



# NBNA NEWS

WINTER 2007

**IN THIS ISSUE:  
Health Policies That Impact Nursing**



THE NBNA NEWS IS THE OFFICIAL PUBLICATION OF THE NATIONAL BLACK NURSES ASSOCIATION

# NBNANEWS

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## NBNA

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The President Speaks .....	1
Members On The Move .....	2-5,7
Race & Ethnicity: In Search of Utopia.....	6
Affirmative Action: A Battle Loss in Michigan .....	7
Two years on an Institutional Review Board (IRB): Lessons Learned.....	8
Thank You Letter.....	9
Scholarship Recipient.....	9
Young Enough to Make a Difference.....	10
The Politics of Nursing .....	11
Public Policy and Healthcare Disparity.....	12
Obesity: Seeking a Public Health Solution .....	13
Controversy Surrounding the Doctorate of Nursing Practice.....	14
Ryan White HIV/AIDS Treatment Modernization Act.....	15
NIH Reform Act of 2006 .....	17
Announcing New Safety Issues .....	20-21
Prescription Drug Coverage .....	22
Chronic Illness Patients Not Getting Recommended Care .....	23
Seniors at Risk for Diabetes .....	24
\$5.2 Billion Over Fee-For-Service Costs in 2005 .....	26
Durable Medical Equipment, Prosthetics, Orthotics and Supplies.....	27
Solving Patient Safety Problems.....	28
The Nurse as a Patient .....	30
African American Women's Summit on Breast Cancer .....	32-33
NBNA Supports \$7.5 Billion for Public Health Programs .....	35
Nursing on the North Slope of Alaska .....	36
NBNA 2006 Conference Photos .....	36-41
Call for Nominations.....	42-43
National Black Nurses Day on Capitol Hill .....	44
2007 NBNA Conference Registration Form.....	45

**ON THE COVER:** Birthale Archie, Keynote Luncheon Speaker and President, Kalamazoo-Muskegon National Black Nurses Association; Dr. Bettye Davis Lewis and U.S. Representative John Conyers, Chairman, House Judiciary Committee

## THE PRESIDENT SPEAKS

**K**nowledge of the best nursing practices is vital at all levels of the nursing profession. Knowledge about nursing practice and its impact on health care is essential for nurses whether the nurses are practicing in clinical settings, education, research or administration. The different areas of nursing afford nurses to make a significant impact in the health policy process. The changing demographics of the Nation as reflected in the census will increase the health care needs of the diverse population of this country. What have been called minority groups will constitute a national majority. This change will provide nurses more opportunities to help influence health policy and share their knowledge with others.

Nursing knowledge and skills related to the profession can strengthen and broaden the health care delivery system. Nurses can be effective in their practice and advocacy in an array of alternative services, delivery systems, conceptualization of the disease process, preventive care and nursing interventions. Concepts of illness, health, wellness and research will definitely influence health policy.

Access to health care can be improved by educating the health care consumer and those stakeholders who influence changes in health care policy. Nurses in clinical practice must utilize their knowledge of best practices to develop and implement quality nursing care. We are all aware that nurses take pride in their call as patient advocates. This is clearly demonstrated by our members as we attended the National Black Nurses Day on Capitol Hill and visiting local, state and national legislators. All nursing curricula should include pertinent information to prepare nurses to meet the demands of a changing health care system. Nurse administrators need to foster policies and procedures that help ensure that health policies are effective. Nurse researchers must utilize their extensive knowledge to do pertinent research and help implement their findings to educate others and influence health policy. Now is the time that nurses are in a position to influence professional policies to practice in the nursing profession. I encourage nurses to serve on boards, committees, councils and other entities that influence health policy. Together, we can help make a difference in our present health care delivery system.

When we attend the NBNA National Conference which will be held in Atlanta, July 25-29, we will be more informed about nursing practice and health by experts in the field. I look forward to seeing each of you in Atlanta. You will have the opportunity to increase your knowledge, network and visit with your friends.

**Sincerely,**

**Bettye Davis-Lewis, EdD, RN, FAAN**

**President**

## MEMBERS

## ON THE MOVE

**Dr. Bettye Davis Lewis**, NBNA president, attended the African American National Health Forum, on February 19-20, 2007 in Atlanta, GA, hosted by the Pharmaceutical Research and Manufacturers of America.

**Dr. Patricia McManus** was the keynote speaker at the Concerned Black Nurses of Newark's Annual Conference on February 24, 2007. The theme of the event was "Black Nurses Accountability for Addressing Health Disparities in the Black Community."

**Reverend Deidre Woods Walton** has been appointed the Officer in Charge of the 7214th IMSU, Troop Medical Clinic in Port Hueneme. The new appointment will begin in September 2007.

**Dr. C. Alicia Georges**, NBNA past president and current Board member spoke at a symposium on November 3, 2006 entitled *Who Will Care for Me? Strategies and Initiatives to Address the Nursing Crisis in New York City and Beyond*. The event was co-sponsored by the Jonas Center for Nursing Excellence and The New York Academy of Medicine.

**Evelyn Collier-Dixon**, NBNA Board Member, represented NBNA at a media briefing hosted by the National Council on Aging (NCOA) on March 8, held in Chicago, IL. The theme of the briefing was *Connect the Dots: Diabetes and Your Heart — How Medicare Helps*. The media briefing was a part of the NCOA annual conference. Azella Collins, NBNA Parliamentarian attended the event.

**Martha Dawson, MSN, RN, FACHE**, NBNA Board Member, will be honored as a Fellow of the American College of Healthcare Executives on March 18 during its annual meeting in New Orleans. Fellowship status is obtained by successful completion of a Board of Governors Examinations, education obtainment, community involvement and continuous education requirement. Ms. Dawson was a Diplomat for three years prior to obtaining the Fellow status.

**Martha Dawson** was appointed to the Center for Health Equity. The Center for Health Equity was established to address the social and economic conditions that impact the civic wellbeing and health inequities of residents in Louisville, Kentucky. The Center serves as a catalyst for collaboration between public health, communities and organizations that work to eliminate the social and economic barriers to good health.

**Martha Dawson** was appointed to the Foundation for a Healthy Kentucky's Community Advisory Committee. The Foundation is responsible for administering a \$45 million dollar fund and is designed to address the unmet health care needs of Kentuckians by providing small grants. The grants may be used to influence health policy, improving access to care, reducing health risks and disparities, and promoting health equity.

**Martha Dawson** participated as a panelist in a Career Development Forum that was sponsored by the Kentucky Chapter of the National Association of Health Service Executives. The Forum was held at the Louisville Urban League on January 18, 2007.

**Martha Dawson** was appointed to the Consumer Advisory Board for Fidelity Financial Group.

**Martha Dawson** presented on the Nursing Shortage to students at the University of Spalding on February 5, 2007.

**Barbara Nichols, DHL, MS, RN, FAAN**, Chief Executive Officer, Commission of Graduates of Foreign Nursing Schools was the Visiting Professor for the M. Elizabeth Carnegie Research Conference on March 14, 2007, in the Armour J. Blackburn Center at Howard University. The event was hosted by the Division of Nursing, Howard University, where NBNA Board Member **Dr. Veronica Clarke-Tasker** is the Associate Professor of Nursing and **Dr. Mamie C. Montague** is the Interim Associate Dean and Associate Professor. NBNA President **Dr. Bettye Davis Lewis** and NBNA Executive Director **Millicent Gorham** attended the event. Over 300 nurses and nursing students attended the conference.



**Donna Rae Richardson, RN, JD** was honored by the high school that she attended, Washington High School of Massillon, Ohio as Distinguished Citizen of 2007. She is being recognized for her contributions and accomplishments in health and law. The activities will be held March 28-30, 2007 in Massillon, Ohio. She will be feted at a tea on the 28th; attend activities at the school on the 29th and it will culminate with a formal banquet on the 30th.

Detroit Black Nurses Association member **Cynthia Taueg** completed the requirement for a doctoral degree in Health Administration from Central Michigan University and participated in graduation ceremonies on December 16, 2006 in Mt. Pleasant, MI. She is currently employed in the St. John Hospital Health System.

**Aletha (Lee) Niles, RN**, passed away on December 28, 2006. She was a member of the New England Regional Black Nurses Association. She had worked at Massachusetts General Hospital for over 30 years.

**Flossie Isaacs, RN**, who was the oldest member of the New England Regional Black Nurses Association, passed away in December 2006.

**Pearl Boone, RN, BSN** presented two poster presentations, *Kaleidoscope Symposium (Overview) Family Centered Care*, March 2006 and *SIDS Risk Reduction*, October 2006 at Texas Children's Hospital in Houston, Texas.

**Juanita Snead, RN**, an NBNA Life Time Member of the Concerned Black Nurses of Newark, passed away January 12, 2007. She was a member of NBNA since 1974 and served as a Board member and Treasurer of the chapter.

**Ritha G. Bookert**, a family nurse practitioner and member of Truevine Baptist Church has opened the Langford Family Health, Inc., in Brandon, Mississippi, a health center on the Church campus, providing immunizations, school and sports physicals, well child visits, child and adolescent health care and Medicaid screenings.

**Dr. Beverly Malone**, CEO, National League for Nursing, has agreed to serve as keynote speaker for our 15th Annual Scholarship and Awards Luncheon, Southern Connecticut Black Nurses Association, Sunday, April 29, 2007.

**Tarma Johnson**, vice president, New England Regional Black Nurses Association, attended the Symposium for the American Medical Association's Committee to Eliminate Health Care Disparities on March 5-6 in Waltham, Massachusetts.

**Dr. Connie Webster**, chairperson, School of Nursing, The University of the District of Columbia was the recipient of the Award from the Black Nurses Association of the Greater Washington, DC Area. The award was presented on March 2 at the chapter's 26th Salute.

**Dr. Ruth Johnson**, Associate Professor, School of Nursing, Fayetteville State University in North Carolina, passed away in March 3, 2007.

**Margaret Jordan** was elected by the Federal Reserve Bank of Dallas' member banks to the Dallas Fed's board of directors. She will serve a three-year term ending Dec. 31, 2009. Jordan is president and chief executive officer of Dallas Medical Resource.

**Shirley Banks Moore** passed away on March 16. She was a member of the Central Carolina Black Nurses' Council, Inc.

The New York University College of Nursing named **Phyllis Jenkins, RN, MA**, a 1969 graduate of the College, to be the guest speaker and honoree at its 16th annual Estelle Osborne Recognition Ceremony. Jenkins is being honored for a lifetime of outstanding contributions to international health and to the support of African-Americans in nursing. The ceremony was held Thursday, February 15. Ms. Jenkins is a co-founder of the New York Black Nurses Association and the National Black Nurses Association.

Born in the Bronx during the Depression, Ms. Jenkins became a licensed practical nurse, in 1952, before finishing high school. She earned her masters degree at NYU in 1969 and began assisting foreign nurses in qualifying for licensure while working in the Montefiore Hospital Psychiatric Unit. During the 1970s, Jenkins served in the Peace Corps in Sierra Leone and Liberia and studied in Ghana. From 1980-86, she taught and consulted with the Swaziland Institute of Health Sciences and set up a postgraduate program. She also helped to establish the Swaziland Nurses Association as it broke from the segregated South African Nurses Association and worked toward acceptance of a nursing program in the University of Swaziland.

The **Estelle Osborne Award** was established to honor the extraordinary leadership of Professor Osborne (1901-1981), the first black faculty member at NYU, who taught from 1945 to 1954 in what is now the College of Nursing.

NBNA Executive Director **Millicent Gorham** was a panelist at a health forum held at the annual conference of the National Association for Equality Opportunity in Higher (NAFEO). NAFEO is the nation's largest association of historically and predominately Black colleges and universities.

The **San Diego Black Nurses Association** held its 31st Annual Luncheon on February 10, 2007. During the luncheon, San Diego BNA presented scholarships to nursing students.

The **Honolulu Black Nurses Association** celebrated its 11th anniversary banquet on February 17, 2007. The theme of the event was *Loving Your Body and Soul*.



The **Central Carolina Black Nurses' Council, Inc.** celebrated its 17th Annual Educational Lecture-Luncheon, with the theme of *Children —An Untapped Resource*, on December 2, 2006.

## FT. BEND COUNTY TEXAS BLACK NURSES ASSOCIATION

**Deborah Davis, RN, CPAN** was recently elected to the office of President-elect of Texas Association of Peri-anesthesia Nurses.

**Deborah Davis, RN, CPAN** participated in a medical mission to Colombia, South America from January 12 - 21, 2007 as a recovery room nurse for Operation San Jose from Houston, where forty-nine surgeries were performed on patients ages 6 months to 37 years of age over a one week period.

**Claudeth E. Jordan, RN** recently retired from the United States Army Reserves as a Lieutenant Colonel after 21 years of service.

## BIRMINGHAM BLACK NURSES ASSOCIATION, INC.

The Legends in White Gala was presented by the Birmingham Black Nurses Association, Inc. (BBNA) on Saturday, November 18, 2006 at the Birmingham Jefferson Civic Center. The legends honored are individuals who have continuously made contributions of great distinction in the profession of nursing. The following legend nurses were selected: **Cynthia Barginere**, former Assistant Vice President and Chief Nursing Officer of the University of Alabama-Birmingham (UAB) Hospital; **Dr. Charlie Dickson**, past President of the Alabama Board of Nursing, Consultant at Tuskegee University; and **Surpora Thomas**, Chief Nursing Officer of Children's Health Systems. Nurses were nominated by their hospitals as Heroes in Healthcare. The following "heroes" were selected: **Stephanie Armstead**, Medical Center East; **Vanessa McNeil**, Trinity Medical Center; **Sandra Rudolph**, UAB Hospital; and **Patricia Moore**, Cooper Green Mercy Hospital. Our 2006 Scholarship Recipient is **Valencia Vann**, a student at Jefferson State Community College and BBNA member.

## ATLANTA BLACK NURSES ASSOCIATION, INC

The Atlanta Black Nurses Association Inc. held its annual holiday membership roundup social on November 25, 2006. The theme for the occasion was *Open Hands/Open Hearts*. Scholarships were awarded to the following students: **Marie Etongo**, Georgia State University; **Paula Cunningham**, Mercer University; and **Ryan Pack**, Kennesaw State University.

Membership/Bylaws Chair **Laurie Reid** received the Director's Recognition Award twice in 2006 for dedicated service and outstanding contributions to the mission and goals of the Centers for Disease Control and Prevention (CDC), coordinating for Infectious Diseases, National Center for HIV/AIDS, Viral Hepatitis, STD, and Tuberculosis Prevention.

Corresponding Secretary, **Luberta (Skip) McDonald** conducted a workshop on Mentoring and "Wellness from the Inside Out" at the Georgia Association of Nursing Convention (GANS) in October 2006.

**Skip** also attended the InterVarsity Christian Fellowship 21st Urbana Missions Conference with 22,000 in attendance. She had the opportunity to minister to and care for nursing students seeking God's will for their lives.

**Skip** recently published *Christian Survival Guide to Nursing School*. Look for a new release in 2007— *Christ, My Life—The Great Exchange*.

**Jackie Henson**, Board Member, attended a presentation on *Optimizing Lipid Management* in Patients with Multiple Risk Factors on December 14, 2006. The program was presented by the Association of Black Cardiologists in conjunction with the Atlanta Medical Association.

## SAN DIEGO BLACK NURSES ASSOCIATION

On November 15, 2006, **Syvera Hardy, RN**, president of San Diego Black Nurses Association, Inc. was invited by the television station KSWB-TV Take 5 to speak on the "Nursing Shortage" as it affects SDBNA.

**Syvera Hardy, RN** and **Carole Norman, RN, NP** received an award, Outstanding Community Partner Recognition on December 13, 2006 from The Community Health Improvement Partners (CHIP) acknowledging their exceptional contribution and commitment to CHIP.

## BLACK NURSES ASSOCIATION, MIAMI INC.

**Jacquelyn Davis**, immediate past president, was awarded the Woman of Impact by the Women's History Coalition of Miami - Dade County, Inc. The Women's History Coalition was founded in 1983 and incorporated in 1986 by a group of women in Miami - Dade County, Florida. Their primary purpose is to sponsor special programs and events, as well as coordinate and promote those of other community groups during Women's History Month, which is nationally celebrated each March. Other projects relating to women's history are highlighted throughout the year.

This year's award ceremony *Generations of Women Moving History Forward*, took place on Thursday, March 1, 2007 at the University of Miami in Coral Gables, Florida.



**Jacquelyn M. Davis** is a pioneer and leader who served as a registered nurse for over 37 years. In that role says her nominator, **Dr. Geraline Gilyard**, "She has consistently demonstrated her commitment and dedicated leadership to this community". This devoted health care worker was a charter member and the first president of the Miami Chapter of the National Black Nurses Association in 1971, and now, 34 years later, (2006) she was once again at the helm of this vital and dynamic organization. Her role in supporting women who have been helped by the Jefferson Reaves Women's Residential Substance Abuse Center is well known. Not known for "sitting by the sidelines", Ms. Davis coordinates and personally supervises the Life Skills workshops, which help the women assume roles as responsible citizens and parents.

## NEW YORK BLACK NURSES ASSOCIATION

**Tanya Hardy Menard** was emcee and chapter honoree at the New York City National Black Nurses Day Celebration on February 23, 2007. The event was hosted by the Harlem Hospital Center. **Dr. C. Alicia Georges**, panelist, expounded on *Nurses: Power, Politics, Progress*. **Alfretta Wilkey**, Queens County BNA was the recipient of the Magee E. Jacobs Award.

**Bernice Simmons** placed second for her age group in the Reggae Half marathon, December 2, 2006, in Jamaica, WI.

**Juanita Lloyd-Stanton** is chair of the New York County's Registered Nurses Association District 13 Retiree Special Interest Group, New York State Nurses Association.

**Ione Carey** was the Service to Humanity Awardee from the Kappa Eta Chapter, Chi Eta Phi Sorority on February 18, 2007. Her creation and implementation of the home health aide project for the New York Visiting Nurse Association was a prototype for the 1966 Medicare Legislation.

**Mirian Moses** was a volunteer for the New York City's Homeless Outreach Population Estimate on January 29, 2007. This program counts the homeless on the streets of New York City and directs them to shelters.

**Bernice Headley**, Mirian Moses and Etta White held *Wear Red for Women Programs* in their respective churches in January and February 2007. These programs were partnered with the American Heart Association to raise women's awareness for their risk for heart disease.

**Jacqueline Baker-Kemp**, co-director of Voices of Haggar HIV/AIDS ministry at St. Mark's AME Church, held a screening, counseling and worship service on March 8, 2007.

## BLACK NURSES ASSOCIATION OF BALTIMORE

Black Nurses Association of Baltimore, Gamma Chapter Chi Eta Phi Sorority, Inc. and Provident Hospital Helene Fuld School of Nursing Alumni Association, three organizations comprised of African American nurses have joined together to celebrate the legacy of Blacks in nursing in Maryland. As Black History Month commemorates achievements of all African Americans during the month of February, these organizations chose the occasion to celebrate Maryland's African American nurse's achievements in the various aspects of the health care profession. The program was held on February 24, 2007 at the Baltimore City Community College, in Baltimore, Maryland.

*The Growth and Metamorphosis of Black Nurses in Maryland from Harriet R. Tubman into the New Millennium: Continuing the Legacy* is the continuing celebration theme. **Esther McCready, BSN**, the first African American nurse to graduate from the University of Maryland School of Nursing spoke on *Preserving and Perpetuating the Legacy of Maryland's Black Nurses: A Nurse Docent's Perspective*. **Lilyan Slater, RN**, a graduate of Provident Hospital School of Nursing shared her wisdom of *Documenting the Legacy of Black Nurses from Articles and Artifacts*. Both nurses have first-hand knowledge of the pursuit and attainment of nursing education for African American nurses in Baltimore along with their individual insights and perspective.

Four nurses were honored for their outstanding achievements: in Community Health Nursing, **Doris Brightful**; Adult Health Nursing, **Clara Gordon Parker**; Maternal /Child Health, **Flora Donal Nickens Gundy**; and Mental Health Nursing, **Lillian Barnes**. Additionally, the Pathfinder Award was presented to **Jackie Bailey, RN, BSN**, a nurse who has been the first to pave the way in his/her field of endeavor. Jackie owns a home health care agency.

**Ronnie Ursin** is the President of Black Nurses Association of Baltimore and a NBNA Board Member.



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# NATIONAL BLACK NURSES ASSOCIATION 35TH ANNUAL INSTITUTE & CONFERENCE

**D**r. Bettye Davis Lewis, President and the Board of Directors of the National Black Nurses Association welcome you to the 35th Annual Institute and Conference. The Conference will be held July 25-29, 2007, at the Hyatt Regency Atlanta. We are expecting 1000 nurses and student nurses to attend the Conference.

The NBNA will conference will showcase prominent guest speakers in plenary session focusing on the most pressing and timely topics of interest relating "Nursing Practice: Influencing the Continuum of Health Policy".

The Conference will also be the venue for NBNA meetings, workshops and thought plenary sessions on public policy issues.

Attendees will be able to focus on specific areas of interest by choosing from seven concurrent Institutes; seven concurrent workshops; two pre-conference sessions on HIV/AIDS and End of Life Care; two plenary sessions; four CEU breakfast sessions; network with colleagues and see the latest products and services available in the exhibit hall. Participants may complete an intensive learning experience in one of the seven concurrent Institutes. The four hour Institutes include, cancer, cardiovascular health, children's health, diabetes, end of life care, research and women's health.

## *Speakers Preview*

Topping the list of invited speakers are Dr. Beverly Malone, President and CEO, National League for Nursing as the keynote speaker. Dr. Malone has returned to the U.S. after seven years as the Secretary General of the Royal College of Nursing. Dr. Loretta Sweet Jemmott, Associate Professor, University of Pennsylvania School of Nursing, will be the Closing Session Speaker. Dr. Jemmott's on-going research is on preventing HIV/AIDS in children and adolescents. Dr. Linda Burnes Bolton, President, American Academy of Nursing and NBNA Past President and Dr. Janet Corrigan, CEO, National Quality Forum have been invited to headline Plenary Session I on patient safety and quality care.

Plenary Session II on Saturday, July 28, 2007 will feature presentations on Models of Health Care. Patricia Kappas-Larson, RN, MSN, Senior Vice President, Ovations will be one of the guest panelists. Ovations is a division of UnitedHealth Group.

## *The Presidents' Leadership Institute*

The NBNA Leadership, consisting of the NBNA Board of Directors, the NBNA past presidents and the 77 chapter presidents and vice presidents will spend a day discussing NBNA chapter operations, specifically on membership, fundraising, budgeting and public relations. Chapter presidents will highlight best practices of chapter management and programmatic development.

## *NBNA Exhibit Hall*

One hundred and sixty exhibitors will showcase their products and services from a myriad of industries, including schools of nursing, pharmaceutical companies, equipment manufacturers, uniform companies, publishing companies and governmental agencies. Bring your business cards, resumes for on-site employment interviews, and offers for appointments to advisory committees and speaking engagements.

## *Book Signing - Soul of Leadership Book*

Dr. Hattie Bessent, the author of the *Soul of Leadership*, will be selling the books for \$35 at the NBNA Conference. On Saturday, July 28 before the Gala, the expert nurses featured in the book will be signing your personal copy. Plan to pick up copies for your colleagues and as gifts.



### Silent Auction

NBNA will host its third annual Silent Auction. Are you looking for an unusual or one of a kind gift for a friend, loved one or for yourself. The Silent Auction is the place to buy that personal, unique and special gift. Consider donating a gift for the Silent Auction.

### Institute of Excellence

In 2006, NBNA launched the Institute of Excellence...an excellent venue to honor scholars for their relentless pursuit of excellence in community-based service, education, practice, public policy, and research. The IOE will encourage new and novel leadership in these five domains while acknowledging and savoring the phenomenal contributions of African American nurses. More importantly, the IOE will collaborate with nursing and health related organizations to provide support for and collaborate with the IOE in all of its endeavors. The NBNA Institute of Excellence will be held on Friday, July 27, 2007.

### Health Fair

NBNA will hold its community health fair at the Wheat Street Baptist Church, co-hosted by the Atlanta Black Nurses Association. The health fair will feature health screenings and educational outreach sessions on hypertension, diabetes, chronic kidney disease, cancer, AIDS testing and dental health. The health fair will be held on Tuesday, July 24, 2007.

NBNA members are asked to help with the community based health fair that is being hosted by the National Dental Association on Friday, July 27.

### Men's Health Forum

The second NBNA Men's Health Forum will be held on Saturday, July 28. Male health providers will be discussing with Atlanta area men health issues such as hypertension, diabetes, prostate cancer, mental health and sexual health. The event is co-hosted by the National Black Nurses Foundation; Dr. C. Alicia Georges is the chair.



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## ***Special Events***

The Black Congress on Health, Law and Economics will host a lecture on Saturday, July 28, 2007 with invited Congressional members, U.S. Representative James Clyburn, House Majority Whip and U.S. Representative Bennie Thompson, Chairman, House Committee on Homeland Security. NBNA Past President Ophelia Long is the chair of BCHLE.

## ***The President's Gala***

NBNA will honor its nurses with the Life Time Achievement Award, the Trailblazer Award, 9 NBNA Nursing Awards and Special Awards. The gala will take place on Saturday, July 28. NBNA Nursing Awards application is due April 15th.

## ***NBNA Business***

NBNA will conduct business during the Annual Conference and elect new Board members and Nominating Committee members. Applications are due by April 15th.

## ***Scholarships***

NBNA will award scholarships to deserving students at all levels, from LPN to doctoral. Scholarship applications are due by April 15. Go to the NBNA website at [www.nbna.org](http://www.nbna.org), click on join, click scholarship program and scholarship application.

## ***Special Events***

The National Dental Association will host its conference July 27 - August 1, 2007.

The National Bar Association will host its conference July 28 - August 4, 2007.

## ***Historic Atlanta and You!***

Atlanta Black Nurses Association Welcomes You to the 2007 NBNA Conference

We welcome you one and all to the 35th Annual National Black Nurses Association Conference in Atlanta, July 25-29, 2007 at the Hyatt Regency Atlanta Hotel. If you have never been to "Hotlanta" you are in for a real treat. Atlanta is a tourist's heaven.

Listed below are some of Atlanta's landmark and historic sites of interest:

- Martin Luther King, Jr. birth home
- Martin Luther King Center for Non-Violent Social Change
- Martin Luther King, Jr. National Historic Site and Sweet Auburn District
- World of Coca Cola
- Zoo Atlanta
- Underground Atlanta
- Georgia Aquarium (Largest in the world)
- Apex Museum
- Six Flags over Georgia
- Ebenezer Baptist Church Heritage Sanctuary
- Atlanta University Center "A mind is a terrible thing to waste"-UNCF
  1. Morehouse
  2. Spelman
  3. Clark Atlanta
  4. Morris Brown
- Sweet Auburn Curb Market
- Centennial Olympic Park
- Jimmy Carter Presidential Library and Museum
- High Museum of Art - The Louvre in Atlanta

These are all just to name a few. As you can see, if you are looking for fun things to do and see, they are here. Atlanta is also home to a host of cultural events throughout the year.

Upon your arrival you will be given information on many of these sights and events, feel free to see and do as much as you can while you are here!

Please let your host chapter know what if anything we can do for you.

Again, we welcome you to "Hotlanta"; see you in July!!!

***SEE REGISTRATION FORM ON PAGE 39.***



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# REDUCING AND ELIMINATING HEALTH DISPARITIES: NURSING INFLUENCING HEALTH POLICY

| *Gloria Ramsey, JD, RN and Jateya Jones*

**T**he diversity among the United States population is one of its greatest assets. The richness of this quality is often overshadowed by the disproportionate burden of disease and illness that is borne by racial and ethnic minority populations and the rural and urban poor. Compelling evidence of the disparate health status of America's racial and ethnic minority populations and the economically disadvantaged are documented in the form of shorter life expectancies, higher rates of cancer, birth defects, infant mortality, asthma, diabetes, cardiovascular disease, and stroke (IOM, 2002). Other areas in which racial and ethnic minorities and the medically underserved suffer a disproportionate burden of morbidity and mortality include: HIV Infection/AIDS, autoimmune diseases such as lupus and scleroderma, oral health, sexually transmitted diseases, mental health disorders, drug use associated mortality, and viral borne diseases such as hepatitis C.

As we continue to document the disproportionate burden of disease and illness among certain segments of our population, these differences, better known as health disparities or health care disparities, require significant attention on the part of healthcare professionals, policy makers, and the public-at-large. In 2002, in the Institute of Medicine report entitled, "Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare," *disparities in health* were defined as differences between two or more population groups in health outcomes and in the prevalence, incidence, or burden of disease, disability, injury, or death. On the other hand, *disparities in health care* were defined as differences between two or more population groups in health care access, coverage, and quality of care, including differences in preventive, diagnostic, and treatment services.

Health care professionals, and nurses in particular, see healthcare disparities across the life span. Nursing has a long-standing commitment to improving public health and believes that it is well positioned to advocate on behalf of and in concert with individuals, families and communities who are in need of quality care (ANA, 2005).

## ***USU Center for Health Disparities Research and Education — Community Outreach and Information Dissemination Core (COIDC)***

The root causes of health disparities and health care disparities are a multifaceted concern. They are the result of, including but not limited to, doctor-patient communication barriers; lack of trust; limited cultural competence of providers; lack of minority health professionals; patients' healthcare beliefs and behavior; stereotypical thinking and biased decision-making by providers; low literacy and limited English proficiency; and lack of access to high-quality hospitals and other facilities (IOM, 2002). Therefore, efforts to address racial and ethnic disparities in health will require nurses, physicians and other health care providers to work together to develop new approaches, in consultation with key members in minority communities, to ensure that research, treatment, and education programs are developed that meet the specific needs of the community.

To that end, the Uniformed Services University Center for Health Disparities Research and Education, an NIH funded Project EXPORT Center, established in response to the 2010 mandate, aims to reduce health disparities among racial and ethnic minorities through research, education, training, community outreach and information dissemination. In particular, the Community Outreach and Information Dissemination Core (COIDC) has been actively involved with community partners in research, training opportunities, and educational offerings to maximize the understanding and reduction of health disparities among African Americans, Hispanics and active military personnel and their beneficiaries. This broad objective is achieved through multiple activities and in response to the health concerns and needs of community partners and community-based organizations with whom COIDC collaborates. One specific aim of COIDC is to inform legislative and policy officials about the importance of, and methods to reduce health care disparities in minority populations; and equip key members of the legislature and their staffers for potential participation in bills related to health disparities. Accordingly, COIDC provided the Maryland State House of Delegates, Health & Government Operations Committee, Minority Health Disparities Subcommittee written educational materials; participated in weekly Minority Health Disparities



Subcommittee Roundtables during Winter Session 2006; testified in support of cultural competency legislation; and provided technical support as requested.

### **Cultural Competence: Healthcare Professionals Education**

The term 'cultural competence' did not begin to appear consistently in the medical literature until the early 1990's (Beach, 2006). After the release of the IOM Report *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare*, there was increased interest in culturally competent care and its impact on reducing and eliminating health disparities. Accordingly, when we consider the question of cultural competence, we must also consider cultural and linguistic barriers between patients and providers and how these barriers are detrimental to effective patient care and delivery of health services (Beach, 2006). The need to train culturally competent providers, and to design culturally competent health care systems, can best be addressed by health professionals educated and trained in a culturally dynamic environment (Beach, 2006). The absence of sound patient-provider relationships are believed to be a major factor in disparities in the quality of care received by ethnic and racial minorities (Hussein, 2006). Good patient-provider communications are associated with better patient satisfaction, better adherence to treatment recommendations and improved health outcomes (Hussein, 2006).

Culturally competent care must be provided to all of our nation's citizens. This issue is so important that the provision of culturally competent care is not merely a moral imperative; rather, it is also a regulatory requirement. In 2006, the Joint Commission on Accreditation of Health Care Organizations (JCAHO) stated that it views "the issue of the provision of culturally and linguistically appropriate health care services as an important quality and safety issue....". Moreover, given that the issue has received increased attention, professional organizations either endorse or require the development of a model cross-cultural curriculum to heighten provider sensitivity when caring for diverse patient populations. For example, the Liaison Committee on Medical Education (LCME), the Association of American Medical Colleges (AAMC), the Accreditation Council for Graduate Medical Education (ACMGE) and the Federation of State Medical Boards (FSMB) have all addressed the issue (Hussein, 2006).

Lastly, states recognize the importance of cultural competency in medical care. Three states, New Jersey, California and Washington, have lead the country by passing legislation that requires training in conjunction with licensure or licensure renewal. There is pending legislation in Arizona, Illinois, Ohio and New York. However, the states of Georgia and Maryland introduced such bills, 2005-2006 legislative sessions, but neither bill was passed (Hussein, 2006).

### **A Case Study: The State of Maryland Plan to Eliminate Health Disparities**

In 2006, The Maryland Department of Health and Mental Hygiene in its Plan to Eliminate Minority Health Disparities identified challenges and solutions to eliminating disparities in the state. Challenges identified included: limited access to quality healthcare; inconsistent source of quality healthcare; insufficient minority representation in the workforce; *insufficient cultural competency in the health workforce and the health institutions*, and incomplete and inconsistent data on health disparities.

Given the growing ethnic diversity in the U.S., and in the State of Maryland, which according to the *Maryland Vital Statistics* of 2005, ethnic and racial minorities make up more than 40 percent of the population (Black-29.9 percent; Hispanic-5.7 percent; Asian American Pacific Islander-5.1 percent; and American Indian-0.4 percent) (Hussein, 2007) the understanding of cultural variation and perspective of disease, treatment modalities and wellness is essential in providing effective care to an increasingly diverse population.

Moreover, with increasing numbers of foreign-born persons residing in Maryland, in 2005 the state's foreign-born population was 12 percent (Hussein, 2007) the burden of health disparities in the population will only escalate if healthcare providers are not equipped with cultural competency skills to effectively communicate and understand the values minorities use when engaged in medical decision-making.

Maryland has made great efforts to increase cultural competence. Efforts include awarding grants for cultural competence, planning a statewide conference on cultural competence, and designating staff members with responsibility for cultural competence. In addition, the state legislature introduced and passed several legislative initiatives to address cultural competency among its healthcare professionals. House Bill 883, which was enacted into law in 2003 states in Section-1, Subtitled-8: "encourage courses or seminars that identify and eliminate healthcare service disparities of minority populations."

Furthermore, House Bill 1455 passed in the 2006 legislative session requires the DHMH Family Health Administration, in consultation with the Office of Minority Health and Health Disparities, to "implement a pilot program that addresses: (1) cultural competency training of healthcare providers, with an emphasis on community-based providers: and (2) health outcomes...by tracking indicators related to the specific healthcare needs of the population in a specific area." Also, legislators introduced a bill (HB 1295: Cultural Competency Workgroup) in the 2006 legislative session requiring the department organize a workgroup of representatives from each of the health



occupations boards and the Office of Minority Health and Health Disparities to “develop specified recommendations for requiring cultural competency instruction as part of an individual’s licensure or license renewal process.” The bill did not pass; however, legislators continue support and requested that the department form a workgroup to address the issues raised in the legislation.

### ***Nursing Practice: Influencing the Continuum of Health Policy***

Many of the disparities seen nationally in health status, healthcare access, and healthcare quality, are also seen in Maryland. Nurses, physicians, and other health care providers are uniquely poised to advocate for racial and ethnic minorities and provision of culturally competent care.

The American Nurses Association believes that health care is a basic human right and access to health care must be acceptable. Acceptable health care services are culturally appropriate, respectful of patients, and their families, and inclusive of patient involvement in treatment decisions (ANA, 2005). Here are a few practical tips for getting involved.

- 1)** Encourage and promote cultural diversity and linguistic education and training for nurses at the national and state levels of professional organizations and associations
- 2)** Include nurses from culturally diverse backgrounds on boards, congresses, committees, task forces, and other policy-making bodies at the national, state and local level
- 3)** Encourage and promote programs in continuing education at the state and national level requiring health care professionals to receive instruction on cultural competency as part of the licensure or license renewal process
- 4)** Encourage and promote education programs aimed at developing and improving cultural competence of health professionals
- 5)** Encourage and promote programs in continuing education at the national level to assist registered nurses in their efforts to work collegially with co-workers of diverse populations to provide safe, sensitive, effective nursing care for culturally diverse individuals
- 6)** Support passage and enactment of public policy at the national and state levels which strives to provide culturally competent care for all of our nation’s citizens
- 7)** Support passage and enforcement of laws and regulations that provide sanctions against racial and ethnic discrimination

Nurses are in a position to influence public policies and professional practice to address racial and ethnic health disparities. Knowledge about cultures and their influence on health care is essential for nurses, whether they are

clinicians, educators, researchers or administrators. The time is now for all health professionals to exercise their duty to influence policy so that culturally competent care becomes universal. A necessary imperative if we are to reduce and eliminate health care disparities by 2010!

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# RETAIL HEALTH CLINICS: AN OPPORTUNITY FOR THE ADVANCED PRACTICE NURSE? | *Dr. Debra Toney*

**D**aylight savings time, fast food, drive in movies, drive in marriages, ATMs, drive in pharmacy, drive in restaurant, driving in the fast lane, life in the fast lane and now health care in the fast lane. Americans are bypassing the doctor's office and going straight to the mall or pharmacy when they come down with minor ailments. Target, CVS, Kroger and WalMart are among the retailers testing the health center concept at grocery stores and pharmacies. Supporters believe retail clinics will decrease unnecessary visits to the emergency room. And, that the uninsured will be able to receive needed health care at a more affordable price. It is expected that there will be several thousand clinics by the end of 2007.

A 2005 Harris online poll reported that 78% of the public thinks the clinics can provide fast convenient basic care. However, 75% were concerned about the quality and only 7% of those surveyed had been to a clinic out of 2,245 respondents. But among those who had attended the clinics, the response was positive. These numbers will not stop retailers from their strategy to make good on their promise to lower the cost of health care by doing away with costly overhead expenses.

According to those in the medical field, the number of doctors going into family practice is declining, creating a shortage of primary care physicians across the country. Patients are frustrated with the long wait times, increasing co-pays and limited service hours for common illnesses. Physicians are frustrated with lowering reimbursement rates and increasing patient volume just to make ends meet. This is resulting in a critical need to improve access to health care services in this country.

To meet the needs of society, health clinics staffed by nurse practitioners have opened in retail shops. According to the Nurse Practitioner Healthcare Foundation this is an acceptable alternative for receiving health care services. This is not a new trend and has been developing over the last decade employing nurse practitioners to serve as primary care providers. The first retail health clinic was in Minneapolis founded by a business man tired of the wait time for a simple illness.

Nurse practitioners are well trained and can handle the day-to-day doctor's visits for many patients, treating the flu, giving annual checkups, and dealing with childhood health concerns. For people who are young or generally healthy, it is felt that nurse practitioners are fine, but people with chronic illnesses or the elderly might want to consider going to a doctor according to the manager of a retail health clinic in Las Vegas who is a nurse practitioner. Retail clinics are not intended to replace ongoing physician care but to complement the work of the family physician.

One of the goals of Healthy People 2010 is to reduce the proportion of families experiencing delays in obtaining health care. The nurse practitioner is trained to provide high quality healthcare with a focus on prevention and education, which improves a patient's ability to become more self-reliant. Services provided by the advanced practice nurse in retail settings bring affordable and accessible care to patients in a familiar, community-based environment; answering needs unmet by the current U.S. health care system. Costs for these services are often offered at a set price and are usually lower than a typical office visit. Most visits take about 15 minutes, don't require an appointment, have extended hours, are open weekends and the prices are clearly posted ranging from \$40 to \$70. Convenience is behind the idea of the retail clinic and services are delivered on a first come, first serve basis.

According to Denise O. McGwinn, a Las Vegas pediatric nurse practitioner, the advanced practice nurse can greatly contribute to minority, underserved, uninsured, and populations unable to access health care in the traditional arenas. Health promotion, education, and health maintenance are vital links toward client, family, and community empowerment. "Society must recognize our knowledge, economic value, and importance to communities across our country and the world."





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Paul Brown, of the U.S. Public Interest Research Group, said pressure to keep costs low is also fueling the switch to nurse practitioners but he doesn't see that as a problem. "For basic things, nurse practitioners are fine for that," Brown said. "I think no matter what we think of this practice, this is the way things are going to be going."

As it grows, retail clinics are creating many opportunities for caring, advanced practice health care professionals. As these clinics become more widespread, research opportunities are available to determine the effectiveness of these services and its quality.

Regulation of retail clinics vary from state to state and in many states are licensed as physician practices, and are regulated by the state's medical board.

Attend the National Black Nurses Association's conference July 25-29 in Atlanta, Georgia to learn more about retail health clinics at the Advanced Practice Nurse workshop.

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ABC News' Barbara Pinto filed this report for "World News Tonight."

Health Care for People Too Busy for Doctor Visits, Minute Clinics Offer Convenient Medical Care for People on the Run, [www.abcnews.go.com](http://www.abcnews.go.com)

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# UNDERSTANDING TYPE 2 DIABETES: KNOWLEDGE IS THE KEY TO GLUCOSE CONTROL | Sharon H. Murff, RN, MSN, CCRN

The past several years have demonstrated a significant increase in the prevalence of Type 2 diabetes (Carulli et al., 2005). Therefore, it is paramount that healthcare professionals are knowledgeable about the disease to facilitate better glucose control in diabetic clients. The desired outcome of glucose control is prevention of complications associated with diabetes.

According to the American Diabetes Association (2007), greater than 20 million Americans have diabetes. Approximately 14.6 million persons have a definite diagnosis of diabetes, but more alarming is the fact that approximately 6.2 million of those with diabetes have not been diagnosed with the disease (American Diabetes Association, 2007).

Diabetes is a disorder in which there is no insulin production (Type 1), a lack of insulin (Type 2) or improper utilization of insulin to support the conversion of food to an energy source for the body. The exact etiology of diabetes remains unclear; however, according to Mokdad et al. (2000), obesity and physical inactivity appear to play a pivotal role in the prevalence of this disease. In addition, as the population ages the risk for diabetes increases.

Another explanation for the cause of Type 2 diabetes is that insulin resistance is responsible for the dramatic increase in blood glucose levels. In other words, for some unknown reason the cells are insensitive to insulin. As a result, glucose accumulates in the bloodstream because it is unable to enter the cell.

In addition to the build up of glucose in the bloodstream, the pancreas is burdened as it attempts to produce more insulin to handle the high glucose load. The end result of this process is an increase in both circulating glucose and insulin levels (Capriotti, 2005).

Insulin resistance is also associated with obesity. According to Peters (2000), there is a direct correlation between an increase in adipose tissue and cellular insensitivity to insulin. Therefore, it can be stated that weight reduction improves glycemic control.

Nurses should have adequate knowledge about the risk factors, pathogenesis and complications of diabetes since this disease has reached epidemic proportions (Capriotti, 2005). In order to empower persons with Type 2 diabetes to achieve better management of the disease, it is incumbent upon healthcare professionals to first have a thorough understanding of Type 2 diabetes. Once those responsible for diabetes education have been equipped with knowledge about the disease, optimal client outcomes can be actualized.

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# DIABETES: THE IMPLICATIONS OF HEALTH MAINTENANCE FOR AFRICAN-AMERICAN WOMEN

*Kathleen R. Parisien, RN, MA*

The number of women afflicted with Type 2 diabetes is increasing in the United States. In general, the prevalence of diagnosed diabetes is higher for Blacks and Hispanics than for Whites across all age groups (Centers for Disease Control (CDC), 2004). In African-American women the prevalence of diabetes is approximately 85 percent higher than Caucasian women (Centers for Disease Control, 2002). As a result, this chronic disease may lead to complications including carotid artery disease which leads to stroke. Consider the statistics: Diabetes is one of the leading causes of death and disability in the United States. Total health care and related costs for the treatment of diabetes run about \$132 billion annually. 3.2 million African-Americans ages 20 years and older have diabetes, one-third of whom are undiagnosed. Additionally, on average, African Americans are 1.8 times more likely to have diabetes as non-Hispanic Whites of similar age (National Institute of Health, 2005). Also, non-Hispanic Black women aged 45-64 have more than twice the rate of undiagnosed diabetes as non-Hispanic White women the same age (Beckles and Thompson-Reid, 2001). Moreover, heart disease is the leading cause of death for Black women in the U.S. (Eberhart, et al., 2001). In light of these statistics, African-American women must scrutinize the factors contributing to uncontrolled diabetes and carotid artery disease.

Many women lack access to disease prevention information and resources that could improve their health status. Diabetes afflicts a large percentage of African-American women because of their socioeconomic status, poor nutrition and lack of physical activity. Sedentary lifestyles also promote obesity, hyperlipidemia, and hypertension (NIH, 2002). Black women have a poor understanding of the importance of cardiovascular disease as a major health threat. In order to address stroke prevention, one must first address the traditional risk factors of hypertension and diabetes. There are non-traditional risk factors such as stress which contributes to elevated blood pressure (DeSalvo, et al. 2005). Many diabetics are prone to high blood pressure which is defined as a systolic blood pressure of  $\geq 140$  mmHg or diastolic  $\geq 90$  mmHg (AHA, 2007).

Diabetes dramatically increases a person's risk for heart disease and stroke and often is associated with other cardiovascular risk factors, such as high blood pressure, cholesterol disorders and obesity. Health care professionals must provide education to their patients on measures to control hypertension and diabetes. Although there is no cure for high blood pressure, patients must be aware that it can be controlled. If one has diabetes and high blood pressure, one must work with their provider to get blood pressure below 130/80. Weight control, regular physical activity and diet help lower blood pressure and manage cholesterol and glycemia (AHA, 2007).

Increasing health care costs have had an impact on diabetic care. The CDC (2002) suggests that "costs related to diabetes are estimated to be almost \$100 billion annually, including direct medical care expenses and indirect costs attributable to disability and premature death". Due to these increased costs, it is imperative that diabetic patients be equipped with tools to help manage their disease. Health care providers must educate diabetics to monitor their blood glucose, make good nutritional choices and partake in a daily exercise regimen. Additionally, medication management plays a tremendous role in the care of diabetics. There are several options for lowering blood glucose: oral agents, insulin and inhaled insulin.

Blood glucose is usually controlled well with a combination of exercise, diet and oral medications. Medication management, coupled with nutrition and exercise will not prevent diabetes, but it may decrease blood pressure, cholesterol and maintain blood glucose levels. Nutrition plays a significant role in blood glucose control. Research has demonstrated that maintaining a diet high in magnesium-rich foods, particularly whole-grain breads, lowers the risk of getting Type 2 diabetes among African-American women (American Diabetes Association, 2007).



Nutrition choices must contain foods that are low in fat and cholesterol, yet high in fiber and protein. Diabetics must be familiar with the concept of glycemic index which may help to make better decisions. For example, diets high in bran, grains and vegetables have a low glycemic index. However, diets comprised of processed foods have a higher glycemic index. As a result, a higher glycemic index will cause a rapid rise in blood glucose. In contrast, a low glycemic index will not cause blood glucose levels to rise rapidly.

The benefits of exercise can not be underestimated: 30 minutes of cardiovascular exercise 5 times a week as well as weight loss of 5-7% of body weight make a difference in health maintenance (American Diabetes Association, 2007). Exercise helps in lowering blood glucose, cholesterol and blood pressure—all factors that contribute to cardiovascular disease.

In summary, Confucius once said "A journey of a thousand miles begins with a single step". Many African-American women have a journey they must travel once diagnosed with diabetes. There must be an understanding of factors contributing to control of blood glucose such as nutrition, exercise and medication management. Health care providers have a responsibility to continue efforts to educate women on ways to reduce cholesterol, blood pressure and maintain optimal blood glucose levels.

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Available at: [http://www.ndep.nih.gov/diabetes/pubs/FS\\_AfricanAm.pdf](http://www.ndep.nih.gov/diabetes/pubs/FS_AfricanAm.pdf)
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- During the 2007 NBNA Conference in Atlanta, attend the Diabetes Institute on Thursday, July 26, 2007 for the state-of-the-art information on diabetes research, treatment, management and control.

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# CULTURAL COMPETENCY AND EVIDENCE-BASED PRACTICE: CHALLENGING PARADIGMS FOR NURSING

*Deborah W. Wilson, DNS, RN*

Cultural competency and evidence-based nursing practice are two of the most challenging paradigms in nursing. Because of radical changes in the health care system, nursing is challenged to provide culturally sensitive and appropriate nursing care to diverse patient populations and make doing so a priority. Likewise, nursing is challenged to incorporate the best evidence currently available for clinical decision making, in order to provide effective, appropriate care that improves patient outcomes.

In the past few years, the movement toward providing culturally competent nursing care and using best practice evidence in nursing has intensified. Nationally and internationally, cultural competence and evidence-based care are discussed and written about extensively in nursing. In the United States, the urgency relates to increased cultural and ethnic diversity within the country, health care disparity between majority and minority populations, and our changing health care system.

How are these concepts related? The concept of cultural competency forms the framework for formulating guidelines that will improve the quality of nursing care provided to diverse populations. Campinha-Bacote (1999, p 203) defines cultural competency as the process in which the health care provider continuously strives to achieve the ability to effectively work within the cultural context of a client (individual, family, or community). She describes it as a conscious, dynamic process in which the nurse strives to maintain the attitudes, skills, and practices that enables them to work effectively in cross-cultural situations.

On the other hand, evidence-based practice integrates scientific evidence, clinical expertise, and patient preferences to provide the best possible care (Sackett, 2000). Since a significant component of evidence-based practice is patient preferences, which are likely to be culturally determined, evidence-based practice and cultural competence seem complementary. Thus, nurses are obligated to consciously and judiciously use the current "best" evidence in providing culturally competent care.

Even though there is an urgency to provide culturally competent nursing care, there is a dearth of evidence-based nursing interventions derived from systematic research. Evidence-based practice will enable nurses to transform knowledge from research evidence into clinical practice. Further, integrating evidence-based practice and cultural competence will enhance the nurse's knowledge, skill, and ability to meet the challenges of providing nursing care to diverse patient populations.

Unfortunately, many nurses are not familiar with either concept. In part, this may be because most nurses practice according to how they were taught in nursing school and their nursing practice experiences (Eastbrook, 1998). Considering the type of program attended, year of graduation, the nature of practice experiences; the nurse may not be knowledgeable or possess the necessary skills to integrate these concepts into practice. Another consideration is that some nurses may view cultural competence and evidence-based practice as another fad or trend that will eventually vanish from professional ideology.

Although there may not be consensus on the relevance and need of cultural competence and evidence-based practice in nursing, nurses must value both. African American Registered Nurses comprise the largest group of culturally diverse nurse in the United States (Bureau of Health Profession, 2000). They are perfectly situated within the health care system to encourage cultural competence and evidence-based practice. Because of their special connection with patients who share a similar background (Wilson, 2002), they can serve as a valuable resource for educating other nurses to improve intercultural awareness, communication, and culturally competent care. African American Registered Nurses might also be educated to engage in evidence-based research that will strengthen their knowledge regarding culturally competent care.

For nursing, there is an imperative to provide culturally competent, evidence-based nursing care to diverse patient populations. This is a challenge that the nursing profession cannot ignore for it will continue to reshape



healthcare. African American Registered Nurse can lead the challenge of promoting understanding of cultural competency and evidenced-based practice.

If all nurses are to meet the health care needs of patients of diverse cultural backgrounds, they must strive for cultural competence. They must appreciate the benefits that cultural competence and evidence-based practice provide for improving patient outcomes and health care systems. Nurses must embrace and commit to integrating both into nursing practice.

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# From This Side of the Table: A STAFF NURSE'S PERSPECTIVE OF BLACK NURSE LEADERS IN LABOR NEGOTIATIONS | Joyce Lemon, RN

The author has participated in labor negotiations between the Service Employees International Union (SEIU) 1199 / Registered Nurse Division (New York) and The League for Voluntary Homes and Hospitals (New York) since 1992. During that time negotiations have progressed from traditional combative bargaining to a more productive interest based format that is guided by shared interests and goals. One thing that has not changed is the racial structure of the nursing leadership negotiation committee. To determine if the racial composition of the negotiation committee has any impact on outcomes requires formal research, however, the make-up of the leadership committee is significant to the rank and file nurses sitting across the table. From that side of the table it is obvious that there has been limited movement of Black nurses into executive leadership positions.

The SEIU/LVHH contract negotiations consist of various participants. The union's committee consists of SEIU executive officers (executive vice-president, vice-presidents), SEIU legal counsel, union organizers and rank and file registered nurses representing the participating hospitals. The hospital's committee is made up of executive officers from the LVHH (president and senior-vice president), legal counsel, accountants, executives from the hospital's department of human resources and nursing administrators or chief nursing officers.

The SEIU/1199 registered nurse bargaining unit (union members) is an example of cultural, ethnic and racial diversity. Their leadership is a nurse of African-Guanines descent. In contrast, of the fourteen hospitals involved in these recent negotiations a Black nurse executive led only one hospital. On the hospital's side diversity was only evident in the ranks of the human resources department, it contained men and women from various cultural and ethnic groups.

There are several possible reasons for the racial disparity in the ranks of nurse executives. Research on racial and ethnic disparities in nursing suggests that the under-representation of African Americans in nursing is related to disparities in educational attainment of minorities (Coffman, Rosenoff, and Grumbach, 2001). The influence of racial discrimination in the healthcare industry is also responsible for impeding the advancement of Black nurses (Wilson, 2003).

Seeing a Black nurse executive across the negotiation table signals shared experiences and struggles. For example, a discussion on the treatment of nurses by the unappreciative medical staff has different connotation to Black nurses whether they are staff or leadership. They share the perception of being treated differently because of their race, whereas a White nurse may view this treatment as a traditional "doctor versus nurse" problem. Seeing fewer Black nurse executives across the table sends the message that for Black nurses the opportunity for advancement is limited.

The author is not suggesting that collective bargaining outcomes would change or improve if the committee was diverse and racially reflected the staff and patients served. Diversity in this setting would allow Black nurse executives to have greater input in formulating policies, standards and employment conditions that could address racial disparities in nursing and healthcare. This subject deserves further research and ongoing dialogue that will provide Black nurses an equal opportunity to sit at the other side of the table.

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# MEDWATCH: MANAGING RISKS AT THE FDA

**W**hen the Food and Drug Administration approves a medical product, it means the agency has determined that the benefits of the product outweigh the risks. “But every product the FDA approves carries some risk,” says Norman Marks, M.D., director of the FDA’s MedWatch program. “And sometimes there are risks that only come to light after a product gets on the market and is used in larger numbers of patients who differ from those studied before approval. They may differ in the complexity of their health problems or other medications that they use, for example.”

That’s where MedWatch comes in.

MedWatch, the FDA’s safety information and adverse event reporting program, plays a critical role in the agency’s postmarketing surveillance—the process of following the safety profile of medical products after they’ve begun to be used by consumers. Through MedWatch, a voluntary program, health professionals report serious adverse reactions and problems related to drugs, biologics, medical devices, dietary supplements, cosmetics, and infant formulas.

“Consumers can also send in reports, but we encourage them to work with a health professional to submit because we’ll get a much richer report,” Marks says. “Health professionals have clinical information that will help us better evaluate the report.”

Marks adds, “What we mean by ‘serious’ adverse reactions is death and disability, life-threatening problems, hospitalization, congenital anomalies, and other problems that aren’t listed on the label as known side effects.” MedWatch also accepts reports of product quality problems with drugs or devices, suspected product tampering or counterfeit drugs, medication errors due to packaging problems or name confusion, and any other unexpected problems with the product that could pose a safety risk.

Once the FDA receives early signals of possible safety issues, the agency can rapidly identify problems and take appropriate actions, including broadcasting new safety information as “MedWatch Alerts.”

“The FDA’s MedWatch program has two main goals,” Marks says. “We want to facilitate the reporting of problems in to the agency and we want to get safety information out to the public.” MedWatch receives about 22,000 reports each year. The agency has a number of ways to alert the public about important information. The MedWatch Web site pulls as much safety information together as possible to make it easier for the public to find. MedWatch sends e-mail notification of all safety alerts and monthly safety labeling changes for drugs to a growing e-mail list of both health care professionals and consumers. By 2003, the number of subscribers to the MedWatch e-mail list jumped to 32,000, from the 5,000 people who signed up in 2000. People on the list receive safety alert summaries by e-mail, with a hyperlink that directs them to more detailed information. Names and e-mail addresses of MedWatch subscribers are not shared with other organizations.

MedWatch also works with 161 “MedWatch partner” organizations to widely disseminate new safety information. For example, the [National Black Nurses Association] receives e-mail notification of MedWatch safety alerts and sends it to the NBNA leadership for them to pass along to their chapter colleagues.

The MedWatch program is also exploring opportunities to work with large health care systems that are already collecting adverse event and medication error reports. “This will facilitate the receipt of these reports by the FDA,” Marks says. “We also work with partners like the American Association of Nurse Anesthetists to encourage their members to report to the FDA. It can be hard to get busy health professionals to report, but what we hope is that they see the whole process working—reports coming in from them and the resulting new safety information going back to them in order to make their work easier and their patients safer.”

After the FDA evaluates reports, the result may be safety alerts, letters to health care professionals, labeling changes, product withdrawals, or further postmarketing research. When the FDA receives a MedWatch report, it is entered into a powerful database that allows a safety evaluator to compare it to similar reports. As few as



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a handful of signals, sent in from locations as diverse as Idaho, Arizona, Florida, and Vermont, may trigger a careful investigation by the FDA and a manufacturer.

"We want the public to know that we depend on their reports," Marks says. "They could prompt important actions that improve the public health."

### How to Report to MedWatch

Log onto the MedWatch site to download the reporting form. You can:

- Submit a report electronically
- Call (800) FDA-1088 to report by phone
- Fax a report to (800) FDA-0178
- Mail a report to MedWatch, FDA, 5600 Fishers Lane, Rockville, MD 20852-9787.

A Special Report From the FDA Consumer Magazine and the FDA Center for Drug Evaluation and Research Fourth Edition / January 2006

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# SEVEN KEYS TO REDUCE CHOLESTEROL

Johns Hopkins Health Alerts, the consumer health information website published by University Health Publishing in conjunction with Johns Hopkins Medicine, recently released an important new Special Report on reducing cholesterol in order to reduce the risk of heart attack and improve one's overall health. The government's National Cholesterol Education Program (NCEP) has estimated that at least 65 million Americans have high cholesterol levels that merit treatment with dietary and other lifestyle changes designed to lower cholesterol. The NCEP also states that as many as 36 million people should be taking cholesterol-lowering medications.

Yet only 12 to 15 million of them are currently taking these medications, such as statin drugs (for example, Crestor, Lipitor, Zocor), and many (probably most) are taking too small a dose of statins to reduce cholesterol to safer levels effectively.

As many Americans are now aware, abnormal levels of cholesterol carried in the blood — and in particular a high level of LDL, or so-called "bad" cholesterol — significantly increase the risk for coronary heart disease and heart attack. It is also well established that reducing cholesterol to achieve optimal levels can significantly reduce the risk of heart attacks and strokes.

## ***Who is at risk of having a heart attack? EVERYONE.***

LDL cholesterol, HDL cholesterol, and triglycerides — are not the only risk factors for coronary heart disease. The risk increases with age, and if you also have a family history of premature heart disease, or are obese, smoke, have high blood pressure, or suffer from diabetes.

Any decision about treating your cholesterol should be made in consultation with your doctor, taking all these heart disease and heart attack risk factors into account.

Whatever your heart health risk factors are, information is your best weapon in the fight against heart disease. Now is the time for you to re-evaluate whether you need to reduce your cholesterol.

In this FREE Johns Hopkins Special Report Seven Keys to Reduce Cholesterol you will learn seven effective, proven, practical keys for lowering cholesterol—with the latest, best information and advice direct from Johns Hopkins, ranked #1 of America's Best Hospitals. These keys include knowing your optimal cholesterol levels, diet, how to boost your HDL, whether statins can benefit you personally, and the latest news on "Combo Therapy" in treating cholesterol.

Written by two of the leading specialists at Johns Hopkins Medicine, Dr Simeon Margolis, Medical Editor of The Johns Hopkins Medical Letter: Health After 50 and Johns Hopkins White Papers for nearly two decades, and Dr. Roger S. Blumenthal, the Director of Johns Hopkins' renowned Ciccarone Center for the Prevention of Heart Disease, Seven Keys to Reduce Cholesterol presents the latest medical research on the dangers of high cholesterol, and provides a powerful range of effective strategies for lowering your cholesterol safely.

Anyone wishing to receive Seven Keys to Reduce Cholesterol can visit the website [http://pull.xmr3.com/p/4817-1EA0/17941755/clickto1\\_opkinsreports.com-cholesterol.html](http://pull.xmr3.com/p/4817-1EA0/17941755/clickto1_opkinsreports.com-cholesterol.html) to download this invaluable Special Report.

The Johns Hopkins Special Reports website is produced by University Health Publishing, which has been publishing branded Johns Hopkins University health-related information for people over 50 since 1988 through the monthly newsletter Johns Hopkins Medical Letter: Health after 50 and the Johns Hopkins White Papers.

**On Thursday, July 26, 2007, NBNA will host the Cardiovascular Institute, a four hours intensive session on heart health, during the NBNA Annual Conference.**

## *Nursing's Contribution to Improving the Quality of Patient Care:*

# THE INTERDISCIPLINARY NURSING QUALITY RESEARCH INITIATIVE (INQRI)

**D**espite nursing's pivotal role in the delivery of patient care, there is limited rigorous research demonstrating causal relationships between the quality of care that nurses deliver and high-quality patient outcomes. Building and sharing the evidence in this area is central to the Robert Wood Johnson Foundation's mission to improve the quality of health and health care for all Americans.

The primary goal of the Interdisciplinary Nursing Quality Research Initiative (INQRI) is to generate, disseminate and translate research to understand how nurses contribute to and can improve the quality of patient care. The program, led by Mary Naylor and Mark Pauly of the University of Pennsylvania, in partnership with Lori Melichar and colleagues at RWJF, supports interdisciplinary teams of nurse scholars and scholars from other disciplines to address the gaps in knowledge about the relationship between nursing and health care quality.

In its first Call for Proposals, the program solicited proposals with a primary focus on measurement. The program's first year of funding supports nine projects, which began in August 2006, that focus on one or more of the following areas: (1) investigating the link between the work of nurses and the quality of care provided in acute care settings; (2) producing and validating measures that capture nurses' contributions to quality care in inpatient settings; and (3) evaluating the impact of innovative nurse-led initiatives on patient outcomes.

Now in the program's second year, we issued a Call for Proposals on October 16, 2006. We are currently reviewing proposals submitted in response to the following topic areas: (1) identifying the linkages between processes of nursing care and the quality of patient outcomes; (2) identifying nursing's contributions to hospitals' performance as measured by quality reporting programs or rewarded by pay-for-performance schemes or developing pay-for performance schemes or other incentive programs that would recognize nursing's contributions and reward nurses for high quality; and (3) projects that are consistent with the broader set of program goals, which have the potential to make methodological or conceptual contributions to the field of quality improvement.

This summer, INQRI leaders will host our second annual meeting in Princeton, NJ. This meeting will unite current grantees with newly selected grantees as well as stakeholders in the field. We hope to foster relationships which will allow our researchers to learn how their work will have the greatest impact to improve the quality of care received by patients.

We have also begun deliberations on topics for our third Call for Proposals, which will be released in October, 2007. The program will again identify a central area of focus, but will also aim to generate interest in investigator-identified research projects that address the overall program goals.

Ultimately, the expectation is that INQRI will result in robust research that can be shared with and inform decisions by policy makers, hospital administrators and others to improve the quality of care that nurses can provide at hospital patients' bedsides.

For more information about the website, please visit [www.inqri.org](http://www.inqri.org).

**To sign up to receive the Call for Proposals, please visit [www.rwjf.org/services](http://www.rwjf.org/services) and register for funding alerts under "Nursing."**

# NOW IS THE TIME FOR A NATIONAL NURSE

Nurses around the country are uniting behind an exciting proposal that would create an Office of the National Nurse. Having a National Nurse would provide a visible representation of nursing and will elevate our profession so that it is viewed as equally important as the medical profession. The goals of the office would be multi-faceted, first bringing understandable health education and promotion to the American public with consistent, regular presentations of national health issues via the media such as television, radio, and Internet in multiple languages. These media presentations will be an effective approach to educating the uninsured who have no regular access to healthcare other than emergency rooms. Additionally, the National Nurse position would provide a national platform to showcase nursing as the professional and committed discipline that it is. The National Nurse position will define and illustrate for the American public all of the work that nurses contribute, which remains invisible because others take credit for their work. It is no wonder that the American public cannot clearly define what a nurse does except that they “care”. Yes, nurses do care but they do much more. Nurses are responsible for educating patients about health and disease processes using language that the patient understands, and then can integrate into their daily lives. Crediting nursing with all of the contributions made to improve the nation’s health is long overdue.

Consumers of health care have extraordinary access to health information from a variety of sources such as the Internet. The problem is compounded by information overload and the consumer’s inability to sift and comprehend all of the data presented. Nurses are well experienced in translating highly technical medical information into everyday language that the public can understand and utilize.

Proposed along with the National Nurse position would be volunteer National Nurse Teams led by a paid, public health nurse in each state. Just like the National Nurse would complement and augment the role of the Surgeon General, the National Nurse Teams would work in collaboration with existing state agencies to deliver the national message of prevention, only they would tailor the message specifically to the language and culture of their own community. If you do not understand the information and how it relates to your situation, then you cannot make use of that information. Nurses are a national resource that should be tapped for a healthier nation, but they must have the infrastructure to provide the health education that this nation desperately needs. The National Nurse position would be a step towards achieving a healthier nation and would inspire more people to become nurses.

With all issues, there are always advocates and opponents. Opponents of the proposal to create an Office of the National Nurse believe that this will contribute nothing that is not already provided by existing organizations and agencies. Though there are very good federal agencies such as the CDC and NIH that make gargantuan efforts towards educating the American public on health issues, there is still a void. Just delivering the message is not enough; it is necessary to ensure that the message is received and understood. The National Nurse and National Nurse Teams would partner in delivering health messages, not start anew. There are also a number of experienced professional organizations representing the profession of nursing. The National Nurse position would not negate the work of these organizations, but would showcase that work to the American public in working towards the same goal, a healthier nation. Nurses know that to affect behavior changes, education and repetition are part of the effort needed. Weekly health education and promotion presentations by nurses will be an integral component to those behavior changes.

To learn more about the campaign for a National Nurse position, visit the website dedicated to this effort, [www.nationalnurse.org](http://www.nationalnurse.org). Review the information and make your own decision regarding support for this campaign. Remember that nurses are a national resource and nurses deserve recognition and credit for their work. Let us work together to achieve this for ourselves, our colleagues and most importantly, our nation.

Paxson Barker, RN, BS is a doctoral student at the University of Maryland School of Nursing. Her research interests are the occupational issues of nurses and their work environment.

# THE SISTER STUDY: SISTERS OF WOMEN WITH BREAST CANCER NEEDED FOR RESEARCH STUDY

**W**omen play many important roles throughout their lives—daughter, mother, and friend—but no relationship is as unique as the one between two sisters. Researchers hope the sisters of women with breast cancer can play another important role by helping them find the environmental and genetic causes of breast cancer.

The Sister Study is a nationwide effort, conducted by the National Institute of Environmental Health Sciences, to learn how the environment and genes may affect the chances of getting breast cancer. Women ages 35 to 74 are eligible to join the study if their sister (living or deceased), related to them by blood, had breast cancer; they have never had breast cancer themselves; and they live in the United States or Puerto Rico.

The Sister Study is particularly committed to enrolling women in every state, and from all backgrounds, occupations, races and ethnicities, so the study results represent and benefit all women. The women enrolled in the Sister Study look like many of our relatives, friends, and co-workers. They may even look like you.

Of the more than 30,000 women currently enrolled, here are a few who are making a difference in breast cancer research. Retiree Cruz Mireles, 58, did it because her sister is a breast cancer survivor. Jean Peelen, 65, a government retiree and senior model enrolled in and helps spread the word about the Sister Study because one sister is a breast cancer survivor and another died as a result of the disease. Also, Donna Castleberry, 46, who works in a busy Los Angeles advertising firm and Barbara Moore, 57 an on-the-go Labor Relations Specialist for AFSCME did it because their sisters died of breast cancer, before they even reached the age of 50.

The study needs to enroll 50,000 women by September 2007, and with your help, it can.

"Many women have heard about the Sister Study, but they haven't signed up yet, and we really need them now," said Dale Sandler, Ph.D., Chief of the epidemiology branch at NIEHS and principal investigator of the Sister Study. "Doctors know very little about how the environment may affect breast cancer, that is why the Sister Study is so important. We hope women will make that call today," she added.

Organizations in partnership with the Sister Study include the American Cancer Society, the National Center on Minority Health and Health Disparities of the National Institutes of Health, Sisters Network Inc., the Susan G. Komen Breast Cancer Foundation, the Y-ME National Breast Cancer Organization, and the Intercultural Cancer Council.

The Sister Study is available in English and Spanish and can be done from home when it is convenient for women. To learn more about the Sister Study, visit the web site [www.sisterstudy.org](http://www.sisterstudy.org), or for Spanish visit [www.estudiodehermanas.org](http://www.estudiodehermanas.org). A toll free number is also available 1-877-4SISTER (877-474-7837). Deaf/hearing impaired call 1-866-TTY-4SIS (866-889-4747).

Woman by woman... Sister by sister... We can make a difference.

**Be sure to attend the Cancer Institute on Thursday, July 27 during the NBNA 2007 Annual Conference.**

## National Black Nurses Association, Inc.

# 34TH ANNUAL INSTITUTE AND CONFERENCE MEMBER SPEAK | August 11, 2006

*Here are some of the comments & questions presented by NBNA members:*

- 1. At future conferences, can the institutes be split, not have all in one day, i.e. break down into 2 hours or have the institutes at separate times.**

In order to receive the full CEU credit for attendance institutes may not be split. CEU hours are strictly regulated and we must adhere to the provider's guidelines.

- 2. Applaud the planning committee conference booklet for overview and breakdown. Allows for planning.**

Thank you... this is a new feature we thought would be helpful to attendees.

- 3. Recommend the organization consider hiring more staff to handle NBNA's business more efficiently.**

The executive director has hired an administrative assistant for the national office. Additional clerical support is hired during busy times of the year determined by the executive director. Also, additional support is provided to the President and Editor of the NBNA Journal.

- 4. How do members get extra newsletters, souvenir programs or NBNA's journal?**

Members may contact the national office. There may be a shipping charge if requesting large quantities. Information will be sent using ground transportation, therefore please plan ahead.

- 5. President's Leadership Institute — Recommend a "How to" format for Presidents/first VPs chapter growth and development.**

This has been referred to the Membership Committee for review.

- 6. When is the NBNA Institute and Conference going back to New York?**

This has been reviewed by the conference services manager and the conference committee. It is felt at this time that it is cost prohibitive to take a conference to New York City. Our conferences for the next four years are as follows: 2007 Atlanta, 2008 Las Vegas, 2009 Toronto, 2010 San Diego, and 2011 Indianapolis.

- 7. Are we going to have Regional Conferences? Helps with leadership development?**

Two regional conferences have been planned for April 2007 in Houston, Texas and Santa Clara, California.

- 8. Concerned that there is not enough support for local chapters. Would like a handbook on how to recruit, sponsorship and have NBNA Board of Directors as speakers.**

This is a concern of the BOD as well and is currently being developed by the Membership Committee. In addition other means to build chapter capacity is under development.

- 9. Concern about continuing a category of Child Health in the Institutes.**

A Children's Health Institute was held at the NBNA conference. NBNA needs to keep nurses apprised of issues around children's health to help reduce the disease risk factors that children have, i.e., obesity, diabetes, immunizations, so that we can reduce the risk factors as they grow and ultimately become adults. In order to support an institute we must have quality abstracts to support and meet the CEU requirements. Annually NBNA advertises for conference abstracts.

- 10. Credentialing went well. Recommend having earlier and alternating the alphabet for appointments.**

Thank you. Referred to the Conference Committee for review.

- 11. Recommend a nursing faculty task force during conference.**

A task force is usually developed to address specific issues. Please provide the national office with issues of concern to be addressed.

- 12. Acknowledge other board members are available when President is not available to come to local chapter activities.**

Thank you. The President sends members of the board to represent her as necessary.

- 13. Recommend volunteers from chapter members to assist National Office.**

Thank you to the Greater Washington, D.C. Area Black Nurses Association, Black Nurses Association Baltimore, Southeastern Pennsylvania Black Nurses Association who have members who volunteer on a regular and annual basis, including Greater Washington DC President Veronica Clarke-Tasker and Baltimore President Ronnie Ursin.

- 14. Commend the officers and board members for a tremendous conference.**

Thank you.

- 15. Compliment — "In Remembrance" in the Souvenir Program and splendid conference. One of the best attended.**

Thank you.



16. **Thanks for the planning of the NCLEX. Recommend for the recruitment of students — having institutes for students on leadership and belonging to professional organizations.**

Great suggestion. It has been referred to the Conference Committee for review.

17. **Commend BOD for their service. Inspired by the association. Recommend more training for students and professional growth and development for nurses.**

Thank you. All conference programming is developed for the growth and development of our members. We have the Presidents' Leadership Institute for chapter presidents and vice presidents. There is a session lead by the student representative for students and a LPN session. We started a workshop two years ago exclusively to address the needs of Advanced Practice Nurse members.

18. **Chapter Liaisons are unknown. Recommend mechanism to communicate which one to correspond to first.**

This information is sent to chapter presidents on an annual basis. Chapter liaisons are directed to contact chapter presidents early in the year to identify themselves. The names of the board liaisons are listed in the leadership roster that is sent to chapter presidents.

19. **Concern with retention in local chapter — bypassing local chapter, going directly to NBNA.**

In reference to membership dues, dues are to be paid at the local level. If a member sends dues to the National Office, including local dues, the local dues will be sent to the Chapter. If member sends national dues only, the National Office contacts the local chapter and the member to make sure that local dues have been paid. If member sends national dues only and have not paid local dues, they are not a member in good standing; and dues will be sent back within 30 days to the applicant.

In reference to internal chapter issues, members are encouraged to discuss matters with their chapter president who in turn can contact the Board liaison if additional assistance is necessary. Members are directed back to the chapter President by the National Office staff for resolution of concerns. It is our hope that Chapter Presidents are given the opportunity to resolve local issues internally.

After discussions internally within the chapter, with the Board liaison, with the National Office who will alert the National NBNA President, who will then alert the Board of Directors, then the Board of Directors may wish to seek legal counsel on matters of concern.

20. **Accolades for recognizing military nurses. Consider doing it again next year. NBNA flag — where to send proposal.**

Thank you, all proposals should be forwarded to the National Office.

21. **Congratulations on conference — well organized. Chapter Liaison did call and communicate.**

Thank you.

22. **Etiquette at reception by the membership was poor.**

It is expected that all members represent NBNA in a professional manner at all times. When this is not done it affects us all in an adverse manner.

23. **Recommend placing on the web-site Chapter Liaisons and Calendar of Events for President. Recommend local chapter sponsor students to come to NBNA conferences. Students — Where are they after they are supported?**

Currently the calendar of events has been on the web-site for several years. Keeping the calendar up to date requires that chapter presidents send their calendar of events to the National Office 30 days prior to an event for inclusion.

NBNA receives "thank you" notes from some students. We rarely hear from the students who received scholarships from NBNA about graduation or post graduation activities, new job or graduate school. Some chapters provide that information to NBNA for the Members on the Move column. It is always of value to students when a chapter is able to support them to the conference. Chapters should include student members in chapter activities.

24. **Recommend a National Student Mentorship Program.**

Referred to Program Committee for review.

25. **Clinical sites shortage for schools of nursing. Is there any type of recruitment plans for strategies to obtain more sites?**

This is not a function of NBNA. Please contact your State Board of Nursing as well as local hospitals. If this is of major concern, perhaps an article could be written by those who are interested in this issue, along with possible recommendations.

26. **Compliment local chapter for their graciousness. Thanks to the President, recognized local chapters' unity and wonderful conference.**

Thank you for the acknowledgement.

27. **More nurturing to students than to peers. Need to work with students to develop them. The desire to be a member of NBNA is an internal burning. Recommend holding a Town Hall Meeting to address retaining nursing students.**

Will refer to the Conference Committee for review.

28. **First time attendee — highly impressed. Proud to be a part of "it."**

Thank you.

The moderators of this session were Dr. Debra Toney, Melba Lee-Hosey and Ronnie Ursin.

## *Pulling It All Together:* THE CRITICAL ROLE OF THE EVERCARE NURSE PRACTITIONER

*In the Improvement of Long-Term Care Delivery | Renee Roberts, RN, MSN, NP-C*

In 1987, two Nurse Practitioners (NPs) from Minnesota recognized the need for greater coordination in the delivery of care for aging, vulnerable and chronically ill individuals living in nursing homes, and founded Evercare. Evercare introduced an innovative care model that would improve the quality of care delivery by coordinating services to reduce duplication, fragmentation and delays inherent in the existing approach. The founders knew NPs were perfectly suited to coordinate care and information between residents, their doctors and their families, and placed them at the heart of Evercare's care delivery model.

As an Evercare NP, I can attest to the difference we make in the lives of nursing home residents, their families, and staff. By providing a level of clinical focus, continuity and clarity, we are helping improve health outcomes and quality of life for Evercare members. Because we play a central role in the coordination of care, we also establish and maintain open communication channels between doctors, family members, and nursing home staff to ensure they remain informed of, and involved in, all critical decisions related to the resident's care.

Working at Evercare has brought such joy and a sense of an accomplishment in my life. I have had a very rewarding and fulfilling career as a nurse for nearly 20 years, but when I joined Evercare in August 2002, it was truly an "ah-ha moment" in my career. At Evercare I am more than an NP. I am a clinician, collaborator, care manager, coach, counselor, communicator and even a cheerleader. Working together with physicians, families and nursing home staff in advance of one goal, to improve the health outcome and quality of life for the resident, I and my fellow Evercare NPs are making a difference and laying a solid foundation for improving all phases of long-term care.

**Renee Roberts, RN, MSN, NP-C**, Clinical Team Leader, Evercare Georgia.

**Learn about "Health Care Models" at the Plenary Session II on Saturday, July 28 during the NBNA 2007 Annual Conference.**

## HEALTH LEGISLATIVE AGENDA IN THE NEW CONGRESS

Several healthcare issues are expected to be major legislative priorities in 2007 as a result of the return of Democratic control of the House and Senate. Among the areas that may be on the agenda for discussion are price negotiations under the Medicare prescription drug plans, State Children's Health Insurance Program reauthorization, embryonic stem cell research and health care information technology.

As part of a new law taking effect in January, the Deficit Reduction Act signed by President Bush in February 2006, healthcare facilities must train staff how to report healthcare fraud. Any company that does at least \$5 million in Medicaid business annually must educate all employees how to detect fraud, waste, and abuse.

# NATIONAL BLACK NURSES DAY ON CAPITOL HILL - AN OVERWHELMING SUCCESS!!!

**M**ore than 300 nurses and student nurses (the largest gathering ever) from across the country attended the National Black Nurses Day on Capitol Hill on Thursday, February 8, 2007 in Washington, DC. The agenda was on two issues: the nursing shortage and health care disparities.

The group was supremely pleased that five Members of Congress presented their issues from their Congressional committee assignments; and addressed the need for universal health coverage and the need for more nurses. Members of Congress joining the day long activities were: Representative Donna Christian Christensen, chairperson, Congressional Black Caucus Health Brain Trust and the NBNA Congressional host; Representative John Conyers, chairman, House Judiciary Committee; Representative John Lewis; Representative Maxine Waters; and Representative Al Green.

The keynote speaker was Lorraine Miller, now the Clerk of the U.S. House of Representatives, the first woman and African American to hold the position. Lorraine talked about the new Democratic controlled Congress; the fast pace of the House Democrats agenda for the first 100 days of the new Congress; and the need for the Presidential candidates to address the issues that are important to nurses and health care in general. Lorraine is also the President of the Washington, DC chapter of the NAACP. Before assuming the role of the Clerk of the House, Lorraine worked in the office of now Speaker of the House Nancy Pelosi.

Awards were given to the current and former Congressional Black Caucus Health Brain Trust Coordinators for their public policy service: Britt Weinstock, Senior Health Policy Advisor, (the current CBC Health Brain Trust Coordinator in the Office of Representative Donna Christian Christensen); Aranthan "AJ" Jones, Director of Policy Analysis and Research, Office of the Majority Whip James Clyburn; and Fredette West of FDWest Network Associates, a consulting firm. A public service award was also presented to Lorraine Miller.

Birthale Archie, NBNA Board Member, discussed the State of Michigan passed proposal ending affirmative action in the State. Patricia Lane, president, Northern Virginia Black Nurses Association provided an interactive session on advancing the nurses' legislative agenda on Capitol Hill and before the State legislature. Derrick Humphries, NBNA General Counsel addressed the group on a wrongful death of a Katrina victim in New Orleans.

Speaking on "Civil Rights and Health Care" was Winston Wilkinson, Director, Office for Civil Rights, U.S. Department of Health and Human Services. Dr. Annette Debisette, Director, Division of Nursing, Health Resources and Services Administration detailed the programs under Title VIII, the Nurse Reinvestment Act as she discussed "Solutions for the Nursing Shortage".

Health care disparities is a high priority agenda item for the National Black Nurses Association. This year, NBNA is highlighting the epidemic of diabetes. Dr. Angela Asom, Medical Scientific Director, Novo Nordisk explained the risk factors for diabetes among the African American population. Sandra Jones, Analyst, Coverage and Analysis Group, Office of Clinical Standards and Quality, Centers for Medicare and Medicaid Services detailed the diabetes screening program sponsored under Medicare Part D. Dr. Marilyn Gaston, Co-Director, Gaston and Porter Health Improvement Center and the former Assistant Surgeon General talked about the need for women to prevent and manage chronic diseases.

**Go to the NBNA website at [www.nbna.org](http://www.nbna.org) for the NBNA briefing papers on the Nursing Shortage and Health Care Disparities.**



*Greater Fort Bend Members Cynthia Hickman, Yvonne Olusi, U.S. Representatives Al Green and John Lewis and Lola Denise Jefferson, NBNA Board Member.*

*Keynote Speaker Lorraine Miller, U.S. House of Representatives Clerk; Donna Christian-Christensen, U.S. Representative, Chair of Congressional Black Caucus Health Brain Trust; and Dr. Bettye Davis Lewis*



*NBNA Parliamentarian Azella Collins and Guest Speaker Patricia Lane, President, Northern Virginia BNA*



*Nursing Students from Howard University*



*Millicent Gorham, NBNA Executive Director (centre) with NBNA Public Service Awardees Fredette West (left) and Britt Weinstock (right).*



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*Dr. Marilyn Gaston, Dr. Bettye Davis Lewis, Susan of CMS.*



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*BNA Baltimore Member, Patricia Medley, Dr. Bettye Davis Lewis, Guest Speaker, Dr. Angela Asom, Novo Nordisk*

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*Dr. Annette Debisette, Director, Division of Nursing, HRSA; Dr. Bettye Davis Lewis and Patricia Medley, Member, Health Policy Committee*



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*William Winston, Director, US. DHHS Office for Civil Rights and Dr. Bettye Davis Lewis*



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*U.S. Representative Maxine Waters and Kristen Williams, AstraZeneca*





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*Gwen Watford-Miller, President, Concerned Black Nurses of Newark, U.S. Representative John Lewis and NBNA Members*

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*NBNA Board Members Birthale Archie and Trilby Barnes*



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*Atlanta BNA President Ora Williams, (2nd L) U.S. Representative John Lewis, Dr. Darlene Ruffin Alexander, NBNA Health Policy Committee Member*

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*U.S. Representative Maxine Waters with NBNA members*



**1. Registration Information (Exhibitors and Sponsors DO NOT use this form)**

Please PRINT CLEARLY or type. One registration per form. Copy form for multiple registrations.

NAME \_\_\_\_\_  
FIRST MIDDLE LAST

CREDENTIALS \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

HOME PHONE ( ) \_\_\_\_\_ WORK PHONE ( ) \_\_\_\_\_

FAX \_\_\_\_\_ E-MAIL \_\_\_\_\_

NBNA ID # \_\_\_\_\_ RN/LPN/LVN LICENSE NO. \_\_\_\_\_

SOCIAL SECURITY # \_\_\_\_\_

NAME OF CHAPTER (REQUIRED INFO): \_\_\_\_\_  CHECK HERE IF A DIRECT MEMBER

EMERGENCY CONTACT: \_\_\_\_\_ PHONE \_\_\_\_\_

PLEASE CHECK HERE IF YOU REQUIRE VEGETARIAN MEALS **NBNA Conference  
2007 / ATLANTA,  
GEORGIA****TO REGISTER:**Fax completed form with credit card information to: **301.589.3223**  
ON-LINE @ **www.NBNA.org****MAIL YOUR COMPLETED FORM WITH PAYMENT TO:****NBNA**  
8630 Fenton Street, Suite 330  
Silver Spring, MD 20910  
(Please allow two weeks for check processing)**2. Registration Fees (Please circle the appropriate fee)**

MEMBER	EARLY BIRD THRU 3/31/07	PRE-CON 4/1- 6/15/07	ON SITE AFTER 6/15/07
RN/LPN/LVN	\$250	\$325	\$450
Student (NON-Licensed)	\$155	\$205	\$330
Retired	\$175	\$250	\$375
One Day member fee: \$450			
ONE DAY STUDENT FEE: \$50 (Friday ONLY)			

NON-MEMBER	EARLY BIRD THRU 3/31/07	PRE-CON 4/1- 6/15/07	ON SITE AFTER 6/15/07
RN/LPN/LVN	\$425	\$500	\$650
Student (NON-Licensed)	\$230	\$280	\$430
Retired	\$250	\$345	\$425

One Day non-member fee: \$650

NBNA CONFERENCE BEGINS WEDNESDAY, JULY 25, 2007

\*REGISTRATION INCLUDES (1) BANQUET TICKET AND (1) BRUNCH TICKET

**3. Institute Registration**

Continuing Education Units will be awarded at the 35th Annual Institute and Conference. To receive the full compliment of continuing education units, you MUST attend the Institute and/or Workshop of your choice IN ITS ENTIRETY. The Institutes will be held on Thursday, July 26, 2007.

Please choose one of the following:

- Cancer       Mental Health       This is my first NBNA Conference  
 Cardiovascular       Research       I plan to go on the Local Chapter Sponsored Tours  
 Diabetes       Women's Health       Presidents' Leadership Workshop (for chapter Presidents and Vice Presidents ONLY—July 25, 2007)

**4. Guest Registration\*** Please check here if you require vegetarian meals 

NON-NURSE GUEST(S) REGISTRATION (ADULTS OR CHILDREN) \$150 EACH: \*REGISTRATION INCLUDES: SESSIONS OPEN TO THE PUBLIC, REFRESHMENT BREAKS, EXHIBITS, SHOW AND SPECIAL ACTIVITIES, SCHEDULED RECEPTIONS, PRESIDENT'S RECEPTION AND BANQUET, AND SUNDAY BRUNCH.

**NON-NURSE ADULTS:**

\_\_\_\_\_

\_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

(IF DIFFERENT FROM REGISTRANT'S)

**CHILDREN:**

\_\_\_\_\_ (age) \_\_\_\_\_

\_\_\_\_\_ (age) \_\_\_\_\_

Number of guests: \_\_\_\_\_ X \$150 = \_\_\_\_\_

TOTAL

**5. Purchase Additional Banquet or Brunch Tickets** Additional President's Banquet tickets and Sunday Brunch tickets may be purchased. BANQUET (\$80 per ticket) X No. of tickets \_\_\_\_\_ BRUNCH (\$50 per ticket) X No. of tickets \_\_\_\_\_

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** \$ \_\_\_\_\_ (totals from 2, 4 & 5)

Credit Card # \_\_\_\_\_ Exp. Date: \_\_\_\_\_

Cardholder Name (please type or print): \_\_\_\_\_

Signature \_\_\_\_\_

(ALLOW 2 WEEKS PROCESSING TIME IF PAYING BY CHECK)

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Milwaukee, WI

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Maureen Goines

Racine, WI

## DIRECT MEMBER (55)

\*IF THERE IS NO CHAPTER

IN YOUR AREA

NBNA Chapter Presidents



## National Black Nurses Association

8630 Fenton Street, Suite 330

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