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Interview with Nurse Practitioner Wellness Coaches

By Charlene "Chuckie" M. Hanson, EdD, FNP, CS, FAAN

I recently interviewed two nurse practitioners (NPs) who practice together as wellness coaches—Darlene Trandel, PhD, MSN, RN/FNP and Eileen T. O'Grady, PhD, RN, NP, who is well known to readers of *NP World News*. These trailblazers, who have earned doctorate degrees in addition to having years of clinical experience, are certified as both NPs and wellness coaches. I found them to be full of energy and infectious enthusiasm for their dual roles.

I know about soccer and football coaches, executive and life coaches. What is a wellness coach?

O'Grady: We use skills from several different disciplines, but mostly from executive/life coaching and positive psychology applied to the wellness arena. Wellness coaches develop a relationship with the people being coached in which the clients are entirely in charge of the agenda. We use an evidence-based methodology to access emancipatory self-knowledge coupled with action. It is really an in-depth appreciative inquiry in which we identify and emphasize each person's core strengths and apply them to all realms of his/her life, making sure those strengths are in play all of the time. Nobody ever leaves a session without having two things—increased awareness and action on that awareness.

Charlene M. Hanson

Trandel: The premise underlying health and wellness coaching is helping people define and design their personal health/wellness goals to create a lifestyle that is based on who they are. Many clients come to us to rev up their wellness status and live a more healthful lifestyle; some seek to prevent/reduce the risk of a chronic illness and to age with vitality; and still others want to better manage an existing condition. Wellness coaches help their clients develop a personal blueprint for their health/wellness, increase their awareness of barriers that impede their progress, and create strategies to overcome the impediments that prevent them from mastering and sustaining their goals in their everyday life. As wellness coaches, we leverage both the relationship and the process to raise self-confidence and self-esteem and encourage clients to feel empowered and in charge of their health.

How does wellness coaching differ from therapy?

Trandel: Health/wellness coaches come from the perspective that the client is creative, resourceful, and whole. We start with

Please see ***Interview with Nurse Practitioner Wellness Coaches****, page 7*

By Melanie Balestra, NP, ESQ

Staying Competitive Today

The same is true whether you are happy working at your current job or are looking for a new position. A nurse practitioner (NP) who wants to be competitive needs to plan beyond the routine of daily practice. Take a little time to consider the following steps.

Melanie Balestra

Staying on the Job

It is important to be conscious of what is going on in health care. Being proactive will make you more valuable to your employer since you are working to stay on top of your field. Be willing to work hard and learn new things to avoid becoming stagnant. Problem

Please see ***Let's Talk Money****, page 4*

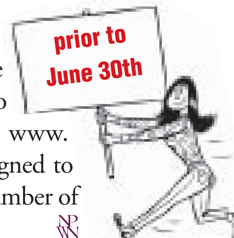
Inside this Issue:

- Volunteering in Africa
- O'Grady: APRNs Form Medical Homes
- Gruber Visits West Texas

What You Need to Know It's Not Too Late to Start...

There is still time to start participating in the 2010 Electronic Prescribing Incentive Program (eRx) and potentially qualify to receive a full-year incentive payment for 2011. In addition, beginning in 2012, the Centers for Medicare and Medicaid Services will apply payment adjustments to eligible professionals who are not successful electronic prescribers under the eRx Incentive Program. To become successful electronic prescribers for purposes of avoiding the 2012 eRx payment adjustment, eligible professionals must report the electronic prescribing measure for a required minimum number of unique electronic prescribing events via claims between January 1, 2011 and June 30, 2011.

Eligible professionals may begin reporting the eRx measure at **any time** throughout the 2011 program year of January 1–December 31, 2011, to be incentive eligible; however, they must do so prior to June 30, 2011, to be exempt from the 2012 eRx payment adjustment. Eligible professionals must have adopted a "qualified" electronic prescribing system in order to be able to report the electronic prescribing measure. Information found on www.cms.gov/ERxIncentive/03_How_ To_Get_Started.asp#TopOfPage is designed to lead you step by step through the process of becoming one of a growing number of eligible professionals who are participating in the eRx Incentive Program.



First-Ever Business Journal for NPs Announces New Editorial Advisory Board

Practice Management: A Business Guide for Nurse Practitioners is the only business journal written by and for nurse practitioners (NPs). A publication such as this has become increasingly more essential with the changes in the healthcare system. NPs must be savvy in business in order to receive the financial returns they deserve so that they can continue to provide quality care. This publication aims to help readers learn more about the business aspects of health care.

We would like to welcome Gale Adcock as the newest member of the editorial advisory board. She is joining current members Susan Kendig, Eileen T. O'Grady, Wendy L. Wright, and Carolyn Zaumeyer. Although the composition of this board may change over time, it will always reflect outstanding leaders in the NP community.

Gale Adcock

Gale Adcock, *MSN, RN, FNP,* is the Director of Corporate Health Services at SAS, the world's largest privately held software company and *Fortune* magazine's #1 company to work for in 2010 and 2011. She has developed an NP-dominant primary-care practice at SAS and currently oversees 55 employees in two states. Gale is an adjunct faculty member at East Carolina University (ECU), Duke University, and UNC-Chapel Hill and serves on the Board of Directors of the ECU Medical & Health Sciences Foundation. In 2007, she was elected to a 4-year term on the 7-member Cary Town Council in Cary, North Carolina.

Susan Kendig

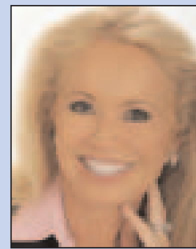
Susan Kendig, *JD, MSN, WHNP-BC, FAANP,* is a teaching associate professor at the College of Nursing at the University of Missouri-St. Louis, where she coordinates the Women's Health Nurse Practitioner program. She focuses her professional activities on practice and policy issues related to healthcare delivery, primary care, and patient safety. Active in policy and advocacy at the state and national level, Sue serves on the CMS Medicare Evidence Development and Coverage Advisory Committee. She is currently Chair of the Board of Directors of NPWH. Sue has written numerous publications related to women's health, advanced practice nursing, and health policy and has telecast nursing continuing education programs to 1,000 hospitals nationwide.

Eileen T. O'Grady

Eileen T. O'Grady, *PhD, RN, NP,* is a certified adult NP and wellness coach. In addition to writing a regular column on health policy in *NP World News*, she serves as policy editor for the *American Journal for Nurse Practitioners*. Eileen is currently a visiting professor at Pace University's Graduate School of Nursing in Manhattan, where she teaches doctoral students health policy and wellness coaching. She has authored numerous articles and book chapters on advanced practice nursing and health policy. She has an active public speaking calendar in which she creates a compelling case for nurses, especially advanced practice nurses, to more forcefully engage in the policymaking process.

Wendy L. Wright

Wendy L. Wright, *MS, RN, ARNP, FNP, FAANP,* is an adult and family NP and the owner of Wright & Associates Family Healthcare. Wendy served as past president of NPACE and is the senior lecturer for Fitzgerald Health Education Associates. Wendy is the founder of the NH Chamber of Entrepreneurial Nurse Practitioners, an organization designed to assist NPs with independent practice issues. She presents nationally to different audiences and has been a speaker at over 500 conferences in 45 states; she has appeared on radio, television, and in print magazines.



Carolyn Zaumeyer

Carolyn Zaumeyer, *MSN, ARNP,* is the founder and owner of Women's Health Watch, Inc., which is based in Lauderdale by the Sea, Florida. Carolyn has written numerous articles published in the United States and Columbia. Since publication of her book *The Nurse Practitioner as Entrepreneur: How to Establish and Operate an Independent Practice* in 1995, she has become widely known for her articles and presentations in which she advises NPs on how to have successful private practices. Carolyn also acts as a small business consultant and coach. Her most recent book is *How to Start an Independent Practice: The Nurse Practitioner's Guide to Success* (2003. Philadelphia: F.A. Davis).

Please share your business experience and expertise that is of value to other NPs by submitting an article for *Practice Management*. Contact me at npcmary@aol.com or call at 713-270-8664.

Cordially,
Mary Carole McMann, *MPH*
Editor
NP Communications, LLC

Nurse Practitioner World News

NP Communications, LLC
5 Jefferson Court, Monroe Township, NJ 08831
(732) 641-2113 • Fax: (732) 641-2116
email: npclkyoung@aol.com
www.webNPonline.com
Postmaster: Address correction requested

Editorial Director:
Charlene M. Hanson, EdD, FNP, CS, FAAN

Editor:
Mary Carole McMann, MPH

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WE'D LIKE TO HEAR FROM YOU

NP World News is interested in the opinions and ideas of all nurse practitioners. Please write to us about your reactions to our articles, your professional activities, and your thoughts on issues important to NPs. We also welcome suggestions for articles and manuscripts on topics of interest to NPs. Finally, please let us know about award and grant recipients in your state, university, or NP organization.

Mary Carole McMann, our editor, can be reached at npcmary@aol.com.

MayJune4.2011 5/2/11 1:44 PM Page 3

The following article is adapted from Carla Mills' blog, which is available at www.maverickhealth.com/blog. Carla has updated the content from the original posting. It is offered to NPs for personal use and enjoyment and/or to share with patients.

Unleashing Your Inner Olympian

By Carla Mills, *ARNP*

A diabetic patient of mine expressed worry about an upcoming trip to Disney World with his granddaughter. He knew he would have to walk more than he was accustomed to doing. I asked him if he ever exercised. He held up his hand in a "stop right there" gesture and said, "Don't speak to me about exercise. I follow the religion of comfort, and exercise is uncomfortable." His statement left me completely speechless (and if you knew me you would appreciate how uncharacteristic that is).

Couch Potatoes Arise!

More than two-thirds of us are overweight,[1] and that percentage is predicted to keep growing, along with our waistlines. Only about one-third of us exercise regularly.[2] Is it any surprise that diabetes is an epidemic and preventable heart disease is disabling and/or killing us? Yet in spite of these dire health outcomes, the majority of us still cling to my patient's "religion of comfort." Why?

Maybe it's the big screen TV, the recliner chair with the cup holder, and a remote control that gives us easy access to 200 channels without ever getting up. Or maybe it's the computer and the Internet. With the virtual world sitting in our laps, why bother to go outside and explore the real one? In order to find the motivation to exercise, we must find a way to get out of our chairs and off of our keisters and unleash our inner Olympian!

Nurse practioners (NPs) can lead the way. Because an NP's scope of practice is holistic, we take care of the whole person across all domains of his/her life. We teach as well as treat; we coach as much as we counsel. We can teach patients by telling them about their health risks, but we coach by being role models ourselves. What do your patients see in you? Are you a couch potato or an Olympian?

Everyone, patients and providers alike, knows that poor diet, excess weight, and lack of exercise are responsible for the blight of chronic disease. While chronic disease is sickening and killing millions of us, it is also bankrupting our healthcare system and our national economy. Yet, knowing this hasn't changed our behaviors. We continue to slouch on toward years of illness and debilitation that lead us to early graves.

Diabetes and heart disease are only two outcomes of our poor lifestyle habits. Certain cancers (endometrial, breast, and colon among others); hypertension; lipid disorders; stroke; gallbladder and liver disease; respiratory problems, including sleep apnea; osteoarthritis; and gynecological problems[3] (such as polycystic ovarian syndrome) can all be tied to poor lifestyle choices.

"The Simple Seven" Are Proving *Not* To Be So Simple

In January of 2010 the American Heart Association released seven criteria (they call them "The Simple Seven") in an attempt to reach a goal of reducing heart disease by 20% by 2020. The simple seven are[4]:

1. Don't smoke (and good for you if you quit more than a year ago!)
2. Maintain a body mass index of <25.0
3. Engage in physical activity for *at least* 150 minutes (2.5 hours) at moderate intensity or 75 minutes (1.25 hours) of vigorous activity per week
4. Eat a healthy diet consisting of:
   - Fruits and vegetables: ≥4.5 cups/day
   - Fish: ≥two 3.5-oz servings/week (preferably oily fish)
   - Fiber-rich whole grains (≥1.1 g of fiber per 10 g of carbohydrate): ≥three 1-oz-equivalent servings/day
   - Sodium: <1500 mg/day
   - Sugar-sweetened beverages: ≤450 calories (36 oz)/week
5. Control total cholesterol <200 mg/dL
6. Control blood pressure <120/80 mm Hg
7. Have a fasting blood glucose<100 mg/dL

One year later, in February 2011, a study done by the University of Pittsburgh found that only *one* out of nearly 1,933 middle-aged Americans met all seven criteria for heart health[5]—that's right, in a random sample, *only one out of 1,933 middle-aged Americans had all seven good heart health habits.*

The Olympian Spirit is a Spirit of Adventure

Think back for a minute, and remember some of the high points and special moments your life. I bet not a single one occurred in front of the TV or computer. Not that those aren't entertaining pastimes; they just don't ask anything of you. Unless you are creating something, you are just sitting there, passively consuming whatever you are fed.

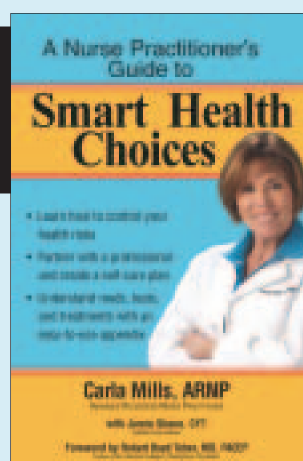
Life's adventures are active—active means you ***move***—you try something new, you travel somewhere, you meet someone new, you practice something to get better at it. These are ultimate 3D experiences because life is happening in, around, and through you, in full color, tickling all of your senses.

Carla Mills

Whether it's running a marathon, climbing a mountain, or just walking to the mailbox and back without getting short of breath, it's the spirit you bring to things that creates adventure. When you connect with your inner Olympian, exercise becomes a pleasurable necessity in your life rather than a dreaded chore. That is what you want to happen for yourself and for your patients.

When you think "Olympian," maybe you think of famous athletes like Michael Phelps or Shaun Johnson who become rich and famous. But they are the excep-

*Please see **NPs on the Edge,** page 6*



This award-winning, how-to, self-help medical reference will help you and your patients take control of health risks and prevent chronic diseases.

Send the Essence of Your Care Home with Your Patients

A Nurse Practitioner's Guide to Smart Health Choices

By Carla Mills, ARNP

"This book should be required reading for every patient and every practicing healthcare provider in America."
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"After reading this book, I finally get it–
I mean really get it."
Formerly uncontrolled diabetic, 45 lbs ago

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MayJune4.2011 5/2/11 1:44 PM Page 4

Continued from page 1

solve, keeping the best interests of the practice in mind. Since your employer may not automatically recognize your efforts, be sure to promote yourself.

Tailor your job to emphasize your strengths. Remember to focus on your employer's priorities, which will enable you to improve your work practices and efficiency level. Be a team player, learn your employer's way of doing things, and ask for feedback on how you are doing. Networking and cultivating relationships will help establish your position within the practice.

These days, many people in health care live under the threat of being laid off or fired. In spite of the stress of this environment, keep your focus on the positives; do not let office politics alter your behavior and relationships with other staff members. Avoid gossip and be careful to pick your battles. People perceived as troublemakers may be the first in the firing line.

Handling Negotiations

Some people might think that a recession is a bad time to discuss an increase in salary. Do not underestimate your worth, even when you first join a practice. Before broaching the topic of a raise, be certain that you are doing an excellent job and can prove your worth to the practice. Do your homework, and become knowledgeable about your practice's compensation policies and pay levels. For example, survey data from 2010 show that the average full-time NP salary was $90,770, with positions in some specialties (eg, emergency department, mental health, and cardiology clinic, among others) paying more. The average part-time hourly rate was $43.77 in 2010, a reduction of $2.08/hour from 2009 (http://nurse-practitioners-and-physician-assistants.advanceweb.com/Features/Articles/National-Salary-Report-2010.aspx). How much income do you generate for the practice? If this is not currently tracked, keep your own detailed records so that you can prove your productivity.

Once you have done your homework, practice what you plan to say in the negotiation. The ideal negotiation results in a win-win situation, which leaves both parties happy. Have a clear picture of the points that you are and are not willing to concede. Know your "make or break" issues, such as salary, vacation, and severance pay. Let your employer know if you have received outside offers. Negotiations are not limited to salary; you may want to address your work hours or benefit package. Do not let your negotiations be ruled by fear. Last, but not least, don't take no for an answer. Even if the discussion does not get the result you had hoped for, consider asking for a bonus as an alternative.

Hunting for a New Job

Sometimes, it is just time to make a change. It may be enough to tell your current employer that you are interested in advancing. But, in many cases, you may want to find a different situation while staying in the same area. Or, you want to try a different area altogether. In any event, you will need to polish up your job-hunting skills.

Keep your hunt for a new position under wraps. You do not want to job hunt while at your present job or post your resume online. Provide an appropriate personal email address and your cell phone number for people who may wish to contact you about a job. It is always wise to have an updated resume. Make it stand out from the crowd by including some of the non-traditional/creative things you did while working as a registered nurse or NP, such as preparing and presenting a prenatal class or volunteering at a clinic or weekend camp. Schedule interviews outside of work time, dress appropriately, and be careful in your handling of references. Never speak negatively about your current employer. Always be fair and courteous when you leave a position—give plenty of notice before you leave, ask for letter of reference, and keep in touch.

NPs who are newly graduated from an accredited program need to be patient when hunting for their first job. There are a number of resources, including networking, looking at ads in print and online nursing journals, and contacting the NP association in your state. Be fully prepared before you schedule a job interview. Do research to find out basic information about the prospective employer before you talk to the interviewer. How is your particular experience and education especially relevant to the job you are seeking?

Being Smart about Contracts

NPs need to be prepared to negotiate contracts. Since most employment contracts are "at will," meaning that you can be terminated at any time for any reason, you need to seek ways to protect yourself. Before you sign a final agreement, be sure to retain the services of an attorney who is experienced in writing medical or NP contracts. Signing a contract without checking it out sufficiently could cost you down the line. Keep the following points in mind when reviewing a contract.

Full-Time Employment

- When negotiating an employment contract, cover key components, including compensation (salary vs. hourly) and benefits (retirement plan; continuing education; severance pay; and malpractice, health, and life insurance).
- Also look for "recitals" (set the ground rules and define the parties involved) and terms and conditions, such as engagement, which covers the principle duties and responsibilities of the employee. This is the part of the contract that covers the critical detail of payment for your "on call" time. The contract should clearly state when it commences and ends.
- When negotiating compensation, you will need to determine both the amount of income that you may bring into the practice and the associated cost to the practice. This area of negotiation is where you should highlight your clinical and teaching skills and discuss any innovative ideas you have for increasing revenue.
- Before you start the negotiation, establish three "must have" and three neutral, or not necessary, items. What do you want and what you are willing to give up? Keeping the discussion honest and forthright benefits all the parties concerned.
- An employment contract should include terms for termination. If it has a non-compete clause—designed to prevent you from working somewhere else within a certain geographic radius of the practice—it is imperative to have it deleted. You want to avoid any restrictions on future employment.
- It is important to spell out details about successors and assignments. The contract should specify that your successors will receive any payment still owing to you if you die while employed by the practice. You want to retain the right to accept or

*Please see **Let's Talk Money,** page 6*

NNPS—Alive and Kicking!

MARK YOUR CALENDARS!

July 14–17, 2011
Copper Conference Center
Copper Mountain, Colorado

www.npsymposium.com
800-996-3233

Contrary to some rumors, the **NATIONAL NURSE PRACTITIONER SYMPOSIUM (NNPS)** is alive and kicking! Get ready to join other nurse practitioners (NPs) in Copper Mountain, Colorado, on July 14–17, 2011. Almost 1000 NPs from around the country are expected to gather for 4 days of content-rich, independently-organized, accredited CE programs in more than 80 specialty sessions and workshops that provide 30+ hours of contact hour credit through ANCC and AANP. CME credit is also available for physician assistants and nurse midwives through ACCME.

Suzanne Gordon, award-winning journalist and author of several books about nursing, will deliver the keynote address, entitled, "Team Work and Team Intelligence: The Challenge for Clinicians in an Era of Health Care Reform." T.R. Reid, author, reporter, and correspondent for NPR and PBS, will be taking part in two presentations. In the ethics forum, following Mr. Reid's description of alternate national healthcare systems, a physician and an NP will present clinical and ethical perspectives. Mr. Reid will then discuss what other national healthcare systems do and do not offer for the United States. Loretta C. Ford, RN, EdD, PNP, FAAN, FAANP, will discuss her role as co-founder of the NP role, what has happened to the profession since then, and what she sees for the future. For more information about the NNPS, please call 800-996-3233 or view our website at www.npsymposium.com

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MayJune4.2011 5/2/11 1:44 PM Page 6

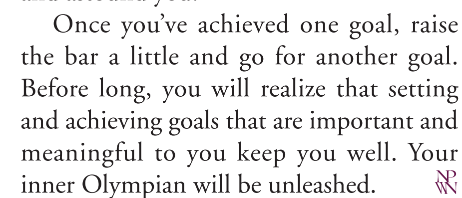
Continued from page 3

tion, not the rule. Most Olympians never become famous, and they go home from the Olympic Games to live lives just like yours. No, Olympians aren't driven by fame and money—it's something else. To understand what I'm talking about, think about the Special Olympians, people with handicaps who choose to reach outside themselves to find out what they can achieve against great odds…and to have fun.

Going for Your Own "Personal Best"

Seeking health and fitness through a nutritious diet and exercise (and weight reduction, if necessary) should be a fun adventure. It should bring you pleasure and a chance to bring out the very best in yourself. Whatever physical activity you choose—and it doesn't matter what it is—just enjoy it. Physical activities that give you pleasure will be the ones you want to return to again and again.

Set some goals for yourself. It doesn't matter what they are as long as they matter to you. Then, as the ad says, "Just do it!" Be consistent. Keep showing up. If you are faithful to your goals, the simple passage of time will bring results that may surprise and astound you.



Once you've achieved one goal, raise the bar a little and go for another goal. Before long, you will realize that setting and achieving goals that are important and meaningful to you keep you well. Your inner Olympian will be unleashed.

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Let's Talk Money

Continued from page 4

reject any assignment of your contract to another party by your employer. For example, you should be able to decide if you want to work for someone purchasing your employer's practice.

- Be sure to negotiate a bonus-payment system or profit sharing, especially if you develop a large patient base. Bonus formulas can be based on several factors, eg, productivity, quality, profit, or patient satisfaction. The language describing the determination of profit sharing should be very clear in the contract. Also negotiate the right to access the company audit and set up a method for handling disputes.

Independent Contractors

- Independent contractors have somewhat different contracts since benefits are generally not included. You need to know if you will be dealing with multiple contracts and/or one or more collaborating physician. Are you answerable to and dealing with different people about clinical matters and finances?
- Independent contractors without benefits

Please see ***Let's Talk Money,*** *page 22*

Interview with Nurse Practitioner Wellness Coaches

Continued from page 1

the premise that our clients are experts in their own life. With that as our focus, we attempt to deepen their awareness and learning, improve their performance, and enhance their quality of life. Unlike therapy, wellness coaching focuses on the present and moves forward, not on attempting to "fix" what went astray in the past. Moreover, Eileen and I use our clients' strengths rather than repairing their weaknesses. If somewhere along the relationship we feel that the client does need therapy, we refer him/her for that care. We also have clients who we coach in tandem with their therapy; the approaches complement each other.

O'Grady: We focus on the present and the preferred future, only referring to the past if there is a particularly successful experience we need to bring into the foreground. We do not let a client spend too much time on the problem.

How did you two get into this?

O'Grady: In traditional primary care practice, I had had very little success in actually getting people to quit smoking, lose weight, or exercise. The only really effective agents in my armamentarium were pharmaceuticals, which are important in mitigating the effects of chronic illness. But I wanted to get under that and find a community of people who were interested in a sustained, dramatic lifestyle change. I knew that people did not need more information about wellness as much as support in living the lives they truly want to be living. Wellness coaching helps people make sure what they value most is regularly expressed in their lives.

Trandel: My orientation towards risk reduction/prevention developed early in my career, once my clinical experience led me to realize that so much of the chronic disease I treated could be prevented through healthy lifestyle choices. I also knew that while NPs were excellent teachers, knowledge alone was not enough to motivate patients to change their behavior and better manage their condition. I think that coaching clients—helping ***them*** define their health/wellness goals, increasing their awareness of barriers, and helping them move into action based on their goals in a manner consistent with their values—may be the missing element in helping them change their behavior.

The people in this country are drowning in lifestyle-induced chronic diseases. According to the Centers for Disease Control and Prevention, 1 in 3 adults is obese, 43 million adults smoke, and 25.8 million have diabetes mellitus. So it is true that what we are doing and dying of is largely related to lifestyle. What has been your most dramatic success story?

Darlene Trandel

Trandel: My practice specialty is working with individuals and groups for weight management. This area influences most health states as well as the trajectory of most, if not all, chronic diseases. We all know diets don't work—if they did, there would be no obesity epidemic. What I find is that providing clients with knowledge about healthy eating and physical activity is only the first step in managing weight. Clients need help to increase their awareness of the physical aspects of hunger/satiety and to deal with internal and external eating "triggers." They also need to work through issues of self-sabotage, body image, and self-esteem. I work from a model I call "The Three H's of Eating: Hunger, Head, and Heart." My most dramatic success story is a client who avoided gastric bypass by attending my groups and working with me on a one-on-one basis. We are still working together to help her lose more weight; however, given her track record, I have every reason to believe that she will reach her goal. Many of my clients are successful in adopting healthy eating habits, which enable them to drop unwanted and unhealthy pounds and sustain a new body image and weight without ever feeling deprived.

Another memorable client was a middle-aged woman who was a lifetime smoker. She came to me with the idea of quitting smoking after she recently developed asthma following an upper-respiratory infection. Using Prochaska's Transtheoretical Behavioral Change Model, I first helped her work through her ambivalence by discussing the pros and cons of quitting smoking. Another important step in the change process was working with her to find a powerful motivator in her life that was imbedded in the values she honored. We also took time to visualize her new identity as a smoke-free and healthy career woman and mother, to plan and prepare exactly how she would quit, and to create substitute behaviors along with environmental and social supports that could assist her efforts. These steps all preceded moving into the action of giving up cigarettes. Failure is often the result of clients jumping into action before they enter a stage of readiness. My client is now 3 months out from her last smoke and counting. We continue to meet to ensure that she receives support and is able to ward off relapse during these first several critical months of abstaining.

O'Grady: I recall a 30-year-old client from Boston whose first goal was to take inventory of his workout clothes. We always start with small goals, and we make sure they are achievable. The client's goals then get more ambitious as we develop trust; the client's success breeds more success. He was overweight and sedentary and having trouble attracting the opposite sex. Six months later, he was 40 pounds lighter and running 10 K races. I know he attributes this transformation to his hard work and not to me, which is the sign of a skilled coach. The client is in charge. My other favorite insight actually came from a teenage client of mine. While we talked about why she was not meeting her own wellness goals, she realized that taking care of herself felt like

Eileen T. O'Grady

she was being manipulated by her parents. This kind of deep insight can be enormously freeing and is often all that is required to get people unstuck, allowing them to say things aloud that they have never said before.

It sounds like the way primary care is delivered in the United States was not getting the results you wanted. What is it about wellness coaching that gives you so many sparks?

O'Grady: It is so freeing to not have all of the answers. I can offer my expertise when we enter the brainstorming session of the encounter, but I have always loved asking and being asked powerful questions that have never been asked before. It is a way of being with people that really honors them—by radical acceptance. We approach coaching from the standpoint that clients are smart, creative, and resourceful—and they are. We are the "anti" New Year's resolutions that often fail because people don't have the support needed for transformative change.

Trandel: The spark for me is the growth-promoting relationship I form with clients, which includes the sense of empowerment they feel in taking control over their health/wellness decisions and actions. Clients come to me because they haven't been successful alone in achieving their health/wellness goals. They've usually tried a variety of strategies but failed or reverted back to their old habits. They are looking for help to get past the barriers that keep them from success. I use a model I've developed in my practice that I call the *EPIC Process for Health and Wellness*. **E** is evaluation, **P** is the partnering, **I** is the informing, and **C** is the coaching role. I use evidence-based coaching methods to facilitate, motivate, and support clients in new awareness and actions that assist them to achieve their health goals, sustain their new behavior, and optimize their overall well-being. By instituting my EPIC pathway, I am able to create a process that enables clients to be successful in meeting and sustaining their goals. It is that process that sparks my coaching practice and passion.

What is the kryptonite for wellness coaches?

O'Grady: Those people who are in resistance usually don't seek out wellness coaches. I think that people who don't have a high degree of self-esteem or self-efficacy can be tricky. Clients have to have a solid respect for themselves in order for coaching to be effective.

As you expand your armamentarium of tools to battle lifestyle-based chronic diseases, what is it like to not give people advice?

O'Grady: It is very freeing. When people identify their own knowledge gap, I can offer suggestions (with their permission), but I do not tell them what to do. We generate ideas, and I have no investment in their doing what I say. This approach validates my experience in primary care in which there was a whole lot of teaching going on and very little learning. We practice radical acceptance and not being judgmental.

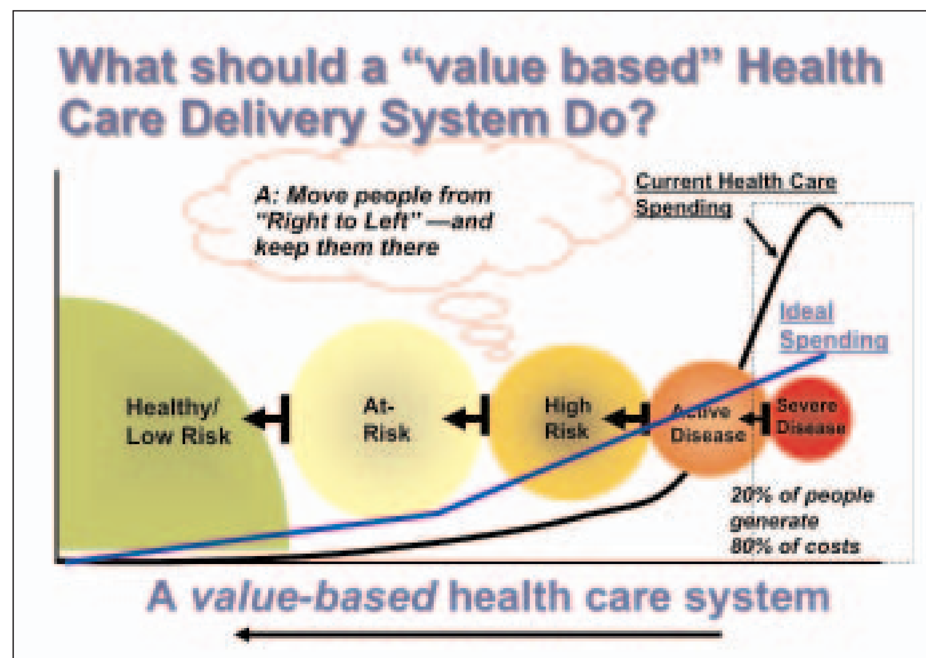
Trandel: I find that when clients are given advice, they move in the opposite direction

*Please see **Interview with Nurse Practitioner Wellness Coaches**, page 9*

APRNs Boldly Form Medical Homes

Value-based purchasing encompasses three central tenets of the health reform bill to achieve a three-part aim: better care for individuals, better health for populations, and lower growth in healthcare expenditures. These aims are to be achieved by 1) investing in prevention and wellness, 2) maintaining long-term fiscal sustainability, and 3) improving patient safety and quality of care. The fee-for-service model creates a disincentive to lower costs and integrate and coordinate care. Doing it right is far less expensive than getting it wrong.

Value-based purchasing links lowering costs with improving quality through more coordination and integration, thereby reducing unnecessary waste and redundancy of time, energy, and resources. There is an emerging evidence base showing that highly integrated care for a defined population is far safer than the fragmented care typically seen in our fee-for-service system. The Affordable Care Act (ACA) provides for financial incentives to move towards this goal of seamless care. The largest payer of US health care, the US government, wants to move away from paying for care that does not measurably improve health. This shift to value-based purchasing represents a significant change in that it switches the financial risk away from the payor and onto the delivery system, which then takes on the risk for poor-quality, poorly integrated, and sketchy care. As illustrated in the graphic, delivery systems will have incentives and be actively working towards moving or keeping people to the left, thereby maximizing the healthy/low-risk bubble and not directing the majority of resources to the most severe disease.

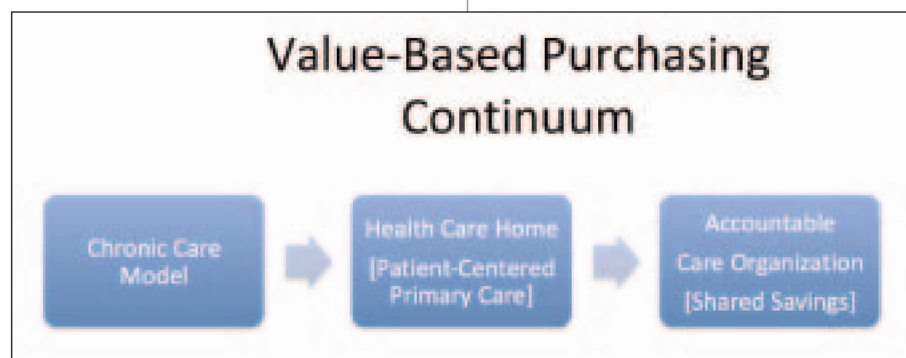


Accountable Care Organizations (ACOs)

ACOs are collaborative practices that become legal entities and accept shared responsibility for the care of a minimum of 5,000 Medicare patients. The ACO must publicly report 65 quality measures; if it meets targeted goals, the providers of the ACO ***share the savings*** that the Federal government would have paid had the care been traditionally delivered, ie, fragmented, uncoordinated, and with no quality reporting. In the first 2 years, the ACO must show at least a 2% improvement over the previous 2 years in cost and quality; in the third year, it must pay Medicare back if it cost more.

Medical Homes

If you are familiar with the Veteran's Administration, you are knowledgeable about the concept of a medical, or health-care, home. It is an outgrowth of the chronic care model, in that it is ***team-delivered primary care*** with emphasis on the health of the whole population as well as the individual. In terms of its evolution, the chronic-care model created the medical home, and the ACO builds in its legal and financial component.



The medical home is considered the foundational building block of an ACO. The ACA authorizes Health and Human Services to contract with community-based interdisciplinary primary-care teams that coordinate care across settings and providers. This may be arranged as a capitated payment or other incentive to improve the management of chronic illness and to prevent rehospitalization and unnecessary emergency room use. It has a strong patient-centered—not provider-centered—approach with clear patient activation, engagement, and feedback; expanded health information technology and access; and linkage of payment to performance. A compelling aspect of expanded access is the notion that it must include alternatives to in-person visits; smooth information transfer across health teams, location, and time; clear self-care plans; and help with lifestyle/behavior change for patients.

Medical homes are similar to ACOs in that they integrate and coordinate care, and both are beautifully matched to the skill set of nurse practitioners (NPs). ACOs place less emphasis on patient-centeredness, while medical homes are grounded in patient-centered primary care. Over time, it is expected that qualified medical homes will receive payment per person for services not traditionally covered in fee-for-service systems. Coordination of care is emphasized in both of these models of value-based purchasing, giving voice and authority to NPs and other advanced-practice registered nurses (APRNs).

It was exciting to see NPs and other APRNs engaged in this way, demonstrating leadership, a pioneering spirit, and creativity to make healthcare experiences different from anything we have seen before. What came through in these presentations was the notion that they did not ask for permission; instead, they saw a community need, designed a practice, and did it. These are by no means easy journeys, but what shone through was their vision of what could be and an unwavering tenacity to make the vision come to life. These medical-home pioneers have bravely struck out and represented the APRN community in a bold and visible way.

Eileen T. O'Grady

Troubling Language

Three days before the Nurse-led Medical Home conference, the Centers for Medicare & Medicaid Services (CMS) drafted an unfortunate set of regulations on ACOs. The APRN community was taken by surprise in early spring when CMS published rules on the ACO defining "assignment of beneficiaries to ACOs…only on the basis of primary care services provided by ACO professionals who are physicians." This narrow definition goes against the spirit and letter of the ACA legislative language that uses the term "ACO professional," which is first defined as "physician and practitioner," and then further defined as NP, clinical nurse specialist, or physician assistant. Thus, expanded leadership roles for APRNs seemed apparent. Yet, while it is clear the intent of the law was to expand the ACOs more broadly, the rules specify ACO leadership narrowly to physicians only. It is hoped that a massive grassroots effort by APRNs commenting on the draft rules will broaden the ACO definition in the final set of rules. You will see information forthcoming from national organizations about a grassroots response to this narrow language.

Opportunities abound for APRNs to serve as highly visible leaders in value-based purchasing. Currently there are over 3,000

MayJune4.2011 5/2/11 1:44 PM Page 9

If you want what you've never had, do what you've never done.

medical-home practices across the United States recognized by the National Committee for Quality Assurance (NCQA), and the number is growing rapidly. As Dr. Greg Pawlson of the NCQA said at the conference, "we must work towards value-driven health care. We need everybody and must drop the argument about who is providing the care." There are no clinicians better prepared than NPs and other APRNs to promote evidence-based practice, lead quality and cost reporting and improvement efforts, and integrate new technologies, all wrapped into highly individualized patient-centered treatment. This approach includes coaching patients and caregivers in an environment; creating care plans; and providing transition, coordination, and integration of care and medication reconciliation.

NP and APRN leadership and our unique skill set could be the lynchpin to help ACOs and medical homes succeed. The future of value-driven health care will be healthcare neighborhoods in which all needs can be met in one place. Like the innovators of the nurse-led medical homes, we must assume that it is our duty to insert ourselves into this evolving landscape and to assume that we are key players in any successful 'hood. A re-imagining and transformation of our delivery system is at our feet.

References

Nursing Alliance for Quality Care is a Robert Wood Johnson Foundation funded grant that aims to advance the highest quality, safety, and value of consumer-centered health care for all individuals-patients, their families, and their communities. www.gwumc.edu/healthsci/departments/nursing/naqc/index.cfm

The Patient Centered Primary Care Collaborative. Evidence on Medical Home Outcomes. www.pcpcc.net/content/pcmh-outcome-evidence-quality

Nurse-Led Medical Homes

The *Nursing Alliance for Health Care Quality* convened a first-of-its-kind conference on "Nurse-Led Medical Homes" in Washington, DC, earlier this spring. Three innovative APRN-led practices were described.

Life Long Care [www.lifelongcare.net] in New Hampshire is the first nurse-led medical home in the nation to be recognized as Level III by the National Committee for Quality Assurance (NCQA). Three APRNs care for 2,500 people in New London. The practice is able to function fully because of New Hampshire's modern state nurse practice act, which has no restrictions on the practice. A true trailblazer.

The Family Practice and Counseling Network in Philadelphia [www.fpcn.com] has 16 NPs caring for 17,000 residents of public housing. They innovatively integrate mental health into primary care, invest intensely in getting patients to self manage, and offer group visits and provider prompts.

The Public Health Management Corporation [www.phmc.org] has three sites in Philadelphia in which the all-NP staff provide primary care to the homeless. They have designed their practice to first build trust to better serve this challenging population—the patients decide what they want to work on or change. They have created patient-centered approaches such as early morning hours to accommodate those having to vacate shelters at 7 a.m., same-day flexible scheduling, and judgment-free providers who have highly developed skills to work with substance-abusing clients.

Interview with Nurse Practitioner Wellness Coaches

Continued from page 7

of where you want them to go. I think that is a trait not just reserved for rebellious youth. We don't like to be told what to do or how to live our lives. When clinicians give advice in good faith, it often backfires. I coach from the assumption that my clients have their answers even though they may be hidden from their awareness. My role as their coach is to increase their awareness of the problem and find strategies and actions that honor their values in moving them forward to attain their goals. In our sessions, clients learn a way of problem solving, and, in so doing, increase their self-efficacy and confidence in their own abilities. Those abilities are powerful tools for clients to possess in their lives. It comes without advice from me—only a guiding hand in helping them find their own answers and actions that work in their life.

How do you deal with your own self-defeating behaviors? Do you feel more pressure as a wellness coach to "walk the walk"?

Trandel: Obviously, yes. But I started following a healthy pathway in my life very early when I became passionate about helping others adopt healthy lifestyle choices to prevent and/or reduce the risk of disease. I live a healthy lifestyle. I try to walk my talk, except perhaps in the area of life balance; I tend to work too much. That's where I could practice better stress reduction. However, I am passionate about my work, so I enjoy almost everything I do, except nitty-gritty administrative details.

O'Grady: Now that I have identified myself as a wellness coach in my community, I am far more mindful about pigging out on chips in public. As a coach, I regularly receive coaching that helps me practice extreme self-care. For the most part, over a process lasting years and my own struggles, I have come to a place in which I feel I honor and take care of myself in the way that I am comfortable with.

How do you have clients in Boston if you both live in the Washington, DC, area?

O'Grady: We do most of our coaching over the phone. Evidence suggests that people are more honest when there is no eye contact, so we get great results when the client is a complete stranger. We can listen more intensely without the distraction of nonverbal messages. However, we do have a few clients who come to our home offices.

Trandel: My clients and groups love the convenience of picking up the phone and having an individual or group coaching session any place they find themselves during scheduled session times—wearing a bathrobe at home, at their office, or even at a distant vacation site. In addition, there is no wasted travel time for an office visit. Occasionally, I have clients who live in my area and request that we meet for a session or two in person, which I'm happy to arrange. In those instances, the clients need the comfort of seeing me in the flesh. However, let me emphasize that a personal meeting is certainly not necessary for effective coaching.

How do you see the future of wellness coaching as it relates to NPs?

O'Grady: Although it takes years to become masterful, I believe there are laser strategies that can be done in a primary-care setting. I see aging baby boomers seeking out help to live a fuller life. I think upcoming conferences will begin to offer more robust content on laser coaching skills—so, look for those. If you are interested in becoming a wellness coach, we recommend two organizations that offer courses over the phone (www.wellnesscoaching.com and www.mentorcoach.com).

Trandel: I see the skills involved in health/wellness coaching as facilitating the ability of NPs to deliver effective and personalized care to their clients. I believe that such skills can help their clients become more effective managers of their chronic conditions, which, in turn, could impact healthcare inflation. These coaching skills are missing right now in academic nursing programs. I am currently teaching student coaches evidence-based methods of coaching and lifestyle management skills for working with their clients. My goals are to offer this curriculum to a wider network of nursing and healthcare professionals through the Internet. I will also continue my coaching work with individuals and groups because they teach me how to better serve their health needs and move their behavior in more positive directions. My clients teach me and help me become a better coach by allowing me to work with them.

I get many calls from NPs asking about wellness coaching, that is, where to seek training and whether they might hire me as their coach. I always enjoy sharing information with others about what a wellness coach does, hoping that I will inspire others to both hire a coach and become a coach. I truly believe that I have the best "job" in the world.

You can obtain more information about Eileen's practice plus contact her at www.eileenogrady.net. For information about Darlene's practice, see her website (www.TheHealthCareCoach.com) or contact her at Darlene.Trandel@Gmail.com

MayJune4.2011 5/2/11 1:45 PM Page 10

Keeping the Animals All Moving in the Right Direction… Health Care in Rural West Texas

Empty store fronts in Tahoka (on a weekday!)

***By Ed Gruber**, PhD, RN, ARNP*

For many people, west Texas is an acquired taste. First of all, it is flat. Town names like Plainview and Levelland paint an accurate picture. Second, it is really hot. The average temperature on most summer days is in the 90s. Third, it is often windy. At the end of a long, hot summer, the wind has dried out the land and whips up freak dust storms that seem to come out of nowhere. As in most rural areas, poverty is a painful fact of daily life. It is especially evident in the small towns dotting the South Plains area. Empty houses and abandoned and boarded-up storefronts bear testimonies to the ravages of this most recent economic recession.

That being said, the area is not without its charms. For those people who care to take a second look, there are many things to admire and enjoy. In a land largely devoid of trees and tall mountains, the sky becomes more prominent. Splashed across this blank canvas, powerful thunderstorms and dazzling sunsets seem more spectacular. After hours of traveling and seeing nothing but farms and ranch land, the view of a town in the distance seems more like an oasis than just another collection of buildings. The people who live in the South Plains seem very genuine and friendly, in part because that's pretty much the culture in this area, but also because in a geographical and economic climate this harsh, it is a necessity. The people who choose to live here do what it takes to help each other carve out a living in this harsh and unforgiving environment. Agriculture is a challenge in the hot, dry climate. Crops such as milo (grain sorghum) and cotton are staples in areas too dry for corn and wheat. Since milo is a good feed crop for livestock, cattle-ranching is also popular. You are probably familiar with the old saying, "It's an ill wind that blows nobody any good." In the spirit of that truism, the wind, which has been cursed by many a west Texas resident, has spawned the newest growth industry, as windmill farms now dot much of the South Plains.

We had just left Austin, Texas, after spending a week with our children and grandchildren and were now headed west to visit Melanie Richburg, a family nurse practitioner (NP). Melanie operates the Lynn County Family Wellness Clinic in Tahoka, Texas, a farming and ranching community of 1900 people located about 30 miles south of Lubbock. We had heard about Melanie from a friend at Texas Tech University. In her email she said that Melanie represents "the very best of our colleagues." When we spoke with Melanie a few days earlier, she mentioned that she also manages an RV park in Tahoka, and we would be welcome to stay there.

We pulled into town about 5:30 p.m. and without much difficulty located the End of the Trail RV Park, a modest, but perfectly adequate overnight accommodation. We put out the slide-outs, connected the water and electricity, fed the cat, and set out to find a restaurant and explore the town. We couldn't help but notice the large number of abandoned storefronts. We easily located the Family Wellness

Melanie Richburg

MayJune4.2011 5/2/11 1:45 PM Page 11

Melanie and patient Willie

Green M&M memorabilia

Clinic, where we would visit tomorrow with Melanie. Since Texas county courthouses are an interest of ours, we then found the one in Tahoka. In most Texas cities, the courthouse is located in the center of town. Many of these magnificent buildings and the surrounding town squares have been well cared for and are the pride of the community. One of our favorites, which is located in Johnson City, is known far and wide for the white lights that cover the entire courthouse at Christmas time. (For those of you who are interested, photographs of all 250 county courthouses in Texas can be found on a website called the Texas Courthouse Trail at www.texascourthousetrail.com).

We found a small family restaurant open near the center of town. After quickly perusing the menu, we decided on the chicken fried steak. This Texas comfort food staple is actually found in most states; however, it just seems to taste better in Texas. It is often made from the toughest and most inexpensive cut of beef; some folks even swear it comes from between the horns. The meat is tenderized and pounded into submission, drenched in egg and flour, and deep fried. It is usually served with mashed potatoes, steamed carrots or green beans, and covered with large amounts of peppered, cream gravy. Not exactly on my low-fat, low-cholesterol diet, but as my grandmother always said, "Moderation in all things will keep you healthy." Hearing my grandmother's voice, I left about one-third of the generous portions on my plate.

The next morning, we were greeted by the clinic's office manager, Eva Alvarado, who showed us into Melanie's office. Apparently most of Melanie's friends and patients have discovered that green M&Ms are her favorite candy because her office is decorated with an amazing number of bright green memorabilia. One wall held a multilayered shelf with countless green M&M characters of all sizes, and a 3-foot tall M&M in a grass skirt and an Irish top hat stood sentry near the door. Most impressive! Eva explained that Melanie is highly respected by everyone in the community. "All the staff here and their families are her patients," she told us.

Melanie soon walked into the office and greeted us with a smile and an unmistakable west Texas drawl, which reflected her upbringing on a cotton farm not far from Tahoka. She completed all her professional education in Abilene at Hardin Simmons University and Abilene Christian University. Her west-Texas farm roots help her understand the challenges of rural living. "I have a passion for helping people who are ill. There are a lot of good people who live out here," she told us. "Most are just trying to raise their families as best as they can. Nowadays if you are the wrong color, or live in the wrong zip code, or have a mental illness, you can't get any help," she observed.

I mentioned the obvious signs of economic stress we noticed, including all the businesses that have apparently closed. "A lot of jobs have left the area," she admitted; "but agriculture jobs keep many people in

Lynn County Family Wellness Clinic

Please see ***Keeping the Animals All Moving in the Right Direction… Health Care in Rural West Texas,*** *page 12*

MayJune4.2011 5/2/11 1:45 PM Page 12

Keeping the Animals All Moving in the Right Direction… Health Care in Rural West Texas

Continued from page 11

town. Folks may still drive to Lubbock to buy their groceries or even to go to work, but they stay here and attend church or get their health care because they know and trust the people who care for them. I have one family that drives 90 miles to see us for their health care. We try to cater to families and frequently care for several generations. I have often said that "if you take good care of grandma, the others will come around."

At least twice during our interview, Melanie excused herself before picking up a ringing telephone. "I have a policy that I won't let the phone ring more than three times," she said in explanation. She then showed us around the modest but nicely furnished offices, treatment room, and waiting room. "This building use to be an old 'ag' office and public health clinic," she said. "The Lynn County Hospital District remodeled it and established this clinic." Melanie works for the hospital district and spends one 24-hr weekday and one weekend per month on call for the local 19-bed hospital emergency department.

I sat in on several visits in order to see Melanie in action with her patients. I have probably said this before, but I often marvel at the skill level of the NPs we have visited. Each has his/her own style and special strength. With Melanie, what struck me most was her ability to listen. Her eyes were focused on the patients' faces as they told their story. The few words she spoke were used to find out more about each patient's concern. The overall impression was, "I've got time for you."

After a couple of visits, Melanie introduced me to Shannon Hammonds, an NP student from Texas Tech. Shannon was raised in the area, and Melanie is actively recruiting her to join the practice after graduation. "I am part-time faculty at Texas Tech," she explained, "and I precept students whenever I can."

We spoke a bit more about the challenges of rural practice. "What," I asked her, "are the most important things for students to know when they come to work in a small rural community."

"I think it is to have confidence in what you know without being cocky," she explained. "We've all seen students who think that they are supposed to know everything. For some, it causes them to push forward when they really should be asking for help. The more gray hair I get, the more I realize there are some things I just don't know. There are days when all I can do is 'direct the circus…and keep all the animals moving in the right direction.' Once you accept your limitations and realize that it is okay to keep a list of people you can call for help, you can relax and be confident in what you do know." I marveled at how—in her own words—she had so clearly explained the difference between a novice and an expert.

"What is your connection to the End of the Trail RV Park?" I asked. She explained that the business is actually owned by a friend of hers. "He lets me park my trailer there so I have a place to stay when I am on call. They call me the 'park ranger.' I mow the lawn and keep the trees trimmed. It helps pass the time while I'm on call."

We said our goodbyes and pointed the RV toward Santa Fe. One more stop for a "green-chili fix" before heading home. What a great visit! Melanie is just another prime example of the NPs working in many rural areas, who are making great contributions to the health and well-being of their communities. They, like Melanie, in their own quiet and unassuming way are "keeping the animals all moving in the right direction." NPWN

NPWH ANNOUNCES 2011 *Inspirations in Women's Health Award*

Who Inspires You?

Deadline for Submissions is August 26!

Do you know an NP whose achievements caring for women inspire others? Think of the person you work with or know of who makes you want to do your best. Maybe you know of someone whose example in clinical practice, research, or teaching helped you or others be that much better. Pay tribute to this person by nominating her or him for the ***2011 NPWH Inspirations in Women's Health Award.***

There will be three winners; awards will be presented on October 13, 2011, at **NPWH's Clinical Conference** in Austin, Texas. Transportation (within the United States), hotel, and meeting costs will be provided, and a scholarship will be awarded, to three individuals who inspire us all.

To obtain more information about the contest, send an email to Aimee Gallagher at agallagher@npwh.org or call NPWH at 202-543-9693, ext 5.

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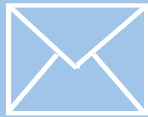
Letters from Our Readers



Dear Ms. McMann;
This article [by Carla Mills in the November/December issue of *NP World News*] was informative but incomplete. No mention was made of the trade name discount cards for prescriptions that offset some of the formularies higher copays (if payer will pay for the drug). I also inform my patients to go online to the drug's website where there might be savings coupons for the drug. These coupons can vary from month to month or offer a free month, such as Januvia/Janumet has done.

I spend a lot of time teaching about the discount generics offered by Target, Walmart, etc. One patient was paying $17 a month for the generic simvastatin, when I informed him of $10 for 90 days at Walmart without insurance.

I teach patients to shop around and tell them that they have the option of not using their insurance drug benefit and paying cash, on a drug-by-drug basis. I teach them that Costco charges 17% over their cost for trade-name prescriptions and that you do not need a Costco membership to use the pharmacy. For example, a vanity drug, Propecia, is about $80+ at CVS; at Costco, it's about $60, and there is a discount savings card.

Marina Abad, MSN, FNP
Dr. Curry & Associates
6231 Leesburg Pike, Ste 200
Falls Church, VA 22044

Marina offers some great examples here. As I tell patients in my article: "Each person's circumstances and coverage will be different, so it pays to learn about your own and shop around."
Carla

* * *

Hi Kevin,
Well, this is a first. I've never heard "nature deficit smeshifit" nor seen it in print. Nor has my husband, who coined the phrase and wrote *Last Child in the Woods: Saving Our Children from Nature-Deficit Disorder*. We really enjoyed your column, Mirth Beat, and Rich especially can relate to the pull of electronics. You'll perhaps be pleased to know that his next book, *The Nature Principle*, due out in April, has many suggestions for adults who find themselves in the similar situation.

Best wishes to you and your family for a terrific 2011. I'll continue to look forward to reading your column every month.
Warm regards from us both,
Kathy Frederick Louv, NP
San Diego

* * *

Dear Mary,

Since you included our story "Healing Beyond Borders—One Nurse at a Time" in the Nov/Dec issue of *NP World News,* we've heard from so many nurse practitioners who either have or want to volunteer their time and talents. Bravo! We thank you again for giving One Nurse at a Time (ONAAT) a wider audience! Our first scholarship recipient for 2011 was an FNP who first learned about us through that article.
Sincerely,
Nancy Leigh Harless
Communications Officer for ONAAT

Dear Nancy,
NP World News is always glad for the opportunity to showcase NPs who are doing such great work all over the world.

Readers—look for the story of ONAAT's first scholarship recipient's volunteer work in Guatemala with *Hearts in Motion* later this year in *NP World News.*

NPWH *Inspirations in Women's Health*
NOMINATION FORM

Nominee's name and credentials: ______

Licensed/recognized as a nurse practitioner in *(list states)* : ______

Current title/specialty: ______

Affiliation(s): ______

NP education: ______

Address: ______

Phone numbers: (W)______ (H)______ (C)______

Email address: ______

Please explain why this NP is an inspiration to others in terms of her/his contributions to women's health, the community, co-workers, students, or others. Describe what this NP has done that is innovative or beyond what is required in her/his current job position. Give as many details as possible. Please note: (1) The information you provide is the only basis upon which our judges will make a decision; (2) Nominees may help you write this section; and (3) There is a 500-word limit; attach additional pages as needed.

Is this NP involved with a project that would benefit as a result of her/his recognition as a winner of the ***NPWH Inspirations in Women's Health Award?*** If so, please describe. ______

Nominator's name *(self-nominations are accepted)*: ______

Affiliation: ______

Relationship to nominee *(Also, please describe how you know this individual and for how long)*: ______

Nominator's phone numbers: (W)______ (H)______ (C)______

Nominator's email address: ______

If you are nominating an NP other than yourself, we encourage you to inform this person that she or he has been nominated. It is an honor to be nominated whether or not the NP becomes a finalist. It also eliminates the possibility that the nominee is unable or unwilling, for any reason, to accept the award.

☐ Check here if you wish to remain anonymous to the nominee.
☐ Check here if the nominee is aware that she/he has been nominated.

FORMS SHOULD BE RECEIVED BY AUGUST 26, 2011.
Please fax to 202.543.9858 or mail to Nurse Practitioner Inspiration Award, NPWH, 505 C Street, NE, Washington, DC 20002

MayJune4.2011 5/2/11 1:45 PM Page 14

Wellness for Healthy Employees: Report from the Health Benefits Conference and Expo 2011

By *Nancy Rudner Lugo,* DrPH, NP

Wellness and health promotion are hot topics for America's businesses. Employer groups and wellness services vendors convened at the Health Benefits Conference and Expo, held on January 31 and February 1, 2011, in St. Petersburg, Florida, to examine strategies for improving employee health. Always a cornerstone of nurse practitioner (NP) practice, health promotion is now the darling of the ball, the magic bullet to improve the health and productivity of employees and to stem the skyrocketing cost of medical care. In his keynote speech, wellness pioneer Dee Eddington, PhD, lamented that years of "wellness programming" in the workplace had not reversed the epidemics of obesity and chronic disease. He called for a healthy culture change, with good health as a core business function, tied to leadership. Recognizing the daunting challenge of creating a cultural shift toward healthy living, Eddington called for a national goal of achieving a zero trend, ie, just not getting worse. While many NP interventions and workplace wellness programs focus on assisting high-risk individuals, he argued that a zero trend requires that we focus on encouraging today's low-risk people to stay healthy and not become tomorrow's high risks.

Several workplace health promotion programs were presented at the conference. Occupational health nurse Patti Clavier described the Health and Well-being Program she manages at Intel Corporation. The cultural expectation at Intel, the world's largest semiconductor manufacturer, is that each employee be at optimal health. The program has evolved from online health resources 12 years ago to risk awareness through screenings, incentives for health program participation, and linking of health improvement to employees' share of the cost of benefits today. Biometrics and health-risk-assessment questionnaires are used to determine each employee's health status and identify opportunities for improvement. Health coaching based on these results combined with supportive programs in nutrition, physical activity, smoking cessation, stress management, fitness, and workplace healthcare services facilitate health improvements. The employees' share of health insurance premiums are determined by their program participation. Intel's goal is to maintain health status as employees age, thereby reducing medical and productivity costs. The data are demonstrating that Intel is exceeding this goal, with 13% of participants shifting out of high risk (ie, having fewer health risks such as elevated blood pressure, elevated cholesterol and glucose levels, overweight/obesity, inactive lifestyle) compared with a cohort of non-Intel employees.

Similarly, Office Depot's employee wellness program has evolved to include more employee accountability. Five years ago, efforts were focused on risk awareness and included health fairs, disease management, and onsite flu shots and mammograms. Self-care guides and a wellness calendar were later added. The next phase of the wellness program included health screenings, weight management programs, and online resources. The most current changes focus on developing a culture of wellness, health coaching, onsite health care, and integrating employee health with benefits. Like many other employers, Office Depot has been moving toward more consumer-driven benefits, with increasing focus on individual decision making, high deductibles, and first-dollar costs for the employees.

Models of workplace healthcare centers presented at the conference were diverse. Some provide primary care, while others focus on health promotion. Although some centers are staffed with physicians, NPs predominate in other models. The argument that NPs cost less does not resonate strongly with many corporations; however, NPs' expertise in health promotion and patient communication makes them attractive to companies seeking to improve employee health through onsite services. NP specialties and roles are also evolving, but the profession's fundamental core competency has always been the ability to guide patients to better health. Considering that patients are more likely to have "consumer-driven" benefits, paying more for the cost of their care, including the significant financial costs associated with poor health and uncontrolled chronic disease, our health promotion skills are needed more than ever.

Patti Clavier

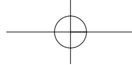
Check Out the NPHF Website

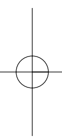
The Nurse Practitioner Healthcare Foundation (NPHF) has two new educational programs available on its website. The first is a white paper on the treatment of chronic pain and the second is a series of easy-to-read diabetes education materials focused on starting insulin.

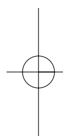
"Managing Chronic Pain with Opioids: A Call for Change" was written by Paul Arnstein, PhD, FNP, FAAN, and Barbara St. Marie, ANP, GNP, RN-BC on behalf of NPHF. In this white paper, the authors identify barriers to the treatment of chronic pain; discuss the problems of abuse, misuse, and diversion; present strategies for managing patients' opioid use, and highlight the need for standardized databases and terminology. They also stress that adequate patient and professional education is essential. The paper then presents recommendations for change that address the interrelated public health concerns of inadequately treated chronic pain and the misuse, abuse, and/or diversion of prescription opioids. The full document may be viewed on the NPHF website: www.nphealthcarefoundation.org

The NPHF and the Association of Clinicians for the Underserved (ACU) are making available a new series of user-friendly handouts for patients who are starting to use insulin to manage their diabetes. The handouts utilize plain language and simple pictures to help patients to understand the safe use of insulin and are specifically designed to address the need for low literacy guides that are easily understood by patients. There are 10 topics in the series, including information on why insulin is needed, how to inject it, needle safety, monitoring blood sugar, diet and exercise, and tips for managing insulin while traveling. The handouts are available in both English and Spanish and at two literacy levels (6th grade, or low literacy, and 4th grade, or very low literacy). The patient handouts can be downloaded without cost from the NPHF website (www.nphealthcarefoundation.org/insulin.html) and distributed to patients.

The NPHF is a nonprofit organization dedicated to "raising the bar" in health care. NPHF works on behalf of the entire nurse practitioner profession to make high-quality and effective care accessible through research, education, health policy, service, and philanthropy. The ACU is a nonprofit, transdisciplinary organization of healthcare clinicians, organizations, and advocates dedicated to improving health care for the underserved and supporting the clinicians who serve these populations. The white paper was developed with sponsorship from King Pharmaceuticals, Inc., and Nipro Diagnostics, Inc. provided financial support for the diabetes education handouts.







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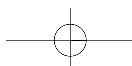
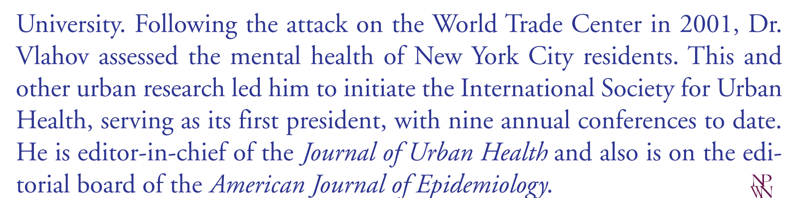


MayJune4.2011 5/2/11 1:45 PM Page 16

David Vlahov

David Vlahov New Dean of UCSF School of Nursing

David Vlahov, PhD, RN, was appointed the dean of the School of Nursing at the University of California San Francisco, effective as of April 1, 2011. Dr. Vlahov left The New York Academy of Medicine, where he held dual positions as senior vice-president for research and director of the Center for Urban Epidemiologic Studies. In addition, he has served as professor of clinical epidemiology at the Mailman School of Public Health at Columbia



University. Following the attack on the World Trade Center in 2001, Dr. Vlahov assessed the mental health of New York City residents. This and other urban research led him to initiate the International Society for Urban Health, serving as its first president, with nine annual conferences to date. He is editor-in-chief of the *Journal of Urban Health* and also is on the editorial board of the *American Journal of Epidemiology*.

AD

They Couldn't Let Him Die

By Joanne Haeffele, *PhD, FNP-BC*

The ability to travel around the globe within hours affords nurse practitioners (NPs) many rewarding opportunities to volunteer and serve as healthcare professionals in other countries. Service in areas radically different from our own helps us realize how small the world really is in spite of the vastness of our globe. Healthcare attitudes are often determined by the cultural beliefs of a particular country, leaving little room for negotiation. For example, NPs considering travel to Islamic countries should understand that the healthcare rights of the individual and the beliefs of the secular West do not apply there. Upon arrival in such a country, their bioethics take precedence.

A Personal Tragedy

I received the call on a Friday morning, totally changing my previous plans for a long weekend of rest and relaxation. My sister had just been informed that her husband John had been injured in an accident while unloading a plane in Kuwait. She asked if I would call and get the medical report since, as an NP, I usually handle all of our family's medical issues. When I called and spoke to an international physician, I received the worse possible news—my brother-in-law had sustained a traumatic brain injury, and his prognosis was very grim. My sister was unaware of the gravity of the situation as she prepared to travel to Kuwait with her two sons; she had never asked for the details. Battling my own fear and uncertainty, I knew that I could not let her go to Kuwait alone. I quickly packed a bag, which I later found to be essentially empty, and boarded a plane to join her at Dulles before catching a connecting flight to Kuwait. Twelve family members and friends made the long and arduous journey.

We arrived the next day in the late afternoon. The outside temperature hovered around 100 degrees, and we all wore jeans and sleeveless shirts. We were obviously outsiders, based on our manner of dress and

*Please see **They Couldn't Let Him Die,** page 17*

MayJune4.2011 5/2/11 1:45 PM Page 17

Continued from page 16

American ways. Our hotel backed up to the Persian Gulf, which is still beautiful in spite of its pollution. The tremendous damage done to this strategic waterway has come from many sources, including the Gulf War in 1991; the drilling and removal of oil, which is further complicated by water evaporation; pollution from ships; and human waste. Strangely enough, although we found the debris in the gulf and the stench to be repulsive, it simultaneously made us homesick. Our group immediately traveled to the hospital, accompanied by an English-speaking Islamic chaperon.

The Kuwait Community Hospital is small, run down, and filthy. John was in the Intensive Care Unit, and we had to navigate the halls and pass through a closet to get to him. His medical chart was sitting on the table over the end of the bed; Kuwait has nothing like the Health Insurance Portability and Accountability Act, or HIPPA. We had finally arrived, exhausted and uncertain, only to receive further devastating news. My sister's beloved husband was essentially "brain dead" and was being kept alive on life support. After spending some time tracking down John's doctor, I introduced myself and my sister. The male physician barely acknowledged my sister and subsequently took small steps back with each medical question I asked.

After spending a number of long, tearful, and heart-wrenching days with John, while simultaneously navigating the Islamic healthcare system, we asked for his life support to be terminated. Kareema, a Kuwaiti nurse explained said that it was against their religious and cultural beliefs to withdraw life support and we could leave him there until he died. I was outraged and screamed, "What—you want us to just leave him here?" Her words seemed meaningless to me. "You want me to tell his wife and children that we're leaving their beloved husband and father in Kuwait?" Overcome with emotion, it was much later before I could intellectually recognize that there had to be a reasonable explanation for their position.

Joanne Haeffele

Islamic Beliefs that Can Affect You

NPs who travel around the globe, either as volunteers or while holding a healthcare position abroad, need to be aware of how local cultural beliefs can affect them personally. No one expects to become terminally ill or to experience a tragic accident such as befell my brother-in-law. However, if you are in an Islamic country, you need to be aware of factors that will come into play should either of these unfortunate events occur.

Islamic beliefs embrace a reverence for life that is thought to be very sacred.[1] Every moment of life is considered to be of great value regardless of the status of the person living it. Physicians and nurses have a duty to save their patients, and it is considered a grave sin to take a life. The saving of one life is the same as saving the lives of many, while killing one person is akin to annihilating all of humankind. Therefore, Islamic countries prohibit both euthanasia and suicide.[2]

As John's loving family, we were angry and frustrated. At the time, we were unaware of Islamic cultural values and frankly did not care about them. We simply wanted John back—alive, loud, large, and full of laughter.

John's Continuing Story

We worked with international authorities to have John transported back to the United States in a medical plane. The doctors told us that his condition was tenuous and that there was no guarantee that he would arrive back home alive. They further explained that if he died during transport, the pilot would have to return the plane to the country of origin, where the medical team would have to follow local laws regarding preparing the body, getting the death certificate signed, and bringing the body home to the United States. Given the predicament, we realized that the route back to the United States would have to be carefully crafted. The family agonized over whether or not a family member should accompany John on the medical transport aircraft. As the NP in the family, I volunteered to go with him. Finally, one of my nephews spoke on his father's behalf, saying that, given the situation, he felt his dad would want all of us to stay together. He further assured us that he was certain his dad would arrive still alive, so that his life support could be terminated in a US hospital.

When we asked the Kuwait Hospital for a copy of John's medical records, they first refused and then offered to provide his vital signs. I objected to receiving only this bare minimum of information, and Kareema suggested that we see the hospital minister of health to get an official answer. Accompanied by another family member who is an attorney, I decided to challenge the system. The minister of health was a large, broad-shouldered male; three women wearing burkas staffed his outer office. Even while I introduced myself and our lawyer as representing the family, I thought, "I'm so out of my element here." As the medical professional in the family, I asked for permission to have his medical records copied to provide continuation of care. His reply was to yell at us, "No, we don't do that here." Swallowing my outrage, I tried to explain. "Sir, with due respect, medical records belong to the patient and should accompany him wherever he goes so that there is continuity of care." Again, he screamed "no" and offered the copy of John's vital signs. I repeated that I needed his medication list,

*Please see **They Couldn't Let Him Die,** page 23*

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We have a very exciting announcement: www.webnp.net has become **www.webNPonline.com!**

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Volunteering in Namibia

By Melanie Balestra, JD, MN, PNP

Although I have wanted to volunteer in Africa since I first became an RN and then a PNP, I did not realize my dream until 2010. I started planning a year in advance in order to research the various volunteer opportunities and schedule a month's time off. I chose Na'an Kuse—"God is watching" in the Sans, or bushman, click-tongue language—in Namibia, the second most sparsely populated country in the world. Na'an Kuse has a philosophy of enriching the lives of the Sans, not only through health care, but also through providing jobs for adults and education for the children. The LifeLine Clinic in Pos (village) 13 Namibia is located in the "bush." This volunteer opportunity was very unusual in that it allowed me to work with animals at a sanctuary in addition to caring for children at the clinic. I decided to go in May—the end of the rainy season and the beginning of fall, with its short warm days and cold nights.

Dr. Rudi van Vuuren and his wife Marlice started the nonprofit Na'an Kuse LifeLine Clinic in 2003 with the goal of providing primary health care to remote communities in the bush. They established the wildlife sanctuary to provide jobs and education for Sans as well as to take care of injured and homeless animals before releasing them back into the wilds in northern Namibia.

Melanie with a 6-month-old snow leopard, at the animal sanctuary

Playful Sans children

Starting the Journey

Dr. Laura Maynard Smith, an internal medicine resident from the United Kingdom, Tedi Milgrom, a Master of Public Health student from Michigan, and Wai Shum Soo, a pharmacist from Australia, met me at the animal sanctuary just outside of Namibia's capital city of Windhoek. Thus began my 5-1/2 hour journey on dirt roads to Pos 13. Namibia has approximately 15 named cities and 18 Pos, which are days apart by foot and typically without health facilities. Laura kept stressing how important it was to arrive by nightfall. Although cars were scarce, animals were difficult to see at night, making it much easier to run into them. Everywhere we looked, baboons were running wild.

On our arrival at the bungalow, which has five bedrooms, two bathrooms, and a kitchen/family room, we were greeted by two pet dogs who met us with barking and licks. The bungalow had electricity, but the huts were lighted by candles. We took showers on days that the water flow was working. Although each of us was responsible for our own breakfast and lunch, we all worked together to make dinner. That first night the discussion centered on a baby who had died of kwashiorkor, which unfortunately is not an uncommon occurrence in the Sans population.

The Sans

Small in stature with high cheek bones, the Sans have an average lifespan of 47 years. Although the children are friendly and have beautiful white teeth, due to the lack of sugar in their diet, many of them die from malnutrition before the age of 3. The women typically have numerous pregnancies, but only few children survive. At one time, the Sans had been a nomadic tribe, following animals for food. They are no longer able to travel from place to place but now live in Pos, which makes sanitation a problem. Homes are made of mud, aluminum siding, wood, and anything else that can be stuck together. Up to 10 or more adults and children may live in one home, without electricity or running water. Pos 13 has one spigot where water can be purchased; however, the water is contaminated by sewage and unsafe to drink. The government allots each Sans family about 5 pounds of maize every few months; the maize is mixed with water to make two meals each day. Since wine is cheaper than food, some Sans give alcohol to their children to help them fall asleep and quiet their crying from hunger. Many young men and women begin drinking wine in the morning to feel good, and a great number of young and old adults become alcoholics. There are no public schools for Sans children. Adults try to find jobs wherever possible.

We occasionally saw Hereros, another group of Namibians from the Bantu group. Herero women are easily identified by their Victorian-style dresses and horn-shaped headwear. Many Hereros have jobs, own cattle, and live in cement houses. A person's wealth is judged by the number of cattle owned. Some Sans are fortunate enough to earn small sums of money by working for the Hereros.

The Clinic

The LifeLine Clinic is located about 500 yards from our bungalow. It opens at 8 a.m. and was already busy when I went to

work that first day. It was sparsely furnished but very clean. We started with a brief orientation, primarily consisting of learning that charts were filed by family names and that there were "nappies" in the cupboards. The pharmacy included a few basic antibiotics, deprovera, liquid vitamins, worm medicine (similar to Vermox®), and ibuprofen for pain. We had two thermometers (all temperatures were taken axillary) and three stethoscopes. Laura had brought the World Health Organization communicable disease book. We did not have an X-ray machine, a hematocrit or hemoglobin centrifuge, or a laboratory to interpret blood samples; only a few liters of normal saline and Ringers lactate were available for infusion. Any patient not seen by nightfall, which came at 5 p.m., had to be treated the next day. That first day at the clinic, I stayed late to review some charts. It was so dark when I went outside that I had to use the clinic's portable otoscope to find my way to the bungalow.

I saw adults as well as children since my scope of practice was not as important as my assessment skills. After being given a chart, I went into one of two examining rooms to see Christina, my first patient; I was assisted by a Sans translator. Christina was 7 months pregnant and had had bloody diarrhea for a month. The immediate treatment for her dysentery was small amounts of diluted electrolyte solution given through a syringe. Her husband had died of HIV, and she had lost three children to meningitis, encephalitis, and pneumonia. Laura started an IV and hung Ringers lactate solution before the patient was driven 2 hours to the nearest hospital in Gobabis. Although the hospital is very clean and is staffed by Herero nurses, we had to ask multiple times for oxygen before getting a tank for Christina. We waited almost 2 hours to meet with the doctor on call, who never appeared. Christina was visibly frightened when we told her we had to leave before nightfall. The Sans believe that most people who go to the hospital never leave alive since many never return to their homes.

Laura was always available for consults. Respiratory infections, hypertension, and complaints of pain were common in adults. At least 75% of the Sans have tuberculosis (TB). Although most of the children and adults have respiratory symptoms and/or diseases, private clinics such as LifeLine are not permitted to give TB skin tests, HIV tests, or immunizations, which can only be obtained at government clinics. Although there was a Herero-staffed government clinic nearby, the Sans did not feel comfortable going there. I accompanied the Sans to the government clinic to make sure they would be seen and given the appropriate test.

There was no successful method for follow-up of patients. Many of them walked for one or more days and nights to get to LifeLine. I measured the height, weight, and upper-arm area to determine the malnutrition scale level of each child, not one of whom was within the normal range the entire time I was at the clinic. Every infant, child, and adult took home a month's supply of liquid vitamins from the clinic.

Melanie Balestra

However, they rarely made the monthly clinic visits necessary to continue receiving vitamins. Most of the time I treated children who had severe respiratory symptoms or otitis media (OM) with an antibiotic (amoxicillin) so that they could return home, which necessitated several days of walking. Alternately, I could treat the symptoms if the family had local friends or relatives with whom to stay. Many families had no home and slept out in the open. Since children who returned home without antibiotic treatment could die of infection, I used antibiotics for infants and children far more frequently than I do in my home practice.

Infected insect bites gave many children impetigo, which was treated with one dose of worm medicine and amoxicillin. Children love to play in pools of stagnant water, which allowed absorption of a water-borne worm, causing cutaneous lava migrans. Treatment consists of soaking the infected feet, hands and/or arms in a Betadine® solution, applying salve, and binding it with a cotton wrap to smother the worms and prevent migration further under the skin.

I saw many infants who could not eat without vomiting. Undernourished mothers produced insufficient breast milk, which was not nutritious enough for their babies to thrive. No formula, baby bottles, or baby food was available. We attempted small frequents feedings through a syringe of donated Ensure® that had been thinned. We convinced the mother to stay nearby until we knew that the infant was able to tolerate nourishment. Cow's milk is left in the sun for days to sour and curdle, making a luxury food called omaere, which often led to diarrhea and vomiting in infants and children. Lacking Pedialyte® or PediaSure®, we made a solution from powdered electrolytes and well water that was given to mothers, infants, and children in hopes of controlling their diarrhea and allowing other liquids to be tolerated. Mothers continue to give omaere to their families.

*Please see **Volunteering in Namibia,** page 20*

Melanie with a Sans mother and child

Families waiting in line for clinic

Volunteering in Namibia

Continued from page 19

In spite of our encouragement, very few women used birth control. Although all of the women said they used condoms, many young women had HIV. It was very difficult to get their partners into the clinic and then refer them to the government clinic for testing. In order to be treated for HIV, patients had to make a 2-hour drive or a 4-day walk to Gobabis. Patients who were late were told to go home and come back for another appointment, making it very difficult for many patients to receive treatment.

Because most infants and children did not wear "nappies," I sometimes had to change clothes after holding or playing with an infant. One day after deciding to give out "nappies" for the infants, I found one of my housemates, who had been into the village, laughing. Evidently, the infant was still not wearing the "nappy," but the mother was wearing it on her head wrapped in a turban.

On Saturdays, we made a lunch of rice and vegetables for some of the village children and played "school" with them, using sticker books, crayons, and coloring books I had brought. The children eagerly stuck the stickers on themselves and colored in the books. Most of them had no toys, so we played dodge ball, a jumping dance, and duck, duck, goose. We had a "shoes" day while I was there. I had brought sandals and shoes, and more shoes had been donated. Since many of the children cannot afford shoes, there was a line out the door, and all of the shoes were gone in less than an hour.

On our 1-day traveling clinic, we met Dr. Helene de Kok at an empty home in Kalahari to treat Sans and Herero patients. Sans were always seen at no cost. A busy clinic day consisted of my seeing three children with mumps and infants and children with conjunctivitis, respiratory infections, OM, and impetigo.

The Animal Sanctuary

After spending 2 weeks at LifeLine Clinic, I left to work in the animal sanctuary located outside of Windhoek. The many volunteers there came from all over the world. We were assigned three to a room in dormitory style. I learned the hard way to take my shower at the end of the day since the water was heated by solar panels, making it ice cold by morning. We rotated every 3 days through different job categories, ie, feeding all the animals, including the big cats; cleaning up animal waste; and working on a project such as digging new holes for fence posts.

I was taught how to work with different animals, including infant leopards, caracals, meerkats, baboons, boars, springboks, lions, and cheetahs, who purred loudly when petted. Most of these animals were orphaned or abandoned pets. The goal is to rear them as babies and gradually introduce them to various stages of captivity, allowing them to eventually be moved to the protected wild animal areas in northern Namibia and released into the wild. Unfortunately, baboons become so friendly that they cannot be released. Baboons are divided into adults, "senior babies," and "baby babies" that still need feeding and caring at night. I had my night with a baby baboon, Clyde, who I bathed, diapered, and gave a bottle before he went to sleep cuddled against my neck.

One night, a staff member rushed into my room to tell me that I was immediately needed in the village; a baby was being born 3 months prematurely. I prayed as we drove because I had no idea what I could do for a premature infant without electricity, an incubator, IV availability, etc. There were two candles lit in the small wooden hut and no water. The mother-to-be lay on a mattress on the dirt floor.

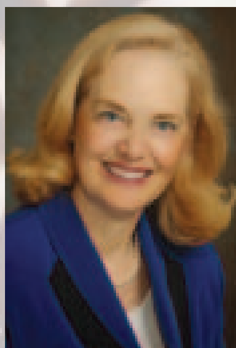
Melanie with a senior baby baboon at the animal sanctuary

The internist who was to replace Laura was delivering the baby, a procedure she had not done since medical school. She was quite worried about the health status of the baby, who may have weighed about 5-1/2 pounds. As soon as the infant was delivered, she was given to me. After first checking to make sure she was breathing, I grabbed a blanket to cover her and a syringe to clear her airway. Water was brought to bathe her. Although the baby was doing well, she would not go to breast, which can be fatal for a newborn with no access to formula and a bottle. I visited baby Dara and her mother several times a day to follow up on bonding and feeding. Dara finally went to breast and continues to do well. There is a philosophical acceptance of birth and death in Namibia; both are accepted parts of life and not celebrated as they are in this country.

At Journey's End…

My life-changing experience at the Na'an Kuse Lifeline Clinic and Wildlife Sanctuary allowed me to combine my love of both children and animals. If you are interested in learning more about my volunteer experience, please feel free to contact me at melaniebalestra@gmail.com or go to www.naankuse.com to learn more about LifeLine Clinic.

Melanie Balestra works as a PNP at the Laguna Beach Community Clinic and is a partner at the law firm of Cummins and White, LLP, in Newport Beach, California.



THE PEARSON REPORT 2011

By Linda J. Pearson, *DNSc, MSN, APRN-BC, FAANP*

Read the complete ***The Pearson Report: A National Overview of Nurse Practitioner Legislation and Healthcare Issues*** by registering online at ***www.webNPonline.com***

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This 23rd annual report includes a review of pertinent state legislation and of rules and regulations that affect NPs, along with pertinent government, policy, and reimbursement information. The report, which is updated every year, is widely disseminated, discussed, and used to promote legislation to allow NPs to practice to their full potential.

The Clever Traveler

By Bridget Hagerty

Dear Clever Traveler,
Here's a touchy question. My brother wants to come visit me (from the other side of the country), and he's a really large guy. He usually doesn't fly due to his size, but this is an important family occasion. How can I help make this easier for him?
Little Sis

Dear Little Sis,
No one of any size is truly comfortable in today's airplanes. The economic model for airlines coming out of bankruptcy is this: put fewer planes in the air with more people on them. The strategy to achieve that end is to add as many seats as possible to existing planes, then lower fares just enough to fill those seats. The effect on passengers is jostled arms, cramped muscles, short tempers, and the kind of discomfort that would be frowned upon at Guantanamo.

One feels compassion for those people whose size makes it even more difficult to fly without encountering difficulties for themselves and making it worse for those seated next to them. And let's be clear: We're not just talking about heavy people; the most uncomfortable guy on the plane is the one who is over 6'5" and seated in coach.

Most airlines have a policy stating that passengers must be able to fit in a seat with a single seatbelt extender and with the armrests down. If that won't work for your brother, he can buy an additional seat at the cost of the original. The websites all sound very reasonable and matter-of-fact, but when human gate agents and flight attendants have to deal with a full airplane, things become more fluid.

Your brother should call the airline reservations number to discuss his needs. (Many airlines will waive the telephone reservation fee for people with special needs.) He should be frank about his size—and we all know how hard it is not to fudge a little.

More importantly, he needs to get to the airport extra early to ensure that he has two seats together if he needs them. He should not check in online but wait to do so at the airport. Stories abound of people who booked two seats together for themselves, and found at the airport that the seats had been separated.

Finally, his attitude on the airplane will help make everyone's experience more pleasant. When I was on a flight yesterday, a large woman dropped her bag into the seat next to mine. As she sat down and asked quite openly for the seatbelt extender, she winked at me and said, "Don't worry honey, we'll share the armrest and you can nap on my shoulder." Her direct approach and acknowledgement of my possible concern made me feel good and made the flight more enjoyable for both of us.

Dear Clever Traveler,
I have a dilemma when I fly: I like to recline my seat, but I'm furious when the person in front of me reclines. I know that's contradictory and I don't want to by a hypocrite.
Conflicted

Dear Conflicted,
Yes, your feelings are inconsistent, but maybe we need to talk first about anger management. It's more and more difficult to contain our rage on airplanes these days, but really dear, you must or you'll find yourself cuffed, fingerprinted, and doomed to the interstate highway system for the rest of your life.

Every single person on that airplane feels exactly the same way (unless they're in first class, then they're just feeling smug). To recline or not to recline is the single most talked about social issue of the day…or maybe second after Lindsay Lohan.

Even Aristotle would find this question tricky. We have the ability to make ourselves slightly more comfortable by making the person behind us a lot less comfortable. The decision becomes excruciating when the person ahead of us reclines into our knees (thereby igniting the afore-mentioned rage).

Airlines could make this easier for us by installing automatic-recline times so every seat did the same thing at the same time. (I'm not holding my breath.)

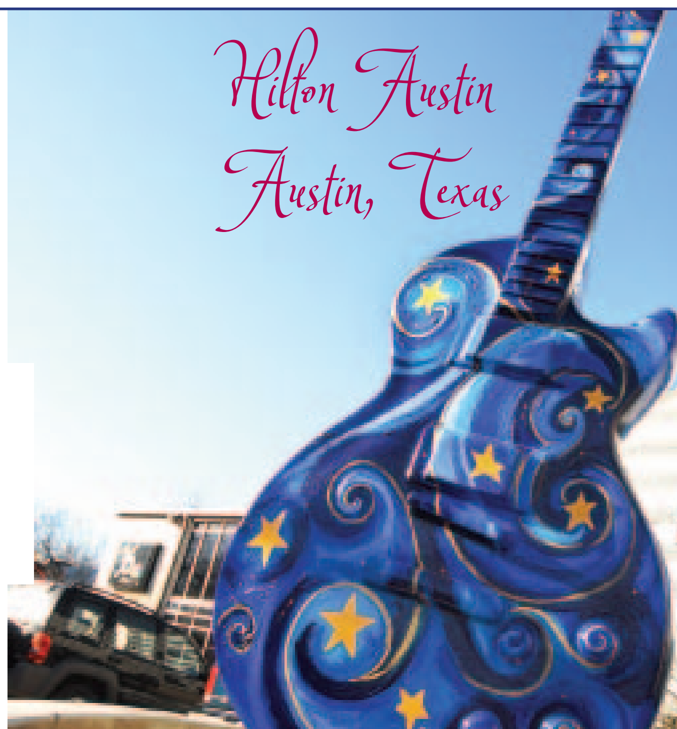
Here's my current thinking: I choose not to recline if I'm on a flight of less than 3 hours. If it's a trans-con or international flight, I recline when everyone else does. If you're on your third flight of the day in a CRJ and your legs are screaming, turn to the person behind to make sure she isn't eating or using her laptop, then lower your seat gently and incrementally.

Dear Clever Traveler,
In your opinion, what is the most important internet tool for saving money on travel?
Bargain Hunting

Dear Bargain Hunter,
Right now, I'm saving the most money by using Priceline for hotel deals. Learn how get the best deals on Priceline by taking the tutorial at BiddingForTravel.com. On the Priceline website, select "name your own price." Happy hunting!

Save the Date

OCTOBER 12-15, 2011



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MEETINGS & EVENTS

May 13-14, 2011: **Utah Nurse Practitioners (UNP).** 18th Annual Pharmacology Conference. Salt Lake City, UT. www.utahnp.org

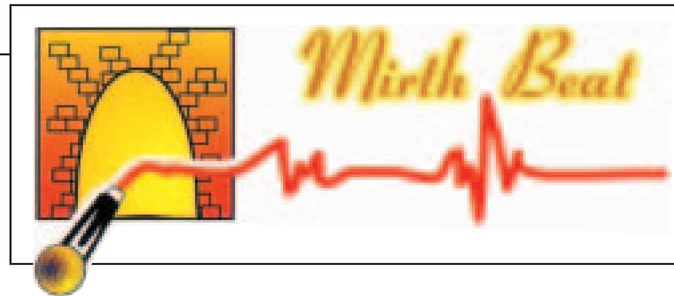
Through May 31, 2011: **Cherokee Uniforms** is accepting nominations for its annual Inspired Comfort Award. http://inspiredcomfort.com

June 22-26, 2011: **American Academy of Nurse Practitioners.** 26th National Conference. Las Vegas, NV. www.aanp.org

July 14-17, 2011: **National Nurse Practitioner Symposium.** Copper Mountain, CO. Milestone Presentations, LLC. www.npsymposium.com

September 15-17, 2011: **Alaska Nurse Practitioner Association.** 28th Annual Conference. Anchorage, AK. www.alaskanp.org

October 12-15, 2011: **Nurse Practitioners in Women's Health (NPWH).** 14th Annual NPWH *Premier* Women's Healthcare Conference. Austin, TX. www.npwh.org.



Pick Your Cherries Wisely

My wife recently left an article on the kitchen counter for me, sticky-note attached with an arrow pointing to the title and a one-word directive, "read." Suspecting that the article contained advice I probably dearly needed, I jumped into action and set it aside for later.

The next night the sticky note remained; I still hadn't read the article.

I glanced at the article title, "Screen-time is ruining our sleep." I was right; the article was indeed pertinent to me. I did not want to be convinced that checking my email or favorite news sites or a funny YouTube video before going to bed was a problem. No doubt the article would include convincing evidence that my late night web habits were messing up my sleep. But I didn't want to hear it. I was cherry-picking my information. Those scientists don't know me! But my wife does…shucks.

As you probably know, *cherry picking* is a form of bias that occurs when we choose data that support our preferences and discount data that do not. This is poor form. (It is an unfortunate term for people who are actual cherry pickers—makes them sound dishonest. "Did you cherry-pick those cherries?")

However, I must admit that when it comes to cherry-picking data that apply to my personal life, I do not always pick the best cherries. For example, I recently read a study about how multitasking makes you less efficient. Well, I didn't actually finish the article because I was checking emails and doing laundry at the same time.

I also have had the habit of quoting "helpful" health studies to my three children. They always picked up on my thinly veiled attempts to influence their health habits. I recently asked my now young adult children what they recalled about my health research stories from years ago. They couldn't recall a one. They had been cherry-picking my "advice" all along. Which is a nice way of saying they ignored me. Savvy little buggers.

"Hey kids," I asked, "what about the dangers-of-texting-while-driving research I shared with you when you first got your driver's licenses? "Obvious one, dad." "What about the dangers-of-smoking and secondhand-smoke studies?" "Obvious one, dad." "What about my advice to wear helmets while playing on the jungle gym?" "We have tried to forget that one dad…but our friends haven't."

I humbly share these examples of my cherry-picking approaches and my not-so-solid rationale.

Breakfast is the most important meal of the day.

This old adage must have been authored when moms donned aprons in the morning and served fresh biscuits to the family and the hired ranch hands. Eating breakfast before heading out is simply a speed bump delaying access to coffee.

A high salt intake increases your blood pressure and risk of stroke.

But I like salt. Salt is the...salt of life. Or something like that. Can you imagine the horror of salt-free pretzels or sodium-free olives? This must not apply to me.

Daily meditation has been shown to have many benefits including decreased blood pressure, improved mood, and more restful sleep.

Do I *have* to sit while I meditate? Can I eat salty food while I meditate and call it even?

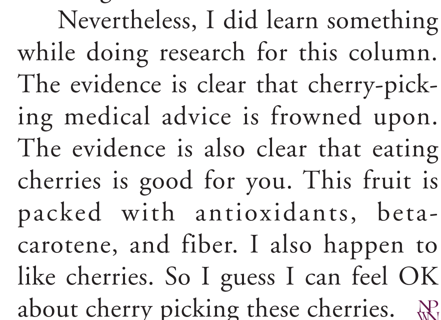
Implementing a routine sleep time 7 nights per week promotes a healthier sleep/wake cycle and improves alertness and memory.

Routines are for kids...and people who are smarter and more alert than me.

I did eventually read that study about late-night screen time and sleep disruption.

In the conclusion, the researchers say something about "additional research is needed." Ha! So there. I can keep doing what I am doing and wait for more convincing evidence. My daytime drowsiness could possibly be unrelated, right?

Nevertheless, I did learn something while doing research for this column. The evidence is clear that cherry-picking medical advice is frowned upon. The evidence is also clear that eating cherries is good for you. This fruit is packed with antioxidants, beta-carotene, and fiber. I also happen to like cherries. So I guess I can feel OK about cherry picking these cherries.



Kevin Lee Smith, RN, FNP, is chief clinical officer with Zipnosis, an adjunct faculty member at the University of Minnesota School of Nursing, and a humor writer and comedian. He can be contacted at kevin@kevinleesmith.com

Let's Talk Money

Continued from page 6

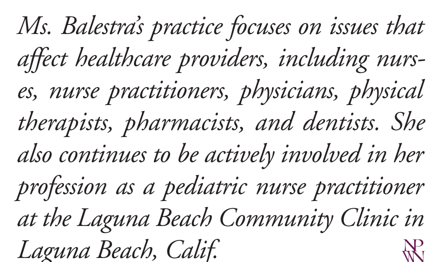
do not want to work full time. Keep in mind that since the employer is not paying for benefits or contributing toward tax liabilities, you are in a good position to negotiate a higher rate of pay.

For more information on this topic, see Melanie Balestra's article "Professional Survival in an Economic Crisis—Focusing on Key Business Details to Weather the Storm" in the summer issue of *Practice Management,* which will be found online at www.webNPonline.com

About the Author

Melanie Balestra, NP, is a partner at Cummins & White, LLP, a business and insurance law firm based in Newport Beach, Calif.

Ms. Balestra's practice focuses on issues that affect healthcare providers, including nurses, nurse practitioners, physicians, physical therapists, pharmacists, and dentists. She also continues to be actively involved in her profession as a pediatric nurse practitioner at the Laguna Beach Community Clinic in Laguna Beach, Calif.



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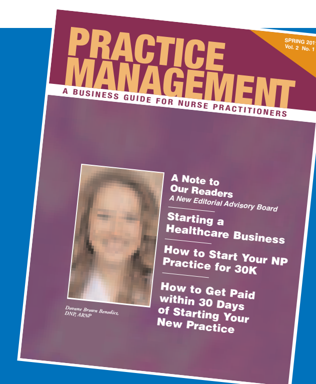

MayJune4.2011 5/2/11 1:46 PM Page 23

Hallas Named Long Island 2010 NP of the Year

The Nurse Practitioner Association of Long Island (NPALI), a chapter of the Nurse Practitioner Association of New York State, recently named Donna Hallas, PhD, PNP-BC, CPNP, as its 2010 Nurse Practitioner of the Year. Dr. Hallas is a pediatric nurse practitioner whose practice serves at-risk children from birth to 21 years of age who receive their primary health care in a pediatric ambulatory care center. Her current research focuses on improving healthcare outcomes for infants and children under the age of 5. She recently completed a randomized controlled trial investigating an intervention to improve the social-emotional development of toddlers. She is currently conducting a study to improve the oral health-care needs of young children. In addition, Dr. Hallas serves as a clinical associate professor at New York University College of Nursing and is the coordinator of the Pediatric Nurse Practitioner Program. She also acts as a peer reviewer for the *Journal of Pediatric Health Care* and the *Journal of Pediatric Nursing.*

Donna Hallas

They Couldn't Let Him Die

Continued from page 17

diagnostic tests with results, consults, and physician and nursing notes, as well as the emergency room report. Although the minister of health ignored me, he finally did listen to a carefully crafted negotiated request by the family lawyer, who also happened to be male. Finally, he agreed to give us everything except the physician and nurse's notes. I believe that it was our lawyer's male gender rather than his legal jargon that convinced the minister of health to change his mind. American law has no jurisdiction in an Islamic country.

John did arrive back in the United States alive, just as his son had predicted. He was admitted to the local community hospital where we were able to say our last goodbyes. His life support was removed, and he was allowed to die peacefully. In addition to always being alive in our hearts, he physically lives on through his organs that were harvested and donated to people in need.

Food for Thought

The events described in this article have changed our lives forever. Months after John's peaceful death, each day still blends into the next. Our outrage and anger toward the Islamic beliefs that so drastically impacted our lives have softened over time, leaving us with a better understanding of other countries' cultural environments. All NPs need to keep in mind that even though we carry our health beliefs with us when we travel or work abroad, our final destination may dictate how those beliefs will be carried out, possibly leaving us feeling powerless.

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Further Reading

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Joanne Haeffele, PhD, FNP-BC, is an assistant professor of nursing at Northern Illinois University, DeKalb, IL. Her email address is jhaeffele@niu.edu

AD