program pairing lower level students with upper level students may be helpful. All students would benefit from supportive educators and more individual counseling related to entry and progression through the program. Educators must be connected to student success, outline responsibilities, clarify expectations, seek informative feedback and provide culturally appropriate constructive criticism. The minority student must feel a sense of approachability toward the educator. Since the learning style of my minority students may differ, incorporating culturally appropriate case studies and scenarios may be helpful. In addition, since 21.3 percent (n=10) were noted to be paying for child care or pocket, it would be beneficial for the college to seek federal supported child care, on-site or off site, for needy students. Partnering with local child care facilities may also provide some added benefits such as discounts to students in need of childcare.

Minority students need to be assessed for difficulties with anxiety since this population may be less reluctant to identify this as a problem. Further, educators need to become more of cheerleaders to all their students offering time, encouragement and showing concern. In addition, this study should give educators an opportunity to assess their own biases toward other racial/ethnic students. To address cultural competency, educators, must take advantages of opportunities to participate in workshops, conferences, and in-service training dealing with multicultural education. Minority students with proper cultural appropriate approach and nurturing can successfully complete nursing school and add to the richness of the nursing profession.

REFERENCES

Bond, M. L. et al. (2008). Voices of Hispanic Students in Baccalaureate Nursing Program: Are We Listening. Nursing Education Perspectives, 29 (3).


Irish Patrick Williams, PhD, RN, CRRN, CFN, has 35 years clinical experience and 14 years teaching experience at Hinds Community College Associate Degree Nursing Program, Jackson, Mississippi. In 2013, Irish was awarded Associate Degree Nurse Educator by the Mississippi Organization of Associate Degree Nurses.
Incivility in Pre-licensure Nursing Education and the Impact on Client Safety

Stephanie Patterson, MPA, BS, Student Nurse
Member, Council of Black Nurses, Los Angeles, Inc.

Scholars agree that incivility in academia in the form of student bullying is a growing problem on college campuses nationwide (Lasiter, Marchiondo, & Marchiondo, 2012). In August 2014, a survey conducted by Kaplan of over 2,000 recent nursing school graduates, found that nearly half of them feared being bullied or victimized (Kaplan, 2014). Lower (2012) maintains that civility has become an increasingly important topic in professional nursing programs over the last ten decades because studies have linked a lack of civility to decreased client safety. A number of research studies even indicate that bullying is a type of peer victimization that is related to worse mental and physical health over time (Bogart, Elliott, Klein, Tortolero, Mrug, Peskin, Davies, Schink, & Schuster, 2014). However, behaving in a civil way is a choice one makes every day (Lower, 2012). Disruptive behaviors such as bullying are now viewed as ethical violations for student nurses and nurses—and organizations face increased institutional liability if they allow such behaviors to persist.

Existing literature on bullying shows it is the mistreatment of a person that is repeated, deliberate and violates another person’s dignity. It creates an intimidating, hostile, degrading, humiliating, or offensive environment for someone. Although researchers have explored the dynamics, causes, and outcomes of such incivility in higher education, the issue is at times overlooked or ignored altogether (Lasiter et al., 2012). There is also some evidence that student nurses who bully are not able to empathize with another’s experience and thus, may not be able to empathize with a client’s experience who is hospitalized and this could adversely affect patient care and safety. In other words, the need to be proactive by addressing negatively manifested student behaviors is paramount because it is an opportunity for learning institutions to initiate change in a positive direction. When bullying incidents do occur, these issues must be addressed immediately.

Rosenstein (2011) suggests that the first step in the process is the organizational commitment to address disruptive behaviors in the context of their negative impact on client safety. The writer holds that such commitment must come from all levels of the organization, including senior-level administration, clinical leaders, frontline staff, and the governing board. In other words, the idea here is that organizations, including academic organizations like nursing schools, must be ready and willing to change and remodel care so as to support individuals and teams that provide direct client care, hence nursing students.

The next step is behavioral education followed by having a disciplinary behavior policy in place to deal with individuals who are noncompliant and to prevent bullying, and to provide services for victimized students when managing disruptive events. In the best case scenario, for example, those who enter into nursing school and ultimately into the nursing profession, do so because of a strong interest in caring for clients. Clarke, Kane, Rajacich & Lafreniere (2012) emphasize that we cannot afford to lose nursing students to bullying especially with a shortage of nurses in the field already.

Lachman (2014) explains that the principle of respect for persons extends to all individuals with whom a nurse or student nurse interacts. However, other scholars counter that the field of nursing is described as a caring profession, deeply rooted in ethics, yet studies commonly describe a culture that perpetuates intimidation (Clarke et al., 2012). Thus, written policies must be implemented that confront the issue of bullying within nursing programs and within health care facilities where nursing students undertake their clinical nursing education (Clarke et al., 2012).

In conclusion, the implications of institutional failure to take action can lead to dire consequences, including interfering with learning and safe clinical practice and legal consequences as well. When negative behaviors are addressed in a professional way, then a positive learning environment can be maintained or established because it means there is a zero policy for student bullying as it relates to pre-licensure nursing education.

REFERENCES


Stephanie Patterson is an Entry-Level MSN student and currently serves as a Student Representative for the Council of Black Nurses, Los Angeles. Stephanie received a Bachelor of Science in Business and Master in Public Administration from California State University Dominguez Hills. She is a member of the AACN/Graduate Nursing Student Academy and active in community-service activities. Stephanie also serves as a volunteer in a clinically-based internship program at UCLA Medical Center. She is a recipient of the Bettye Smith-Williams scholarship and Micheal Antonovich Scholarship (County of Los Angeles).
Black Nurses Association of Greater Phoenix

Dr. Deidre Walton, NBNA President, received a re-appointment to the AMEC Judiciary Committee for Southern California and Nevada.

Greater Washington DC Area Black Nurses Association

Karen V. Scipio-Skinner, MSN, RN, Executive Director, Board of Nursing was recognized by the National Association of Health Services Executives (NAHSE) for her contribution to healthcare. Karen was recognized during an event held by NAHSE during the 2014 Congressional Black Caucus Annual Legislative Conference.

Atlanta Black Nurses Association

Johnnie Mae Lovelace, BS, RN, CCM, DN, President & CEO of Lovelace Multicare Health Services and Training Institute, member of the Atlanta Black Nurses Chapter, was recognized at the 2014 NBNA Institute and Conference as the NBNA Entrepreneur Nurse of the Year.

Birmingham Black Nurses Association

BBNA’s annual scholarship event was held on Saturday, November 1, 2014 at Vulcan Park and Museum in Birmingham, AL. During the breakfast program, “Giving Back and Paying it Forward”, BBNA awarded scholarships to two undergraduate nursing students. Carolyn Etheridge, a student at Jefferson State Community College, and Asia Dawson, student at the University of Alabama, Capstone College of Nursing received chapter scholarships. Reflections were offered by former scholarship recipient, Lindsey Harris, nurse practitioner at UAB Hospital. Lindsey received a BBNA scholarship while she was an undergraduate student and she relayed the value of the financial assistance as she completed nursing school.

BBNA in partnership with the American Heart Association (AHA) received a $10,000 Community Health Innovation Award (CHIA) from the University of Alabama at Birmingham’s Center for Clinical and Translational Science. BBNA and AHA completed a rigorous, progressive application process that included a written proposal, face-to-face meetings, and a short innovative presentation for the judges. As the final presentation to a panel of judges, the BBNA team performed the AHA Hands Only CPR dance to the tune of John Travolta’s Stayin’ Alive video. Be HeartSmart—Act Now will be implemented by BBNA and AHA in Birmingham area churches and community organizations.
BBNA in partnership with Drexel University Online sponsored a cocktail reception and free screening of the movie “Nurses: If Florence Could See Us Now” at the Alabama Theater in Birmingham on September 18.

BBNA member Kimberly Ayers received the UAB 2014-2015 Melanie Schultz Leadership Champion award for excellence in patient and family-centered care, servant leadership, generosity of spirit, and dedication to team success. Kim also recently successfully completed her comprehensive examinations and is scheduled to graduate with a Master's in Health Education from the University of Alabama at Birmingham in December 2014.

New York Black Nurses Association

September 6: President, Jean Straker and Marcia Skeete attended the Moravian Women's Health and Wellness Forum at the Grace Moravian Church in Queens NY. President Straker served as a panelist presenting on the topic “Pre-hypertension in African Americans”. She was later honored on October 19th for that presentation at the church's Women’s Day Service.

September 20: Jean Straker and Marcia Skeete performed blood pressure screening at the Free People’s Medical Clinic in Brooklyn, NY. The clinic was sponsored by Simone Leigh of Creative Times.

September 21: Patricia McLean attended the 46th Luncheon & 25th Annual Scholarship Award Ceremony of the Trinidad & Tobago Nurses Association held in Queens NY. Ms. McLean presented a scholarship to Meika Sorzano, a senior student of nursing at NYC College of Technology.

September 27: Jean Straker attended the Eastern Region Moravian Women's Fall Workshop in Allentown, Pa., where she did a presentation entitled God’s Farmacy.

October 1: Bernice Headley and Mirian Moses attended a taping on domestic violence (DIVA) presented by Bronx NY Borough President, Rubin Diaz Jr.

October 8 & 17: Zainabu Sesay-Harrell participated in an Ebola Health Forum and prayer vigil at Lincoln Medical Center Bronx NY.

October 9: Mirian Moses, Chair of the Lincoln Hospital Center Auxiliary participated in the 175th birthday celebration of the hospital, honoring the nursing division. Mrs. Moses, who was also interviewed by Bronx 12 TV News, was presented a plaque by the auxiliary for her “excellent leadership and passionate advocacy.” Bernice Headley and Joyce Fowler were also in attendance at the event which raised funds to upgrade the playrooms at Lincoln Medical Center.

October 14: Stacey Johnson and Ericka Murrell performed blood pressure screenings at the NYS Dormitory Authority, in NYC.

October 17: Professor Hayward Gill Jr., recognized by W.L. Bonner College in Columbia S.C. for his academic and educational contributions.

October 24: Zainabu Sesay-Harrell participated in the Ebola community dialogue at Harlem Hospital Center, and LaGuardia College both in NYC.

October 25: Etta White, coordinator of health and awareness at Paradise Baptist Church NYC, spear-headed the church and community wide outreach in “A Challenge Call for Survivorship and Family Caregiver Day” event.

October 25: Hayward Gill Jr. and Zainabu Sesay-Harrell were guest speakers at the Chi Eta Phi Sorority Omicron Chapter Inc.’s seminar entitled “The Ebola Outbreak in West Africa”. Also in attendance were Bernice Headley, Stacey Johnson, Mirian Moses, and Carol Pope.

October 27: Zainabu Sesay-Harrell and Bernice Simmons attended a seminar on Hepatitis B sponsored by ABBVIE Pharmaceuticals held in the Bronx, NY.

October 30: Recognition and appreciation to Dr. Rose Ellington Murray for her ongoing physical and spiritual health outreach in Harlem NYC, through various forums and seminars.

Above Left: Jacquetta Miller-Whaley & Jasmin Waterman.
Center: Cirse Scotland educating a health fair participant
Right: Jean Straker providing education to family members on their medication and Jasmin Waterman providing a demonstration of CPR on a resuscitation mannequin.
November 8, 2014 NYNBA celebrated their Annual 43rd year of service Dinner Dance & Scholarship Award at Antun’s in Queens, NY. Our own NBNA President Dr. Deidre Walton and Dr. Ronnie Ursin, NBNA Parliamentarian, were in attendance.

Black Nurses Association, Miami Chapter

Dr. Annette Gibson, Professor Emeritus from Miami Dade College was selected as the winner of the 2014 March of Dimes Nurse of the Year in the category of Academic Nurse Educator. Dr. Gibson is pictured sitting, 4th from the left.

Yuvonne Martin was selected as one of the Finalists the 2014 March of Dimes Nurse of the Year in the category of Advanced Practice.

Dr. Marie O. Etienne has been selected as one of the 2014 Top Black Educators in Miami by Legacy Magazine.

Milwaukee Black Nurses Association

Members of the Milwaukee BNA received scholarship and recognition at the chapter’s annual scholarship gala in November 2014. NBNA Scholarship Recipients 2014-2015 Left to right: Kamella Jackson; Rashida Dockery; Lyah Holmes; Destiny Watson; Detra McCoy

The American Nurses Credentialing Centre (ANCC) has presented an award to Dr. Stephanie Ferguson, Director of the International Council of Nurses’ Leadership for Change Programme and the ICN-Burdett Global Nursing Leadership Institute in October at the 2014 ANCC National Magnet Conference, in Dallas, TX. Dr Ferguson received the HRH Princess Muna Al-Hussein Award in recognition of her significant contributions to healthcare across borders and a dedication to nursing. Dr Ferguson was chosen for her many contributions over the years to the advancement of international nursing collaboration with ANCC. Dr Ferguson is a World Health Organization (WHO) Consultant working for several Regional Nurse Advisors and Regional and Headquarters’ Directors; a Consulting Associate Professor for Stanford University and an affiliate faculty at Virginia Commonwealth University School of Nursing.
Atlanta Black Nurses Association, INC.

August 17: Congressman David Scott 10th Annual Health Fair at Mundy’s Mill High School. Members of ABNA assisted the providers with breast exams and directing women to the portable mammogram vehicle. Breast exams were done on 166 women. ABNA members in attendance: Evelyn Houston Bell; Mary Dawson, Corresponding Secretary; Beverly Dinkins-Learmont; Jacqueline Henson, Treasurer; Emma Knight; LaTonya Hines, Recording Secretary; Michelle Jordan, NBNA Student Board member and ABNA student board member; Emma Knight; Johnnie M. Lovelace; Seara McGarity, ABNA Vice President; Evelyn C. Miller, ABNA President; Traci Rucker; Robin Simmons; Bianca Woodall-Jones; and Patricia Gooden-Moorer. Beverly Dinkins-Learmont, NP also performed breast exams along with other providers at the event.

EDUCATIONAL AND COMMUNITY EVENTS ATTENDED BY ABNA MEMBERS

- August 31: Rev. Dr. Darlene Ruffin-Alexander was the keynote speaker/preacher at the Antioch Baptist Church.
- Sept. 11: The inauguration of Dr. Valeria Montgomery Rice as Morehouse School of Medicine 6th President. ABNA members in attendance: Evelyn C. Miller, President, Atlanta BNA; Betsy Harris, past President Atlanta BNA and past NBNA board member and Vice President and Laurie Reid, NBNA board member and past President of Atlanta BNA.
- Sept. 17-19: National Women of Achievement, Inc. and the United Way conducted training on the Role of the Board of Directors. Dr. Darlene Ruffin-Alexander, past President of the National women of Achievement, Inc., was a presenter at the two day event.
- Dr. Darlene Ruffin-Alexander past first vice President of TLODAPC served as the keynote presenter at the Top Ladies of Distinction, Inc annual Royal Orchid Innovating Service Connections.
- Oct. 7: Bridging the Gap Event addressing the Faith community and End of Life presentations and discussions sponsored by Vitas Health Care. ABNA members in attendance: Evelyn C. Miller, Atlanta BNA President and Laurie Reid, NBNA Board member and past President of ABNA.
- Oct. 9: Tans disciplinary Collaborative Center for health disparities Research “Health Policy to Practice Forum” Ebola and the Social Determinants of Global Health. Held at the Louis Sullivan National Center for Primary Care at Morehouse School of Medicine. ABNA member in attendance: Evelyn C. Miller, Atlanta BNA President.
- Oct. 23: Atlanta Regional Health Guide Launch 2nd edition Press Briefing at City Hall. The health guide is for the uninsured and the underinsured. Evelyn C. Miller, President Atlanta BNA was a presenter. ABNA member in attendance: Laurie Reid, NBNA board member and past President Atlanta BNA.
- Oct. 28: Movement and Memory: A Prescription for your Brain’s Health workshop held at Emory Alzheimer’s Disease and Research Center. ABNA members in attendance: Betsy Harris, Mary Dawson; and Johnnie M. Lovelace.
- Nov. 5: Training on HV Counseling and Testing at the American Red Cross attended by ABNA member Evelyn C. Miller.
AWARDS AND HONOR

Nov. 11: Atlanta BNA member Lt. Irma Cameron Dryden was presented with High Honors as the oldest living Documented Original Tuskegee Airmen Nurse (1941-1949) at 94 years young. Lt Dryden was given the highest recognition by President Obama. Major General Stacey D. Harris, employed at Dobbins Air Force Base as a pilot and the first highest-ranking Black female officer in the Air Force, presented Lt. Dryden with a prestigious Gold Metal in Atlanta, Georgia. Lt. Dryden was escorted by Joni Lovelace, RN, CEO of Lovelace Multi-Care Health Services, who is our 2014-15 Nurse Entrepreneur Nurse of the Year and Veteran Officer of the Army Nurse Corps. She is also her professional nurse caregiver. This event was covered by our local Fox 5 News.

Oct. 23: Mayor Kasim Reed presented the 2nd Edition of the Atlanta Regional Health Guide: Resources for the Uninsured and Underinsured in Metro Atlanta, in Metro Atlanta at a special briefing for community health and social service providers held at City Hall. The Guide is a resource for residents of the Atlanta metropolitan region to connect them to affordable health care resources throughout the area. This publication was originally introduced in 2011, and was made possible through collaboration between the National Association of Hispanic Nurses (NAHN), National Black Nurses Association (NBNA), and Pfizer RxPathways, formerly Pfizer Helpful Answers.

“Recently, our residents have received greater access to more affordable healthcare options and plans made in part to changes to the nation’s health care services,” said Mayor Reed. “Yet, finding the right services for your health needs and budget can still be a challenge. This guide can help those in need identify affordable medical care, programs and services that are appropriate for their individual and family situation.”

The Atlanta Regional Health Guide: Resources for the Uninsured and Underinsured in Metro Atlanta is a comprehensive listing of health care resources, providing contact information and health tips in an easy-to-use and easy-to-read format in English and Spanish. The Guide will be available to the public via the Mayor’s Office, community health centers and other community-based service providers, NAHN, NBNA or by calling toll-free at 1-888-720-1337.
“We are happy to have been able to sponsor the publication of the second edition of the Atlanta Regional Health Guide and to continue our collaboration with the National Association of Hispanic Nurses, the National Black Nurses Association and Mayor Reed’s office to help the uninsured and underinsured residents in the Atlanta metropolitan area,” said Gary Pelletier, senior director of corporate responsibility - Pfizer RxPathways. “Access to medicines is a cornerstone of Pfizer’s commitment to health care. Through Pfizer RxPathways, we provide assistance that helps eligible patients in need get access to their Pfizer medicines and we welcome opportunities to inform and educate the public about the program.”

Pfizer RxPathways also recently collaborated with the Hispanic Health Coalition of Georgia to offer training to community health workers about the program. Approximately 25 “promoters” who offer bilingual health education and assistance to Hispanics in their communities were trained on how the program works to provide access to Pfizer medicines for patients in need.

Pfizer has helped millions of uninsured and underinsured patients gain access to the medications they need. In the last five years (2009-2013), Pfizer has helped nearly 3.1 million uninsured and underinsured patients get access to more than 37 million Pfizer prescriptions, equaling more than $7.3 billion. More than 32,400 of those patients were from Georgia, where 312,065 Pfizer prescriptions valued at more than $76.9 million at wholesale cost. Information about the Pfizer RxPathways program as well as other similar valuable resources is an example of the support services that are contained in the guide.
Delegate Shirley Nathan-Pulliam (Maryland), Beverly Morgan, Rep Donna Christiansen (Delegate from Virgin Islands); Dr. Deidre Walton, Dr. Claudia Kregg-Byers; and Linda Houghton in attendance at the Congressional Black Caucus Foundation Health Brain Trust.
Stuffing the personal care bags for clients at the city shelter.

SON Faculty, Dr. Nancy Tkacs, Associate Professor of Nursing and Committee Chair Yvonne Martin of Black Nurses Association of Miami.

Dr. Antonia M. Villarruel, Professor and Margaret Bond Simon Dean of Nursing, Dr. Loretta Sweet Jemmott, Associated Dean for Diversity and Inclusivity van Amerigen Professor in Psychiatric Mental Health Nursing Director, Center for Health Equity Research, Yvonne Martin, Youth Leadership Institute Chair, Debbie McGregor, member BNA, Miami, Dr. Sharon Iveying, Assistant Professor, Nurse Practitioner at the Children’s Hospital of Philadelphia.
Class has started...
Nursing history.

Professor Yates addressing the class

Dr. Lucy Yates of Southeastern Pennsylvania Area Black Nurses Association and students

School of Nursing Faculty presenting the lesson.
Learning about the human brain.

Job well done!

Ebony Martin daughter of Yvonne Martin, Black Nurses Association, Miami
School of Nursing Faculty, Male Simulator and students. “WOW this is great”!

Listening to the heart beat.
NBNA Thanks The University of Pennsylvania School of Nursing for an Amazing Day!

What a wonderful day!
2015 CONFERENCE SCHEDULE AT-A-GLANCE

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

TUESDAY, JULY 28
12:00 am - 4:00 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 and Networking Reception

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 session; 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)

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

12:00 pm - 4:00 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.

8:00 am - 6:00 pm
Adult Mental Health First Aid USA Pre-registration is required.
Just as CPR helps you assist an individual having a heart attack—even if you have no clinical training—Mental Health First Aid helps you assist someone experiencing a mental health related crisis. In the Mental Health First Aid course, you learn risk factors and warning signs for mental health and addiction concerns, strategies for how to help someone in both crisis and non-crisis situations, and where to turn for help.

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.

1:00 pm - 5:00 pm Caribbean Exploratory Research Center
1:00 pm - 5:00 pm Breast Cancer Screening Practicum
5:00 pm - 6:00 pm New/First Time Attendee Reception

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.

1:00 pm - 5:00 pm Exhibit Hall Grand Opening
Refreshments will be served
6:00 pm - 8:00 pm Opening Ceremony

FRIDAY, JULY 31

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
“Developing the Next Generation of Nurses”
At the completion of the program participants will be able to:
• Describe the role of the nurse in the health care system
• Identify two healthy lifestyle behaviors
• Identify two test-taking strategies that will increase the participants success in science and math
• Participate in a community service activity

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

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 _______________________________
   MUST PROVIDE
   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)
   NUMBER OF VEGETARIAN MEAL REQUIRED: _______
   ARE YOU UNDER AGE 40? ○ YES ○ NO
   ARE YOU A NURSE PRACTITIONER? ○ YES ○ NO

2. REGISTRATION FEES (PLEASE CIRCLE THE APPROPRIATE FEES)

   MEMBER EARLY BIRD THRU 3/31/15 PRE-CON 4/1-6/15/15 ON SITE AFTER 6/15/15
   RN/LPN/LVN $375 $450 $575
   Student (NON-Licensed) $230 $280 $405
   Retired $300 $375 $500
   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

   NON-MEMBER EARLY BIRD THRU 3/31/15 PRE-CON 4/1-6/15/15 ON SITE AFTER 6/15/15
   RN/LPN/LVN $550 $625 $775
   Student (NON-Licensed) $305 $355 $505
   Retired $375 $470 $550
   INCLUDES (1) Gala ticket (1) brunch & closing session ticket (1) general 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 will attend the Under Forty Forum
   ☐ I want to volunteer: ○ Registration ○ Moderator ○ Exhibit Hall (Friday)
   ☐ I am a LPN/LVN and will attend the LPN/LVN Workshop
   ☐ Workshop Monitor
4. GUEST REGISTRATION*

NON-NURSE ADULTS: ______________________________________________

__________________________________________________________

Address: __________________________________________________

__________________________________________________________

(IF DIFFERENT FROM REGISTRANT’S)

CHILDREN:

________________________________________(age) _____________

________________________________________(age) _____________

________________________________________(age) _____________

________________________________________(age) _____________

# 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

(Please allow 2 weeks for check processing)

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