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ANA - NEW YORK NURSE

WE MAKE A DIFFERENCE FOR NURSES IN NEW YORK STATE

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ANA - New York Nurse will reach over 72,600 New York nurses and schools of nursing.

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PRESIDENT'S MESSAGE

Marilyn L. Dollinger, DNS, FNP, RN

I am writing this column from Belfast, Northern Ireland. I had the incredible opportunity to spend the first few weeks of March in Belfast. I want to share some of what I learned about nursing and nursing education during a wonderful afternoon talking with Professor Sonja McIlfatrick MBE, PhD, RN, FHEA, FAAN, FRSCI, FRCN. Dr. McIlfatrick is Dean of the Ulster Doctoral College and the past Head of School (Dean) for the School of Nursing and Paramedic Science in the Faculty of Life and Health Sciences.

The most astounding difference in nursing education in Northern Ireland (N.I.) is that the N.I. Department of Health tells the two universities that teach nursing, Ulster University and Queen's University, how many students they can admit to the undergraduate (UG) nursing programs each year. There are two good reasons for this: N.I. has excellent healthcare workforce data that allows them to predict openings over the next few years for new nurses—something that we do not have yet in the U.S.; and, the government pays the full tuition and a stipend for all UG nursing students in N.I.! Although starting salaries are lower than in the U.S., new nurses are not bearing the student loan burden that U.S. graduating nursing students are. Perhaps we have something to learn from our N. I. colleagues.

Unlike UG nursing education in the U.S., where students study all aspects of nursing and must pass a licensing exam that covers all general and specialty practice competencies, students in N.I. select a specific UG program specialty. During the application process for the nursing program, they select one of the following tracts: a focus on adults, children and young people, midwifery, mental health, or those with learning disabilities.

The UG programs run year-round for 3 years, include over 2000 hours of clinical (direct care—not including simulation) and students pass competencies throughout the program—both clinical and academic-- to become "qualified" at graduation. After a six month "residency" working as a R.N., they are the U.S. equivalent of a licensed, registered, post-residency nurse.

Graduate education offers diplomas and master's (MSc) opportunities that include different specialties: Cancer Nursing (Supportive and Palliative Care), Leadership and Management, Mental Health Care, Care of Older People, Midwifery Care, Care of Children & Young People, Intellectual Disabilities and Practice Education. These programs require tuition, but the rates are comparable to in-state SUNY costs and scholarships are available.

The nurse practitioner (NP) role is one Specialist Program option. Although currently there is no N.I. government regulation of NP practice, NPs practice in team settings, and yes—there are concerns and conflicts with physicians related to role and scope of practice.

As different as the nursing education and health care systems are from U.S. models, the most important lesson I bring back is that nurses across N.I. and other parts of the U.K. share many of our challenges and issues. The U.K. nursing workforce data show that 50% of new nurses are leaving practice at the bedside within a few years and the resulting shortages are exacerbated by agency nurses who are earning much more than their colleagues at the bedside. This sounds too familiar.

Our N.I. colleagues also worry about workplace culture, patient safety, and the quality of care delivered under difficult working conditions. Nurses are salaried in the U.K. National Health System (single payer/universal access) and although all nurses are unionized, only recently have nurses gone on strike in the U.K. Strikes are a last resort for nurses everywhere who are trying to change the system.

Underlying all of our differences is the same goal: a health care system where nurses can work and thrive in a safe and supportive environment, with enough staff to provide the excellent care their patients deserve.

FROM THE DESK OF THE EXECUTIVE DIRECTOR

Jeanine Santelli, PhD, RN, AGPCNP-BC, FAAN

Its hard to believe that in just a few years we have gone from only having one ANA-NY event to having multiple events in a month! Our Program Committee has the office staff hustling with a calendar bursting at the seams. No matter what type of activity you are interested in, we have you covered.

You can do some light reading and join us for Books & Brunch. This year's series is on gardening tips. We are offering CE credit for Books & Brunch this year.

For all of us feeling a pinch in the pocketbook, we have another webinar series being offered by ANA partner, Prudential.

Following along with ANA's Racial Reckoning Statement, we have several programs on equity scattered throughout the year including our 11th Annual Conference with the theme: Nurses Lighting the Way. The subthemes for the conference are: Supportive Work Environment, DEIB, and Health Equity.

If you're a policy junky, you can participate virtually or in person at our Lobby Day and/or join our Advocacy SIG. We also have SIGs for IDD and Climate Change.

If these activities are too passive for you, then join in a Regional Clean-Up or Arbor Day activity out in the fresh air. Who knows, in April we might finally have snow! Watch for the details for our two summer socials – one planned for NYC and another planned for the central NY region.

In case this all seems to be too much for you, that's okay, we have you covered like your favorite blanket – keep an eye on our new website anany.org(,) YouTube channel, quarterly newsletter, monthly office updates, weekly bulletins, and social media feeds to get all the information you need from the comfort of your couch.

Keep an eye on your email to make sure that you don't miss a deadline for the activities that are in your neighborhood and/or area of interest. See you around the state!

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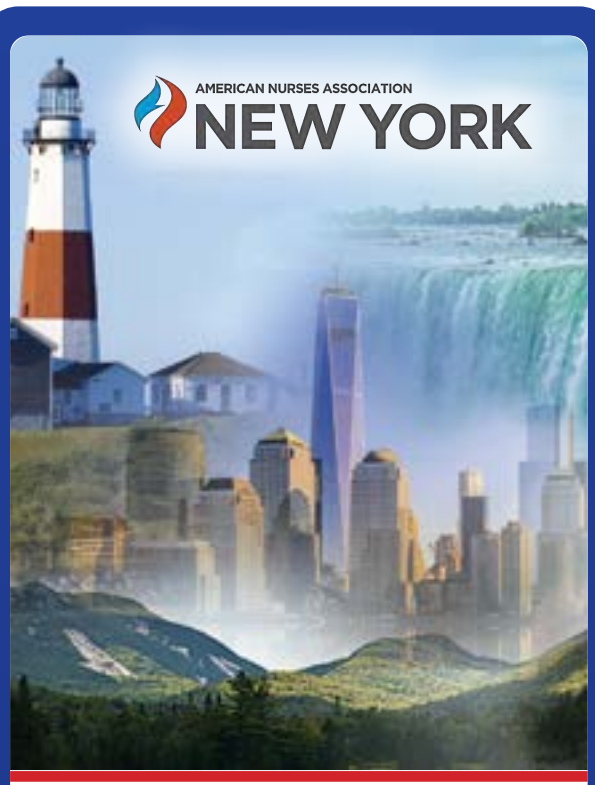

Article Submission

- Subject to editing by the ANA-NY Executive Director & Editorial Committee
- Electronic submissions ONLY as an attachment (word document preferred)
- Email: membership@anany.org
- Subject Line: *ANA-New York Nurse* Submission: Name of the article
- Must include the name of the author and a title.
- ANA-NY reserves the right to pull or edit any article / news submission for space and availability and/or deadlines
- If requested, notification will be given to authors once the final draft of the *ANA - New York Nurse* has been submitted.
- ANA-NY does not accept monetary payment for articles.

Article submissions, deadline information and all other inquiries regarding the *ANA-New York Nurse* please email: membership@anany.org

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LEGISLATIVE UPDATE

By Amy Kellogg and Caiti Anderson

The 2023 legislative session began on January 10, 2023, when Governor Kathy Hochul delivered her State of the State address. On February 1, she unveiled her proposed $227 billion state budget, a 2.4% increase over the prior year's budget. Although the general economic outlook is less rosy than it was last year, the Governor presented an optimistic vison of the State's finances, as New York expects to end its current fiscal year with an $8.7 billion surplus as the result of increased tax collections throughout the prior fiscal year. The Governor's budget also calls for spending increases in healthcare including an increase of $1 billion in health care capital funding, as well as $100 million to expand Medicaid coverage for 7.8 million New Yorkers.

The budget will be all-consuming until the budget deadline on April 1. Included in Governor Hochul's proposed budget are several proposals that would directly impact the nursing profession in New York. The first proposal would add New York to the Interstate Nurse Licensure Compact. The Nurse Licensure Compact proposal allows nurses from other Compact-Member states to practice nursing in New York. We are currently reviewing the proposal and educating the legislature on the logistics that need to be reviewed if New York decides to join the Compact. Another proposal that we have been monitoring relates to changes to how emergency medical services are billed and reimbursed in New York. We are monitoring this proposal because in the past, these changes have also contemplated a community paramedicine model that did not properly recognize the role of nursing. The proposal this year does not include the community paramedicine piece but would broaden the definition of emergency medical service to include, among other things, the ability to provide preventative care in a non-emergent situation.

The Governor's budget also contains a proposal that would ban the sale of flavored tobacco and vapor products, including menthol cigarettes. As we have mentioned in the past, ANA-NY is part of Tobacco Free New York, a coalition advocacy group dedicated to fighting against tobacco use in the state. The coalition strongly supports this legislation as well as legislation that would increase the tax on cigarettes in New York. Another budget proposal we are reviewing would create regulations for nurse staffing agencies. This proposal would require nurse staffing agencies to register and report data regarding their operations. The goal of this reporting is to increase transparency into the utilization and costs of contract labor and travel nurses.

An additional budgetary proposal would create a temporary pilot program that would allow certified medication aides to administer "routine and prefilled" medications in residential healthcare facilities. We have sent a letter outlining our concerns with this proposal, as it would allow medication aides to administer insulin and other diabetic injectables and injections for low molecular weight heparin. While we know there is a dire staffing issue, we noted that it is not appropriate for untrained medication aides to use injectables, especially when the misuse of those injectables may be fatal.

Finally, there is a budget proposal that would move the oversight and licensure of all healthcare professionals, including the nursing profession, from the State Education Department to the Department of Health. This proposal was also in the Governor's budget last year and was ultimately removed. ANA-NY has not taken a formal position on which agency should have oversight of the professions, but we have made known that whoever has oversight needs more resources and staff to meet the licensing and regulatory needs of the profession.

In addition to the Governor's proposed budget, we are actively advocating, with a host of other nursing groups, to have the preceptorship personal income tax credit bill included in the Assembly and Senate's one-house budget proposals. The one-house budget proposals are the Legislature's response to the Governor's proposed budget and will be released in mid-March. Currently, the preceptorship credit bill, S2067/A2230, is standalone legislation. The bill would establish a clinical preceptorship personal income tax credit for certain health care professionals who provide preceptor instruction to students studying to be a health care professional. The credit would be for $1,000 for each 100 hours of community-based instruction, with a maximum credit of $3,000. We have seen positive progress with the standalone bill, with the Senate version advancing to the Senate Finance Committee in mid-February.

Once the one-house budget bills are released, negotiations will begin in earnest between the Assembly, Senate and Governor with the goal of completing the negotiations by April 1. It is not until those final negotiations are completed that we will have a clear picture of which of the above proposals will be included and which will be eliminated and/or modified accordingly. We will be sure to include an update on the outcomes in our next update.

We are also focusing on non-budgetary legislative issues. One of our top legislative priorities is the passing the simulation bill, S447-A/A3076. This bill would allow for one-third of clinical training to be completed through simulation. As you are all aware, clinical placement opportunities have become especially scarce since 2020. This bill has advanced to the Senate calendar, meaning it could be called before the Senate for a full vote at any time.

In addition to the bill that would expand the use of simulation, we are also working with the State Department of Education to urge them to expand the scope of allowable simulation for clinical training. Their most recent meeting of the State Board of Nursing primarily focused on this issue. The Board examined draft guidelines for clinical education and simulation laboratory education for new programs, but no formal action was taken. Those draft guidelines will be examined again at a future meeting of the Board.

Once the budget is complete, we will exclusively focus on non-budget issues until the conclusion of the legislative session on June 8, 2023. We will continue to work with the Legislative Committee and the Board to weigh in on issues impacting the profession throughout the course of this legislative session. Unlike the last few years, everything is in-person again, including lobby days. ANA-NY's lobby day will be taking place on May 9, 2023, during National Nurses Week. We hope that many of you can join us in Albany that day.

Finally, we would like to remind you that ANA-NY now has a Political Action Committee (PAC). The ANA-NY PAC will be supporting candidates that support the profession and issues of importance to our members. We urge you to visit the ANA-NY PAC web site and donate.

If you have any questions about the legislative process or the priorities of ANA-NY, please contact a member of the Legislative Committee. As always, we welcome your questions, thoughts, ideas or comments on legislation or the bill track.

Announcing Members-Only Special Interest Groups!

Get involved with ANA-NY in a way that does not involve running for the Board or serving on a Board Committee!

Our Special Interest Groups (SIGs) are members-only communities within ANA-NY that are focused on a single topic or area of interest.

SIG No. 1	Nurses who work with the intellectually and developmentally disabled population to discuss ideas for better care by removing barriers to nursing care and reimbursement.
SIG No. 2	Nurses who are interested in climate change and its impact on health to propose strategies that nursing can implement to have a positive impact.
SIG No. 3	Nurses who want to learn more about policy and advocacy to discuss the details of the policy and political process and learn more about the ANA-NY Legislation Committee activities.
SIG No. 4	Nurses who are interested in advancing the profession of nursing through igniting compassion for nurses.
SIG No. 5	Nurses who are interested in the technological advances happening in the nursing practice with a focus in innovation and informatics.

Learn More & Sign Up at ANANY.org!

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BOARD BUZZ

- Welcomed, in January, new Staff Members: Deb Spass, Program Manager, and Kennedee Blanchard, Member Engagement Associate.
- In Executive Session, approved the budget for FY 2023. Thanks are given to the Finance Committee chair, Phyllis Yezzo, and her committee for all their hard work on this budget.
- Accepted the Committee rosters and Board liaisons determined. ED Santelli reported that some committees have already met.
- Received updates on the status of legislative issues from our lobbyist Amy Kellogg as the new year is starting at the Capital.
- Received updates on the 2023 Annual Conference and approved schedule of monthly BOD meetings.
- Gained a new organizational affiliate - New York League for Nursing (NYLN).
- Reviewed proposal to the ANA 2023 Membership Assembly (MA) on the National Transformational Change for the Advancement of Nursing Education from Karen Ballard and Barbara Zittel. Affirmative vote to support and approve the proposal with the addition of adding a clinical practice component to the document.
- Continued to participate in virtual leadership activities with ANA and other professional organizations.
- Approved list of Upcoming Events for all members. Information on ANA-NY website.
- Received news of ANA-NY's selection as recipient of the 2023 Nightingale Award given by the Center for Nursing.
- Received a draft copy of ANA-NY's Nurse Resident White Paper for BOD review and comments by 2/24/23 to ED Santelli.
- Lobby Day 2023 is May 9, 2023, at the Capital. It will be face-to-face. President Dollinger encouraged all board members to be involved.
- Congratulations to Membership Engagement Associate, Kennedee Blanchard, on her acceptance to the Advisory Group of Project MZ CSNA.
- Endorsed a proposal by ED Santelli to create a "How to" series. The series will be recorded seminar presentations from members who have expertise in particular areas. These seminars will be available on the ANA-NY YouTube™ channel.

Details on these and other Board activities reside in the Approved BOD Minutes on the Members Only website.

FROM THE DESK OF THE HISTORIAN

Look Behind the Curtains

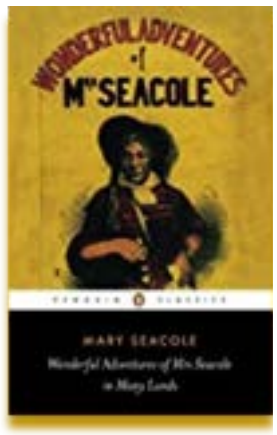
Gertrude B. Hutchinson, DNS, RN, MA, MSIS, CCRN-R

As you read this month's issue, this column's January 2023 hiatus is over and once again, my thoughts turn to the significance of Black History Month (just ending) and the start of Women's History Month in relation to our noble profession. Once again, I turn to my bookshelf and the PBS network.

Two nursing students from RSC attended the NSNA Conference in 2022, and brought back Hattie Bessent's book, *The Soul of Leadership: Journers in Leadership and Achievement with Distinguished African American Nurses (2005)*. For those readers who may not be familiar with the late Dr. Bessent, here is a brief introduction from a 2013 interview conducted by the Nurses Educational Fund. She was born March 7, 1908, earned her degrees from Florida A&M University (B. S. in Nursing), Indiana University (M. S.), and University of Florida (EdD in Psychological Foundations) and had a long and illustrious career. She was a psychiatric nurse, a nurse educator, an international advocate for raising awareness of the health and wellness, or the lack thereof, in communities of color in America and around the world until her death on October 31, 2015. She received many accolades and honors throughout her lifetime such as inductions into the ANA Hall of Fame and the AAN as a Living Legend, ANA's Mary Mahoney and Linda Richard Awards, and a Lifetime Achievement Award from the National Black Nurses Association. She served on many boards of national, international, and professional organizations such as Phi Lambda Theta, Phi Delta Kappa.

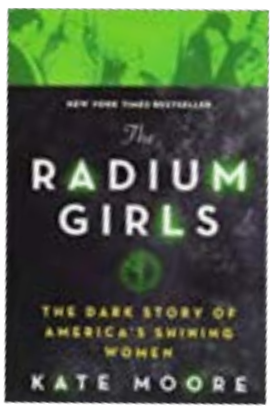
Her above referenced text has four chapters discussing "Project Lead and Soul" (what leadership is and why it is important), "African American Women Who Lead" (which highlights 11 nurse leaders, many of whom are still currently active), "Principles of Leadership" (from creativity, networking, preparation, mindfulness and self-awareness), and "Soul of a Leader" (purpose, preparation, planning, perseverance, and politics). She opens and ends this book with two poems penned by Maya Angelou, "Phenomenal Woman" and "Still I Rise."

Moving back to the 19th century, Mary Seacole's *Wonderful Adventures of Mrs. Seacole in Many Lands* (1857) and republished in 2005 is a first-hand account of her experiences growing up in Jamaica. She learned the art of healing and herbal medicine from her mother, became a business woman in four countries (Jamaica, Panama, Turkey and finally England), and surmounted many odds and hardships to nurse soldiers in the Crimean War. She was a contemporary of Florence Nightingale, although she did not characterize Nightingale as a colleague or friend. This book will hold your attention as you experience life through Mrs. Seacole's eyes.



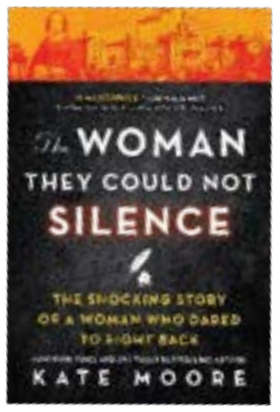
If you want to learn more about Black History in America, I commend to you "Making of Black America" available on your local PBS TV affiliates. This 4-part series written by historian Dr. Henry Lewis Gates, Jr. uses photographs, primary and secondary documents, and conversations in barbershops and hair salons to enhance the viewers knowledge and understanding of the Black experience in the United States from 1619 through to the present.

Now at the start of Women's History Month, two books authored by Kate Moore, are *Radium Girls* (2018) and *The Woman They Could Not Silence* (2022). These are well-researched tomes. Moore delves into health issues, the true stories many women's battles to obtain proper health care, cover-ups, and ultimate effects on healthcare policy.

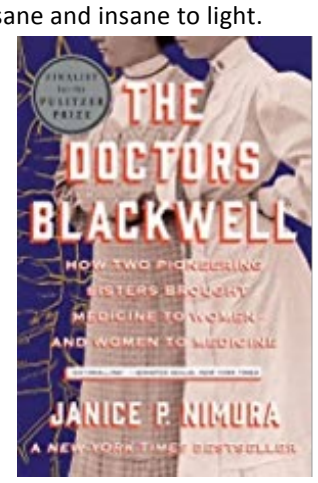


The Radium Girls chronicles the infatuation with the green glow of radium as young girls painted watch dials for the military in both World Wars. Moore spared no words in describing the physical, mental, and emotional deterioration these women faced. Radium bound these women and their families together while engaging in a "David v. Goliath" match across many states often without legal representation until … they found a champion who knew how to make the legal and federal systems work for these women.

Mental health and the abominable treatment of women in the 1860s is the focus of this book, which introduces us to Elizabeth Packard – a woman who suffered atrocities in the mental health system in Illinois as well as the social indignities of being a woman without rights in the 19th century because of her marital status. Moore takes Mrs. Packard's own writings and secondary sources to bring this champion for the sane and insane to light.



Finally, *The Doctors Blackwell: How Two Pioneering Sisters Brought Medicine to Women—and Women to Medicine* (2021) written by Janice P. Nimura, bring for the groundbreaking stories of Drs. Elizabeth and Emily Blackwell to the fore. Knowledge of this book came to me courtesy of the Jemima Johnson Chapter, KYDAR (Paris, KY) as the last one on their reading list for 2022. The Blackwell family was very tightknit. While not the oldest of the Blackwell children, she determined at an early age to become a physician. Nimura paints a picture of the family from their writings, plus other primary and secondary sources. What is particularly appealing to me was learning of Elizabeth's Upstate NY connection as she attended and was the first female graduate of Geneva Medical College in Geneva, NY. Dr. Elizabeth "strongly encouraged" her sister Emily to follow her educational and career example to provide healthcare to poorer women in New York City. Eventually, Emily did earn her MD diploma, but you have to read this book to learn "the rest of the story" as the late radio personality Paul Harvey used to say.



In closing, all of these books contain many interesting details and situations. To find out "the rest of their stories," please consider reading them or viewing the Dr. Gates' series.

Until the next issue,
Trudy

COMMITTEE SPOTLIGHT

Finance Committee

The ANA-NY Finance Committee is a standing committee of the Board. They meet several times a year to review the Profit and Loss Statements. Their most significant role is to review and endorse the annual budget. The Executive Director compiles the annual budget based on the past several years' budgets and requests for future spending submitted by the committees and the office team. The Treasurer reviews the proposed budget and then brings it to the committee for review and discussion. The Board of Directors has final approval of the budget. The fiscal year of ANA-NY is the calendar year. The committee will periodically review relevant policies such as the Reimbursement Policy to assure they are current and relevant for ANA-NY. Volunteer for this committee if you have a head for numbers and/or want to see where your membership dollars are going.

The 2023 members of the Finance Committee are:

Chair – Phyllis Yezzo, DNP, RN, CPHQ, NEA-BC

Phyllis M. Yezzo is the EVP and CNE of the WMCHealth Network. In her role as EVP/CNO Phyllis oversees patient care services and nursing practice for the nine-hospital system including Westchester Medical Center, Maria Ferrer Children's Hospital, Behavioral Health Hospital of WMC, Mid-Hudson Regional Hospital, Good Samaritan Hospital, St. Anthony Community Hospital, Bon Secours Community Hospital, Health Alliance Mary's Avenue and Broadway Campuses, and Margaritaville Hospital. Working with senior leadership, frontline staff, state, and national organizations, she translates evidence-based practice into clinical practice to meet the strategic goals and initiatives of WMCHealth.

Phyllis holds a Doctor of Nursing Practice degree and a master's degree in Healthcare Administration as well as a bachelor's degree in Nursing. She is a certified professional in healthcare quality (CPHQ) and is a board-certified nurse administrator, advanced (NEA-BC). She is also a graduate Fellow from the Wharton School of Management for Nurse Executives as well as an Institute for Healthcare Improvement (IHI) Advisor.

Phyllis has held positions in nursing administration, quality management and clinical transformation throughout her career. She is the current Treasurer of the American Nurses Association of New York (ANA-NY) and a member the American Organization for Nursing Leadership, National Association for Healthcare Quality and American College of Healthcare Executives on local and national levels. She also serves as an active member of the Hospital Advisory Committee of The Joint Commission for Hospital Accreditation Programs. Phyllis enjoys teaching and was an adjunct professor for quality management at IONA College and is currently an adjunct professor for nursing leadership and nursing research at Touro College.

Melissa Derleth, MS, RN, NEA-BC

Melissa Derleth is the Chief Nursing Officer at Highland hospital, a 261 bed Magnet designated community hospital; an affiliate of UR Medicine, in Rochester New York. Melissa has served in her current role since 2017. Prior to Highland, she spent 20 years at Strong Memorial hospital. Six of those years as the Director of Emergency Nursing in the only level I trauma center and comprehensive stroke center in the Finger Lakes region. She has served on community boards, is a member of many local and national organizations and enjoys mentorship. As a graduate of the University Rochester School of Nursing, and postgraduate of the Simon School of Business, Melissa's passion has always been around leading teams in delivering high quality care, systematic and operational harmony, and high levels of staff pride and satisfaction. Melissa enjoys traveling, music and spending time with family and friends.

Elisa (Lee) Mancuso, MS, RNC-NIC, FNS, AE-C

Lee has been an NICU Level III RN, NICU NP and Bereavement Counselor for over 39 years and a Professor of Nursing at Suffolk County Community College (SCCC), specializing in Pediatrics, Mental Health & Leadership. She was honored with Professor Emeritus and failed retirement as she is Adjunct Pediatric clinical professor for Adelphi University.

Early in her career she became involved in professional nursing organizations and political advocacy. Lee served as ANA-NY President (2016-2020), Nurses Supporting Nurses Program coordinator, Delegate to Membership Assembly, ANA Reference Committee/Professional Policy Committee and is President of the Professional Nurses Association of Suffolk County (PNASC).

In her spare time, she is an ANCC Peer Reviewer for ANA's Northeast Multistate Division and a member of Suffolk County Medical Reserve Corporation responding to numerous emergencies and disasters over the years and administered over 50,000 COVID vaccines. Lee is the recipient of two NIH National Human Genome Research Institute Fellowships, SCCC Governance Leadership Award for Academic Excellence & Service, NYSNA Nurse Educator Award, SUNY Chancellor's Award for Excellence in Teaching and Who's Who in American Nursing.

Lee is Deacon for Christ Community Church and coordinates outreach ministry; Women's Annual Retreat, home care visits, Vacation Bible School, and international mission programs. July 2022, she provided women's health care seminars in 3 remote areas of the Dominican Republic and planted the seed for a community health clinic in Crucero, DR.

For the past 11 years she has shaved her head for St. Baldricks to raise funds for Pediatric cancer research and her total is now over $61,000. Please support St. Baldrick's by visiting her webpage: https://www.stbaldricks.org/participants/mypage/1111464/2023. Lee is passionate in promoting professionalism, patient advocacy, mentoring and inspiring nurses to reach their optimal potential and be change agents to "Pay it Forward."

Tara Cullen, MBA, BSN, RN

Tara Cullen has been a member of the finance committee since 2021. Tara has been an Emergency Department Nurse for 20 years. She is a high-energy, goal-oriented, solutions-based Nursing & Healthcare Operations Executive, with more than 10 years of proven success as an effective leader in and out of the hospital setting. Tara currently works in concierge medicine at Sollis Health, a membership based urgent and emergent care start-up in NYC.

Grace Crockett, BSN, RN, CPHON

Grace Crockett works at Memorial Sloan Kettering Cancer Center in the PICU. She has been working with the organization since she was a new graduate starting in the pediatric inpatient unit and has been in the PICU for a little over a year now. She serves as a Safe Patient Handling Champion, Magnet Champion, and Informatics Committee member within MSK. In early 2022 she completed a Nursing Research Fellowship at MSK in which she was the PI for a nursing research project she initiated. Grace is also involved in various fundraising opportunities for cancer research at MSK which led to her running the 2021 NYC Marathon with Fred's Team and participates in the Cycle for Survival cycling event every year. She is CPHON certified and is currently in school at Johns Hopkins University to get her DNP as a Pediatric Critical Care Clinical Nurse Specialist. She loves to explore the outdoors and travel which has brought her to various snowboarding locations across the US and to 7 US National Parks so far to hike.

Donna Tanzi, PhD, RN, NPD-BC, NE-BC

Donna Tanzi has a career that spans over 4 decades. Over 25 years of her career has been spent in Nursing Education but in the acute care setting as well as adjunct faculty at various nursing programs. Additionally, she brought a Long Island Hospital successfully through their 4th and 5th Magnet designation. Currently she is the Magnet Program Director for a tertiary hospital in Suffolk County New York. She has presented nationally and internationally on topics ranging from the Professional Image of Nursing, Nursing Education Initiatives and Innovations, and Post COVID-19 research study disseminations. She is certified in Nursing professional development and as a Nurse Executive.

ORGANIZATIONAL AFFILIATES

ANA-NY is Proud and Honored to be Associated with our Organizational Affiliates

Chi Gamma Chapter Sigma

Genesee Valley Nurses Association (GVNA)

Greater New York City Black Nurses Association (GNYCBNA)

Mohawk Valley Nurses Association (MVNA)

New York League for Nursing (NYLN)

New York State Association of Nurse Anesthetists (NYSANA)

New York State Association of Occupational Health Nurses (NYSAOHN)

New York State Association of School Nurses (NYSASN)

Nigerian Nurses Association of USA Inc (NNAUSA)

Northeast New York Professional Nurses Organization, Inc. (NNYPNO)

Nurses Association of the Counties of Long Island, Inc. (NACLI)

Philippine Nurses Association of New York (PNANY)

Professional Nurses Association of Dutchess/Putnam, Inc. (PNADP)

Professional Nurses Association of Rockland County (PNARC)

Professional Nurses Association of Suffolk County (PNASC)

Professional Nurses Association of South Central New York (PNASCNY)

Professional Nurses Association of Western New York, Inc. (PNAWNY)

Are you a member of a nursing group that should become an Organizational Affiliate (OA)?

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ORGANIZATIONAL AFFILIATE SPOTLIGHT

ANA-NY Welcomes Newest Organizational Affiliate, New York League for Nursing (NYLN)

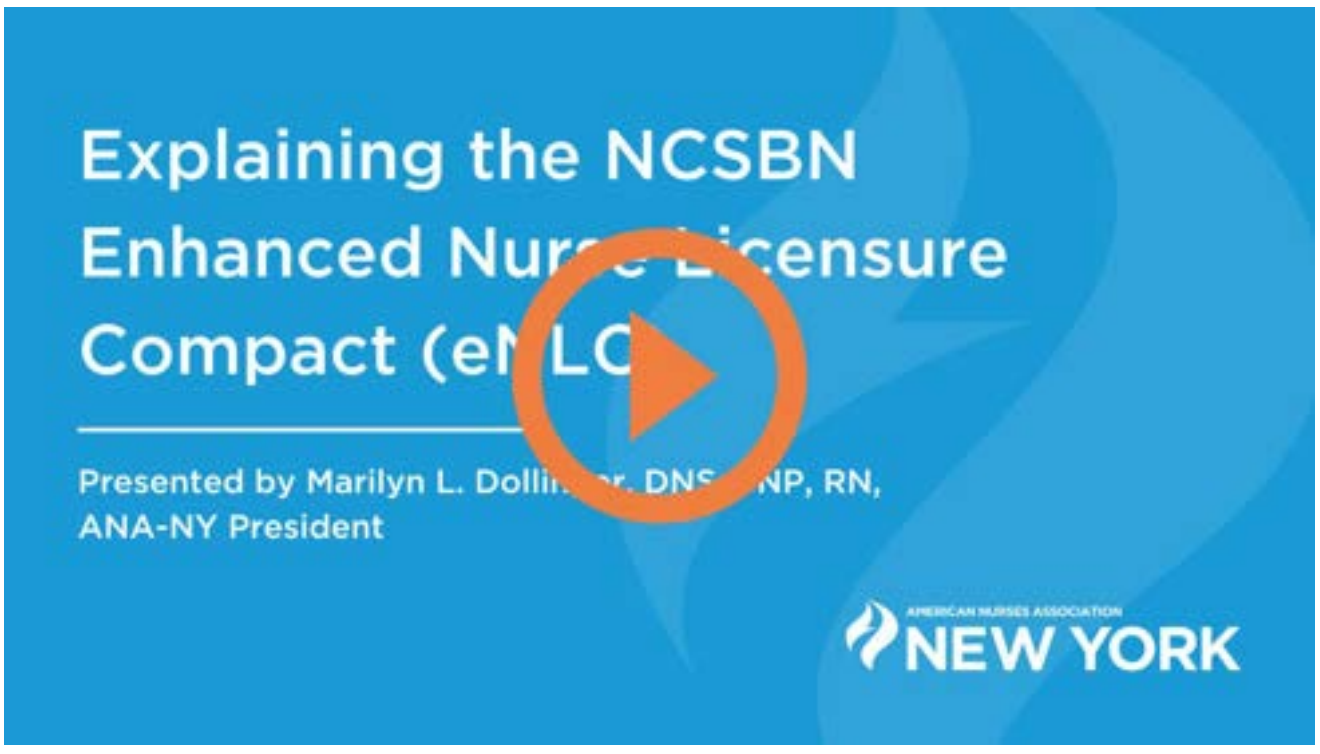
The mission of the New York League for Nursing is to build a strong and diverse nursing workforce to advance the nation's health at the constituent level.

"The impetus for the launch of the NYLN came during the 2011 National League for Nursing (NLN) Education Summit", said Karin Pantel, EdD, RN, CNE, founding NYLN president. A core group met in January 2012 on a snowy day for an initial planning session. Together, an amazing group of dedicated and passionate nurses and nurse educators collaborated to set a foundation for the NYLN that was sustainable. A core belief was the necessity of bringing affordable and accessible resources to nurses and nurse educators at the ground level. In the spring of 2014, the NYLN was granted full affiliate status as a constituent league of the NLN.

Today, the NYLN has over 80 members. Our strategic plan aligns with NLN goals. We promote the services of the NLN, in particular, the NLN's assessment services, the NLN's Ambassador program, and the NLN's certification for nurse educators. We provide two continuing education events every year, often partnering with other NYS nursing organizations. We participate in the dialog fostered by the New York Nursing Alliance.

The NYLN Board is composed of 12 NYS nurse educators, representing professional nursing education programs of all levels. The board holds virtual meetings every month.

We welcome new members and we are pleased to become an organizational affiliate of ANA-NY!



NO KIDDING

Which supplement do you put into a submarine? Fish oil

Connie J. Perkins, Ph.D., RN, CNE

Fish oil is a popular supplement around the world to promote heart and brain health. Just as the title insinuates, fish oil is extracted from mackerel, herring, tuna, and salmon tissue (Shane-McWhorter, 2022). These days the fishy smell is contained in capsules or with flavoring, but in Roman times garum, rotting fish intestines mixed with salt, was often used to top porridge or as a flavoring (Bare Biology, 2023). Gross, I think I'll just stick with granola on my porridge. Fish oil is made up of two key omega-3 long-chain fatty acids: eicosapentaenoic acid (EPA) and docosahexaenoic acid (DHA) (Shane-McWhorter, 2022). Because our bodies don't produce essential fatty acids on its own, we need to consume them. Typical Western diets don't include the recommended 2 servings of oily fish (sounds appetizing) a week, so we turn to supplements. While fish oil is the most common title found on the supplement's bottle, it often is called by its ingredients (i.e. Omega-3) depending on the manufacturer. While heart disease remains the most popular reason to take fish oil, studies have been conducted that show potential benefits in other diseases such as ADHD, depression, rheumatoid arthritis, menopause, lupus, and Raynaud's disease (Mount Sinai, 2023). Studies have even shown that patients with schizophrenia that take EPA/DHA experience fewer symptoms (Mentalhelp.net, 2023).

According to a National Health Interview Survey, over 18 million adults and over 600,000 children in the United States take fish oil (U.S. Department of Health and Human Services, 2018). While that works out to be less than 10% of our population, globally the demand is growing at the predicted rate of 6% by 2030 because of government health initiatives to include fish oil in supplements and functional foods available to various populations (Straits Research, 2022). With already nearly 30% of fish oil being made from fish waste due to the lack of whole fish availability, the aquaculture industry has adopted artificial intelligence (AI) to help optimize and grow the fish supply (Straits Research, 2022). AI is being used to automate feeding, remotely monitor water conditions, and gather data that help farmers make decisions (Rawat, 2022). I don't know about you, but I have a new found respect for this industry and am waiting for the new fashion trend of overalls with lab coats.

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Donate Life New York State

Each year during the month of April, Donate Life New York State (NYS) celebrates National Donate Life Month, raising awareness of the lifesaving impact of organ, eye, and tissue donors, and honoring those who have saved lives through the gift of donation. Throughout the month, we join donation advocates across the nation to remind the public that we all have the power to save lives by registering as organ, eye, and tissue donors. We also focus efforts on raising critical funds to continue helping those in need of lifesaving transplants

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EVIDENCE YOU CAN USE

Professional Generosity: Are You a Giver?

Victoria Record Ed D, AGPCNP-BC RN CN

Background

The United States nursing shortage will intensify leaving the growth of the profession and the retention of nurses as key strategies. The US Bureau of Labor Statistics projects that more than 195,400 additional nurses are needed from 2021 to 2031. (Registered Nurses: Occupational Outlook: U.S. Bureau of Labor Statistics (2023). This coupled with an aging nursing workforce poses significant challenges in meeting the healthcare needs of the communities. As of 2022, one million registered nurses were older than 50, with expected retirement in the next 10 to 15 years. (Haddad & Annamaraju, 2023). This number includes nurse faculty and presents a twofold problem: academic institutions are faced with enrollment limitations limiting the number of graduates a nursing school can generate. The American Association of Colleges of Nursing (AACN) reports that in 2021, a total of 91,938 qualified applications were not accepted at schools of nursing noting associated factors to include the number of faculty, available clinical sites, facility capacity, and financial restrictions. (Byrne et al., 2022;American Association of Colleges of Nursing [AACN], 2022).

Increasing the number of nurse faculty is a vital part of the nursing shortage solution. Factors such as salary, geographic location, culture fit, and vaccine requirements are important factors associated with choosing employment in academia (Byrne et al., 2022) Further as with any role in nursing, mentoring, professional development opportunities, and institutional encouragement to thrive are key elements of role success and can be broadly explained under the umbrella of professional generosity.

Practicing with professional generosity is a notion suggested to affect the experience of an individual and for purposes of this article, specifically, nursing faculty. Explorations of the literature defined professional generosity as “a spirit of willingness, openhandedness, magnanimity, and collegiality” (Disch, 2013, p. 195). It is through sharing lessons learned, providing opportunities for one’s advancement personally and professionally, practicing collaboration and collegiality, and encouraging the growth of another, one exhibits professional generosity.

Horvat (2021) conducted a qualitative study to examine the lived experience of professional generosity among nursing faculty. The study revealed that professional generosity had a positive correlation to retention, satisfaction, and giving to others. Further, the impact of professional generosity can add value to the profession of nursing, not only among nursing faculty but for nurses at all levels and in all specialties.

Results

Horvat (2021) explored the lived experiences of professional generosity for nursing faculty using Van Manen’s hermeneutic phenomenological method. A hermeneutic phenomenological approach is used to gain an increased understanding of a phenomenon through a repetitious review of the interview transcript, audio recordings, and emerging themes leading to interpretation (Polit & Beck, 2020). Further, it is noted that a “hermeneutic approach is a credible, rigorous, and creative strategy to address aspects of professional practice.” (Margo Paterson & Joy Higgs, 2005, p. 339)

For this study, Horvat (2021) used a convenience sample of tenured nursing faculty (8) with an earned doctorate who were recruited through a blog post. The age range for faculty was 38-62 years old, with 17-45 years of experience as an RN, and 11-43 years of experience in nursing education in various levels of educational programs from an associate degree to a doctoral. Each faculty was interviewed using open-ended questions starting with “Describe a time when you have experienced giving or receiving professional generosity among nursing faculty.” All interviews were recorded and transcribed by a CITI-certified transcriber. Horvat used thematic analysis and adequate saturation emerging 4 themes and 16 subthemes.

Theme 1: “I feel valued,”

Subthemes: “Belief and concern about me. Appreciated and validated. Authentic listening and sensing. The feeling of protection.”

Theme 2: “Core Relationship”

Subthemes: “Sense of cohesiveness and community. Family. Nurturing and unconditional acceptance.”

Theme 3: Reciprocity

Subthemes: "There's always a give and take. The environment of visioning and envisioning. The persistent meaningful feeling of empathy."

Theme 4: Growing our profession through connectedness.

Subtheme: “Sharing the same vision. Offering opportunities. Making the journey lighter. Passing the torch.”

Further, the author continued to reflect on the themes, subthemes, and quotes, revealing that the concepts of prosocial behavior (helping, sharing, comforting) strengthen the significance of the study’s results. An interpretive summary statement was developed in the final analysis: "Professional generosity is a personal sense of feeling valued developed through reciprocal core relationships between nursing faculty colleagues. As a result of these experiences of connectedness, a strengthened commitment towards growing the profession of nursing is fostered." (Horvat, 2021, p. 72).

Discussion

The results of Horvat’s (2021) qualitative study examining the experience of professional generosity within nursing academia evidence that generosity has a positive correlation to the experience of nurse faculty and can be projected to have the same correlation in other areas of nursing if further explored. The four themes identified; feeling valued, relationships, reciprocity, and growing our profession along with the concept of prosocial behaviors with underlying threads of helping, comforting, and sharing are the core of nursing practice and all of which contribute to the satisfaction and retention of the nursing workforce.

Feeling Valued

The participants identified "feeling valued" as one of support, appreciation, and validation which in turn motivated them to share with other new faculty. As quoted in the study, "I feel like I've had incredible opportunities to learn and grow with the support of my colleagues". This is an example of the support one participant experienced. Moreover, feeling valued and appreciated is linked to overall satisfaction and retention.

Core Relationships

Core relationships were the second theme identified and in this study, and were defined as collegial, positive, respectful, collaborating, trusting, and nurturing. One participant shared,“Another amazing person who came…and until then I didn’t feel like I had a true colleague, but we…we resonated”. This supports the literature and suggests a positive correlation to intention, satisfaction, engagement, and retention. (Rodwell et al., 2016)

Reciprocity

Reciprocity, the third theme, identified that resource sharing, providing feedback and sharing of experience and lessons learned created a sense of confidence and desire to “pay it forward” to other new nurse educators. One participant stated “Her generosity with reading my work, reading my grants, publications, mentoring me—she was just a sheer mentor. She gave of her time. And that has reciprocated in me doing the same for others,” These eight individuals became givers as well as receivers.

Growing our profession

The profession of nursing grows through engagement, networking, outreach, and connectedness. One participant described her colleague: “They introduced me to the right people I needed to know.” Their responses were consistent with the description of how generosity can manifest itself. Together, the depth and breadth of nursing practice and nursing education grow. Further, nurses at all levels and in all areas of practice must take an active role in growing our professional family through mentoring, relationships, and generosity.

Prosocial behavior

Prosocial behavior such as helping, sharing, and comforting are described as more than an act but a value, and all resonate with the core values of nursing. Taking the time to help another nurse is rewarding, and the opportunity to contribute to the growth of an individual also contributes to personal growth. Horvat (2021) succinctly sums up prosocial behavior, “Nursing is a profession that is associated with caring, and it is through this caring that helping, sharing, and comforting are integral parts of the profession.”

Understanding the experience of professional generosity can add value to the profession of nursing, particularly among nursing faculty as identified in

Horvat’s 2021 study. However, it is believed from personal experience and the literature that all professional nurses can benefit as well.

Conclusion

Practicing with professional generosity is a call to action and a professional responsibility. It is about teamwork, collaboration, and making others feel welcomed and valued. It means sharing knowledge, evidence-based practice, promoting outreach, facilitating connections, providing feedback for growth, and using storytelling and reflective practice. We must mentor and encourage networking and collaboration, hold each other accountable to high standards, and promote scholarship. The time is now, practice with professional generosity, and be a giver!

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MEMBERS ON THE MOVE

Maternity Care Deserts in the US

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In 1991, the federal government launched Healthy Start to improve maternal-child health outcomes. In 2021, the program provided more than $115 million in funding for 101 community collaborations to improve access to perinatal care, empower women to adopt healthy behaviors, and provide pregnancy and early childhood supports. Although infant mortality rates have improved, the nation's maternal mortality rate increased from 17.4 deaths per 100 000 live births in 2018 to 23.8 deaths per 100 000 live births in 2020, with the rate for Black women nearly triple that of White women. The US has the highest maternal death rate among high-income countries—nearly 3-fold higher than France, the country with the second-highest maternal death rate.

Within this context, childbearing services are becoming scarcer. Nationwide, more than 400 maternity services closed between 2006 and 2020. Between March and June 2022 alone, 11 health systems announced they were closing their obstetric services, citing low birth volumes and staffing challenges. As birthing units close, obstetricians and nurse-midwives are more likely to leave the area, exacerbating "maternity care deserts."

Maternity services are especially scarce in rural areas. Between 2004 and 2014, 9% of rural counties lost hospital maternity services; another 45% had no maternity services to begin with. Rural areas have greater proportions of Medicaid recipients than urban areas, with Medicaid paying substantially less than private insurers for child birthing. Ongoing closures of rural health services impede hospitals' abilities to improve maternal and infant outcomes.[1]

Two strategies could reduce maternity care deserts: expanding community-based models that are safe and affordable for low-risk women, and addressing workforce challenges.

Community Models of Perinatal Care

Child birthing centers (CBCs) have demonstrated excellent outcomes for women with low-risk pregnancies. Freestanding CBCs provide perinatal care, including labor and delivery services, using a midwifery and wellness approach, but partner with hospitals to provide care if complications arise. A hallmark of CBCs, the provision of continuous support during labor is associated with shorter labor, fewer cesarean deliveries and vaginal interventions, newborns with a high Apgar score, and higher patient satisfaction.[2]

Similarly, continuous support is characteristic of home births attended by a certified nurse midwife (CNM) or certified midwife (CM) (the term certified midwife refers to all licensed midwives who are not nurses; they are educated to provide perinatal care, including in women's homes and childbearing centers). Home births with CNMs or CMs who are part of an integrated network of care have comparable or better outcomes compared with in-hospital births for low-risk women.[3]

In 2016, the American College of Obstetricians and Gynecologists affirmed women's rights to childbearing choices, including CBCs and home births, when eligible. Both models cost considerably less than hospital birthing. One analysis estimated that a 10% increase in the use of these models would save more than $10 billion annually.

Workforce Challenges

The US has fewer health care professionals who offer maternity care, including obstetricians, than other high-income countries (except Canada). The number of midwives is 4 per 1000 births vs 25 to 68 midwives per 1000 births in comparable nations.

The safety and quality of care provided to low-risk women by CNMs and CMs in hospitals, CBCs, or homes is well established. One review found that midwifery-led "continuity models of care" were associated with fewer interventions (epidurals, episiotomies, instrumental births), higher patient satisfaction, and comparable or lower rates of maternal or infant adverse outcomes than other care models.[4] Twenty-three states still do not permit full practice authority to CNMs.

Historically, lay midwives provided care to poor women in the US, particularly in the South, before there was a movement by physicians and nurses to restrict the practice of Black lay midwives.[5] Much of the nursing profession opposed the use of licensed midwives who are not nurses until the 1990s. In 2022, the American College of Nurse-Midwives affirmed its support for CMs who are educated at the master's level. As of 2021, 36 states license midwives who are not nurses, but only 18 of these states pay for their services under Medicaid.

The use of doulas is expanding as a cost-effective way of reducing health disparities by providing support to women before, during, and after labor and delivery, including through community-based organizations.[6] Doula support is associated with fewer cesarean and interventional vaginal births, as well as lower rates of postpartum depression and anxiety. This movement is growing, including through Healthy Start funding of community-based doula initiatives.

Policies to Reduce Maternity Deserts

In June 2022, the White House published a blueprint for addressing maternal health disparities, including improving the readiness of hospitals lacking maternity services to provide safe deliveries.[7] Wider availability of evidence-based midwifery-led care and doulas for low-risk women can prevent and rectify maternity care deserts. The following key policy changes could accelerate this movement:

Paying CNMs, CMs, and doulas for perinatal care in all settings. This includes federal recognition of CMs and payments under Medicare and Medicaid. TriCare (which does not pay for care by CMs) and private payers should cover these services, and states should amend their Medicaid plans to do likewise.

Adequate coverage by all payers for eligible births at home and in freestanding CBCs. Periodic evaluation of Medicaid payments, which cover about 40% of all US births, is needed to ensure they cover reasonable costs.

Invest in growing and diversifying the perinatal workforce. The federal government currently funds states for innovations related to perinatal home visitation, including clinical care and workforce development. These supports should be enhanced, especially for programs targeting Health Professional Shortage Areas, including scholarships, loan forgiveness, and graduate medical education funding for institutions that develop obstetrical residency programs serving rural hospitals.

Invest in building community-based maternity services. To end maternity care deserts, start-up funds are needed for planning, launching, or expanding services. An approach comparable with the Hill-Burton Act of 1946, which invested in increasing the nation's capacity for acute care hospitals, is needed to expand community-based maternity care that includes primary care when limited.

The childbearing period is crucial to healthy children, mothers, and communities, but the US fails to ensure adequate perinatal and birthing care. Evidence-based, community solutions to eliminate maternity care deserts are within reach.

The Center for Nursing History Celebrated Black History Month

The Bellevue Alumnae Center for Nursing History archives at the Foundation of NYS Nurses, Inc. stores an impressive history of remarkable and courageous nurses who paved the way for the nursing profession since the 1800's. Some of the most notable are Black Nurses whose journey was often met with challenges unlike their white colleagues. To celebrate their many triumphs and honor their courage, the Center for Nursing History created a brief timeline.

1879 – Mary E. Mahoney: First Black Professional Nurse

Mahoney received her diploma from the New England Hospital for Women and Children in Boston, Massachusetts. In April 1954, the American Journal of Nursing celebrated the 75th anniversary with an article that stated:

"Mary Mahoney is honored not only because she was the first Negro who had the courage to enter a school of nursing, side by side with her white sisters, but because this nurse was an outstanding student and tender practitioner, an exemplary citizen, and an untiring worker in both her local and national professional organizations".

1886 – The Atlanta Baptist Female Seminary

The Seminary established the first nursing education program offering a Diploma in Nursing, exclusively for Black women. The Seminary was later renamed Spelman College, and numbers among the historically Black colleges and universities in the United States.

1898 – Lincoln Hospital Training School Established

Formed out of the Society for the Relief of Worthy Aged Indigent Persons in New York, Lincoln Hospital was the first school of nursing for Black women in New York.

1908 – Establishment of the National Association of Colored Graduate Nurses (NACGN)

Black nurses were permitted to join the American Nurses Association only if their state allowed membership in its nurses' association. Many nurses, especially in the South, were unable to join the ANA. The NACGN was established partly in response to this discrimination. The organization's goals were: to advance the standards and best interests of trained nurses; to break down discrimination in the nursing profession; and to develop leadership within the ranks of Black nurses.

1918 – Frances Reed Elliott Davis joins the American Red Cross Nursing Service

A graduate of Freemen's Hospital School of Nursing, Davis was the first Black nurse to join the Red Cross. She went on to practice at the Henry Street Visiting Nurse Service (NYC) and the New York Board of Charities.

1923 – Harlem Hospital Training School opens

The driving force behind the opening of the school was Mr. William Vassals and his daughter, Lurline, who was denied entry into Bellevue Hospital School of Nursing because of her color. All 20 students of the first graduating class of Harlem Hospital passed the State Board examination to become registered, licensed nurses.

1932 – Chi Eta Phi is formed at Freedmen's Hospital

Its purposes are to:

- o Develop a corps of nursing leaders;
- o Encourage continuing education;
- o conduct continuous recruitment for nursing and other health professions;
- o stimulate close and friendly relationships among members; and
- o develop working relationships with other professional groups.

1941 – Army Nurse Corps opens to Blacks

"The policy of the United States is to encourage full participation in the national defense program by all citizens of the United States, regardless of race, creed, color or national origin, in the firm belief that the democratic way of life within the Nation can be defended successfully only with the help and support of all groups within its boarder." President Franklin Delano Roosevelt

1947 – Mabel Keaton Staupers receives the Mary Mahoney Medal

It is in thanks primarily to the efforts of Mabel Keaton Staupers that Black nurses were integrated into the military during World War II. Staupers, a graduate of Freedmen's Hospital School of Nursing, served as the first executive director and last president of the National Association of Colored Graduate Nurses. Established by the NACGN in 1936, the Mary Mahoney Medal is presented to an individual who has been instrumental in promoting equal opportunity to a minority person in nursing at the American Nurses Association.

1951 – The NACGN merges with the ANA

"It would be difficult to say whether the founding of the National Association of Colored Graduate nurses in 1908 or its dissolution in 1951 gave greater satisfaction to its members." Mable Staupers Keaton

1954 – *Brown vs the [Topeka] Board of Education*

The editor of Nursing Outlook, R. Mildred Hall, wrote:

"But the satisfaction we feel in the 'rightness' of this step is only a beginning. We know that Negro nurses are employed by many hospitals and health agencies. We know that Negro nurses hold commissions in the armed services, that they receive all the benefits and carry the responsibilities which go with those commissions. We know that 710 of our 1148 accredited schools of nursing accept qualified Negro students. We know, too, that some, although not many, Negro nurses hold administrative positions in hospitals and agencies. No, this is not enough. Is participation on the boards, on committees, and on staffs of all service groups extended on an equitable basis? Are all nurses free to take part in our organizations' programs, policy decisions, and conferences? There is much yet to be done. And we shall do it – slowly and quietly. What is most important just now is to look to the future and determine what this ruling will mean in the next few decades."

1954 – Ivy Nathan Tinkler Appointed Director of Nursing at Lincoln Hospital

Ivy Nathan Tinkler was both the first Black Director of Nursing and the first graduate of the Lincoln Hospital Training School to hold this position.

1964 – Lt. Colonel Margaret Bailey

The first Black nurse to attain the rank of Lieutenant Colonel, Bailey joined the army in 1944 and spent almost 9 of her 27 years of service outside the US. She was promoted to full Colonel in 1970, the first Black nurse to attain that rank.

NBNA
NATIONAL BLACK NURSES ASSOCIATION, INC.

1971 – The National Black Nurses Association is Founded

The NBNA mission is "to serve as the voice for Black nurses and diverse populations ensuring equal access to professional development, promoting educational opportunities and improving health." Today, NBNA represents 308,000 Black registered nurses, licensed vocational/practical nurses, nursing students and retired nurses from the USA, Eastern Caribbean, and Africa, with 114 chartered chapters, in 34 states. NBNA.org

1978 – Barbara Nichols, MS, RN, Becomes the First Black President of the American Nurses Association

After her service as ANA president, Nichols was named secretary of the Wisconsin Department of Regulation and Licensing; with that appointment she became the first Black female in Wisconsin to hold a state Cabinet-level role.

1979 – Hazel Johnson-Brown Becomes the Chief of the Army Nurse Corps

Johnson-Brown, the first Black nurse to hold this position, was also the first Black nurse to achieve the rank of Brigadier General and the first Chief of the Army Nurse Corps to hold an earned doctorate.

1984 – ANA Hall of Famer Mary Elizabeth Carnegie Publishes The Path We Tread: Blacks in Nursing 1854-1954

"Yes, I have seen many positive changes in attitudes toward and opportunities for black nurses in this country in education, service, and organized nursing, and I have all the faith in the world that this trend will continue. This is my belief and it is a belief that man is not always inhumane to man. I believe nursing is leading the other professions in its commitment to equality for all its members." M.E. Carnegie

1985 – Vernice Ferguson Becomes President of Sigma Theta Tau International

A Bellevue Hospital School of Nursing graduate, Ferguson was the first Black nurse to hold this position.

Sigma

1992 – Eddie Bernice Johnson Becomes the First Registered Nurse to be Elected to Congress

Representing the 30th District of Texas, Johnson later became the first Black and first female ranking member of the Science, Space and Technology Committee

2000 – Blacks in Nursing at the Dawn of the 21st Century

According to the March 2000 National Sample Survey of Registered Nurses, 133,041 or 4.9% of the RNs in the US were Black. Minority nurses were increasing at a faster rate than their white counterparts, were more likely to work full-time, and a higher precent held master's or doctoral degrees.

2005 - Verlia M. Brown, MA, RN, BC

Brown was elected and served as president of the New York State Nurses Association.

2007 – Beverly Malone, PhD, RN

Dr. Malone was appointed Chief Executive Officer of the National League for Nursing. Previous offices held during this decade include General Secretary of the Royal College of Nursing (2001 – 2006) and Deputy Assistant Secretary for Health (1999 – 2001), the highest position held by any nurse in the U.S. government to that date.

2014 – Black Nurses Rock is Founded

Black Nurses Rock is the largest online community where professional Black nurses share, network, and develop together. Black Nurses Rock Official Home Page

2018 – Ernest Grant Becomes the First Male President of the American Nurses Association

Dr. Grant was the first Black man to graduate with a Ph.D. in Nursing from the University of North Carolina (UNC) Greensboro. In 2002, President George W. Bush presented Grant with a Nurse of the Year Award for his work treating burn victims from the World Trade Center site.

2022 - Kenya Beard Becomes Chairperson for the New York State Board for Nursing.

Beard also represents the National League for Nursing as a commissioner for the National Commission to Address Racism in Nursing.

National Sample Survey of Registered Nurses

In 2018, the most recent date for which these data are available, the National Sample Survey of Registered Nurses revealed that 257,926 (8%) of America's licensed and employed nurses were Black.

The Bellevue Center for Nursing History is one of three centers at the Center for Nursing at the Foundation of NYS Nurses, Inc. www.cfnny.org

Most photos courtesy of the Bellevue Alumnae Center for Nursing History archives. Photo of Barbara Nichols and Ernest Grant courtesy of ANA, photo of Beverly Malone courtesy of NLN, photo of Kenya Beard courtesy of LinkedIn.

Timeline originally compiled in 2015 by Gertrude Hutchinson, DNS, RN, MA, MSIS, CCRN-R when she was employed as the Archivist at the Center for Nursing. Revised, updated, and compiled by Susan Birkhead, DNS, MPH, RN, CNE and Deborah Elliott, MBA, BSN, RN.

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Nurse License Protection Case Study: Falsifying the Record of a Medication Error

Nurses and License Protection Case Study with Risk Management Strategies Presented by NSO

A State Board of Nursing (SBON) complaint may be filed against a nurse by a patient, colleague, employer, and/or other regulatory agency, such as the Department of Health. Complaints are subsequently investigated by the SBON in order to ensure that licensed nurses are practicing safely, professionally, and ethically. SBON investigations may lead to outcomes ranging from no action against the nurse to revocation of the nurse's license to practice. This case study involves a registered nurse (RN) who was working as a traveling nurse on an oncology floor.

Summary

The insured registered nurse (RN) involved in this matter was a traveling nurse working on an oncology floor. The RN took a dose of pregabalin capsules out of the automated medication dispensing cabinet and requested that another nurse on the floor, who was also a traveling nurse, administer it to her patient. The second nurse took the medication and gave it to a patient. The second nurse soon realized she had given the medication to the wrong patient. She immediately called the physician on call and notified the Charge Nurse that the wrong patient had received a dose of pregabalin. The RN then recorded the medication error in the patient healthcare information record per hospital policy.

While the RN and the second nurse told the physician on call and the Charge Nurse what actually happened with the pregabalin dose, both also agreed to record the improperly administered pregabalin dose as a waste on the Controlled Substance Discard Record. The RN then went to the pharmacy to obtain a new dose of pregabalin for her patient. When the pharmacist asked why she needed another dose, the RN stated that she had accidentally dropped the other capsule on the floor and had disposed of it in the sharps container.

The pharmacist later ran a report on the automated medication dispensing cabinet to track how much pregabalin was dispensed the date of the incident. While the pharmacist expected to find two doses administered to the correct patient that day and one dropped/wasted dose, she found that two were administered to the correct patient and one had actually been administered to the wrong patient. The pharmacist reported this discrepancy to hospital administrators, who initiated an internal investigation into the nurses' conduct.

Investigation

The RN later admitted to hospital personnel that she was untruthful to the pharmacist about wasting the pregabalin. Both nurses stated that they had been untruthful about wasting the medication so that the RN's patient would not be charged twice for the dose of pregabalin due to their mistake.

The hospital investigators also concluded that the RN falsified the signature on the Controlled Substance Discard Record. The signature on the record was illegible. When the RN was asked who had signed the record, she gave the name of another nurse who worked on the floor. This statement was soon revealed to be untrue when it was discovered that the nurse the RN named had not been working on the date of the incident.

At the conclusion of their internal investigation, hospital personnel terminated the RN's contract and reported the RN to the State Board of Nursing (SBON). The hospital also complied with the subsequent SBON investigation into the RN's alleged conduct.

Resolution

At the conclusion of their review of the facts of the matter, the SBON admonished the RN for failing to follow appropriate procedure for obtaining a second dose for the correct patient. The SBON also lamented that the RN documented false information about the medication error in the Controlled Substance Discard Record without any need to do so- she had already disclosed the medication error.

The SBON decided to place the nurse on probation for three years. The total costs incurred to defend the nurse in this case exceeded **$7,000.**

(Note: Monetary amounts represent the legal expenses paid solely on behalf of the insured registered nurse.)

Risk Control Recommendations

Nurses can reduce risks associated with medication errors by following suggested actions:

- ***Remember that no medication safety method is infallible.*** Understand that while technologies such as bar-code scanning can help reduce medication errors, this and other medication safety methods are not immune to system or human error. This is why it is important to employ multiple, concurrent safety measures, including consistently verifying the "six rights" when administering medications to patients:
  - Right patient;
  - Right drug;
  - Right dose;
  - Right route;
  - Right time; and
  - Right documentation.
- ***Know the medication(s) being administered to the patient.*** Although nurses do not prescribe, and only rarely dispense medications, they are responsible for administration. Nurses represent the last line of defense to prevent medication errors from reaching the patient. Therefore, they must understand why the patient is taking a specific medication, as well as interactions, side effects, or adverse reactions that may occur.
- ***Eliminate sources of distraction and interruption,*** as much as possible, when administering medication.
- ***Follow established medication protocols.*** If "work-arounds" persist, consult with the facility's nursing leadership about opportunities to improve medication protocols and systems, and methods to enhance staff monitoring and compliance.

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Earthquakes and Aftershocks

Giselle Gerardi, Ph.D., RN & Omari Maynard

A Mostly Uneventful Birth

Shamony Makeba Gibson and Omari Maynard welcomed their second child into the world on September 23rd, 2019. Despite needing a repeat cesarean section, the birth was relatively uneventful. Shamony and her son were discharged and sent home to join the rest of their family. Shamony did require blood thinners, as some clots were noted when her IV was started.

Venous Thromboembolism (VTE) related conditions are one of the leading causes of pregnancy-related death in the United States (Centers for Disease Control and Prevention, 2017) and New York State (New York State Department of Health, 2022). Due to physiologic changes during pregnancy, birthing people are hypercoagulable. This hypercoagulable state causes birthing persons to be at an increased risk of VTE, deep vein thromboembolisms (DVT), and pulmonary embolisms (PE) (Bates et al., 2016). The risk of VTE-related events continues through the postpartum period.

Neglecting the Signs

After the birth of her son, Shamony was short of breath. Despite various encounters with healthcare providers, where she described acute shortness of breath and fatigue, she was assured that this was normal during the postpartum period. Shamony Makeba Gibson died on October 6th, 2019, thirteen days after the birth of her son. The cause of death of the 30-year-old was related to a pulmonary embolism.

With proper assessment and management, perinatal deaths related to VTEs and PEs are often found to have been preventable (New York State Department of Health, 2022). This was not different for Shamony as she had various risk factors and exhibited symptoms such as severe shortness of breath and fatigue. Despite being treated with blood thinners, her medical history and presenting symptoms should have prompted additional interventions and assessments that could have identified and treated the PE that ultimately took Shamony's life.

Knowledge is not enough

Shawnee Benton-Gibson, a reproductive justice advocate and Shamony's mother, was concerned about her daughter's deteriorating state after she came home. Aware of the clots, Ms. Benton-Gibson educated her daughter on PEs. However, Shamony reassured her mother that she was adequately assessed before discharge and was receiving interventions to prevent clots like anticoagulants and compression garments. Two weeks after the birth of her son, Shamony became unresponsive. When EMS arrived, despite Shawnee letting the team know that she had recently given birth and that it could be related to her clots, many emergency personnel asked repeatedly about substance use. Shamony went into cardiac arrest and coded at home.

Poor outcomes are a problem for all birthing persons in the United States. Maternal morbidity and mortality continue to increase in the US, despite an overall improvement globally (Douthard et al., 2021). While New York State (NYS) has improved maternal health outcomes over the past 10 years, there is much room for improvement as the state ranks 23rd in the nation based on maternal mortality rate (America's Health Rankings, 2019). Furthermore, there are stark differences in outcomes between racial and ethnic groups.

In 2020, the national mortality rate for Non-Hispanic Black birthing parents was 3 times higher than their Non-Hispanc White counterparts (Hoyert, 2022). Unfortunately, that disparity widens in NYS where Non-Hispanic Black Women have a rate 4 times higher than that of their Non-Hispanic White counterparts (New York State Department of Health, 2022). While the social determinants of health contribute to health disparities between Black and White people, when controlling for socioeconomic and education factors, disparities continue to exist (Williams et al., 2016). Systemic racism, racism, and implicit bias all contribute to these disparities (O'Brien et al., 2020). While this may be an unsettling fact, it is important that healthcare professionals, especially nurses, are aware of the impact that they have. We are in a key position to perpetuate, widen or diminish these disparities.

A Father's Grief: Words from Omari Maynard

Losing your life partner as you bring new life into the world is an exchange that I would not wish on my worst enemy.

As our children grow and we stare into their eyes, the eyes that stare back are of their better half.

As our children grow and we watch them develop into their whole selves, their mannerisms are those of their better halves.

As our children grow and question the world around them, they develop a life knowing that something is missing.

When they look through us, they feel that something is missing. When they question where their mothers are, they know that something is missing.

I can give my children the world but I can never give my children motherly love.

I can do my best to replicate it but only Shamony can give them that. Intimacy and grief remind me of that every day.

I hold them and reassure them that everything is going to be ok but I honestly don't know if it will. Intimacy and grief remind me of that every day.

Shamony Mekeba Gibson's death was and is a tragedy. The healthcare system took something away from my family and I that can not and will never be replaced. As special as Shamony is, her story is far too common. Hundreds of women pass away every year during and after childbirth. Tens of thousands of women have near-death experiences every year. Most of these losses and traumas are avoidable as 80% of maternal mortality cases are preventable (Trost et al., 2022).

There are hundreds of thousands of families that are far too familiar with intimacy and grief. There are far too many families that feel their cries fall on deaf ears.

There are far too many families that feel like their voices are not being heard.

There are far too many families that feel like their story does not matter.

Moving Forward

Tacking disparities in healthcare and improving overall outcomes is a daunting task. However, nurses are in a position to contribute to positive changes, individually and as a group. Nurses are the most trusted profession, we should be proud of this and continue to build upon it. To summarize the ANA Code of Ethics, it is our duty to righteously advocate for others in whatever capacity we can (American Nurses Association, 2015). Nurses are in positions that heal, educate, research, and support others. We must be cognizant that our work promotes health and reduces disparities equitably.

Aftershock Documentary

https://www.aftershockdocumentary.com/

About the film: Following the preventable deaths of their loved ones due to childbirth complications, two families galvanize activists, birth workers, and physicians to reckon with one of the most pressing American crises of our time – the US maternal health crisis.

ARIAH Foundation:

www.theariahfoundation.org

The Advancement of Reproductive Innovations through Artistry and Healing or ARIAH foundation continues to be a voice for the voiceless. This is what drives us to continue to show up because without our stories, without community, without our blood, sweat, and tears, change can not occur.

saveArose Foundation

https://www.savearosefoundation.org/

saveArose is a nonprofit organization that seeks to eliminate the systemic flaws within maternal health care, to bring the first-ever freestanding Midwifery led birth center to the Bronx, and to bring better birthing options to the community.

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Five Things We Learned about Alzheimer's Disease in 2022

2022 was a productive and promising year for Alzheimer's research, including discoveries related to the causes, risk factors and treatment of Alzheimer's disease and other dementias. Here are five important things we learned about Alzheimer's in 2022:

1. **Alzheimer's treatments are getting better.** In November, pharmaceutical companies Eisai and Biogen announced positive results from their global Phase 3 clinical trial of an Alzheimer's drug called Lecanemab, slowing the rate of cognitive decline in study participants by 27% over 18 months. These are the most encouraging results we have seen to date for an Alzheimer's treatment.
2. **A daily multivitamin may slow brain aging.** Research published in September found that taking a multivitamin-mineral supplement every day for 3 years resulted in a statistically significant cognitive benefit. This is the first positive, large-scale, long-term study to show that multivitamin-mineral supplementation for older adults may slow cognitive aging. With confirmation through research, these promising findings have the potential to significantly impact public health — improving brain health, lowering health care costs and reducing caregiver burden — especially among older adults.
3. **Frozen pizza, candy and soda may raise the risk of cognitive decline.** At the Alzheimer's Association International Conference (AAIC) last summer, new research results found that eating a large amount of ultra-processed food, which make up more than half of American diets, can significantly accelerate cognitive decline. The good news is there are steps we can take to reduce risk of cognitive decline as we age. These include eating a balanced diet, exercising regularly, getting good sleep, staying cognitively engaged, protecting from head injury, not smoking and managing heart health.
4. **Experiencing racism is linked to poor memory.** Also at AAIC 2022, researchers reported that experiences of structural, interpersonal and institutional racism are associated with lower memory scores and worse cognition in midlife and old age, especially among Black individuals. These data are especially important given Black Americans are about twice as likely, and Hispanic Americans are about one and one-half times as likely, to have Alzheimer's or other dementias according to the *2022 Alzheimer's Disease Facts and Figures* report.
5. **Wearing hearing aids may reduce risk of dementia.** Individuals with hearing loss who used hearing restorative devices had a 19% decrease in risk of long-term cognitive decline, according to research published in December. These data appeared five months after the FDA announced it will allow hearing aids to be sold over the counter, greatly expanding access to 30 million Americans living with hearing loss. In addition to improving daily communication, use of hearing aids may also benefit brain health.

While advancements are happening, the significant impact of Alzheimer's remains. Over a recent 20-year period, deaths from heart disease went down 7.3%, while deaths from Alzheimer's increased 145%. In 2022, Alzheimer's and other dementias will cost the nation $321 billion.

With several FDA decisions expected on Alzheimer's treatments in 2023, this is a very exciting time in the fight to end this disease. Thanks to increased research funding from the federal government and nonprofit organizations there is great hope that we'll see more advances and discoveries for people living with, and at risk for, Alzheimer's disease and all other dementia.

For more information, visit alz.org or call 800-272-3900.

Congratulations!

ANA-New York is proud to announce that **Park Ridge Living Center** has achieved the prestigious Pathway to Excellence in Long Term Care® redesignation. Pathway to Excellence recognizes excellence in positive practice environments and ensures that nurses are empowered, engaged, and have a strong voice in their practice.

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ANCC AMERICAN NURSES CREDENTIALING CENTER PATHWAY TO EXCELLENCE

AMERICAN NURSES ASSOCIATION NEW YORK

Welcome to our New Team Members

Please join us in welcoming our new team members, Deborah Spass, Program Manager and Kennedee Blanchard, Member Engagement Associate.

My name is Deborah Spass and I'm excited to join ANA-NY as your new Program Manager! My most recent position was a Confidential Secretary at a local Community College. I am looking forward to working with every one of you as we continue to provide opportunities for our members to grow professionally. In my spare time, I enjoy spending time and having fun with my family and friends.

My name is Kennedee Blanchard, and I am delighted to introduce myself as your new Member Engagement Associate. Some of you may know me from my previous role at the Center for Nursing, where I worked for the past 8 years, however, I am excited to resume and start new relationships in my new position at ANA-NY. In my spare time, I enjoy spending time with my family, including my fur baby, Ernie, and friends. I look forward to being a critical resource for all of you and growing our membership to build a community of empowered nurses in New York State.

CONTINUING EDUCATION

Transition Into Practice: Hospital Acute Care VS. Community Care

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- This nursing continuing professional development activity was approved by American Nurses Association Massachusetts, an accredited approver by the American Nurses Credentialing Center's Commission on Accreditation.

In this newsletter we have two brief, related articles for continuing education. Our first article addresses the ups and downs of transition into practice and the second article takes that transition a step further by mapping out how membership in a professional organization can help new nurses to thrive.

Transition into Practice: Hospital Acute Care VS. Community Care

Aliza Bitton Ben-Zacharia & Tara Zacharzuk-Marciano

New nurses' transition to their initial employment site and nursing workforce is often described as challenging and stressful.[1] Transition experiences to practice are associated with nurses' satisfaction and their retention in the workforce and profession. There are multiple facilitators to transition including the importance of an orientation period, preceptors, mentors, supportive co-workers, and social interactions to promote a positive and a healthy work environment.[1,2] Contrastingly, reasons for non-attrition of new nurses in acute care settings include unreasonable workloads, poor nurse-physician work relationships, high patient acuities, unfamiliar and advanced medical technology, and lack of collaborative knowledge sharing.[3,4,6] Mostly, new nurses feel lack of confidence when transitioning into the workforce facing workloads with high patient acuity levels, lack of self-efficacy, and lack of organizational commitment.[1,2,7]

Often, academic faculty and hospital educators encourage new nurses to transition into acute care or medical-surgical units in various hospitals to develop the needed clinical reasoning and clinical judgment skills. The hypothesis of these professionals surrounds on the fact and premise that hospital experience is mandatory to the success and expertise of novice nurses transitioned into the workforce regardless of the new nurses' knowledge, skills, and comfort level in an acute environment. It is evident that new nurses require at least one year to feel confident practicing in acute care settings.[3] This leads to poor retention rate in acute care with up to 48% of novice nurses leave their position within the first year of practice.[3,4,8] Therefore, transition into workforce must include an individualized plan and consultation by academia and hospitals. New nurses have different personal characteristics and experiences; thus, new nurses may fit into community workforce as opposed to acute hospital settings.

Mentorship, preceptorship, and support of new nurses are critically important in all settings. Preceptorship is a fixed-period process where experienced and competent nurses provide education and support to learners to promote their learning and development.[5,6] Contrastingly, Mentoring is voluntary, mutually beneficial, and usually includes long-term professional relationships.[5,6] Schlossberg's Transition Theory7 is useful when investigating the transitions of new nurses into the workforce and the effects of their preceptors and mentors. Schlossberg described the new nurses' transition process by 4 Ss: support, strategies, self and situation.[7] Based on this theory, each nurse deals with the event differently depending on these 4 Ss.[7] The components of the 4 Ss affect the ability of nurses to cope during the transition into the workforce and they are regarded as potential assets or liabilities allowing for changes during the transition (Figure 1). Thus, the transition theory can be applied in clinical practice promoting an understanding of the transition experience of new nurses.[7] This theory also emphasizes the role of preceptors followed by mentors to new nurses in their positions and sites. Moreover, well-planned and executed orientation programs tailored to each individual learning needs while acknowledging prior experiences increase the retention of newly hired nurses.[3,7]

Transition of new nurses into the workforce must be individualized. New nurses may enroll into acute or chronic settings. New nurses may individualize their workforce options based on their comfort in acute care, their experiences as a student in the different sites, their critical thinking skills, and global knowledge. New nurses may benefit from transitioning into community positions such as, school, industry, private practice, residentials facilities and others. Academic institutions and hospital ought to develop consulting services to aid new nurses in their decision-making and choosing the best practice for them. It is unnecessary for each new nurse to start their career in acute care. Nurses have multiple options in the workforce to promote their confidence, self-awareness, and empowerment.

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Schlossberg's Transition Theory and the transition process and the NGN or RN changing practice settings. Adapted from Figure 2.1 (The Individual in Transition), Counseling Adults in Transition, Fourth Edition: Linking Schlossberg's Theory With Practice in a Diverse World by Mary Anderson, PhD; Jane Goodman, PhD; Nancy Schlossberg, EdD. Reproduced with the permission of Copyright © 2011 Springer Publishing Company, LLC.

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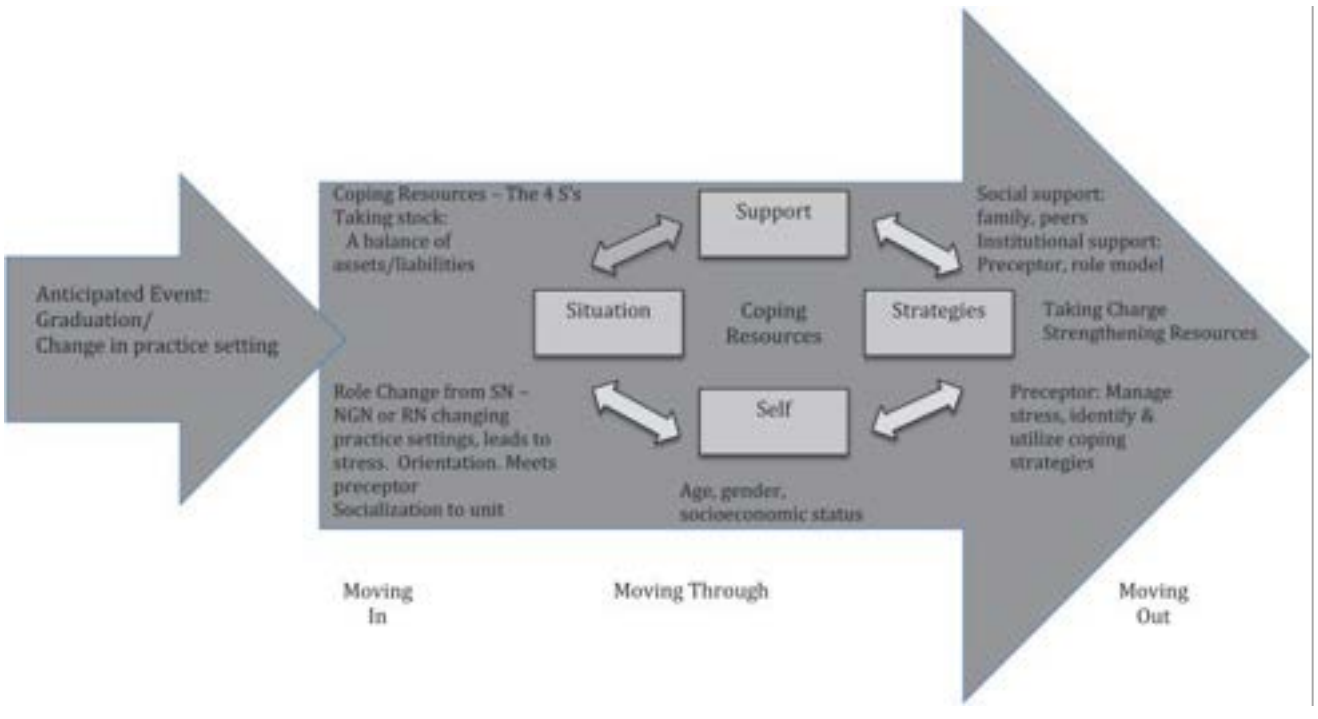

CONTINUING EDUCATION

Helping New Nurses to Thrive Through Membership in a Professional Organization

Joanne Lapidus-Graham Ed.D, RN, CPNP, CNE

Why join a professional organization?

As a nursing student back in the early 1980's, the professor in our professional issues course indicated that we needed to join a professional nursing organization. The students were asked to answer the question: what is the purpose of a professional nursing organization and why should you join? Many students thought joining the organization would look good on a resume. The real question is, should a new graduate nurse, or any nurse, join a professional it looks good on your resume? **This is definitely not a reason to join.**

What the author discovered after graduation is that the nurse has much to gain from a professional organization and so much more to offer the profession of nursing, particularly our newest nurse graduates. In this short article, the author will explore the major reasons she joined a professional nursing organization (over 40 years ago) and what has continued to keep her motivated and actively involved today.

1. Professional growth and development

Serving first as a committee chair in the New York State Nurses Association within 4 years after graduation helped me to discover the value of participation and how it could contribute to improving nursing practice. Early volunteer opportunities propelled me further and led to the discovery of other related organizations such as the Nurses Association of the Counties of Long Island (NACLI), in which the author served first on the board and later served as President. The experience gained from NACLI led to being elected to the first board of the American Nurses Association of NY (ANA-NY), followed by serving as the Vice-president. The author currently serves as President of the Chi Gamma Chapter of Sigma and as Chair of the ANA-NY Nursing Education Committee.

Multiple positions and participation in volunteer activities was rewarding and always offered many additional networking opportunities. Being an active member allowed me to cultivate my leadership skills, provided many opportunities for learning and to gain new skills, and allowed ***my voice to be heard***. Professional organizations as a resource for new graduate nurses emphasize how to address and embrace change in an ever-changing health care delivery system.

2. Educational opportunities

Nursing and health care science and technology change rapidly and the professional organizations provide opportunities to be a lifelong learner and to practice nursing more safely. Most of these organizations offered continuing education courses (CE) for free or at reduced rates for members, and published peer- reviewed journals. The conferences also offer educational and networking opportunities. Some organizations also offer certifications in your specialty which demonstrates a commitment to excellence in your practice.

New graduate nurses need to know that the first chapter of the educational process does end when they graduate from a nursing program, but the second chapter of education actually begins with the first nursing position. It can take at least a year to build confidence in nursing practice, so regardless of whether you are in a formal mentor or nurse residency program, new nurses need to use opportunities to enhance and build their practice by taking advantage of continuing education courses.

3. Networking and mentoring opportunities

The opportunity to meet and to interact with other professionals throughout your nursing career is invaluable and provides many new opportunities. ANA has several online communities (such as Healthy Nurse/Healthy Nation) to connect with people around the world and to improve the health of the nursing profession. ANA also has a virtual career center. You have the opportunity to build a national or international network to share ideas and make career connections.

ANA has a mentorship program in which new nurses can connect with more experienced nurses and share strategies for enhancing their practice, build resilience, and prevent burnout. New graduate nurses need to align with individuals who are positive role models who help in building self-esteem, self-confidence, by emphasizing the new nurse's strengths and qualities.

Most nurses truly care about each other and want to see new nurses thrive and be successful and provide the best care for our patients through teamwork, collaboration and with the most effective use of communication. Communication is the key to a successful career in nursing and is one of the most valuable tools. ANA has resources and webinars that facilitate communication in nursing practice.

4. Advancing nursing as a profession

Americans have ranked nursing as the most trusted profession for 21 years, but what about the world's perspective of nursing? Professional organizations promote safety, ethics, advocacy, health and wellness for nurses in the workplace. ANA teaches and models the importance of lobbying on behalf of nurses and health care at the local, state, and national levels of government. What nurses quickly learn is that **just one nurses voice** can make a difference but **millions of nurses voices** can make a greater difference for policy changes advocating on important health issues that affect both the nursing profession and the public. The common goal for most professional nursing organizations is to improve health care and foster high standards of nursing practice.

5. Scholarships and research funding

Many of the organizations offer student scholarships and research grants. The National Student Nurses Association (NSNA) is a perfect example of an organization that has many scholarships available to students. Membership fees and fundraising by these organizations are used to help student nurses at all levels of their nursing education. Nursing research grants are very competitive and these grants often help nurses doing smaller studies that would not be eligible for assistance elsewhere.

How to select a nursing organization

You have already made the best choice in joining ANA. ANA actively engages in building, enhancing, and strengthening the leadership competencies of nurses and those working or serving the nursing profession.

Which other organizations are best for you? It all depends on your interests. On a national level, the American Nurses Association **is the first organization our graduates and colleagues should join as it** represents the interests of almost 4.4 million nurses. Specialty nursing organizations also can help you as well.

Once you join and become involved in a professional nursing organization, it is up to you to decide how you want to contribute and become involved, Taking the first step shouldn't be hard, especially since it will help you to navigate your new profession. I have never regretted my decision to join and become involved in the nursing profession.

In Honor and Memory of Winifred (Winnie) Kennedy

Founding Member and 1st President of ANA-NY

1949-2023

COVID-19 Pandemic Update for Ambulatory & Primary Care Settings

Dear Colleagues:

We thank you, and all New York healthcare providers, for the life-saving efforts you made during the COVID-19 pandemic over the past three years. Since the first COVID-19 case was confirmed in New York State on March 1, 2020, we have learned and adapted, and overcome fear, stress, trauma, and exhaustion to provide care to the people of your communities. Nevertheless, COVID-19 variants continue to circulate as do other respiratory viruses (e.g., RSV, influenza, and enteroviruses).

It is important to highlight that COVID-19 is a treatable disease, and the standard of care is to evaluate a patient for treatment as clinically appropriate. It is expected that primary and ambulatory care clinics will evaluate and manage these patients in person, as clinically indicated. While telehealth is an appropriate and valuable setting of care for some patients, patients with suspected or confirmed COVID-19 and other respiratory illnesses should not be automatically triaged to telehealth for infection control purposes. These illnesses do not require specialized treatment settings, and there is no State requirement that patients with confirmed or suspected respiratory illnesses, including COVID-19, be excluded from primary and ambulatory care settings.

Ambulatory care settings should follow best practices for infection control, including COVID-19 infection control recommendations from the CDC: Infection Control: Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) | CDC. Please be sure clinic staff are trained in these best practices to properly protect themselves and their patients. Following infection control policies and procedures will diminish the risk of COVID-19 or other infection among healthcare personnel. CDC guidance addresses management of exposure risk and appropriate return to work policies: Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2 | CDC.

Ambulatory care settings can test patients easily and rapidly with point-of-care tests for many respiratory diseases, including COVID-19, influenza, and RSV. In New York State, there are two programs that issue CLIA (Clinical Laboratory Improvement Amendments) certificates. Physician Office Laboratories (POLs) that are entirely owned and operated by a physician or group of physicians and perform laboratory tests, personally or through their own employees solely as an adjunct to the treatment of their own patients, can obtain certification through DOH's Physician Office Laboratory Evaluation Program. Application materials for POLs can be found at Physician Office Laboratory Evaluation Program | New York State Department of Health, Wadsworth Center. All laboratories that do not fit the model of a POL would submit applications through the Clinical Laboratory Evaluation Program at Clinical Laboratory Evaluation Program.

NYSDOH encourages patients to contact their ambulatory care providers when they develop illness because treatment is available. Patients with mild to moderate COVID-19 who may be at risk of developing more serious illness, including people aged 50 or older and those with chronic conditions such as obesity, diabetes, and hypertension, should be evaluated for appropriate treatment. Find additional information here: Underlying Medical Conditions Associated with Higher Risk for Severe COVID-19: Information for Healthcare Professionals | CDC.

Oral therapeutics Paxlovid and Lagevrio are now available to treat COVID-19. The National Institutes of Health recommends Paxlovid as first-line COVID-19 therapy, Remdesivir as second-line therapy, and Lagevrio as third-line therapy: Nonhospitalized Adults: Therapeutic Management | COVID-19 Treatment Guidelines (nih.gov). While the list of drug-drug interactions for Paxlovid is lengthy (Drug-Drug Interactions Between Ritonavir-Boosted Nirmatrelvir (Paxlovid) and Concomitant Medications), many of these medications can be decreased or stopped during the short treatment course of Paxlovid. The Infectious Disease Society of America (IDSA) developed recommendations for the top 100 prescribed medications to assist clinicians with management of medications while taking Paxlovid: Management of Drug Interactions With Nirmatrelvir/Ritonavir (Paxlovid®): Resource for Clinicians (idsociety.org). It is expected that healthcare providers will consider patients on a case-by-case basis, as with other diseases, and determine if treatment is indicated.

As we begin our fourth year of circulation of the SARS-CoV-2 virus along with other respiratory viruses, ambulatory and primary care settings should be available and accessible to evaluate and treat patients.

Please consider these best practices:

- Use routine visits to help manage and educate patients on their current and future risks.
- Promote prevention by encouraging patients to stay up to date with all recommended vaccines including influenza and COVID-19.
- Maintain vaccines on site to provide to patients as needed.
- While patients with suspected or confirmed COVID-19 and other respiratory illnesses should not be automatically triaged to telehealth for infection control purposes, telehealth is an appropriate setting of care for some patients.
- Understand the effect Long COVID is having on patients' daily lives and functioning.
- Make informed treatment decisions for each patient based upon their specific risk and your clinical expertise.

While all patients should have access to ambulatory or primary care settings, the New York State Department of Health offers a free hotline for individuals who test positive for COVID-19 and lack a healthcare provider or are unable to connect with their healthcare provider. All New Yorkers outside New York City who test positive for COVID-19, regardless of income or health insurance coverage, are eligible to be evaluated for treatment by calling **1-888-TREAT-NY** (888-873-2869) or completing an online virtual urgent care visit at NYS COVID-19 ExpressCare Therapeutics Access website. This service is intended to ensure that all New Yorkers have equitable and timely access to COVID-19 treatments as medically appropriate.

Integrating patient visits, diagnostics, and treatments for COVID-19 into our ambulatory and primary care practices is essential to caring for people with COVID-19 as we enter our fourth year with this virus.

Thank you for all you do to keep New Yorkers healthy and safe.

Sincerely,

James V. McDonald, M.D., M.P.H.
Acting Commissioner

Additional resources:

Information for Healthcare Providers | Department of Health (ny.gov)
01/26/2023 - Updates on COVID-19 Treatment Recommendations (ny.gov)
COVID-19 Treatments and Medications | CDC
COVID-19 Therapeutics Decision Aid (hhs.gov)
Side-by-Side Overview of Therapeutics Authorized or Approved for the Prevention of COVID-19 Infection or Treatment of Mild to Moderate COVID-19 (hhs.gov)
Federal Response to COVID-19: Therapeutics Clinical Implementation Guide. Outpatient Administration Guide for Healthcare Providers (hhs.gov)
EUA 105 Pfizer Paxlovid DHCP Letter Aug 2022 (fda.gov)
PAXLOVID Patient Eligibility Screening Checklist and Drug Interaction Tool 02012023 (fda.gov)
Prescriber Checklist for Molnupiravir 02012023 (fda.gov)
COVID-19 Therapeutics Locator (arcgis.com)

Nurse Scientists Help Hospital Nurses Learn How to do Research

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Ellen Beck

Hospitals are hiring nurse scientists to help bedside nurses advance their careers, providing the education, training and support they need to conduct research, present their findings at national conferences and get published in peer-reviewed journals.

Hospitals benefit because often the research these nurses do is based on problems and needs they see every day caring for patients, and the best practices developed in the process can be implemented right back in the unit, improving outcomes and even lowering costs.

Nurse scientists are a small but growing niche in the nursing profession. Employed by a hospital or health system, these nurses hold doctorates and other advanced nursing degrees that are complemented by their clinical nursing experience.

"We're tying in together the academic with the clinical world with these positions and using the best of both worlds to elevate the practice," said Michelle Romano, chief nursing officer and vice president of patient care services at SSM Health Cardinal Glennon Children's Hospital in St. Louis, the only hospital in the system to have a nurse scientist.

"Being able to have a nurse scientist was key in helping advance the nursing profession," she said. "How can we take ourselves to the next level, improve patient outcomes, improve quality, patient experience, improve our employee engagement."

Tifuh Amba, who holds two doctorates and has extensive clinical experience as nurse practitioner in critical care, is the nurse scientist at SSM Health Cardinal Glennon. She said she loved teaching but wanted to do more than be in a classroom. She also loved patient care and wanted to help promote nursing excellence at the bedside. It can be difficult for nurses in the clinical setting to also attend classes and do research.

"Nurses barely have time for a lunch break, let alone to get more education," Amba said. "These nurses are treating people daily – bedside people do the work."

The role of the nurse scientist is to bring that opportunity for learning into the hospital, where nurses can fit classes into their schedules. Twice each year Amba holds six-week classes for nurses to learn about evidence-based practice. They get help and mentoring to design and carry out research projects in their own units.

Amba also heads up monthly meetings to talk about research and the goals for the hospital, such as disseminating literature and having nurses attend conferences to present their studies.

Danielle Sarik is a nurse scientist and director of Nursing Research and Evidence-Based Practice at Nicklaus Children's Hospital in Miami. She is a pediatric NP with a doctorate in health services who started nursing as a second career after working for a global health organization. Her job is to support clinical staff in their scholarship, including research, evidence-based practice and quality improvement.

She also works to develop the infrastructure for scholarship within the hospital, putting together protocols for studies and education programs for nurses, while making connections with regional nursing schools. She also has her own portfolio, so she applies for research grants and has received funding for two studies.

"The thing I really love about being a nurse scientist is you are so close to the clinical side and you really have that opportunity to make an impact," Sarik said.

It can be years between when research is conducted and published and when changes are implemented at the bedside, she said. Having a nurse scientist as part of the hospital staff allows nurses to create studies, gather evidence and implement results quickly. "We're changing practice in real time," Sarik said.

Sarik meets with nursing staff and leadership to put together research abstracts and publish papers, works with hospital executives and educates nurses about research and writing for publication.

She said she "meets nurses where they are" to provide opportunities for those new to the profession as well as veteran nurses who already may have done research. She conducts an eight-month program where nurses complete an evidence-based project and get guidance through the research writing process.

"I do think that this role is growing and evolving," Sarik said. "I think that's part of the reason there is more of an interest, because people realize that there is so much you can do."

What's needed, Sarik added, is a supportive hospital administration and nursing leaders who understand the role of nurse scientists, the skill set and the importance of nurses engaging in scholarship.

"Research is a big part of taking the profession to the next level," Romano said. "We see it in the medical side, and we wanted to bring that to the nursing side."

Romano said this research element also is important to hospitals, such as Cardinal Glennon, that have achieved Magnet status because that designation comes with higher standards for nursing. She sees more institutions creating nurse scientist positions, if not teams, to help guide practice.

"I only see this growing," Romano said.

Traumatic Brain Injury Screening Letter

Dear Colleagues:

I write to bring to your attention the very important issue of screening patients for signs and symptoms of **traumatic brain injury (TBI),** particularly patients who report or are suspected victims/survivors of domestic and sexual violence. TBI is an injury to the brain or skull caused by an external force, such as a strike or impact. Nearly 156 incidents of TBI occur daily in New York State, resulting in hospital treatment or death. Each year, TBIs result in more than 2,200 deaths, 17,000 hospitalizations, and almost 38,000 emergency department visits among New York State residents.

Victims/survivors of violence who have been hit in the face or head, fallen and hit their head, or been shaken, strangled or choked are at risk for TBI. Victims/survivors of domestic violence are at increased risk of TBI. Domestic or sexual violence victims/survivors may suffer a brain injury when objects strike the head or neck, when they are pushed against a wall or other surface or pushed down a flight of stairs, or from physical shaking or strangulation. Empirical studies suggest that TBI is present in 19 percent[1] to 75 percent[2] of intimate partner violence cases.

Brain injuries are often permanent and disabling, and therefore timely recognition and appropriate response is crucial to improve all patients' health outcomes. However, many victims/survivors of domestic violence may choose not to fully disclose their injuries, or they may sustain a TBI without their knowledge. Making matters more dangerous, many individuals may not seek medical care or intervention at the time of injury, thus dramatically increasing the likelihood of recurrent TBI(s), which may result in more severe neurological damage.

A provider's role in screening domestic and sexual violence victims/survivors for TBI is crucial, as diligent screenings and appropriate referrals are essential to improve patient outcomes. I ask you to please carefully review the following screening questions and tools to ensure this vulnerable patient group is properly assessed and promptly treated.

Signs of TBI

Patients with a head injury, including TBI, may report or show signs of:

- Repeated vomiting
- Worsening or severe headache
- Being unable to stay awake during times you would normally be awake
- Severe drowsiness or difficulty being awakened
- One pupil larger than the other
- Convulsions or seizures
- Inability to recognize people or places
- Growing increasingly confused, restless, or agitated
- Difficulty walking, with balance or decreased coordination
- Difficulty with vision
- Slurred speech
- Unusual behavior
- Loss of consciousness (a brief loss of consciousness should be taken seriously and the person should be carefully monitored)

Screening Questions

All hospitals are required to have written policies on the identification, assessment, treatment and referral of confirmed or suspected cases of domestic violence. For more information on these policies including recommended screening practices, please refer to the August 11, 2021 Dear Colleague letter, available here. When screening for domestic violence, ask your patients the following questions to assess whether they may be at risk for a TBI:

1. **Has your partner ever:**
   a. Hit you in the face or head?
   b. Made you fall and hit your head?
   c. Shaken you?
   d. Tried to strangle or choke you?

2. **Are you having trouble:**
   a. Concentrating?
   b. Remembering things?
   c. Finishing what you started?

3. **Are you having physical problems like:**
   a. Headaches?
   b. Fatigue?
   c. Changes in your vision?
   d. Ringing in your ears?
   e. Dizziness or problems with balance?

Assessment Tools

The federal Centers for Disease Control and Prevention (CDC) has created Acute Concussion Evaluation (ACE) Forms and Care Plans to assist the provider when assessing and responding to patients who may have had a head injury, HEADS UP to Health Care Providers: Tools for Providers | HEADS UP | CDC Injury Center, and has also developed an online Concussion Training Course for Clinicians, HEADS UP Online Training Courses | HEADS UP | CDC Injury Center. These are useful starting places to build head injury screenings into your existing patient assessment protocols and help assess whether a more serious head injury, including TBI, exists and warrants diagnostic testing. Free continuing education credits are also available through the American Academy of Pediatrics for providers who complete the HEADS UP online training course.

Keeping a Trauma-Informed Response

Providers should implement a trauma-informed approach when caring for patients who report or appear to be victims/survivors of domestic and sexual violence. This requires providers to not only screen patients using the approaches and tools above, but also to establish a connection with the patient that is based on respect and allows for collaboration in the treatment plan. To engage in this respectful collaboration, providers should engage in active listening and validate the individual's emotional state, even if the patient is not choosing to leave the abusive situation or seek help. This strategy enables the service provider to foster trust and guide the patient through strategies to reduce the risk of further trauma.

While all providers are encouraged to practice trauma-informed care, I also remind providers in an Article 28 General Hospital that, pursuant to Section 2805-z of the Public Health Law, upon admittance or commencement of treatment of a confirmed or suspected domestic violence victim/survivor, the hospital must advise the patient of the availability of the services of a domestic violence or victim assistance organization, and contact the appropriate organization and request that a victim assistance advocate be provided if the patient requests one.

Further Resources:

- Department of Health's Traumatic Brain Injury webpage
- Department of Health's Domestic Violence and Public Health Law § 2805-z webpage
- Public Health Law § 2805-z Dear Administrator letter, which includes a model domestic violence policy for hospitals
- Hospital Staff Domestic Violence training video
- Traumatic Brain Injury Waiver information
- Office for the Prevention of Domestic Violence's Domestic Violence Service Providers
- Office for the Prevention of Domestic Violence's Sexual Violence Service Providers

Thank you for your time and attention to this important matter.
Sincerely,
James V. McDonald, M.D., M.P.H. Kelli Owens

1 Iverson K. M., Dardis C. M., Pogoda T. K. (2017). Traumatic brain injury and PTSD symptoms as a consequence of intimate partner violence. Comprehensive Psychiatry, 74, 80–87. doi:10.1016/j.comppsych.2017.01.007

2 Valera E. M., Cao A., Pasternak O., Shenton M. E., Kubicki M., Makris N., Adra N. (2018). White matter correlates of mild traumatic brain injuries in women subjected to intimate partner violence: A preliminary study. Journal of Neurotrauma, 36, 661–668. doi:10.1089/neu.2018.5734.

New York's Health Care Associations' Four New Reports Recommend Continue Collaboration to Improve Patient Care and Outcomes

Reports highlight collaborative work on hospital-home care innovation, mental health, public vaccination, and aging in place

Local collaboration is the key to confronting public health challenges, according to four new reports issued by the Home Care Association of New York State, Iroquois Healthcare Association and the Healthcare Association of New York State.

As part of the Statewide Hospital-Home Care Collaborative for COVID-19 and Beyond, funded by the Mother Cabrini Health Foundation, the three organizations' new reports detail best practices for establishing new models of hospital-home care innovation, meeting the growing demand for mental health services, public vaccination efforts, and partnering with the aging services network.

"When New Yorkers come together to help each other and serve their communities, everyone benefits," said Al Cardillo, president and chief executive officer of the Home Care Association of New York State. "Our work is not done; collaboration and communication must continue so the healthcare system and professionals are ready for future challenges. The innovative partnerships made will undoubtedly help us continue to address community health needs across the state, particularly those affecting the homebound."

"What we have learned from the pandemic is that organizations need to continue to find ways to work collaboratively to improve access and quality of care for the people of New York State," said IHA President and CEO Gary J. Fitzgerald. "The strongest organizations that will emerge in the next several years will be those that have found ways to turn competition into collaboration, have integrated individual and siloed programs into the continuum of care and have found ways to share data in a manner that protects patient privacy, while also sharing data for better outcomes. The models and organizations featured in this hospital-home care collaboration grant have not only done these things, but they have also identified programs that could be replicated in the future by others."

"These reports highlight how essential collaboration was during the COVID-19 pandemic and how much potential there is in continued and increased partnerships," said Bea Grause, RN, JD, president, Healthcare Association of New York State. "We must continue to innovate as we transform our healthcare system and address very serious workforce and fiscal challenges."

"The collaboration between facility-based care and Offices for the Aging is paramount to support older New Yorkers, caregivers, and families, and allow individuals to age in place. The Association on Aging in New York is thrilled to partner with the Home Care Association, HANYS, and IHA to highlight best practice models for holistic care," said Becky Preve, executive director, Association on Aging in New York.

Among the reports' key findings:

Compendium of Statewide Hospital-Home Care Collaborative Models

- Hospitals and home care providers in New York state can build upon the developments made and lessons learned during the COVID-19 pandemic to create an integrated, patient-centered healthcare system.
- Strong coordination across the continuum of health and social services can improve clinical outcomes for patients and reduce preventable emergency department utilization and inpatient admissions.

Innovative Hospital-Home Care-Mental Health Collaboration Models: A Primer

- Mental healthcare needs must be considered when making plans to age in place or return to the community post-hospital discharge. Hospital, home care and mental health providers bring unique strengths to work together to serve the whole patient.
- Approaching patient care from a team-based perspective and engaging with the patient to work toward a shared goal can improve cost-effectiveness and reduce medical errors.
- Telehealth has the potential to fill a significant care need as it is transforming the healthcare system by decreasing barriers and increasing access to services. It is an easy and effective way to receive needed mental health services on the computer, cellphone or tablet.

2022 Collaborative Prototypes & Lessons Learned During the COVID-19 Vaccine Rollout

- Pharmacies and community-based organizations used their roles effectively as trusted neighborhood healthcare providers to combat vaccine hesitancy and improve distribution. Limited broadband access in rural areas, as well as digital illiteracy, made online registration for vaccine appointments difficult to impossible.
- The ten regional hubs in New York each created a health equity task force (HETF) to organize the equitable distribution of vaccines. The HETFs broke down transportation barriers, reached the homebound population and employed targeted, community-based messaging to reach the underserved.
- An organized reporting structure and single points of contact for reporting and communication can reduce duplicative work, uncertainty and miscommunication. A centralized, real-time reporting system and database are needed for future projects.

Hospital and Home Care Partnerships with Aging Providers: Collaboration Models and Lessons Learned

- The number of New Yorkers ages 65 and older increased by 647,000 (26%) over the past decade. During the same period, New York State's overall population grew by 3%. There are now more New Yorkers ages 65 and older than there are children under the age of 13.
- Because of the growing preference to age in place, multiple sectors must collaborate to fortify care transitions. The transition from the hospital to the home is particularly crucial. Significant investments must be made to recruit and retain the workforce needed to care for the growing aging population.

The associations look forward to continuing their engagement with providers across the healthcare continuum, community partners and policymakers to advance collaborative models of patient care.

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