NATIONAL BLACK NURSES ASSOCIATION

NBNA
NEWS

ADVANCING NURSING LEADERSHIP

NBNA's 40 and Under Awardees

Also inside this issue:

WWW.NBNA.ORG

FEATURES

ON THE COVER

NBNA's 40 and Under Awardees
Crystal C. Akah, Dr. Kamila Barnes, Dr. Sandy Cayo, Norman Cyprian, Sheren Edinboro, Fallon Flowers, Kristin Glover, Fharen Grant, Dorothea Houston, Alexandria-Jones-Patten, Dr. Julius Johnson, Daika Moegerie, Kimberly Sanders-Hebert, Krista Simmons, Latasha Simpson, Carter Todd, Patrise Tyson, Essence Williams and Ebonie Wright

FEATURES (continued)

Leadership in Nursing: Facets and Opportunity

Greetings All,

Nursing is a dynamic profession with a dedicated vision of advancing health and well-being for all. Within the current environment of perpetual systems transformation, strong leadership will be required to successfully manifest the aforementioned vision on a global scale. The National Academy of Medicine (formerly the Institute of Medicine) has specifically recognized the need for strong and capable nursing leadership if the vision for transforming healthcare is to ever be realized. This means nurse leaders positioned to influence every level of the healthcare delivery system.

Opportunities for nurse leaders continue to grow. Leadership positions are available in all areas of nursing. These areas include education, clinical practice, policy, politics, and organization. Each area of nursing has unique features. Therefore, successful leaders must possess a complementary skill set for their area of leadership interest beyond that of personnel management. For example, leaders in education drive the academic and supply engines for the profession. Essential skills for an academic leader would include competencies in curriculum design, pedagogy, assessment & evaluation methodologies, and academic-specific technologies. In contrast, leaders in clinical care would require a knowledge base and competencies that speak to the successful implementation of quality management, performance measurement, macro- and microsystems, and other topics of clinical and administrative relevance.

Nurse leaders will continue to play a significant role in the revitalization and transformation of the health care system. To this end, the NBNA will continue to support the growth of strong nurse leaders dedicated not only to service in leadership; but, also to realizing the vision of a transformed health care. A care system designed to enhance the health and well-being of individuals and communities throughout the nation.

This edition of NBNANews is dedicated to leadership in nursing. Articles are written by notable NBNA members and friends who are successfully engaged in the business of leadership. Articles in this edition of NBNANews are substantially diverse and contain information of relevance for current and aspiring nurse leaders. It is my hope that the concepts of leader and leadership are highlighted in a way that expands thought and advances knowledge.

A warm thank you to all who contributed to the 2018 success of NBNANews. Please continue to submit your materials and communications about current health care advances, board members and local chapter activities, acute and chronic diseases, nursing research, national healthcare discussions, career and education opportunities, and health legislation. I look forward to working with each of you in 2019 as we continue to fulfill our mission of quality health for all.

Warmest wishes for a happy Holiday season and a wonderful New Year.

Respectfully,

Yolanda M. Powell-Young, PhD, PCNS-BC, CPN
Editor-in-Chief

Mentoring our Next Generation of Leaders for Leadership Advocates

Eric J. Williams, DNP, RN, CNE, FAAN
President, National Black Nurses Association

The debate endures – are leaders born or made? To this end, individuals are typically categorized by one of three schools of thought. Leaders are (a) genetically predisposed for leadership, (b) adversity-created for leadership, or (c) nurtured for leadership. Regardless of the path to leadership, however, mentoring provides the guidance, motivation, emotional support, and role modeling needed to prepare leaders to successfully navigate the mantle of leadership.

Generally speaking, a leader can be defined as an individual with a legitimate power and sphere of influence. Leadership is the strategy that a leader might utilize to effect influential change. Mentoring is a strategic tool that, when used properly, facilitates leadership development and readiness. These concept characterizations demonstrate the relational interdependence that mentoring shares with acquiring those leadership qualities that make a successful leader.

Current trends suggest that like the shortage of registered nurses, the shortage of nurse leaders will continue to grow. This projection is alarming for a number of reasons. One of the most significant of these reasons is that nurse leaders are identified as a critical component in the comprehensive approach to healthcare transformation. Reports and initiatives such as the Future of Nursing Report and the Nurses on Board Coalition highlight not only the need for but the importance of nurse leaders as an integral member of the healthcare reform team.

The NBNA has a storied history of mentoring nurse leaders. Mentoring programs have ranged in focus from early career to senior-level leadership. The NBNA believes that mentoring provides knowledge, skills, professional socialization, and personal support to facilitate success. In addition to well-established, effective mentoring, the NBNA mentoring programs positively influence diversity in leadership. The inclusion of diverse, well-informed and skilled leaders who bring valuable perspectives and experiences is an integral part of fostering excellence in leadership.

We will continue our commitment to growing leaders and building bridges that foster collaborative transformations in health and healthcare. Thank you for an exiting 2018. I look forward to serving the members of the NBNA in 2019 as we continue our onward journey in representing and providing a forum for Black Nurses to advocate and implement strategies to ensure access to the highest quality of healthcare for persons of color.

Wishing you and your loved ones peace, health, happiness, and prosperity in the New Year.

Sincerely,

Eric J. Williams, DNP, RN, CNE, FAAN
12th NBNA President

All of Us RESEARCH PROGRAM | The Future of Health Begins With You

National Black Nurses Association supports the NIH All of Us Research Program.

NBNA is educating NBNA members, nurses and other health care providers and the community about the program.

NIH wants to register 1 million American residents, half will be people of color.

To learn more about this important national research program, go to joinallofus.org

Please give a shout out to our five chapters helping to spread the word and make a difference! Share with your colleagues!!

Bay Area BNA • Bayou Region BNA • Birmingham BNA BNA, Miami • Greater New York City BNA

Lilly Helpline Offers Customized Insulin Affordability Options

Lilly, a global leader in diabetes since 1923, has opened the **Lilly Diabetes Solution Center** to assist people who need help paying for their Lilly insulin, such as those with lower incomes, the uninsured, and people in the deductible phase of a high-deductible insurance plan. Data show this program could benefit more than 400,000 people living with diabetes in the U.S. and Puerto Rico.

Lilly Diabetes Solution Center

Call 1-833-808-1234

The helpline is open Monday through Friday from 9AM to 8PM, ET

Savings

Increased financial assistance for people who may need help paying for any Lilly insulin

Free Clinics

Donation of free insulin to approximately 150 free clinics across the U.S.

Immediate Need

Options to support someone with an immediate need for insulin

Patients who call the helpline will be connected with a representative who, after a confidential conversation and determining eligibility, may be able to offer solutions based on each person's circumstances.

Learn more at **insulinaffordability.com/solutions**

Patricia Lane, NBNA Second Vice President, addressing session on Brain Health

It's all about Brain Health: Dr. Lenette Jones, Dr. Roberta Waite, Patricia Lane, Erica Davis, Dr. Keith Plowden.

Brain Health Session: Sarah Lock, AARP, Patricia Lane, Bon Secours, James Dotson, AARP.

Mercy Booth

Grand Canyon University Booth

NBNA Diabetes Institute Sponsored by DaVita, Inc.
Amanda Hale, CNO, DaVita.

Pfizer Booth

American Heart Association Booth

NBNA Summer Youth Institute 2018

NBNA Summer Youth Institute at BJC College, Goldfarb School of Nursing.

Susan G. Komen and NBNA Celebrates the birthday of Henrietta Lack with her family members.

NBNA Summer Youth Institute

NBNA Conference – 2018

Nurse by Choice: Steve Jackson, Dr. Cheryl Taylor, Chenelle Tate.

Red Dress Day: Patricia Lane, Erica Davis, Jayne James, Joan Pierre.

Conference Attendees.

Sasha Dubois, Dr. Cheryl Taylor, Dawn Patrick.

Member

Dr. Sandra Millon Underwood, Crystal Norman, Mandy Hale, Marsha Henderson, Dr. Larider Ruffin.

Member

Nursing Supervisor is My Joy

Lola Denise Jefferson, MA, BSN, RNC, CVRN

Joy has kept me involved in nurse leadership my entire nursing career. My last 18 years in nursing has been as a nursing supervisor. It is a challenging and rewarding role that affords me a vast amount of opportunities to use clinical, administrative, role modeling, and leadership skills. Excellence in this role demands intentional commitment to the nurses and patients that is sustained by Joy.

Nurse supervisor responsibilities include managing staff, overseeing all patient care, and guaranteeing compliance with the hospital's established policies and procedures. Other responsibilities of a nursing supervisor include assigning staff with patients according to their level of competencies and monitoring their job performances. A few challenges of being a nursing supervisor is finding the right bridge to link staff, patients and patient family members. It is also imperative to maintain professional collaborations with the staff and physicians. A major part of the nurse supervisor's role is the administrative part or "paper work."

Being a successful supervisor is about having faith and confidence in yourself. You were selected for the position. Say to yourself, "I will now go and perform well." Be positive with everyone. Begin the start of the shift with "Good Morning!" and/or "How are you on this beautiful day!" If you notice something different regarding an employee, make a positive note of observation. Also, occasionally inquire about their families and activities that they enjoy.

Employees are your greatest asset. Always let the employees know their worth and treat them accordingly. At times, it is good for employees to witness the supervisor helping on the floor, answering the call lights and then going in to assist the patient as needed. Offering to help patient care assistants (PCA) with a task is an indication that you understand that they are extremely busy and may need a little bit of help. The nurse supervisor may offer to go get medication from the pharmacy to lighten the nurses load. Small things mean a lot and have big ROI (Return on Investment). By working as a team, it strengthens and builds the bond between the staff and the nurse supervisor.

Another key element for building a strong team is communication. It is essential that supervisors convey to employees that they are encouraged to tell the supervisor what is important to them, because it is most welcomed and useful in building strong

Lola Denise Jefferson, MA, BSN, RNC, CVRN is currently the House Supervisor and Co-Chair of the Nurse Council for Kindred Sugar Land Hospital. She is the NBNA 1st Vice President and Programs Chair of the National Black Nurses Association and the Founder, Past President, & Executive Director of the Fort Bend County Black Nurses Association. She is currently pursuing a Doctor of Philosophy from the Family Life Bible College of the Gospel Ministry Outreach Theological Institute.

work environments. I have an open-door policy at my place of employment. Employees walk right in and begin talking with no regard to what I am doing. If time permits I stop what I am doing, turn towards them, give direct eye to eye contact and give them my undivided attention. I listen without interrupting and allow them to finish their thoughts. I then observe that the employee seems to feel some level of empowerment and can voice their concerns. I notice that employees come more and more to share with me the concerns of the patients and the hospital unit.

As the Supervisor, I communicate the expectations clearly and concisely. I give examples of what I am trying to verbalize. Some employees need more explanations than others. So occasionally, I will ask the employee to repeat what was verbalized to make sure we are in an agreement. Sometimes, constructive criticism is needed. Explanation of the expectation is vocalized with examples of acceptable behavior or tasks. Then I ask for feedback to assess understanding of the matter.

It is important to encourage the staff to grow professionally. Continuing education is an integral part of a career that can be obtained through higher education, certification, professional organization membership and/or reading nursing journals. Commend and make a big deal out of it when they accomplish their goal. Motivate them to be creative and participate on committees or events.

Being a great supervisor is a day by day journey. Stand tall on ethical and moral behavior and recognize that change is an on-going process. You must strive to be the best supervisor while sustaining a balanced work environment for your staff. Joy is the machine that drives success.

Attributes of Leadership—

My Tribute to Dr. Mary Elizabeth Carnegie

Patricia C. Lane, MBA, BSN, SCRN, FAAN

2018 has been an extraordinary blessed year for me as I celebrated being a NBNA Neuroscience nurse for thirty years. I received a scholarship from NBNA to complete nursing school at George Mason University and started my career as a nurse at Howard University Neuro Intensive Care Unit in 1988. My path to leadership as a Neuroscience Nurse had begun. At this point in my career I was a novice nurse and I was like a sponge soaking in as much about Neuroscience as I could from the interns and residents preparing for daily rounds with the neurology attending at Howard. I had received a bachelor's degree from Virginia State University in biology and was hardwired with science but as I began my career as a nurse I needed to learn the art of nursing and master how to intertwine the two.

Leadership traits were role modeled by my family and instilled upon me at a very early age. My mother was a kindergarten teacher and so from her I learned qualities of sharing, being kind, and how to nurture. My father was a principal and then a D.C. city administrator and advocate for voter's rights. From my father I learned social justice and that my voice matters. I remember being at my father's family reunion in the early 90's and my cousin said I know you are a nurse let me introduce you to a cousin who is also a very busy nurse her name is Mary Elizabeth Carnegie.

Little did I know that Mary Elizabeth Carnegie was the first black nurse elected to serve as a voting member to the board of directors of a state nursing organization, or that she was the president of the American Academy of Nursing and a true Living Legend. Here is what I knew, in our family you were expected to be a leader and to pave the way for others. I learned many valuable lessons of leadership that day. However, the most profound lessons incorporated know who paved the way for black nurses to be leaders and give back. One of her famous leadership quotes from the *Soul of Leadership* states, "If I have done anything by taking a stand for racial equality in the nursing profession and making sure that black nurses are in the literature, having been left out for so long then I feel that I have fulfilled my purpose for having been in this world".

Patricia is currently the Administrative Director for Bon Secours Mercy Health System in Richmond Virginia. Pat received her Bachelor's of Science in Biology from Virginia State University, Bachelors of Nursing from George Mason University, and her Masters of Business Administration from Regis University.Pat served on the Board of Directors for American Association of Neuroscience Nurses from 2014-2017. She became a Stroke Certified Nurse in 2015.Pat is a member of the American Heart/American Stroke Association Hospital Business Accreditation Committee and on the AHA Board for Central Virginia. Pat also serves on the Epilepsy Foundation of Virginia Board. In 2013 Pat received the NBNA Trailblazer award for her commitment to the community and leadership. Pat is the 2nd Vice President of the National Black Nurses Association and serves on the Board of Directors for the National Coalition of Ethnic Minority Nurses. Pat was inducted as a Fellow in the American Academy of Nursing in fall of 2018

In closing I would like to share attributes of Leadership that have helped me over the years to become a Nursing Leader:

L – Listen; listen as I did that day with my cousin to learn her path to leadership

E – Educate, continue your education so you can serve others with knowledge and research

A – Articulate and Advocate, your voice matters –speak up and speak out

D – Diversity, diversity embraces perspectives

E – Empowerment –allows you to be courageous and authentic to make change

R – Respectful, go back to kindergarten days; it's not what you say it's how you say it

S – Spirituality – it is by His grace and mercy that we serve and sometimes you have to "Let Go and Let God"

H – Humbleness and humility are traits of true leadership

I – Integrity, you cannot be a leader without being credible and honest

P – Passionate, leaders help to motivate and it has helped me over the years in sharing my leadership message

In closing leadership is both formal and informal. As a NBNA nurse, you are a leader in the community and to the profession. Hopefully you can utilize my attributes of leadership for your path in nursing.

The Reluctant Leader and the Leader Who Is Always Ready to Lead

Beverly L. Malone, PhD, RN, FAAN

Dr. Malone's tenure as the CEO of the National League for Nursing has been marked by a retooling of the League's mission to reflect the core values of caring, diversity, integrity, and excellence and an ongoing focus on advancing the health of the nation and the global community. In 2018, Dr. Malone was presented with a citation from the American Psychological Association for her outstanding leadership in advancing excellence in health care for the nation and global community and named one of the Top 25 Minority Executives in Healthcare by Modern Healthcare magazine.

I am very fortunate to work with a colleague who never doubts her readiness and ability to lead. She is full of high-voltage energy. With one look at her face, her leadership knowledge and ability are apparent — they seem to spring from her eyes as Athena sprang from Zeus' head.

An exquisite leader, she has the authenticity one has to have to stand in a leadership role with power. She understands the strength and thoughtfulness one must bring to transactions with others; and yet, she is capable of stepping back and allowing others to lead, smiling and encouraging as they move forward and sometimes back. She knows about zig zag leadership (Sawyer, 2013): two steps forward and one back; then three steps forward and one back, even when, with the last step back, it seems the entire enterprise is lost. In such instances she is there with her mentees, helping them understand that the fall or backward step was only a small diversion on the journey to success. In my mind, she is the leader who is Always Ready to Lead. You must know that I appreciate and admire her greatly.

As for me, I am the Reluctant Leader, one who is never quite sure, quite so clear about my power and how to use it successfully. When I was a student, there were those who thought I should take a leadership role, but I was certain that others fit the description of leader much better than I did. I was that student who feared that someone would tap me on the shoulder and shout out that I was not supposed to be in that class or that conference. I tried to remain under wraps, concerned that I was not as bright as others seemed to assume I was, that the power frequently ascribed to me did not in reality exist. For me this was true. My self-evaluation and reflection did not produce the results that others assigned to me.

But when I found nursing -- or nursing found me -- I knew it was time to leave my self-ruminations at home and speak up for people who had mental health issues in systems that, most of the time, were unresponsive. I knew I had healing power and that my leadership could be based on that truth. I was amazed. I started breathing more deeply into the power base of psychiatric mental health nursing, influenced by the work of nursing theorist Hildegard Peplau, whose middle-range theory of interpersonal relationship (Peplau, 1992) was based on the work of famed psychiatrist and psychoanalyst Dr. Harry Stack Sullivan. I was struck by lightning, or perhaps enlightenment.

There is a principle that I remember learning as a child from my great-grandmother. It became more clearly visible after her death and as I grew into accepting my responsibility, my opportunity to lead: *It's a cinch by the inch; it's hard by the yard.*

There are times and projects you may have to inch your way through. Although I finished my dissertation in only a few years, writing it was an ordeal. But as I inched along, I learned that it's important to celebrate along the way. I have colleagues who say they will celebrate when they are finished, but that, I believe, is called a funeral. Life needs to be lived and celebrated, even while you struggle.

By the way, it doesn't matter in which area of study you begin your postgraduate work -- just begin. If you are an LPN/LVN, move forward to your bachelor of science in nursing. Oh, did I skip over the associate degree? Do I have something against associate degree education? Not at all, but shouldn't you, if you have the

will and desire, move directly toward that BSN and hop over the ADN? If you already have an associate degree and are planning to go back to school, after making arrangements for your family, your finances, and your myriad of other responsibilities, hop over the BSN and move directly into your master's. The same rationale applies. When you can move forward with academic progression, my advice is to move. There are times when you don't have to inch your way along.

Does it seem that I have grown from being a Reluctant Leader to one who is Always Ready to Lead, like my colleague? Not quite. The difference is that while I understand that I am a leader and I am grateful to be one, I'm still basically an introvert who happens to be able to make the switch to extrovert behavior as needed. I love being useful and with nursing I can make a difference in the lives of others. It's a joy....

References

1. Peplau, H. E. (1992). Interpersonal relations: A theoretical framework for application in nursing practice. *Nursing Science Quarterly, 5(1),* •13-18. •° doi:10.1177/089431849200500106

2. Sawyer, K. (2013). Zig zag: The surprising path to greater creativity. San Francisco, CA: Jossey-Bass.

NBNA Newsletter

The Winter Newsletter deadline is February 10, 2019.

☆ ☆ ☆ ☆ ☆

Submit an article on any subject of your choosing!

- It could be a novel approach to nursing practice; or
- new model of integrated care; or,
- a health policy topic;
- or, the "hot" button topic at the moment; or,
- on your research.

NBNA Newsletter criteria:
- The articles should be 500-750 words
- title of the article
- author's name and credentials
- three line biographical sketch
- head shot photo
- resources where appropriate
- 3-5 social media statements for Facebook and Twitter.

Please send the articles to nbnanews@aol.com and millicent@nbna.org.

Human Trafficking (HT): Documentation and the New ICD-10 and Z Codes

Dr. Martha A. Dawson, FACHE

Dr. Martha A. Dawson
National Black Nurses Association Historian, Divisional Director of Nursing and Health Systems Leadership
University of Alabama at Birmingham School of Nursing
Past NBNA First Vice President and Secretary

There are many forms of violence. Modern day human slavery is one of the worst forms of violence. Although society does not call it slavery, the concept of human trafficking (HT) is no less the involuntary imprisonment and forced servitude of an individual. HT is a demeaning system where one person (trafficker) exploits another individual (slave) for profit, usually monetary or exchange of something of value; and it is a global issue (US Department of State, 2018). The trafficker uses threats, force, fraud, and coercion against the victim to control and manipulate the enslaved person to engage in commercial enterprises that are often illegal.

HT occurs where we live, work, play and unfortunately, worship. These activities can include child abduction and selling, forced prostitution, forced marriage, human cages, child beggars, forced labor, and other activities. As noted in Table 1, HT is a complex

TABLE 1

- There are more slaves today than at another time
- It is estimated that 27 million people are enslaved
- HT is the second largest criminal industry with illegal drugs being #1
- HT is a big profit industry of $32-$150 billion annually
- HT is a global market
- Females constitute 80% of HT victims
- Average age for sex trafficking victims is 11-14years
- Every 2 minutes a child becomes victim of sex trafficking
- Of the 27 million HT victims, half are children

and financially profitable venture. It is projected that HT will surpass drugs as the number one illegal activity in the world.

In 2000, the US passed the Trafficking Victims Protection Act to lessen the practice of treating the victim as the criminal. The National Conference of State Legislatures (NCSL) provides an overview of the activities of some states to define trafficking activities, methods, and penalties. "Twenty-nine states and the District of Columbia have laws that promote access to information about human trafficking through the use of the National Human Trafficking Hotline, (NCSL, 2018)." Information from the NCSL can be found at http://www.ncsl.org/research/civil-and-criminal-justice/human-trafficking-laws.aspx. The NCSL site also provides a link to the 2018 report, *Prosecuting Human Traffickers: Recent Legislative Enactments* (NCSL, 2018). This report summarizes how states are addressing the HT cases and the complexities of getting victims and others to both recognize and report suspected activities. According to NCSL (2018), more than 170 countries have agreed to act to eradicate these crimes and seek punishment against the trafficker. Globally, health care providers and workers can play a significant role in identifying and helping HT victims because many of these victims seek medical attention and interface with providers and caregivers. In June 2018, The American Hospital Association released ICD-10 codes that address HT. These new ICD-10 codes that became effective October 1, 2018 will assist with documentation and reimbursements relating to treatment for abuse, neglect, and other forms of maltreatment of children and adults. There are also Z codes for examination and observation of victimization. Providers document evidence of a patient's personal history in relation to past and current abuse or trauma using these codes as a guideline for assessment and documentation. Table 2 lists some terms that providers may use to document verbal and physical assessment findings.

TABLE 2

- **Human trafficking**
- **Sex trafficking**
- **Labor trafficking**
- **Domestic servitude**
- **Commercial sexual exploitation**
- **Forced sexual exploitation**
- **Forced prostitution**
- **Forced labor**
- **Exploitation for manual labor**
- **Exploitation of sexual labor**
- **Forced exploitation of domestic labor**
- **Any combination of these terms**

Healthcare staff should not attempt to rescue potential or actual victims; providers should be aware of how to engage law enforcement and other community agencies. Support literature and information can also be given to the suspected victims. Access to the National Human Trafficking Hotline may be gained by calling 1-888-373-7888 or 711 to access the line using TTY or Text Telephone. Reports may also be made online at https://humantraffickinghotline.org/get-help. Nurses, social workers, case managers, nurse practitioners, and physicians are encouraged to use the following link to access information on effective documentation of observations using appropriate terminology: https://www.aha.org/icd-10-cm-coding-human-trafficking-resources. The aforementioned link also provides an educational video to help healthcare workers learn about the new ICD-10 and Z codes. Healthcare workers should also visit the American Hospital Association site at https://www.aha.org/infographics/10-red-flags-your-patient-could-be-victim-human. This site identifies 10 human trafficking red flags that could alert providers to potential abuse, maltreatment, and enslavement.

While HT is recognized as a global problem, regional, state, and local action is essential to bring attention to the issue and to begin to find viable solutions. With the expected growth in HT, society must address HT with a mindfulness that victims will or may be too fearful to self-report. Desmond Tutu may have said it best, "If you are neutral in situations of injustice, you have chosen the side of the oppressor. If an elephant has its foot on the tail of a mouse and you say that you are neutral, the mouse will not appreciate your neutrality." (https://www.brainyquote.com/authors/desmond_tutu)

This article is a call to action for health providers and caregivers to become the difference and to help identify and treat victims of human trafficking.

References

1. American Hospital Association (2018). Hospitals against violence: New ICD-10 human trafficking abuse codes. Retrieved from https://www.aha.org/hospitals-against-violence/human-trafficking/workplace-violence

2. National Conference of State Legislatures (2018). Human trafficking state laws. Retrieved from http://www.ncsl.org/research/civil-and-criminal-justice/human-trafficking-laws.aspx

3. US Department of State (2018). 2018 Trafficking in persons report. Retrieved from https://www.state.gov/j/tip/rls/tiprpt/

Rising Maternal Morbidity, Mortality Rates in the US

Karen Cox, PhD, RN, FACHE, FAAN
The Leadership Role for Nurses in Advocacy

Dr. Karen Cox currently serves as the President of Chamberlain University. She was the Executive Vice President and Chief Operating Officer of Children's Mercy – Kansas City, an independent, academic medical center in Missouri. Dr. Cox led the organization to receive Magnet designation by ANCC, becoming the first hospital in Missouri and the region in 2003

Each year in America, 50,000 women suffer life-threatening complications[1] and 700 of those die[2] from childbirth. Deaths suffered by women of color are the driving factor behind the country's climbing maternal death rate,[3] and more than half of these deaths are preventable.

The steadily rising maternal death rate in the United States is now 26.4% per 100,000 births.[4] However, the rest of the developed world, including Germany, France, Japan, England and Canada, posts flat or declining rates.[5] Between 1990 and 2015, the number of maternal deaths in Germany, France, Japan, England and Canada, has been flat or has declined.[6]

Although America touts its healthcare system as one of the world's most advanced, these results indicate a serious threat to women of color. Hypertension and excessive blood loss, the two leading causes of maternal death in America, can be managed effectively, and death prevented by implementing well-known safety procedures. For example, closely monitoring high blood pressure and blood loss are two effective ways to proactively identify a new mother in potential trouble.[7]

The country's largest black-white divide in the maternal death rate, which is seen in New York City, is getting larger even as the city's overall maternal rate declines.[8] New York City's black women, for instance, suffer increased rates of morbidity and mortality when compared to their white counterparts even when they are college educated, have a normal weight and are affluent. In fact, black women from the city's wealthiest neighborhoods have poorer maternal outcomes than white, Asian and Hispanic mothers from the city's most economically challenged areas.[9]

1 Young, A. (2018). Hospitals know how to protect mothers. They just aren't doing it. USA TODAY. Available online from https://www.usatoday.com/in-depth/news/investigations/deadly-deliveries/2018/07/26/maternal-mortality-rates-preeclampsia-postpartum-hemorrhage-safety/546889002/

2 The Editorial Board. (2018). High maternal death rate shames America among developed nations. USA TODAY. Available online from https://www.usatoday.com/story/opinion/2018/07/31/high-maternal-death-rate-shames-america-developed-nations-editorials-debates/866752002/

3 lost mothers: maternal mortality rates in the U.S. (2018). ProPublica and National Public Radio. Available online from https://www.npr.org/series/543928389/lost-mothers

4 (2016). Global Burden of Disease Study 2015 provides GPS for global health 2030. The Lancet. Available online from https://doi.org/10.1016/S0140-6736(16)31743-3

5 Tavernise, S. (2016). Maternal Mortality Rate in U.S. Rises, Defying Global Trend, Study Finds. New York Times. Available online from https://www.nytimes.com/2016/09/22/health/maternal-mortality.html

6 (2016). Global Burden of Disease Study 2015 provides GPS for global health 2030. The Lancet. Available online from https://doi.org/10.1016/S0140-6736(16)31743-3

7 Young, A. (2018). Hospitals know how to protect mothers. They just aren't doing it. USA TODAY. Available online from https://www.usatoday.com/in-depth/news/investigations/deadly-deliveries/2018/07/26/maternal-mortality-rates-preeclampsia-postpartum-hemorrhage-safety/546889002/

8 Waldman, A. (2018). New York City Launches Initiative to Eliminate Racial Disparities in Maternal Death. Propublica. Available online from https://www.propublica.org/article/new-york-city-launches-initiative-to-eliminate-racial-disparities-in-maternal-death

9 Waldman, A. (2018). New York City Launches Initiative to Eliminate Racial Disparities in Maternal Death. Propublica. Available online from https://www.propublica.org/article/new-york-city-launches-initiative-to-eliminate-racial-disparities-in-maternal-death

California, which has implemented many of the gold standard practices outlined in the Alliance for Innovation in Maternal Health Program (AIM),[10] stands out as the lone exception to this startling trend. Putting in place a data-driven national safety and quality improvement program centered on AIM's "safety bundles," a toolkit of quality-focused tactics, helped that state reduce maternal complication rates 21% in two years.[11]

New York City is spending $12.8 million to reduce by half the black-white disparity in maternal deaths in the next five years[12] by:

- Underwriting implicit bias training for medical staff at private and public facilities.
- Training nurses how to identify and treat the top two frequent of maternal death — hemorrhaging and blood clots — in city-owned hospitals.
- Offering maternal care coordinators to high-risk mothers-to-be.
- Launching a city-wide public awareness campaign.
- Improving data collection about pregnancy- and childbirth-related deaths.

Science and evidence are critical in helping to formulate and implement innovative patient safety programs such as the one underway in New York City. Data and research must be used to create and, later, prove the impact of the intervention.[13] Data and research offers knowledge, but that knowledge needs to be evaluated in the context of each setting.

With leadership from professional organizations such as the National Black Nurses Association and the American Academy of Nursing, all nurses can be advocates. This is an opportunity for all nurses to demonstrate evidence-based advocacy in their communities. If we aren't successful, the US will continue to be the most dangerous place in the developed world for women of color to give birth.

Dr. Karen Cox started her healthcare career as a licensed practical nurse. Subsequent degrees include an Associate Degree in Nursing from Excelsior College, a BSN from the University of Kansas, an MSN and PhD from the University of Missouri–Kansas City.

Dr. Cox is President of the American Academy of Nursing (2017-2019). Previously, she was elected to the American Hospital Association, Section on Maternal and Child Health Governing Council, and appointed to the Children's Hospital Association, Child Health Committee.

Dr. Cox was named a Fellow in the Robert Wood Johnson Executive Nurse Fellowship Program (1999-2002). She is also a Fellow in the American College of Health Care Executives. She was appointed to a term on the National Advisory Council on Nurse Education and Practice, U.S. Health and Human Services. She served as board chair of the National Initiative for Children's Health Quality. Dr. Cox served as board member and chair of the Health Care Foundation of Greater Kansas City board of directors, a $400 million foundation dedicated to eliminating barriers and promote quality health for the uninsured and underinsured in the Kansas City area. She is a member of the UMKC Board of Trustees.

Dr. Cox has contributed articles to publications including Modern Healthcare, American Journal of Nursing, Nursing Economics, Seminars for Nurse Managers, Journal of Nursing Administration, Nursing Leadership Forum, Nursing Administration Quarterly and Journal of Public Health Nursing.

10 Alliance for Innovation in Maternal Health. Available online from **https://safehealthcareforeverywoman.org/aim-program/**

11 Young, A. (2018). Hospitals know how to protect mothers. They just aren't doing it. USA TODAY. Available online from **https://www.usatoday.com/in-depth/news/investigations/deadly-deliveries/2018/07/26/maternal-mortality-rates-preeclampsia-postpartum-hemorrhage-safety/546889002/**

12 Waldman, A. (2018). New York City Launches Initiative to Eliminate Racial Disparities in Maternal Death. Propublica. Available online from **https://www.propublica.org/article/new-york-city-launches-initiative-to-eliminate-racial-disparities-in-maternal-death**

13 Carroll, A. (2017). What We Mean When We Say Evidence-Based Medicine. New York Times. Available online from **https://www.nytimes.com/2017/12/27/upshot/what-we-mean-when-we-say-evidence-based-medicine.html**

Invitation to Register in Nurses on Boards Coalition (NOBC) Website—Be Counted!

Debra A. Toney, PhD, RN, FAAN serves on the Board of Directors of Nurses on Boards Coalition. She is the president of the National Coalition of Ethnic Minority Nurse Association and past president of the National Black Nurses Association. Dr. Toney is Quality Manager for the Nevada Health Center, the largest federally qualified health center in the State of Nevada.

Debra A. Toney, PhD, RN, FAAN

You have an important voice and perspective that can make a difference through your serving on a board. The National Black Nurses Association is proud to continue to support the mission and work of the Nurses on Board Coalition as a member organization as we push toward our mutual goal of 10,000 nurses on boards by 2020! This means we are committed to work together to advance the NBNA and NOBC mission to improve health in communities across the nation through the service of nurses on all types of boards (local, state and national).

What is NOBC? The Robert Wood Johnson Foundation, AARP and 19 nursing organizations joined forces to form The Nurses on Boards Coalition (NOBC) in 2014 as a direct response to the landmark 2010 Institute of Medicine (IOM) report, The Future of Nursing: Leading Change, Advancing Health. Now with 30 coalition members and growing the goal is to improve the health of communities and the nation through the service of nurses on boards. The goal is to ensure that at least 10,000 nurses are on boards by 2020 by raising awareness that all boards would benefit from the unique perspective of nurses to attain improved health and efficient and effective health care systems at the local, state, and national levels.

What types of boards? All boards can benefit from the nursing perspective, including corporate, governmental, non-profit, entrepreneurial, advisory or governance boards, commissions or appointments that have fiduciary or strategic responsibility. Think outside the box including boards unrelated to nursing and healthcare such as United Way, PTA, religious boards, school boards, etc.

I encourage you to:

- Register your current board service or indicate your interest in serving on a board. Be sure to register ALL the boards you serve on. **https://www.nursesonboardscoalition.org/**
- If you are already registered, consider updating your information to include recent board placements
- Add your resume and CV and share your story by completing the "The Reason I Serve Survey."
- Share this invitation with a colleague so that ALL nurses are counted!

Thank you for joining me in this groundbreaking work! Board service is an extension of leadership. Through our partnership, as nursing leaders, we will make a significant and lasting impact in improving health in communities across the nation through the service of nurses on boards.

For questions, please contact Laurie Benson, BSN, Executive Director, NOBC **laurie@nursesonboardscoalition.org**

The Status of Nursing Leadership

Trista R. Campbell, PhD, RN, CPHQ

Dr. Campbell is the Health System Manager of the Nursing Research and Performance Improvement Department at Cedars-Sinai Medical Center, Los Angeles, CA.

In our fast paced and rapidly changing healthcare environment, succession planning is becoming more challenging and complex today. Authors of "*Growing Nurse Leaders: Their Perspectives on Nursing Leadership and Today's Practice Environment*" found that growing future nurse leaders is a long-term quest that requires both planning and action. The article highlights that, "Our emerging leaders will ultimately replace our current leaders and continue the very important work being done to improve nursing practice environments, and most importantly, patient outcomes".

The ongoing nursing shortage has fueled the increasing demand for all levels of nursing, however, more so for nursing faculty, chief nurse executives and chief nurse officers, who are working past their expected, planned or scheduled retirement dates. This issue can be explained by the lack of resources for nurses in the pipeline and a poor succession planning. These positions are no longer perceived as the end all career goal. The future nursing workforce is looking for opportunities that provide more work and life balance. However, the current nurse leaders are working upwards of 50-60 hours per week, this may not always seem desirable to the next generation.

Across the country, our Black nursing leadership has a much more complex role to accomplish, to meet the growing demand of the half a million nurses that will be retiring over the next decade. As we become more culturally diverse and our Black patient population continues to age with more uncontrolled co-morbidities; Black nursing leadership is at an all-time crisis in all areas of the profession; including education, administration and direct provider/clinical settings. We need to sustain our gains and have more success in transitioning more nurses of color in leadership positions. This will allow us to be able to provide more culturally diverse research, academia and staffing to meet patient, family, and health economy demands in improving population health.

In this predominantly female profession, there are several system-wide barriers undoubtedly contributing to women leaving leadership roles or not pursuing leadership roles; such as the family medical leave act (FMLA), nurses feel compromised with the short time period. In addition to nurses transitioning from clinical to an academic position and balancing both can cause role strain. According the American Association of Colleges of Nursing, role strain stems from a conflict between the familiar expectations in your current role as a clinician and the new demands of an academic position. Taking time to thoroughly consider the transition to academia is the first step; and use a theoretical framework for transitioning and identifying the positions for transitioning along with the roadmap for attaining the position. Some key categories of concern that need to be taken into consideration are; knowledge deficit, culture, support, salary, and workload. Nurses entering the profession, should engage in road mapping their career ladder early on to ensure there is constant vertical growth most of the time and move laterally or cross functionally to move to a different type of job role.

According to *The Future of Nursing: Leading Change, Advancing Health*, from the Institute of Medicine, nurse leaders are an important part of transforming the healthcare system. The responsibilities of nurse leaders are to advocate for patients, nurses and the profession. The credibility is the foundation of leadership, if people do not believe in you, they are unlikely to follow your lead (Arkansas State University). Some of the traits that define great leadership are awareness, decisiveness, empathy, accountability confidence, optimism, honest focus and inspiration.

"The nurse manager is responsible for creating safe, healthy environments that support the work of the health care team and contribute to patient engagement. The role is influential in creating a professional environment and fostering a culture where interdisciplinary team members are able to contribute to optimal patient outcomes and grow professionally," the American Organization of Nurse Executives said.

Characteristics that are common among successful nurse managers are advocacy, participation, mentoring, maturity, professionalism, and being supportive. "Strong leadership qualities in nursing middle management have been associated with greater job satisfaction, reduced turnover intention among nursing staff, and improved patient outcomes". (add source)

As we begin to think about succession planning, here are some helpful tips from *Forbes Magazine* to keep in mind; define your legacy, plan in phases, aim for continuity, begin with the end in mind, be intentional and supportive, create a visible career path, identify successors, retain your talent with future possibilities, be a conduit to key relationships, and create an exit strategy (Forbes, September 2018).

References

1. 8 Characteristics of Great Leaders. (2017, December 6). Retrieved from https://www.huffingtonpost.com/alex-pirouz/8-characteristics-of-grea_b_7680566.html

2. American Association of Colleges of Nursing (AACN) > Education Resources > Tool Kits > Transitioning from Clinical Nursing to Nursing Faculty Tool Kit. (n.d.). Retrieved from https://www.aacnnursing.org/Teaching-Resources/Tool-Kits/Transitioning-Clinical-Faculty

3. Dyess, S., Sherman, R., Pratt, B., Chiang-Hanisko, L., Growing nurse leaders: their perspectives on nursing leadership and today's practice environment. OJIN, 21 (1) (2016), 10.3912/OJIN

4. Forbes Coaches Council. (2018 September 27) The Importance of Succession Planning and How You Can Start. Retrieved from https://www.forbes.com/sites/forbescoachescouncil/2018/09/27/the-importance-of-succession-planning-and-how-you-can-start/#3e23232631b6

5. The Roles of a Nurse Manager: Leading the nursing profession into the future. (2018, July 17). Retrieved from https://onlinenursing.duq.edu/blog/roles-nurse-manager-leading-nursing-profession-future/

Medication Adherence in Older Adults: A Clarion Call to Arms!

Birthale Archie, DNP, MSN, BS, RN

Birthale Archie, DNP, MSN, BS. RN is the immediate past NBNA Second Vice President, former Interim Chair Department of Nursing and Assistant Nursing Faculty in Graduate Nursing Program / Nursing Research, Bowie State University. Dr. Archie is the founding member of the Kalamazoo-Muskegon NBNA and the Greater Bowie Maryland NBNA.

Introduction

Medication Adherence is critical to facilitate health and wellness. Lack of medication adherence can cause health conditions of older adults to worsen and lead to hospital and nursing home admissions. Awareness raising is necessary to call attention to this need. This article is based on Archie's (2015) Medication Adherence and Medication Adherence Algorithm. This algorithm was designed to be used as a clinical tool to promote medication adherence (MA) in older adults.

According to the Centers for Health Transformation (CHT)] (2010), 125,000 people die yearly due to poor medication adherence. The CHT noted that 342 people die daily from not taking medications and moreover that 10% to 25% of hospital and nursing home admissions are caused by not taking medications as prescribed. As many as 40% of patients do not adhere to treatment regimens and up to 20% of all new prescriptions go unfilled (CHT, 2010).

Definitions

For older adults, medication adherence is defined as taking prescribed medications in the right dose, [right route], right time, frequency (Ágh et al., 2015). The Older Adult is defined as a person 65 years of age and older.

Review of the Literature

There are a multitude of reasons for older adults to not take medication as prescribed. Archie (2015) examined three (3) reasons impacting medication adherence. The provider uses information gathered to design an individualized educational intervention plan. The three (3) reasons are 1) denial of the need for medication, 2) forgetfulness, and 3) busy lifestyle.

Denial. Denial can be based on the belief that medication is not needed (Grissinger, 2010). In addition, the patient/client does not think that there is a health care problem.

Forgetfulness. The patient/client does not take medications as prescribed due to forgetfulness. This forgetfulness is not dementia related. The Medication Adherence Algorithm (MAA) provides guidance to health care providers to use medication simplification protocols to decrease polypharmacy (Kaufman, 2015). Addressing polypharmacy decreases frequency of administration of medication and facilitates adherence.

Busy Lifestyle. A busy lifestyle can impact the way individuals take medications. Russell, Ruppar, and Matteson (2011) noted that the need for a paradigm shift to focus on daily activities instead of the characteristics of motivation and intentions. Encouraging older adults to take medications with daily activities such as watching a specific TV program may increase adherence.

Selected Medication Adherence Algorithm Key Interventions for Practice

The assessment for Medication Adherence in older adults involves engaging in a dialogue on how they are taking medications. The questions should be open ended. For example: Ms. Jones, tell me how you are taking your medications?

Methods to Improve Medication Adherence

A few select interventions to assist with medication adherence are addressed below.

Patient – Client Education. Pertinent information facilitates health

literacy for medication adherence. Information is provided on need, safe dose, common side effects to observe and what adverse consequences are if medications are not taken.

Medication simplification. If medication is prescribed three (3) or four (4) times per day, other members of the healthcare team should be engaged to determine if frequency can be decreased to twice a day.

Medication synchronization. Once medication simplification has occurred, the health care provider should assist in ensuring that the patient /client has a sufficient quantity of medications to set up their pill organizer for a full week.

Pill Organizer. Patients/clients should have a pill organizer to set up medications for one week. Encourage patients to travel with their pills.

Clarion Call to Arms

It is important to empower the patient/client because poor medication adherence claims the lives of 125,000 people each year and hospital and nursing home admissions are increased 10% to 25%. This empowerment can be done with a Medication Adherence Day.

References

1. Ágh, T., Dömötör, P., Bártfai, Z., Inotai, A., Fujsz, E., & Mészáros, Á. (2015). Relationship between medication adherence and health-related quality of life in subjects with COPD: A systematic review. *Respiratory Care, 60*(2), 297-303. Retrieved from http://dx.doi.org/10.4187/respcare.03123

2. Archie, B (2015). Medication Adherence and Medication Adherence Algorithm, Case Western Reserve University, Cleveland, Ohio

3. Centers for Health Transformation. (2010). The 21st century intelligent pharmacy project. The importance of medication adherence. Retrieved from http://www.mirixa.com/uploads/pdfs/2010_-_CHTMedAdhrWp.pdf

4. Kaufman, G. (2015). Multiple medicines: the issues surrounding polypharmacy. Nursing & Residential Care, 17(4), 198-203.

5. Grissinger, M. (2010). The five rights. *Pharmacy and Therapeutics, 35*(10), 542.

6. Russell, C. L., Ruppar, T. M., & Matteson, M. (2011). Improving medication adherence: Moving from intention and motivation to a personal systems approach. *Nursing Clinics of North America, 46*(3), 271-281. doi:10.1016/j.cnur.2011.05.004

Simulation Strategy used to Enhance Nursing Education

M. Meg Brown, PhD, RN, ACNS-BC

Simulation is replicating real life through the usage of strategies to enhance learning in nursing education. Some form of simulation is a common educational tool. Those forms may include manikins, standardized patients, computer based simulations, or role play. In Fundamentals class, students may learn how to take vital signs by using each other as patients. Learning to perform injections may include practice with an orange or injectable pads. During checkoffs for health assessment, students may bring someone to serve as their patients. Manikins are used in learning skills such as landmarks for injections, intramuscular injections, Foley catheter and nasogastric tube insertion. The advances in technology promoted a major shift in the facilitation of learning for undergraduate and graduate nursing students.

Limited clinical facilities or patient population may hinder nursing students' learning experiences for the course. For example, births are not predictable unless scheduled. Normal vaginal deliveries may not occur during the students' hours in clinical. Patients with disease processes being studied for that semester may not be available. High fidelity manikins provide nursing faculty with opportunities to meet students' learning needs. Nursing faculty use high fidelity manikins to guide a realistic clinical experience in a controlled environment. The outcome is improved skills, clinical knowledge, and quality of care without harming a human. Clinical time may be replaced by simulation experiences. The State Board of Nursing can provide information on the limitation of replacing simulation for clinical hours. The most common number of simulation hours for clinical hours seen is 10%-15% with as high as 50% in pre-licensure programs. In *A Vision for Teaching with Simulation, A living document from the National League for Nursing NLN Board of Governors, April 20, 2015,* The National Council of State Boards of Nursing (NCSBN) conducted a multi-site longitudinal study to explore the roles and outcomes of simulation in pre-licensure clinical nursing education in the United States (Hayden, Smiley, Alexander, Kardong-Edgren & Jeffries, 2014). The NLN endorsed the findings that simulation can be substituted for up to 50 percent of traditional clinical experiences.

Lavoie and Clarke (2017) explained that simulation isn't always cheaper when compared to traditional clinical placements. The development of a simulation environment with equipment and

Dr. Meg Brown currently serves as Associate Dean and Associate Professor in the School of Nursing at Grambling State University.

She completed the undergraduate degree in nursing from Alcorn State University, Master of Science in Nursing at Northwestern State University in Louisiana and the Doctor of Philosophy in Nursing from Southern University and A & M College. Dr. Brown has more than 35 years of nursing experience with expertise in adult and critical care. She maintains board certification as an Adult Clinical Nurse Specialist.

technology can be costly and can quickly reach hundreds of thousands of dollars. Faculty may require additional time to develop simulation scenarios. There is limited information on which simulation equipment meets the nursing students' needs at a reasonable cost. There is no evidence that investing in higher end simulation equipment will have better student learning outcomes. The common practice of video recording for debriefing has not been shown to produce "noticeably" better learning.

Simulation is a teaching strategy to guide learning experiences as well as a tool for evaluation of the learning experience. The inclusion of simulation as a teaching strategy ensures patient safety, produces prepared novice nurses, and provides a solution for the lack of clinical sites or patient population. There are several types of simulation available and the selection should be based on the educational needs, the desired realism, and budgetary constraints. The level of commitment to simulation as a teaching strategy will be determined by course faculty. The improved student learning outcomes will validate simulation as an effective teaching strategy for nursing students.

References

1. Hayden, J., Smiley, R., Alexander, M., Kardong-Edgren, S., & Jeffries, P., (2014). Supplement: The NCSBN National Simulation Study: A longitudinal, randomized, controlled study replacing clinical hours with simulation in pre-licensure nursing education. Journal of Nursing Regulation, 5(2), C1-S64.

2. Lavoie, P., & Clarke, S. (2017). Simulation in nursing education. Nursing 2017, 47(7), 18-20.

3. NLN (April 20, 2015). A Vision for Teaching with Simulation. A living document from the National League for Nursing, NLN Board of Governors. nln.org.

Leading an NBNA Chapter

Georgette Mims, MSN, RN

For years, nurses have served as the voice of their patients. *Among the many responsibilities, Nurses are charged with keeping members of the care team updated with designated goals for patient recovery, giving professional recommendation to what works in the best interest of the patient, informing the doctor of medication effectiveness and presented to Congress on the behalf of the patient. The voice of today's nurse has proven to garner a huge impact on the "well-being" of each patient while in residence, and for any "long-term care" for those patients upon discharge from the hospital and in return to their normal way of life.*

Georgette is the President of the New Orleans Black Nurses Association. She received her Bachelor of Science degree from Dillard University of New Orleans, a Master's Degree in Nursing, Business and Health Care Management from the University of Phoenix and was also a Graduate of the Byron Bell Leadership Program.

With that in mind, one may even say that the nurse, today, has become the drivers of change in the medical community. And because the face of medial care has evolved from the manual blood pressure cuff to the advance blood pressure monitor with auto-off switch, our nurses have been key agents to leverage technology, and drive the procedures that provide better care. This positions them to hold the key to affordable care for every needy individual in every community across the world! The Registered Nurse is the leader in developing health care policies and practices, improving care quality and advancing health information technology.

So with all of these advantages to being a nurse, let's talk about some of the core objectives required for that nurse to make use of his/ her full potential and become a leader in his/ her field?

Setting the Stage:

To the nurse, because you have been designated the core of the nurses station on your assigned floor, you guide, and direct your station and the nurses on your unit. For the past 16 years, out of 22 professions, the nurse has been noted as one of the most trusted professions. According to the Gallup poll, nurses have an 82% rate of being honest and are viewed as having substantial ethical standards among professionals.

In addition to being the "Go-to Person" for doctors, other nurses: and the patients in your unit/ ward, set your mark as one who can effectively handle the responsibilities of your title. You have the potential to become a pioneer, like the woman who established nursing as a legitimate profession, Florence Nightingale. Like Florence Nightingale you are in position to define what it meant to be a nurse in today's ever-changing times.

Here are some key examples to leading your unit effectively:

- Identify your mission. This in your opportunity to find your true purpose and what you want to achieve. Knowing your mission will help guide you in moving forward, getting others engaged.
- Be courageous – Do not allow opposition or antiquated views prevent you from doing your work. When you run into a brick wall, find a way around it (3).
- Have discipline – To know the right order and not practice it will not lead to effective outcome. Demonstrate what you know and know what you demonstrate (3)
- Show empathy – Giving awareness to a situation give quality to patient care. You must know what to observe and how to observe.
- Demonstrate respect – Backbiting, misrepresentation, bad temper, bad thoughts, complaining and prying into another person's concerns will not give way to respectful environment. The spirit of mutual respect in the workplace ring out with crystal clarity.
- Always offer encouragement – Encourage others to perform beyond one's own expectations (3)
- Have aspiration – Continue to raise the bar. Commit to never ending improvement (3)

This above qualities are tools I have used as President of New Orleans Black Nurses Association. The use of those qualities has given me the opportunity to grow as an individual. My growth led to the growth of the chapter and its membership. Members are more engaged and eager to involve themselves and other members in community events with their employers and within their neighborhoods.

Being a leader requires you to be humble, a good listener and understanding. Not everyone will agree with your decision. As a team, however, you can agree to compromise. Keep the goal in site at all times and remember, A GOOD LEADER KNOWS WHEN TO FOLLOW.

Reference

1. Thomas, T., Seifert, P., & Joyne, J., Registered Nurse Leading Innovative Change. Retrieved from http://ojin.nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/TableofContents/Vol-21-2016/No3-Sept-2016/Registered-Nurses-Leading-Innovative-Changes.html#Thomas

2. Nurses Watch: Nurses Again Top Gallup Poll of Trusted Professions and Other Nurse News. Retrieved from https://www.aha.org/news/insights-and-analysis/2018-01-10-nurse-watch-nurses-again-top-gallup-poll-trusted-professions

3. Leadership Lessons for Florence Nightingale Retrieved from https://www.valuescoachinc.com/leadership-lessons-from-florence-nightingale

Transformational Leadership

Chadwick Ricks, RN, BSN

Over the years transformational leadership has received considerable attention. Burns(1978) defined transformational leadership as connecting leadership with a need and a purpose. Transformational leaders look for motives of their followers and engage the full person in reaching a mutual purpose(Joel, 2013). Bass(1985) further defined transformational leadership as being able to elevate the interest of their followers and their ability to look beyond their own self - interest to that of the group. Transformational leaders have been described and perceived to be very charismatic and are able to bring out the best in their followers. This type of leader tends to show great competence and confidence. They tend to be inspirational to their followers and are very intellectually stimulating(Bass, 1985; Bass and Riggio, 2008).

Kouzes and Posner(2007) defined leadership not by title, power, or authority but by relationships, credibility. The relationship is between the person who aspires to lead and those who choose to follow. Credibility includes being honest, competent, and inspiring and is the foundation of leadership. Credibility is established by doing what you say you will do. There are five principles of leadership (1) modeling the way, (2) inspiring a shared vision, (3) challenging the process, (4) enabling others to act, and (5) encouraging the heart(Kouzes & Posner, 2007). In number one, "modeling the way,'' the leader needs to find their voice and articulate their values. Based on these values, common principles and ideals can be generated with others. An example of this is to allow actions to speak louder than words. In number two "inspiring a shared vision," it is the vision that creates enthusiasm and helps to get others engaged. We have learned thru research that engaging other through shared dreams is key to successful change. In practice three "challenging the process," leaders are willing to challenge the status quo and take the necessary risk of experimenting with new ways of doing things.

Pastor Chadwick Ricks, RN, BSN has been an ICU/ER nurse for over 20 years. He is currently the director of an emergency department in the San Bernardino County area. He has been a travel nurse all over the country and has been in management for over 5 years. During this time, he has found that transformational leadership has great and lasting benefits to those who choose to implement the principles. Not only does it empower the leader, but the staff is empowered as well and constantly engaged to think outside of the box and make comparable decisions.

By doing this, leaders learn from their successes and their failures and continue to adapt to new ways of doing things. In practice four, "enabling others to act," the leader recognizes the importance of the team. Team building creates trust and collaboration with others and makes them successful. These leaders are considered authentic leaders. In the fifth practice "encouraging the heart," leaders provide support and encouragement through the change process and recognize the contributions of their team, and celebrate their successes regularly (Kouzes and Posner, 2007).

In conclusion it has been found that, transformational leaders are role models (i.e., idealized influence) who inspire and motivate their followers' (i.e., inspirational motivation), are genuinely concerned with their followers' needs (i.e., individualized consideration), and encourage their followers to be creative (i.e., intellectual stimulation) (Burns, 1978)

A Local Chapter's Call to Action: Resilience, Mentorship and Membership Engagement
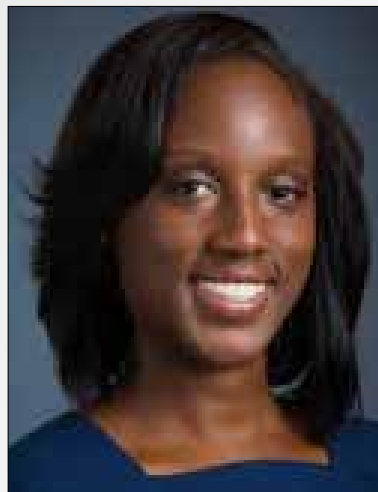
Lindsey Harris, PhD, FNP-BC, President, Birmingham Black Nurses Association and President-elect, Alabama State Nurses Association.

Martha A. Dawson, DNP, RN, FACHE
Deborah Andrews, MSHSA, RN
Geneva Irby, RN, BBNA Vice President Emeritus
Carthenia Jefferson, RN, Esq.
Deborah Thedford-Zimmerman, MSN, RN, CWOCN
Deborah Walker, MA, BSN, NE-BC, BBNA President Emeritus
Jennifer J. Coleman, PhD, RN, CNE, COI

*Authors are members of the
Birmingham Black Nurses Association, Inc*

Dr. Lindsey Harris, president of the Birmingham Black Nurses Association (BBNA), was elected president-elect of the Alabama State Nurses Association (ASNA) at the 2018 ASNA Annual Convention in October. When Dr. Harris assumes the presidency of ASNA in 2020, she will make history as the first African American president of the state association.

ASNA was founded in 1913 (ASNA, 2018). For over 100 years ASNA has existed to represent the nurses of Alabama. One of ASNA's inaugural initiatives involved the need for nurse licensure in Alabama, and in 1923 the organization called for creation of what has become the Alabama Board of Nursing. For decades ASNA has maintained a diverse membership of registered nurses (RNs), licensed practical nurses, and nurses from varied races and ethnicities. Despite the diversity of its membership, during the 105 years of existence, the organization had not elected an African American nurse as its president.

BBNA members have been very supportive of ASNA, with members serving as officers and in other leadership roles (secretary, committee chairs, vice president, convention delegates). BBNA members are active participants in ASNA's Annual Nurses Day at the Capitol, coordinating transportation and serving as session speakers. One of the past presidents of BBNA has served as chairperson of the state rally.

Despite BBNA's active engagement in all of ASNA's initiatives, it appeared to be nearly impossible for an African American nurse to advance to the president's seat. However, BBNA leaders felt that the time was ripe for change. While change is always difficult, institutional and cultural change can be insurmountable. BBNA leaders and members accepted this call to action and became more resilient after each failed attempt, while still supporting ASNA and maintaining the partnership with the organization. Yes, the relationship with ASNA is a partnership as BBNA also receives support from ASNA and leverages that support to improve the health of Birmingham's residents. However, even with strong partnerships, there are opportunities for improvement and change.

Resilience is defined as the ability to bounce back from tough times, to have courage, and to connect effectively with others to bring about positive change (Webster's New World College Dictionary, n.d.). Thus, BBNA implemented its plan for change in the leadership of ASNA. Each year a BBNA member declared official candidacy for ASNA president, and each year would lose by one or two votes. These RNs are all well qualified, experienced professionals. They are past presidents of BBNA, board members of ASNA, board members of the National Black Nurses Association (NBNA), chief nursing officers, and nurse attorneys. With each setback, BBNA

leaders and members rebounded and increased their professional engagement with ASNA. BBNA members actively recruited new members, encouraged members to serve as delegates, nominated nurses for professional awards, and supported the organization with vendors/exhibitors for scheduled events. Most importantly, in 2018, BBNA's current president stepped up and moved forward as a serious candidate. All of the aforementioned events constituted the thoughtful, painstaking plan that would lead to our ultimate success. Previous candidates supported and encouraged Dr. Harris, and members engaged in the process with renewed commitment.

BBNA has a long and successful history of mentorship and investment in students and the next generation of nurse leaders. This mentorship started with BBNA's founding members in 1989 and continues to this day. The unique aspect about BBNA's mentorship approach is that students and new nurses are mentored by multiple members. Each mentor, official and unofficial, provides a different perspective to shaping a young member into a professional nurse and future leader. The objectives of BBNA's mentorship program are to (a) foster professional growth among mentees, (b) increase the number of students graduating into the nursing profession, and (c) increase student exposure to career choices.

On October 6, 2018, BBNA mentors' efforts paid off with big dividends when our current young president, Dr. Lindsey Harris, became the first African American president-elect of ASNA. After 105 years in the making, it did indeed take a "village." BBNA's effort demonstrates leadership, advocacy, and mentorship in action.

Dr. Harris began her association with BBNA as a nursing student. Mrs. Geneva Irby, BBNA vice president emeritus, and other members took the young nursing student under their professional wings and groomed her for success and leadership. After receiving her nursing degree from Samford University, Dr. Harris earned her master of science in nursing as a family nurse practitioner while BBNA continued to support, encourage, and nurture her in our local and national organizations. Dr. Harris has continued to grow with BBNA and NBNA. She received the BBNA chapter scholarship and the *Minority Nurse* scholarship. In 2011, Dr. Harris was recognized as NBNA Staff Nurse of the Year. In 2015 she received the NBNA Advance Practice Nurse of the Year award, and was recognized in 2016 as a member of the next generation of nursing leaders with the NBNA 45 under 40 Award. Dr. Harris continued her education and received her doctor of nursing practice from the University of Alabama at Birmingham School of Nursing. She has held several positions with ASNA, including chair of the Commission on Professional Issues, Environmental Committee, delegate-at-large, and current ASNA secretary.

BBNA past presidents, Mrs. Deborah Andrews and Dr. Carthenia Jefferson helped to create the path for Dr. Harris to ascend to successive positions in ASNA and the eventual move into the top leadership position. Hans Selye, MD, PhD, DNSc said, "It is not what happens to you that matters, but how you take it." BBNA leadership and members are to be commended for their professional resilience.

At its October chapter meeting, BBNA celebrated Dr. Harris with yellow roses, a congratulatory reception, and heartfelt testimonials. BBNA president emeritus, Deborah Walker, and vice president emeritus, Geneva Irby, reminisced about Dr. Harris' first days as a student member of BBNA. Dr. Jennifer Coleman reminded everyone that Dr. Harris was a student of Dr. Coleman's at Samford University. Several members spoke of the dedication, commitment, and passion for nursing that Dr. Harris consistently demonstrates. BBNA members are indeed continuing to celebrate and cannot stop smiling!

The promotion of excellence in nursing is the mission of ASNA; and with the election of Dr. Lindsey Harris, the organization is now positioned to embrace its vision of being the professional voice of all registered nurses in Alabama. Congratulations to Dr. Lindsey Harris, ASNA president-elect!

Author Bios

Martha A. Dawson, DNP, RN, FACHE is Director of Nursing and Health Systems Leadership, Coordinator of Nursing and Health System Administration at the University of Alabama at Birmingham School of Nursing. Dr. Dawson is the current NBNA Historian and past NBNA secretary.

Deborah Andrews, MSHSA, RN has over 25 years of healthcare experience with a focus in nursing administration and clinical operations. Her skills include strategic planning, business development, human resource management, fiscal management, quality improvement, nursing standards, and building community relationships.

Geneva Irby, RN is BBNA vice president emeritus. She is also an official consultant of Traci Lynn Fashion Jewelry.

Carthenia Jefferson, RN, Esq. is an attorney and owner of Jefferson Law Firm LLC. She is also a legal nurse consultant and medical chart reviewer and was inducted as a Fellow into the American Bar Foundation in 2016.

Deborah Thedford-Zimmerman, MSN, RN, CWOCN is retired from the University of Alabama Birmingham Hospital where she was Bariatric Coordinator in the Transplant and Surgical Division. She is the current president-elect of BBNA.

Deborah Walker, MA, BSN, NE-BC is president emeritus of BBNA. She is retired from the University of Alabama Birmingham Hospital where she was Nurse Manager of Rehabilitation Nursing.

Jennifer J. Coleman, PhD, RN, CNE, COI is professor of nursing at Ida Moffett School of Nursing at Samford University. She coordinates the nurse educator concentration courses in the doctoral program and teaches core doctoral courses. Dr. Coleman is chair of BBNA's mentorship program. (Contact – jacolema@samford.edu)

References

1. Alabama State Nurses Association (2018). How it all happened: The history of ASNA. Retrieved from **https://alabamanurses.org/mission/**

2. Webster's new world college dictionary (n.d.). Resilience. Cleveland, OH: Pearson Education Macmillan.

3. Bass, B. (1985). *Leadership and Performance beyond expectations.* New York: The Free Press.

4. Bass, M. B., & Riggio, R. E. (2008). *Transformational Leadership* (2nd ed.). Mahwah New Jersey: Erbaum Associates.

5. Burns, J. (1978). *Leadership.* New York: Harper & Row.

6. Joel, L. (2013). *Advanced Practice Nursing* (3rd ed.). Philadelphia PA: F.A. Davis.

7. Kouzes, J., & Posner, B. (2007). *The leadership Challenge* (4th ed.). San Francisco: John Wiley & Sons.

Successful Leadership in Today's Healthcare Environment

Pier A. Broadnax, PhD, RN

Pier A. Broadnax, PhD, RN, is the President of the Black Nurses Association of Greater Washington, DC Area and the Program Director/RN to BSN Program, University of the District of Columbia.

As we prepare to return to school, one question that I always ask students enrolled in my nursing leadership course is, "Are leaders born or are they made?". It always leads to a lively discussion among the students as they attempt to convince their classmates of their point of view. If only it were that simple! The stakes are higher today than ever before for nurse leaders. Whether they are in clinical or academic settings, success is possible. The healthcare environment is dynamic and, in some ways, accurately, considered unstable. Leaders must maintain quality in the midst of financial challenges, stringent regulatory requirements and customer demands. How does one become a successful leader in today's healthcare environment? An important element of am successful leader is to walk and talk the organization's vision. What are the characteristics of successful leaders? Five essential characteristics of a successful leader are:

1. Innovative Leadership

2. Strategic Thinker

3. Skilled Communicator

4. Intelligent Risk Taker

5. Resilience

Innovative Leadership

Innovation leadership is complex and difficult to define but critical to an organization's success. Hunter and Cushenbery (2011) define innovation as, "novel ideas of viable products that are put into operation". Creativity which may be is similar to innovation is analogous to brainstorming without any additional activity. The innovative leader must be able to move the organization past the status quo to implement new clinical projects, revise curricula to improve NCLEX scores, design research projects that address current healthcare issues and to engage in fundraising. One of the first steps is to create an organizational climate which not only stimulates innovation but also celebrates efforts to find solutions. These demands will require leaders to be proficient in assessing organizational behaviors, recognizing emerging developments in the areas of changing patient or student demographics, faculty and staff competencies and professional trends in order to move effectively towards organizational goals. Innovative leadership encompasses a combination of activities, knowledge, and behaviors needed to produce positive outcomes.

Two types of innovation described in the literature (Jansen, Van den Bosch, Volberda (2006); Rosing, Frese, Bausch, (2011) are:
1. Exploratory innovation, which generates new ideas; and

2. Value-added innovation, which focuses on improving established ideas.

In developing new projects, either innovation model or a combination of the two may be required and effectively used by nursing leaders.

Strategic Thinker

A visionary leader must be able to see the "big picture" but plan in great detail in for effective implementation. What can the leader expect to achieve after implementation? What resources are available? What are the new performance measures or accreditation standards? How will repeal of elements of the Affordable Care Act, responding to the IOM recommendations, or changes in the opioid epidemic shape the organization's ability to deliver quality services? The leader cannot have all of the answers but should know that these are critical questions that must be addressed in any strategic plan. The strategic plan is the recipe for success. A strategic thinker will build relationships and political capital in support of efforts to carry out an initiative. The visionary leader is able to convey how success of a strategic plan also will be of benefit to other professional colleagues and the overall organization.

Skilled Communicator

Successful visionary leaders inspire the confidence of followers by conveying the clear path and its benefits to those who will move towards a new vision. They are charismatic and able to coach those who need additional support, but willing to learn from the naysayers who may have additional insights into how to achieve success. Effective communicators are able to build teams by making everyone feel as if their participation is essential to the project's success and that their input matters.

Intelligent Risk Taker

When embarking on new endeavors, the leader must be willing to risk failure. There will be setbacks. However, in the development of a plan, the leader must include as many measures as possible to ensure success. When there is a setback, debrief with the team to discuss what worked and what did not work and why. It can be instructive to evaluate successful efforts with the same attention to detail to facilitate continued forward movement. Support team members to prevent loss of momentum towards goal achievement. The leader in this role assumes the risk but also becomes a cheerleader for the team and for the success of the initiative.

Resilience

A resilient leader is one who is generally ahead of the times and persists in moving towards identified goals despite family problems, serious personal health threats, financial challenges and/or occupational stressors. Resilience is not simply bouncing back but moving ahead in spite of difficulties. Such leaders provide stability in periods of transition guidance when others are stuck in

the process. Their willingness to move ahead against seemingly overwhelming odds is a characteristic of a successful leader.

Leadership is never easy, but it is especially difficult in times of rapid changes. It requires different organizational skills at various times and the abilities of accomplished leaders at every level to inspire others to achieve the ultimate goal. Their success lies in creating effective teams of diverse individuals moving in the same direction.

References

1. Hunter, ST Cushenbery, L. (2011). Leading for innovation: direct and indirect influences. Advances in developing human resource, 13, 248-265.

2. Jensen, JJP, Van den Bosch, FAJ & Volberda, HW (2006) Exploratory innovation, exploitative innovation and performance: Effects of organization antecedents and environmental: moderators. Management Science, 52, 1661-1674,

3. Rosing, KM Frese, M. & Bausch, A (2011). Explaining the heterogeneity of the leadership-innovation relationship: Ambidextrous leadership. The leadership Quarterly, 22 856-974.

Is a Lack of Cultural Diversity in Healthcare Harming our Patients?

Beverly Dandridge, MSN, FNP, MSAJS, CCHP

CAPT Beverly Dandridge is an active duty officer in the U.S. Public Health Service Commissioned Corps. She has deployed multiple times to assist those adversely impacted by hurricanes, and served on the medical response team in support of the Papal visit to the U.S. in 2016. CAPT Dandridge has co-authored 2 chapters in the recently published Ninth Edition, Community Public Health Nursing: Promoting the Public Health textbook.

Diversity awareness acknowledges and appreciates the existence of differences in attitudes, beliefs, thoughts, and priorities in the health-seeking behaviors of different patient populations. This awareness also reflects the nursing profession's contract with society and our [nursing] responsibility to act according to a strong code of ethics, (i.e., to be aware of our own attitudes, beliefs, thoughts, and priorities in providing care to individual patients, families, communities, and populations) [1].

In this millennium, diversity, cultural awareness, and cultural sensitivity, are words routinely included in most organizational leadership strategic plans, recruitment plans, or operational assessments. Diversity is defined by Webster as the condition of having or being composed of differing elements [2]. The English Oxford Dictionary defines diversity as the state of being diverse; a range of different things [3]. The Agency for Healthcare Research and Quality (AHRQ) states that all nurses should provide culturally competent care [4]. In summary, regardless of the individual differences of our patient population, our competent nursing care delivery must include cultural sensitivity and awareness.

The patient provider relationship is critical when evaluating and identifying patient outcomes and the quality of care. Nursing's reflection of the patient population being served in terms of gender, race, and ethnicity, has been noted to positively affect patient compliance with health care management and outcomes. The diversity within the nursing profession can also impact patient care delivery. Campinha-Bacote (2003) notes "There is more variation within cultural groups than across cultural groups". In addition, "no individual is a stereotype of one's culture of origin, but rather a unique blend of the diversity found within each culture, a unique

accumulation of life experiences, and the process of acculturation to other cultures" (Campinha-Bacote)

The benefits of diversity are increased motivation, productivity, creativity, and innovation among the members of a working group. Enhanced cultural competence, critical thinking skills, and multicultural acceptance have also been noted as benefits of diversity. Increased compliance with healthcare management, and enhanced health literacy are observed patient outcomes of a diverse healthcare workforce.

Acknowledging that with positive outcomes there are challenges, diversity in the healthcare workforce has yielded exclusion, isolation, alienation, anxiety with the integration of various groups of people (minorities), social assumptions and unconscious biases. One would not readily acknowledge the unconscious biases present among health professionals. However, we are all human beings in a social environment that inherently creates biases, and therefore, not immune to that "state of mind". Cultural history and life experiences are critical factors contributing to the unconscious biases in each person. The greater challenge is how are we managing the individual (inherent) biases, and how are these impacting our nursing care delivery?

To enhance the benefit of health care workforce diversity on population health, what should be done? The starting point is to understand, value, and appreciate differences, promote inclusiveness with respect and values, expand interactions to include minority groups, and ensure recruitment activities

are focused on qualifications, merit, and interest. Nurses can also acknowledge unconscious assumptions and biases, and encourage collaborative discussions among healthcare team members to support the paradigm shift which outlines diversity as a strategy to support quality health care for all, thereby reducing health disparities among minority populations.

In the tapestry of life, ensure the nursing multicultural threadwork is caring, competent, and culturally sensitive across the lifespan. Continue to make a difference — one culture at a time.

References

1. American Nurses Association. Diversity Awareness Clinical Practice Model. https://www.nursingworld.org/practice-policy/innovation-evidence/clinical-practice-material/diversity-awareness/

2. Merriam Webster Dictionary https://www.merriam-webster.com/dictionary/diversity

3. English Oxford Dictionary https://en.oxforddictionaries.com/definition/diversity [3] APHA pushes for health workforce diversity on Capitol Hill. Public Health Newswire, 23 Sept. 2015 www.publichealthnewswire.org/?p=13891)

4. Agency for Healthcare Research and Quality http://www.ahrq.gov/news/events/nac/2011-11-

   Campinha-Bacote, J. (2003). Many faces: Addressing diversity in health care. Online Journal of Issues in Nursing. Vol. #8 No. #1, Manuscript 2. Available: http://nursingworld.org/ojin/topic20/tpc20_2.htm

   National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care (2013) https://www.thinkculturalhealth.hhs.gov/pdfs/enhancednationalclasstandards.pdf

   Wilson, Astrid H., Sanner, Susan J., McAllister, Lydia E. (2003) Building Diverse Relationships. The Honor Society of Nursing, Sigma Theta Tau International Diversity Resource Paper. https://www.sigmanursing.org/docs/default-source/position-papers/diversity_paper.pdf

A Call to Action: Ensuring Diversity and Inclusion in Schools of Nursing

Rebecca Harris-Smith, EdD, MSN, RN
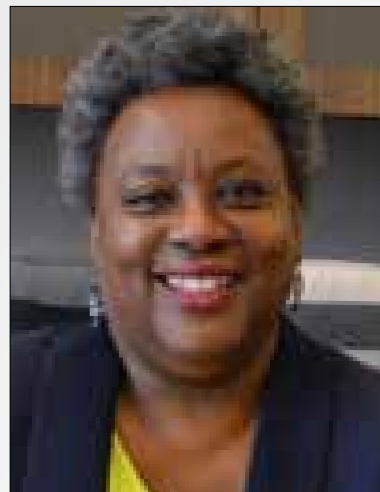
Currently, **Rebecca Harris-Smith** serves as the Dean of Nursing and Allied Health at South Louisiana Community College in Lafayette, LA. Dr. Harris-Smith maintains active membership in several professional organizations that include education, nursing and as the Past President of the New Orleans Black Nurses Association Chapter (NOBNA) from 2004 – 2008. Immediately following Hurricane Katrina Rebecca reinvigorated the chapter to continue their service to the community. Dr. Harris-Smith has 45 years of nursing experience, ranging from bedside care to administration, community nursing, and has served as a nurse educator since 2003.

I s it surprising to ponder that diversity in healthcare was identified as early as 1950's when Madeleine Leininger developed The Transcultural Theory of Nursing that identified a missing component in nursing care? The Transcultural Theory identified the nurse's lack of ability to provide cultural care due to an inability to understand differences in patient care populations (Petiprin, 2016). Leininger's theory attempted to provide an understanding of culturally congruent nursing care to ensure nurses were knowledgeable and competent in providing care for individuals, groups or institution's cultural values, their beliefs and lifeways which would prove valuable for people of diverse or similar cultural backgrounds (Petiprin, 2016). Diversity generally includes sexual orientation, gender, race and other factors but for the sake of this article I will focus on inclusion of African American and students of color access into schools of nursing.

In 1954 in the academic arena, segregation in public education forced Americans to address the racial divide as Brown versus the Board of Education exposed the delusion behind separate but equal. Separation of the races in the classroom begin to change as the Supreme Court declared racial segregation in public schools unconstitutional by recognizing it violated the equal protection clause of the Fourteenth Amendment (Delinder, 2004). The courts declared separate but equal inherently unequal. African American parents fought and won equal access to education hoping to secure a quality education for their children under the law. But as we won the battle by ridding the system of "separate but equal," the inequity did not change as the majority white population merely change the strategy to maintained segregation. Before whites would accept desegregation, there was a massive exodus to the suburbs which created a new form of separation. White flight to the suburbs left the educational system suffering financially, allowing segregation to continue as it opened the doors to a new form of discrimination.

A decade later, Congress attempted to address segregation with the Civil Rights Act of 1964. The purpose of this legislation was to eliminate discrimination and segregation based on race, religion, national origin and gender in the workplace. It also addressed schools, public accommodations and federally assisted programs, an issue which was initially addressed in Brown versus the Board of Education. Although this legislation addressed multiple issues related to segregation Title IV specifically addressed Desegregation of Public Schools. The Civil Rights Act required schools to take actual steps to end segregation, addressing "Freedom of Choice" by enforcing busing, redistricting or creating magnet schools (Bessent, 1997).

As we move into the next two decades (1970 – 1980) there continues to be an issue related to the education of African Americans as the healthcare system came under attack when Allan Blakke versus Medical School at the University of California at Davis. The Civil Rights Act of 1964 was viewed as a problem and was challenged when a white student was denied admission to medical school on two occasions. Of the 100 potential spots for medical school admission, 16 were reserved for women and minorities thus being the question of reverse discriminatory. The unlawful ban of minorities, in the form of segregation that existed for years was now being challenged as 16 seats in the class was reserved to admit qualified women and minorities. It appears easier to forget the injustices of the past that created this situation even as qualified minorities were denied admission. To ensure the admission of qualified underrepresented applicants was considered an injustice to the majority white population any many considered it token representation.

To address the lack of available education options in the Black community, prior to the Civil War, Richard Humphreys founded the first HBCU in 1837 in Cheyney, Pennsylvania followed by Lincoln University, in Pennsylvania (1854) and Wilberforce University, in Ohio (1856) (Cheyney University, 2018). These institutions provided elementary and secondary education for African American students that were denied an education. Post-Civil War, public support provided the Second Morrill Act in 1890, which required states to provide a land-grant institution specifically for blacks in support of the "separate but equal" doctrine that made a way for 16 black institutions (Cheyney University, 2018). According to the Office of Civil Rights (1991), African American's developed the HBCU "to provide for the educational needs of Black Americans because basic education for blacks at traditionally white institutions was prohibited in parts of the nation" (pg. 1). Therefore, it should be acknowledged that as a people, African Americans has always fought for and valued education.

With the overturn of Plessy v. Ferguson, affirmative action came under attack which challenged the college/university's ability to establish a reserved quota to ensure admission of qualified people of color. HBCUs served as a shelter from racial bias, but they have come under fire for perceived racial discrimination. There are whites and others that claimed affirmative action discriminates against whites which begin the process of dismantling the work of prior generations. Many younger Black students do not fully embrace the struggles of a people that fought to ensure access to education. To deny an education of any race is to ensure their bondage, so as we educate, we elevate. Therefore, when research has been conducted to address the benefit of educating the underrepresented student why have we become complacent with the lack of movement in this area?

Over the years, disparities in health care and health outcomes has been well documented (Phillips & Malone, 2014) and as we investigate the 21st century, movement to achieve an increase in admitting underrepresented students in schools of nursing remains slow. With an emphasis on healthcare, during the next two decades (1990 – 2010) literature was published addressing diversity in the workforce and nursing education (Bessent, 1997; Bleich, Macwilliams, & Schmidt, 2015; Hill, 1998; Pacquiao, 2007; Trice & Foster, 2008). According to Phillips and Malone (2014), the need to include African Americans and people of color in the healthcare workforce require concerted efforts, and to address this issue there must be a conscious effort to increase the number of underrepresented students in schools of nursing. This lack of diversity in nursing education led to a call for diversity in schools of nursing from the National League of Nursing (NLN), American Association of College of Nursing (AACN), and the Institution of Medicine (IOM).

According to the National League of Nursing (NLN) the percentage of students enrolled in basic RN-Programs by Ethnicity between 1995 – 2014 as documented by NLN reflect the following rates:

- Whites 79% - 84.5%
- African American 9.4% to 12.2%,
- Hispanic 3.5% – 8.1%,
- Asian or Pacific Islander 4.0% – 5.9%,
- Others/Unknown 4.6% - 7.5%
- American Indian 1.2% – 1.5%, (National League of Nursing, 2005 - 2018).

Therefore, professional healthcare organizations have called for a change in providing healthcare and healthcare education as noted below:

- Institute of Medicine (IOM) researched diversity and inclusion in the field of medicine to provide a systematic investigation designed to establish a fact and/or evidence focused on African American and people of color ability to matriculate and graduate. Later the IOM published a report brief in 2010 that addressed "The Future of Nursing: Focus on Education. This report calls for an increase in diversity of schools of nursing classes to match the demographics of the community (p. 128). The report also suggests a continuation of efforts to recruit men into nursing (p. 127-128).

- National League of Nursing (NLN) provided research that addressed diversity in the workforce, nursing education, to include nursing faculty, and as a result developed a "Tool Kit" as a means of addressing this issue. This focus on diversity and inclusion addresses the four dynamic and integrated core values that permeate the NLN which are: Caring, Integrity, Diversity/Inclusion, and Excellence. These core values address the need to ensure diversity and inclusion. The rationale for increasing diversity in the nursing student population and health care workforce is clear: increased diversity can improve the overall health of the nation (Sullivan Commission, 2004). Recruiting and retaining nursing students from diverse backgrounds is, therefore, paramount (National League of Nursing, 2018).

- American Association of Colleges of Nursing (AACN) recognizes diversity, inclusion, and equity as critical to nursing education and fundamental to developing a nursing workforce able to provide high quality, culturally sensitive, and congruent health care in partnership with individuals, families, communities, and populations. Therefore, AACN notes that nursing school leaders, administrators, faculty, staff, and students must continue to collaboratively engage in efforts to recruit, retain, and graduate students who will advance institutional missions, which should address issues of diversity, inclusion, and equity (American Association of Colleges of Nursing, 2017).

- Dr. Hattie Bessent, member of the National Black Nurses Association published the book: "Strategies for Recruitment, Retention, and Graduation of Minority Nurses in Colleges of Nursing." This publication addressed all areas of concern to ensure the concept of democracy in nursing education for African American and students of color. As we broaden our understanding for diversity and inclusion in educating the underrepresented in the field of healthcare, the nation will benefit (Bessent, 1997).

Considering the years of disparity and the volume of research supporting the need to increase diversity in the workforce in healthcare and SON, the call to action from the nursing profession supporting this issue remains elusive. According to Bleich, MacWilliams, et. al, (2015) "Nurse leaders call for a more diverse nursing workforce, but too few address the concept of inclusion as a recruitment and retention strategy or as part of improving the academic learning milieu" (p.89). Addressing issues of diversity within a college of nursing is necessary if the cultures of our academic units are to change and become more inclusive (Peery, Julian, Avery, & Henry, 2013, p. 120). Therefore, with the volume of research and articles addressing this issue, why are there so few underrepresented students of color being admitted into SON across the nation? Is there a commitment to address the call to increase diversity and inclusion? Is it easier to turn our attention away from the very issue that many of the Baby Boomer of this organization experienced? Why has the inclusion of this population of students in nursing remained low? As nurse leaders in higher education, are we answering the call to action?

The mission of our prestigious National Black Nurses Association is to "represent and provide a forum for Black Nurses to advocate and implement strategies to ensure access to the highest quality of healthcare for persons of color" (National Black Nurses Association, 2018). To ensure that we strategically address this mission, I propose we adopt an initiative that addresses the increase in diversity in the workforce by providing a means of ensuring the admissions, retention and graduation of Black Nurses and people of color. This disparity has continued despite the research supporting the need to address this issue, and who better to answer the call of action than NBNA.

As the Dean of Nursing and Allied Health at South Louisiana Community College in Lafayette, Louisiana, I examined the demographics of the incoming class of forty-one students and noticed the lack of diverse cultural representation. In reviewing the statistics of the State of Louisiana, the local community, and the admitted class, you will see the noticeable lack of diversity of the incoming class as noted on the following table.

Demographics of State and Local Population in Louisiana

Race/Ethnicity	State	Lafayette	SLCC / SON
White	63%	61%	87.0%
African American	32.6%	30.7%	12.0%
Hispanic	5.2%	4%	0.2%
Asian	1.9%	2.2%	0.0%
Mixed/Other	1.8%	1.7%	0.8%

(United States Census Breau; Statical Atlas, 2015)

In reviewing these statistics, I noticed there is a disproportionate representation of people of color in the ASN program. This situation must be strategically addressed to ensure the representation of the underrepresented students of color. We are currently in the initial stages of developing a plan of action to begin this journey. The work of Dr. Hattie Bessent must be continued. Therefore, I implore nurse educators, administrators, and others to examine your recruitment, retention, and graduation of students of color at your institution and ask yourself if you are working to ensure diversity and inclusion into your program of study. It starts with us, we can answer the clarion call to correct this disparity by implementing and evaluating initiatives that focus on this disparaging situation. I encourage all NBNA Faculty, Deans of Nursing and other interested members to collaboratively address the disparity that many of our current members have experienced. We must continue the work of our ancestors by ensuring diversity and inclusion in the workforce and academia across the nation. Considering the work of our ancestors to secure equal education for all, the Theory of Transcultural Nursing developed 50 years ago, the plethora of research related to the value of a diverse workforce, and the Call for Action from multiple professional nursing organizations, it therefore becomes our duty to uphold our mission to: "advocate and implement strategies to ensure access to the highest quality of healthcare and healthcare education for persons of color".

Committed to education, Dr. Harris-Smith has presented at Local and National Conferences for many organizations which include; Peri-Anesthesia Nurses Organization, Panelist for Aetna at the 100 Black Men Conference, National Black Environmental Justice Network, National Association of School Nurses, National Black Nurses Associations, and numerous church and community organizations. She has been featured on a local TV News Network to address the shortage of nurses caring for mental health patients in New Orleans, secured a small grant to provide HIV/AIDS training for the NOBNA members, and functioned as the local chairperson for the 31st NBNA Conference in New Orleans. Dr. Harris-Smith is currently an active

member of the National Nursing Network/National Nurse Leader for the American Red Cross where she serves as the Chairperson for the Communication and Partnership Committee.

References

1. American Association of Colleges of Nursing. (2017, March 20). *Diversity, Inclusion, and Equity in Academic Nursing.* Retrieved from American Association of Colleges of Nursing: http://www.aacnnursing.org/News-Information/Position-Statements-White-Papers/Diversity

2. Bessent, H. (1997). *Strategies for Recruitment, Retention, and Graduation of Minority Nurses in Colleges of Nursing.* (H. Bessent, Ed.) District of Columbia, Washington: American Nurses Publishing.

3. Bleich, M. R., Macwilliams, B. R., & Schmidt, B. J. (2015, March/April). Advancing diversity through inclusive excellence in nursing education. *Journal of Professional Nursing, 31*(2), 89-94. Retrieved from http://dx.doi.org/10.1016/j-profnurs.2015.09.003

4. Cheyney University. (2018, June 27). About CU. Retrieved from Welcome to Cheyney University of Pennsylviana: http://www.cheyney.edu/about-cheyney-university/cheyney-history.aspx

5. Delinder, J. V. (2004, Spring). *Brown v. Board of Education of Topeka: A Landmark Case Unresolved Fifty Years Later.* Retrieved June 27, 2018, from National Archives: https://www.archives.gov/publications/prologue/2004/spring/brown-v-board-1.html

6. Hill, M. H. (1998). Strategic management: A process for increasing cultural diversty in nursing. *Journal of Multicultural Nursing & Health,* 32 - 36.

7. National Black Nurses Association. (2018, July 05). *Who We Are/Mission.* Retrieved from National Black Nurses Association: https://www.nbna.org/mission

8. National League of Nursing. (2005 - 2018). *NLN Biennial Survey of Schools of Nursing, 2014.* Retrieved June 10, 2018, from Percentage of Minority Students Enrolled in Basic RN Programs 1995 - 2014: http://www.nln.org/newsroom/nursing-education-statistics/nursing-student-demoographics

9. National League of Nursing. (2018, June 20). *Diversity.* Retrieved June 20, 2018, from The Voice of Nursing Education: http://www.nln.org/professional-development-programs/teaching-resources/toolkits/diversity

10. Office of Civil Rights. (1991, March). *U. S. Department of Education.* Retrieved July 15, 2018, from Historically Black Colleges and Universities and Higher Education Desegregation: https://www.2.ed.gov/about/offices/list/ocr/docs/hq9511.html

11. Pacquiao, D. (2007). The relationship between cultural competence education and increasing diversity in nursing schools and practice setting. *Journal of Transcultural Nursing,* 28S - 37S. doi:0.1177/1043659606295679

12. Peery, A. I., Julian, P., Avery, J., & Henry, S. L. (2013, Fall). Diversity must start somewhere: The experience of one college of nursing. *Journal of Cultural Diversity, 20*(3), pp. 120 - 123.

13. Petiprin, A. (2016). *Leininger's Cultural Care Theory.* Retrieved July 7, 2018, from Nusing Theoy: http://www.nursing-theory.org/theories-and-models/leininger-culture-care-theory.php

14. Phillips, J. M., & Malone, B. (2014, Jan-Feb). Incerasing racial/ethnic diversity in nursing to reduce health disparities and achieve health equity. *Public Health Report,* 45 - 50. doi:10.1177/00333549141291S209

15. *Statical Atlas.* (2015, April 18). Retrieved July 5, 2018, from Race and Ethnicity in Lafayette, LA: https://statisticalatlas.com/place/Louisiana/Lafayette/Race-and-Ethnicity

16. Strauss, V. (2018, July 10). *Actually, we still need affirmative action for African Americans in college admissons. Here's why.* Retrieved from The Washington Post: Democracy Dies in Darkness: https://www.washingtonpost.com/news/answer-sheet/wp/2017/08/02/actually-we-still-need-affirmative-action-for-african-americans-in-college-admissions-heres-why/?noredirect=on&utm_term=.7d287763d2ac

17. Trice, L. B., & Foster, P. H. (2008, March). Improving nursing school diversity through use of a group admission interview. *AORN Journal ,* 87(3), 522 - 532.

18. *United States Census Bureau.* (n.d.). Retrieved July 5, 2018, from Quick Facts US: https://www.census.gov/quickfacts/fact/table/US/PST045217

Simmons University Dotson Bridge and Mentoring Program: Mentoring our Future Nursing Leaders

Dr. LaDonna L. Christian, is the Associate Professor of Practice-Nursing and Director-Dotson Bridge and Mentoring Program, Simmons University, School of Nursing and Health Sciences, Boston, Massachusetts.

LaDonna L. Christian PhD, MSN APHN-BC

I n 2009 the Dotson Bridge and Mentoring Program at Simmons University Department of Nursing became the first major diversity and inclusion program on campus. Our goals include mentoring students of color, improving course pass rates, improving NCLEX pass rates, and fostering volunteerism and leadership in this population.

About the program

The program began with eight Scholars and six Mentors, a program faculty and director. At the end of the first year we graduated one Black Scholar and added another fourteen Scholars of color. Today the program has mentored almost 288 Scholars and graduated over 167, with an attrition rate of six percent. There are presently 94 scholars in the program and 54% self identify as Black/African descent. About 15% of our Black/African descent graduates go on to get a masters degree or higher which is consistent with the national average of 14.6% (Minority Nurse).

Why do we call them Scholars?

A scholar is a said to be person who specializes in a field; an authority in the learned area of study (Webster 2018). The word Scholar carries with is it a sense of knowing and scholarship. The word also holds the Scholars to another level of expectations and direction. The Scholars feel that they can succeed and view themselves as accomplishing a career goal that will make a difference in their communities.

Leadership in nursing

Only 9.9% of nurses in America self identify as Blacks/African descent (Minority Nurse). Black nurses continue to be the most educated group of nurses, but we are not in the leadership positions at the same rate. Many of our Scholars are first generation college students and graduating is a major accomplishment. They do not necessarily view themselves as leaders and often view leadership as something they could not do. Mentoring by nurses in leadership positions, allows the Scholars to not only see nurse leaders in their field that look like them, but also allows them to picture of themselves in a leadership position.

Picking up the mantel

Mentoring our leaders of tomorrow is on the shoulders of our leaders of today. We must take time to support and foster leadership in our future Black/African descent nurses. They must understand the meaning of being at the table in order to help make changes in the health of our communities. My late Dean, Rhetaugh Dumas, Dean Emeritus of the University of Michigan School of Nursing, once said to me "you must succeed, no excuses, do the work and do it well". I continue to carry those words with me today and pass them on to my Scholars.

How does the Dotson Program mentor our future nurses to be leaders?

We provide:

1. leadership programs that are ongoing through volunteerism, group activities and campus organizations.

2. leadership activity opportunities through African American, Latino, Asian, Native American (ALANA) nursing Liaison and support the Scholar throughout the process.

3. dedicated Mentors that are assigned to our Scholars to follow them and push them to see themselves as a leader and to apply for leadership positions.

4. membership fees for the New England Regional Black Nurses Association and scholarship for leadership programs offered by our chapter.

A Success story

In the spring of 2018, Dr. Millicent Gorham, the NBNA Executive Director, came to the Simmons University to do a leadership program for the Dotson Bridge and Mentoring Program. Forty-six of our Scholars were able to attend the program. Dr. Gorham spoke to them about why they should go on for a higher degree, why leadership is important, how to present your self as a leader, what to wear, and what to include in the resume and cover letter. The students left so professionally charged that several of them decided that day to go on for their master's degree and became executive board members of organizations on campus.

Conclusion

The vision of the NBNA includes supporting and mentoring our new leaders and offers many programs to help build leadership in our members. We should all be involved in the leadership and mentoring programs at some level. Giving of our time to help build better outcomes for our communities is the most precious gift you can give. Give the gift of leadership

References

1. Merriam-Webster(2018) **https://www.merriam-webster.com/dictionary/scholar**

2. Minority Nurse (2015). **https://minoritynurse.com/nursing-statistics/**

3. NBNA (2018) Who we are. **https://www.nbna.org/who**

Coaching Students and Faculty to Stop Smoking While Creating a Tobacco-Free Campus

Dr. Ruffin is an Assistant Professor of Nursing at Stockton University, Galloway, NJ; Chief Executive Officer at Reverence Pharmacy, Pleasantville, NJ; Adult & Gerontological Nurse Practitioner at Clover Health, Jersey City, NJ; Chair, NBNA Ad Hoc Committee on Substance Use Disorders and past president of the Northern New Jersey Black Nurses Association.

Larider Ruffin, DNP, APN, RN, ANP-BC, GNP, CTTS

Smoking remains the number one cause of preventable disease and death in the United States (US). Nicotine dependence and tobacco use disorder remain a chronic, relapsing and costly disorder, which is linked to a number of co-morbid conditions including, heart disease, stroke, asthma, and cancer. Across the globe, six million tobacco-related deaths occur annually (World Health Organization [WHO], 2018). It is estimated that nearly 20% of deaths occurring in the U.S. annually are tobacco related. Cigarette smoke (including direct and second-hand smoke) is responsible for nearly 500,000 deaths annually in the U.S (CDC, 2018). Worldwide direct and indirect tobacco-related deaths are expected to rise to more than eight million per year by 2030 unless urgent action is taken (WHO, 2018). A half century ago the U.S. Surgeon General delivered the first public warning regarding the dangers associated with smoking and tobacco use. However, current and trended data suggest that smoking and tobacco use persists among a significant proportion of the population. Moreover, the American youth is expected to die prematurely with smoking related illnesses. While a number of national campaign has been successful, the deleterious effects of tobacco use, and smoking appear to have little impact on smoking cessation rates (Ruffin, 2017). Given our current opioid epidemic, much more emphasis should be placed on the importance of smoking cessation due to astonishing associations between smoking and opioid abuse. The colleges and universities are very well positioned to make an impact in student's life.

Smoking Among College Students

Smoking continues to be very high among college students. Whether it is social smoking or habitual smoking, this habit remains very dangerous to our youth. Many risk factors, including tobacco use, peak from 18-25 years of age; college attendance could be a turning point in choosing not to use tobacco. About 24.8% of full-time college students aged 18-22 years old were current smokers (ANRF, 2018). The fact that nearly all adult cigarette smokers begin smoking round the college years, colleges and universities are in a very important position to prevent smoking initiation among nonusers, while also protecting students, faculty, staff members, and guests from secondhand smoke exposure (Wang et al. 2018).

The Youth and E-Cigarette

The Food and Drug Administration (FDA) launched efforts to address the challenges of e-cigarette through the "The Real Cost" Youth E-cigarette Prevention Campaign (USHHS, 2018). The use of e-cigarettes has been on the rise among the youth. Although tremendous progress has been made since the first Surgeon General's Report on Smoking and Health in 1964, recent data on youth e-cigarette use are alarming. In 2017, 2.1 million middle and high school students currently used e-cigarettes, making them the most commonly used tobacco product among youth. These numbers highlight the urgent need for a targeted campaign to educate the youth and slow down the epidemic of e-cigarette. There is strong evidence that e-cigarettes are associated with initiation of cigarette smoking among youth (Hammond et al., 2017). It is highly plausible that common factors account for a substantial

proportion of increased cigarette-smoking initiation among e-cigarette users. Curbing tobacco influence on campuses could prevent a new cohort of lifetime smokers.

Campus Smoking Policies

There is a growing number of college campuses going 100% smoke-free on a yearly basis. The American College Health Association (ACHA) has been credited for its efforts in adopting a position statement on tobacco back in 2009 and updated in 2011. Therefore, there is a need to protect employees and students from exposure to second-hand and third-hand smoke on college campuses and create an expectation that this living and working environment be totally smoke-free. Smoke-free college campus policies have been associated with a drop in student smoking rates (Seo, et al, 2011). However, the role of campus smoking policies on reducing student smoking behavior remains concerning, said Bennett and colleagues (2017). While policies were found to significantly reduce smoking behavior and pro-smoking attitudes over time, smoking cessation was minimal. There is an urgency to incorporate smoking prevention and cessation programming within the universities, which produces better results in terms of reducing smoking behavior. Hahn et al. (2012) found that college smoking policies that integrate smoking cessation services may increase the use of such services as well as promote smoking cessation. University health centers are at the forefront of addressing this issue by offering smoking cessation program to the students.

Conclusion

The University campus may be the prime setting to make an important impact in student's behaviors. Implementing evidenced-base strategies to support students beyond the non-smoking policies is essential. While the policies may refrain students from using tobacco products on the campus setting, that does not refrain students from smoking. Working with the campus health centers, universities may be able to implement evidenced-base smoking cessation program to truly assist students to kick the smoking habit. This type of intervention would be a shift from telling patients to stop smoking, to coaching patients to stop smoking. Throughout the community, there has been low smoking cessation rates, which may be associated with barriers that prevent clinicians' ability to maximize intervention strategies within the primary care setting. Given our current opioid epidemic, it is more important than ever for university campuses to collaborate to stop the spread of this smoking epidemic while still having access to such a vital and convenient population. Helping an individual to be tobacco-free means supporting a family to be healthier, which in turn help build a healthier community.

References

1. Ainscough, T. S., Brose, L. S., Strang, J. and McNeill, A. (2017). Contingency management for tobacco smoking during opioid addiction treatment: a randomized pilot study. *BMJ Journal* 7:e017467. doi:10.1136/bmjopen-2017-017467

2. Bennett, B.L., Deiner, M. and Pokhrel, P. (2017). College anti-smoking policies and student smoking behavior: a review of the literature. *Tobacco Induced Diseases.* 5(11). https://doi.org/10.1186/s12971-017-0117-z

3. Hahn, E. J., Fallin, A., Darville, A., Kercsmar, S. E., McCann, M., and Record, R. A. (2012). The three Ts of adopting tobacco-free policies on college campuses. *Nurs Clin North Am.* 2012;47:109–17.

4. Seo D.C., Macy, J.T., Torabi, M.R., and Middlestadt, S. E. (2011) The effect of a smoke-free campus policy on college students' smoking behaviors and attitudes. Prev Med. 2011;53(4-5):347–352.

5. Wang, T.W., Tynan, M.A., Hallett, C., Walpert, L., … King, B. (2018). Smoke-Free and Tobacco-Free Policies in Colleges and Universities – United States and Territories, 2017. *MMWR Morb Mortal Wkly* Rep 2018;67:686–689. DOI: http://dx.doi.org/10.15585/mmwr.mm6724a4

6. Weinberger, A. H., Platt, J., Esan, H., Galea, S., Erlish, D., and Goodwin, R. D (2017). Cigarette smoking is associated with increased risk of substance use disorder relapse: A nationally representative, prospective longitudinal investigation. *Journal of Clinical Psychiatry* 78(2):e152-e160, 2017.

7. Young-Wolff, K.C., Klebaner, D., Weisner, C. Korff, M. V., and Campbell, C. (2017). Smoking Status and Opioid Related Problems and Concerns among Men and Women on Chronic Opioid Therapy. *Clin J Pain.* 2017 Aug; 33(8): 730–737. doi:10.1097/AJP.0000000000000461

The Right Leader

Dr. Angelo D. Moore, PhD, MSN, RN, NE-BC

Dr. Moore is the President & CEO of Moore & Moore Healthcare Consulting. He enjoys mentoring and teaching. He has numerous publications in peer-reviewed journals and presented podium presentations at local, regional, national, and international conferences.

There have been several conversations over the years about whether individuals are born leaders or trained as leaders. Some individuals find themselves in several leadership positions and tend to do very well while others view leadership positions as too challenging or stressful. I commonly hear people say "I tried being a Nurse Manager, but I hated it. I was tired of being in charge of people. I rather just have to worry about myself." In contrast, I have heard others say "I never really wanted to be in charge, but I always find myself in leadership positions. I was asked to take a leadership position on a temporary basis, and it turned out to be a permanent position." Very few people start out with a goal of being a leader in an organization, yet most people will be called upon at least once to assume a leadership role.

I do not believe that individuals are born to be leaders; however, I do believe that some individuals have some innate characteristics that allow them to excel in leadership positions when combined with leadership training and mentorship. Although there are individuals that attend several leadership trainings, they do not necessary become very good leaders. Their education, training, experience, and longevity in an organization may create the opportunity for them to hold leadership positions; however, they are not effective leaders. It is quite possible for these individuals to create toxic work environments resulting in high turnover rates. On the other hand, good leaders create healthy work environments where individuals are empowered to thrive professionally, educationally, and personally. They function well together as a group, take pride in where they work, will sacrifice themselves for the good of the group, and want to emulate their leader.

Leadership is the ability to influence people. A position does not make someone a leader. Even in my many years serving in the military, there were people put in positions that were not leaders, yet we had to respect the position and/or rank. True leaders have followers. If someone claims to be a leader but have no followers, they are not a leader. Good leaders have the ability to consistently make good decisions under pressure and in stressful situations. Every decision will not be the best decision; however, they take responsibility for the decision and make a conscious effort to learn from it. Good leaders empower people and understand that input from others are important and useful. In addition, they give others credit and praise for their efforts at appropriate times. Good leaders

attempt to make everyone better, and they are not insecure about someone taking their position or replacing them. Good leaders are able to see the potential in others and encourage them to set goals and provide support while pursuing those goals. Good leaders are accountable for their actions and decisions and while also making others accountable for their decisions and actions.

A leader's actions are more important than a leader's words. Good leaders do not have to tell others that they are a leader, because people will see their actions and garner the respect of a leader. In contrast, some leaders are inconsistent with what they say and do causing others not to trust them. These types of leaders often demand others to respect them creating a toxic environment.

It also matters where you find the right leader. Organizations often select individuals from within to fill leadership positions, because they are the most senior staff member. If an organization provide leadership training and has a good leadership program, it could be an advantage to hire someone from within the organization. However, the organizations must be cognizant of where in the organization they are placed. Organizations may view hiring from within an easier option, because the individual is familiar with the organization and can easily get them through the Human Resource process. Nevertheless, it is very difficult for the newly identified leader to change roles from a peer to now the leader. If an organization is in need for a change, it is often better to hire someone from outside of the organization. It is hard to change the culture of the organization with people from within the organization, because the culture has become their norm. Changing a culture requires different perspectives which can come from infusing an organization with new good leaders.

A good leader must have integrity, consistency, accountability, confidence, humility, transparency, adaptability, decision-making

skills, and able to communicate effectively. These characteristics must be seen through actions. Look around in your organization. Do you have the Right Leaders?

Social Media Statements for Facebook and Twitter:

1. Leadership is the ability to influence people.

2. True leaders have followers.

3. A leader's actions are more important than a leader's words.

4. Characteristics must be seen through actions.

5. A good leader must have integrity, consistency, accountability, confidence, humility, transparency, adaptability, decision-making skills, and able to communicate effectively.

FINALLY – There's Hope for hATTR Amyloid

Cynthia J. Bither, MSN, ANP, ACNP, CHF, AACC

Cindy Bither, past president for the American Association of Heart Failure Nurses, has been caring for heart failure patients the last 24 years of her career. She specializes in the Advanced Heart Failure/ Stage D population and most recently she has had the privilege of doing global nursing education on HF internationally for the American College of Cardiology.

Heart failure has been my career since the mid 1990's. When I first started and had my initial introduction to patients with Amyloid cardiomyopathy, it was a sad but simple decision. They were always found very late in the disease process and therefore my primary job was to help them transition to hospice and comfort care. While many other areas of stage D heart failure progressed over the years, amyloid remained a terminal diagnosis.

Many health care workers over the years have been retrospectively tracking the symptoms that are precursors to the disease and have partnered up with specialists from the other organ systems that are involved. We now know that people with carpal tunnel surgery in the past, peripheral neuropathy that is not related to diabetes and chronic GI symptoms such as diarrhea and nausea can lead the practitioner to start screening for cardiac amyloidosis. The mis-folding of proteins with subsequent infiltration of nerves and organs that is caused by an abnormality in the liver, is what leads to the disease known as hATTR or hereditary transthyretin-mediated amyloidosis. This is one of the two forms of cardiac amyloidosis most commonly found worldwide, with the other being AL amyloidosis or light chain amyloidosis that stems from a bone marrow-based disease that again causes proteins to mis-fold.

hATTR finally has treatment besides liver transplantation. Early diagnosis, prior to symptoms becoming so severe that they would not tolerate the therapy available, is vital. Nurses can make a big impact. We are all involved with people who have symptoms of heart failure that do not match the documented ejection fraction and we all know that heart failure patients have many comorbidities. Someone has to step back and try to put all the pieces together. For example, if they have HFpEF or heart failure with an EF .>40% and have had carpal tunnel surgery or chronic diarrhea with no cause, they would benefit from screening.

Screening Tests:[1] Echocardiogram assesses the thickness of their heart walls. The misfolded proteins as they get trapped in the cardiac myocytes cause the walls to expand and have a speckled appearance on the ultrasound. This will also lead to low voltage on an ECG. MRI can show patterns of infiltrative disease but cannot diagnose. If positive, next step would be an endomyocardial biopsy which would be positive under Congo red stain. What you need to do now Is figure out which type of amyloid the patient has. This will be determined by a blood test that looks at Kappa/Lamda light chain ratios. These are naturally occurring but if the ratio is elevated, this would lead to the diagnosis of AL amyloid. For the hATTR patient, the light chains will be in a normal ratio. The definitive diagnosis will be found with a nuclear test using technetium pyrophosphate. This tracer binds to hATTR more so than AL, so it helps point to this type of Amyloid. Once the diagnosis is made, genetic testing should be done to look at the patient as well as their family members that are interested in finding out if they have the risk of developing the disease. Genetic counseling is imperative at this point to help make sure that the results are understood.

Diagnosis made: For this patient HF GDMT is not recommended. They have multiple conduction deficits and might benefit from an ICD/pacemaker. Because of some peripheral nerve issues, afterload reduction with ACE/ARB should be avoided because of profound postural hypotension. What we should now look to provide in hATTR are the newest therapies available. Patisiran, a small RNA interfering IV therapy that interferes in the production of the abnormal TTR[2] and Tegsedi, a weekly subcutaneous therapy that targets the RNA[3] to help decrease the production are approved for use in the patient with both polyneuropathy and cardiomyopathy.

As a provider that works in the Washington DC area which has a large population of African American residents, I am relieved that

there is now hope. Val122Ile, a form of the mutation of hATTR is found in 3-3.5% of those African descent and is generally found late in life. We can now make a difference in this population as we work to strive for early diagnosis and referral to a center where these therapies are available.

1. Joseph P. Donnelly, MD and Mazen Hannah, MD. Cardiac Amyloidosis: An Update on diagnosis and Treatment. Cleveland Clinic Journal of Medicine 2017 December;84(suppl 3):12-26.

2. Adams, David, Gonzlea-Duarte, Alejandra, et al. Patisiran, an RNAi Therapeutic, for Hereditary Transthyretin Amyloidosis. New England Journal of Medicine 2018; 379:11-21.

3. Merrill D. Benson, Marcia Waddington-Cruz, John L Berk, et al. Inotersen Treatment for Patients with Hereditary Transthyretin Amyloidosis, New England Journal of Medicine 2018;379: 22-31.

BBNA Members on the Move - October 2018

BBNA members Drs. Theresa Rodgers and Jennifer Coleman presented an educational session on safe infant sleeping environments to the physician and staff of Alabama Regional Medical Services on July 6, 2018. BBNA's *Safe to Sleep* initiative is the result of a mini-grant that BBNA received from the US National Institute of Child Health and Human Development at the US National Institutes of Health. Dr. Theresa Rodgers is the principal investigator of the grant that provides education to encourage parents to place infants on their backs to sleep and to pay attention to the sleep environment to reduce the risk for sudden infant death syndrome.

BBNA members provided health education and screenings at several health fairs this past summer. On July 21, BBNA attended Ephesus Seven Day Adventist Church Health Fair; members were at Hays High School Alumni-East Avondale Fun Day on August 25; and on September 15, members were at Mt Zion Baptist Church's annual health fair. BBNA also attended the second annual health fair at Rising Star Baptist Church.

BBNA members recently provided a series of community education sessions on obesity, diabetes, and hypertension. BBNA members worked with the Metro Birmingham Chapter of the National Association for the Advancement of Colored People (NAACP) at community engagement events in a local Birmingham park on August 26 and September 9. BBNA members staffed a vendor booth and provided educational information and mini health talks.

BBNA also secured the services of a local chef who prepared and served a heart healthy pasta dish to all attendees.

BBNA collaborated with Alacare Home Health and Hospice to offer a workshop titled "What's Trending in Healthcare Medication Management" on September 8, 2018.

Ephesus Academy 2018 – BBNA president-elect, Deborah Thedford-Zimmerman with members Sandra Middlebrook and Dr. Jennifer Coleman teaching hands-only CPR at Ephesus Academy

RisingStar Church – BBNA members working health fair include BBNA president, Dr. Lindsey Harris; Gwendolyn Collins; BBNA president-elect, Deborah Thedford-Zimmerman; Rose Britton

Rising Star Health Fair – BBNA lifetime member, Rose Britton; and BBNA president, Dr. Lindsey Harris

NAACP rally – BBNA members at the NAACP community event include Gladys Amerson, Dr. Martha Dawson, and president-elect Deborah Thedford-Zimmerman

BBNA Members on the Move (cont.)

On September 17, BBNA members taught hands-only CPR to the students at Ephesus Academy in Birmingham. BBNA president-elect, Deborah Thedford-Zimmerman, heart health committee chair, Dr. Jennifer Coleman, and BBNA member Sandra Middlebrook provided education, demonstrations, and return demonstrations to 148 students at the school. (See attached photo titled Ephesus Academy2018)

Dr. Jennifer Coleman, BBNA mentorship chair, spoke at the Junior Optimist International Annual Youth Conference in Birmingham on September 22. Dr. Coleman spoke on "Healthy Food Choices & Exercising". Youth Optimists from Birmingham and Montgomery attended the conference.

BBNA held its Scholarship & Fashion Show Extravaganza on September 22 at the Boutwell Auditorium in Birmingham, AL. Fashion boutiques, vendors, and models provided the atmosphere and décor as BBNA awarded chapter scholarships to four nursing students. Scholarships and tuition assistance awards were presented to Shanteia Beavers of Jacksonville State University, Natasia Fanning of Tuskegee University, Lauren Smith of Bevill State Community College, and Lindsay White of Jefferson State Community College.

BBNA recently received the Alabama Nurses Foundation Community Grant from the Alabama State Nurses Association. The grant is designed to increase the visibility and public image of nurses with community-based projects that make a positive difference in relation to a current health issue. BBNA president-elect, Deborah Thedford-Zimmerman was the principal investigator on the grant that focused on diabetes, obesity, and hypertension in the Birmingham community.

BBNA president, Dr. Lindsey Harris became the first African American president-elect of the Alabama State Nurses Association (ASNA) at the organization's 2018 Annual Convention on October 5, 2018. Dr. Harris will assume the presidency of ASNA in 2020 and will become the first African American president in the 105 year history of the state association. (See attached photo titled Lindsey and Dr. Sams)

BBNA members participated in the City of Birmingham 12th Annual Party with a Purpose on October 6, 2018. The annual community event, held at a local park and recreation center, focuses on education, health, and career opportunities for local residents. BBNA staffed the first aid tent and provided health education materials and answered health related questions. BBNA also manned a vendor booth inside the park building for education counseling and literature related to diabetes and healthy food choices. Over 5,000 residents attended the free event.

Dr. Martha A. Dawson presented and co-led a workshop on the opioid crisis at the American Association of Men in Nurses Annual Conference in Milwaukee, WI. She was proud to witness the installation of her former student, Blake Smith, as the youngest president in the 40 year history of the organization.

Dr. Jennifer Coleman

BBNA president, Dr. Lindsey Harris with photo of Dr. Lauranne Sams at NBNA Annual Conference in St. Louis

Party with a Purpose first-aid tent — BBNA members

Members on the Move

Congratulations to **Dr. Lindsey Harris,** the first African American elected to President-Elect of the Alabama State Nurses Association (ASNA). Dr. Harris is the president of the Birmingham Black Nurses Association.

Rear Admiral Sylvia Trent Adams, PhD, RN, FAAN will be inducted into the National Academy of Medicine in 2019. She is the Deputy Surgeon General of the United States.

Millicent Gorham, PhD(Hon), MBA, FAAN, NBNA Executive Director, co-authored an article "Increasing Diversity in Clinical Trials: Overcoming Critical Barriers". The article will be published in *Current Problems in Cardiology.*

Good Samaritan Foundation 2018 "Excellence in Nursing" Gold Medal Award

Dr. Mary Ellen Trail Ross, Dr.PH, MSN, RN, GCNS-BC was recently awarded the Good Samaritan Foundation 2018 "Excellence in Nursing" Gold Medal Award in the "Nursing Education: Faculty" category.

Dr. Ross is an Associate Professor at The University of Texas Health Science Center at Houston, Cizik School of Nursing. She has taught 17 different courses, with main concentration in Gerontology and Community Health Nursing.

The Good Samaritan Foundation pays tribute to registered nurses and nursing educators who demonstrate a passion for the nursing profession and exemplify excellence in teaching, mentoring, leadership and service.

DEDICATION

The 2018 ASNA Annual Convention and House of Delegates is dedicated to Dr. Bobbie Holt-Ragler

The 2018 Annual ASNA Convention is dedicated to Dr. Bobbie Holt-Ragler. Dr. Holt-Ragler, or Bobbie as many of us affectionately know her, has been a member of the Alabama State Nurses Association (ASNA) and Mobile County Nurses Society since 1992. She has held the position of Treasurer at both the local and state level and is in her 10th year participating as a delegate representing her district at ASNA Annual Conventions.

Her accolades include numerous awards for excellence as a student, nurse, mentor, and leader. Bobbie has been recognized by her peers in nursing many times including the Lillian Holland Harvey Award, Sigma Theta Tau President's Award for Outstanding Service, Award for Excellence in Nursing Mentorship, and the Lillian B. Smith Award. In 1996 she wrote and produced the American Nurses Association's Convention and Centennial Celebration Theme Song "A Nurse's Tribute."

Phillipians 2:4 states, *Look not every man on his own things, but every man also on the things of others.* Bobbie lives this verse daily. She is a member of the Greater Allenville A.O.H. in Whistler, Alabama where she is involved in the ministry of music and Sunday School.

Her servant's heart shows through in her community work in programs to bring recognition and an end to domestic violence, advocating for the USA Center of Excellence for Healthy Communities to eliminate health disparities, the American Cancer Society and American Heart Association, and coaching elders at local libraries through the Matter of Balance program.

It is with great respect and affection we the nurses of the Alabama State Nurses Association dedicate this 105th ASNA Annual Convention to Dr. Bobbie Holt-Ragler.

Chapter Presidents

ALABAMA

Birmingham BNA (11) . . . . Dr. Lindsey Harris . . . . Birmingham, AL
Montgomery BNA (125) . . . . Katherine Means . . . . .Montgomery, AL
Tuskegee/East Alabama NBNA (177) . . . . Kendra Ward Harris. Tuskegee, AL

ARIZONA

BNA Greater Phoenix Area (77) . . . . LaTanya Mathis . . . . Phoenix, AZ

ARKANSAS

Little Rock BNA of Arkansas (126). . . . . Yvonne Sims . . . . Little Rock, AR

CALIFORNIA

Bay Area BNA (02) . . . . Gregory Woods . . . . Oakland, CA
Capitol City BNA (162) . . . . Sherena Edinboro .Sacramento, CA
Central Valley BNA (150) . . . . Dr. Jeanette Moore . . . . Fresno, CA
Council of Black Nurses, Los Angeles (01). . . . . Pastor Chadwick Ricks . . . . .Los Angeles, CA
Inland Empire BNA (58) . . . . Kim Anthony . . . . Riverside, CA
San Diego BNA (03) . . . . Ethel Weekly-Avant. . . . . San Diego, CA
Stanislaus and San Joaquin Counties BNA . . . . Gia Smith . . . . .Modesto, CA

COLORADO

Eastern Colorado Council of BN (Denver) (127). . . . . . . Dr. Margie Ball-Cook. .Denver, CO
Mile High BNA (156) . . . . Yumuriel Whitaker. . . . . Aurora, CO

CONNECTICUT

Northern Connecticut BNA (84) . . . . Florence Johnson . . . . Hartford, CT
Southern Connecticut BNA (36) . . . . Dr. Katherine Tucker . . . . New Haven, CT

DELAWARE

BNA of Northern Delaware (142). . . . . Tracy Harpe . . . . .Wilmington, DE

DISTRICT OF COLUMBIA

BNA of Greater Washington, DC Area (04) . . . . Dr. Pier Broadnax .Washington, DC

FLORIDA

Big Bend BNA (Tallahassee) (86) . . . . Katrina Rivers. . . . . .Tallahassee, FL
BNA, Tampa Bay (106) . . . . Rosa Cambridge . . . . Tampa, FL
Central Florida BNA (35) . . . . Lois Wilson. . . . . .Orlando, FL
Clearwater/ Largo BNA (39) . . . . Audrey Lyttle . . . . .Largo, FL
First Coast BNA (Jacksonville) (103) . . . . Dr. Carol Jenkins-Neil . . . . Jacksonville, FL
Greater Fort Lauderdale Broward
   Chapter of the NBNA (145). . . . . Lyn Peugeot. . . . . Fort Lauderdale, FL
Greater Gainesville BNA (85) . . . . Voncea Brusha . . . . Gainesville, FL
Miami Chapter - BNA (07) . . . . Patrise Tyson . . . . .Miami, FL
Palm Beach County BNA (114) . . . . Avis Brown. .West Palm Beach, FL
Treasure Coast Council of BN (161). . . . . Dr. Ophelia McDaniels . . . . Port Saint Locie, FL
St. Petersburg BNA (28). . . . . Janie Johnson . . . . St. Petersburg, FL

Chapter Presidents

GEORGIA

Atlanta BNA (08). . . . . Seara McGarity . . . . College Park, GA
Columbus Metro BNA (51) . . . . Pamela Rainey. . . . . Columbus, GA
Concerned National
   BN of Central Savannah River Area (123) . . . . Romona Johnson . . . . .Martinez, GA
Emory BNA (165) . . . . Dr. Jill Hamilton . . . . Atlanta, GA
Middle Georgia BNA (153) . . . . Dr. Debra Mann . . . . Dublin, GA
Okefenokee BNA (148). . . . . Rosalyn Thomas . . . . .Waycross, GA
Savannah BNA (64) . . . . Cheryl Capers . . . . .Savannah, GA

HAWAII

Honolulu BNA (80) . . . . Linda Mitchell . . . . Aiea, HI

ILLINOIS

BNA of Central Illinois (143). . . . . Rita Myles. . . . . Bloomington, IL
Chicago Chapter NBNA (09). . . . . Ellen Durant. . . . . Chicago, IL
Greater Illinois BNA (147). . . . . Jacinta Staples . . . . Bolingbrook IL
Illinois South Suburban NBNA (168) . . . . Dr. Carol Alexander. . . . . Matteson, IL
North Shore BNA . . . . Mary Harris-Reese. . . . . .Gurnee, IL

INDIANA

BNA of Indianapolis (46) . . . . Sallye Morris . . . . Indianapolis, IN
Lake County Indiana BNA (169) . . . . Michelle Moore . . . . .Merrillville, IN
Northwest Indiana BNA (110). Mona Steele. . . . . Gary, IN

KANSAS

Wichita BNA (104). . . . . Linda Wright. . . . . Wichita, KS

KENTUCKY

KYANNA BNA, Louisville (33) . . . . Alona Pack. . . . . Louisville, KY
Lexington Chapter of the NBNA (134) . . . . Dr. Lovoria Williams. . . . . .Lexington, KY

LOUISIANA

Acadiana BNA (131). . . . . Dr. Nellie Prudhomme. . . . . Lafayette, LA
Bayou Region BNA (140) . . . . Salina James . . . . Thibodaux, LA
Louisiana Capital BNA . . . . Steven Jackson, Jr. . . . . Baton Rouge, LA
New Orleans BNA (52). . . . . Georgette Mims. . . . . New Orleans, LA
Northeast Louisiana BNA (152) . . . . Lisa Smart . . . . .Monroe, LA
Shreveport BNA (22) . . . . Bertresea Evans . . . . .Shreveport, LA
Southeastern Louisiana BNA (174) . . . . Rachel Weary. . . . . .Abita Springs, LA
Teche BNA (158) . . . . Theleisha Nelson . . . . New Iberia, LA

MARYLAND

BNA of Baltimore (05) . . . . Dr. Vaple Robinson .Baltimore, MD
BN of Southern Maryland (137) . . . . Kim Cartwright. . . . . Temple Hills, MD
Downtown Baltimore SON BNA (154). . . . . Bassey Etim-Edet . . . . .Baltimore, MD
Greater Bowie Maryland NBNA (166) . . . . Dr. Jacqueline Newsome-Williams . . . Chevy Chase, MD

Chapter Presidents

MASSACHUSETTS
New England Regional BNA (45) . . . . Tarma Johnson . . . . Roxbury, MA
Western Massachusetts BNA (40). . . . . Anne Mistivar-Payen. . . . . .Springfield, MA

MICHIGAN
Detroit BNA (13) . . . . Nettie Riddick . . . . Detroit MI
Grand Rapids BNA (93) . . . . Aundrea Robinson . . . . Grand Rapids, MI
Greater Flint BNA (70) . . . . Juanita Wells . . . . Flint, MI
Kalamazoo-Muskegon BNA (96). . . . . Shahidah El-Amin . . . . Kentwood, MI
Lansing Area BNA (149) . . . . Meseret Hailu . . . . Lansing, MI
Southwest Michigan BNA (175) . . . . Deborah Spates . . . . Berrien Springs, MI

MINNESOTA
Minnesota BNA (111) . . . . Sara Wiggins . . . . St. Paul, MN

MISSOURI
BNA of Greater St. Louis (144). . . . . Quita Stephens . . . . St. Louis, MO
Greater Kansas City BNA (74) . . . . Iris Culbert . . . . .Kansas City, MO
Mid-Missouri BNA (171) . . . . Dr. Ann Marie McSwain . . . . .Jefferson City, MO

NEBRASKA
Omaha BNA (73). . . . . Shanda Ross . . . . Omaha, NE

NEVADA
Southern Nevada BNA (81) . . . . Lauren Edgar . . . . Las Vegas, NV

NEW JERSEY
Concerned BN of Central New Jersey (61) . . . . Sandra Pritchard . . . . .Neptune, NJ
Concerned Black Nurses of Newark (24). . . . . Dr. Lois Greene . . . . .Newark, NJ
Mid State BNA of New Jersey (90). . . . . Tracy Smith-Tinson . . . . Somerset, NJ
Middlesex Regional BNA (136) . . . . Cheryl Myers . . . . New Brunswick, NJ
New Jersey Integrated BNA (157). . . . . Yolanda Jackson . . . . Lyons, NJ
Northern New Jersey BNA (57). . . . . Dr. Melissa Richardson . . . . .Newark, NJ

NEW YORK
Greater New York City BNA . . . . Dr. Sheldon Fields. . . . . Brooklyn, NY
New York BNA (14) . . . . Nelline Shaw . . . . .New York, NY
Queens County BNA (44). . . . . Darlene Barker-Ifill . . . . .Cambria Heights, NY

NORTH CAROLINA
BN Council of the Triad (160) . . . . Rashida Dobson . . . . Winston Salem, NC
Central Carolina BN Council (53) . . . . Bertha Williams . . . . Durham, NC
Sandhills North Carolina BNA (138) . . . . Dr. LeShonda Wallace. . . . . Fayetteville, NC

OHIO
Akron BNA (16) . . . . Cynthia Bell . . . . .Akron, OH
BNA of Greater Cincinnati (18) . . . . Marsha Thomas. . . . . Cincinnati, OH
Cleveland Council BNA (17). . . . . Stephanie Doibo . . . . Cleveland, OH

Chapter Presidents

Columbus BNA (82) . . . . Burton Solomon, Jr.. . . . . Columbus, OH
Youngstown Warren BNA (67). Carol Smith . . . . Youngstown, OH

OKLAHOMA

Eastern Oklahoma BNA (129) . . . . Rickesha Clark. . . . . .Tulsa, OK
Oklahoma City BNA (173) . . . . Irene Phillips . . . . Jones, OK

PENNSYLVANIA

Pittsburgh BN in Action (31). . . . . Dr. Dawndra Jones . . . . .Pittsburgh, PA
Southeastern Pennsylvania Area BNA (56) . . . . Monica Harmon. . . . . .Philadelphia, PA

SOUTH CAROLINA

Columbia Area BNA (164) . . . . Whakeela James. . . . . Columbia, SC
Tri-County BNA of Charleston (27) . . . . Wanda Brown . . . . .Charleston, SC
Upstate BNA (155) . . . . Dr. Colleen Kilgore . . . . Greenville, SC

TENNESSEE

Memphis-Riverbluff BNA (49) . . . . Betty Miller. . . . . Memphis, TN
Nashville BNA (113). . . . . Shawanda Clay . . . . Nashville, TN

TEXAS

BNA of Austin (151) . . . . Janet VanBrakle . . . . Austin, TX
BNA of Greater Houston (19). . . . . Dr. Bettye Davis Lewis . . . . Houston, TX
Central Texas BNA (163) . . . . Mack Parker. . . . . Temple, TX
Fort Bend County BNA (107) . . . . Marilyn Johnson . . . . .Pearland, TX
Galveston County Gulf Coast BNA (91) . . . . Lillian Mcgrew . . . . .Galveston, TX
Greater East Texas BNA (34). . . . . Melody Hopkins . . . . Tyler, TX
Metroplex BNA (Dallas) (102). . . . . Jacqueline Miller. . . . . Dallas, TX
San Antonio BNA (159). . . . . Lionel Lyde. . . . . .San Antonio, TX
Southeast Texas BNA (109) . . . . Stephanie Williams . . . . Port Arthur, TX

VIRGINIA

BNA of Charlottesville (29) . . . . Dr. Randy Jones . . . . Charlottesville, VA
Central Virginia Chapter of the NBNA (130). . . . . Dr. Tamara Broadnax . . . . North Chesterfield, VA
NBNA: Northern Virginia Chapter (115). . . . . Joan Pierre. . . . . .Woodbridge, VA

WISCONSIN

Milwaukee BNA (21) . . . . Dr. Melanie Gray . . . . Milwaukee, WI
Racine-Kenosha BNA (50) . . . . Joyce Wadlington . . . . .Racine, WI

Direct Member (55)*
*Only if there Is no Chapter in your area