Spring 2018 Volume 48, No. 1 A publication of the Washington State Nurses Association

# The Washington Nurse

Nurse "telepresenters" provide efficient care with a human touch

Frequently asked questions about Telehealth

Nurses advancing telehealth services in the era of health care reform

Expanding access to mental health care through telemental health

## How telehealth is changing nursing...

1.0 CNE inside!

Project ECHO connects community providers with heart failure experts

Bringing subspecialists to rural patients via telehealth

Telehealth gives busy ED a partner in acute stroke care

Telehealth camera eliminates distance between patient and physician

Telestroke means better outcomes for Skagit Valley patients

Risk management issues, strategies and resources

The Washington Nurse How telehealth is changing nursing Legislative session wrap-up $2.9 million victory at Yakima Regional Volume 48, No. 1 Spring 2018

WSNA UNION
# Leadership Summits

6
CNE credits

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**May 19**
**Teamsters 58, Vancouver**

**June 2**
**Good Shepherd Center, Seattle**

**June 10 and 11**
**Campbells Resort, Chelan**

**Sept. 8***
**Red Lion (Columbia Center), Kennewick**

**Sept. 30 and Oct. 1***
**Campbells Resort, Chelan**

**Nov. 3**
**Skagit Casino, Mt. Vernon**

* Sept. 8 and 30 events include Nurses Speak reception

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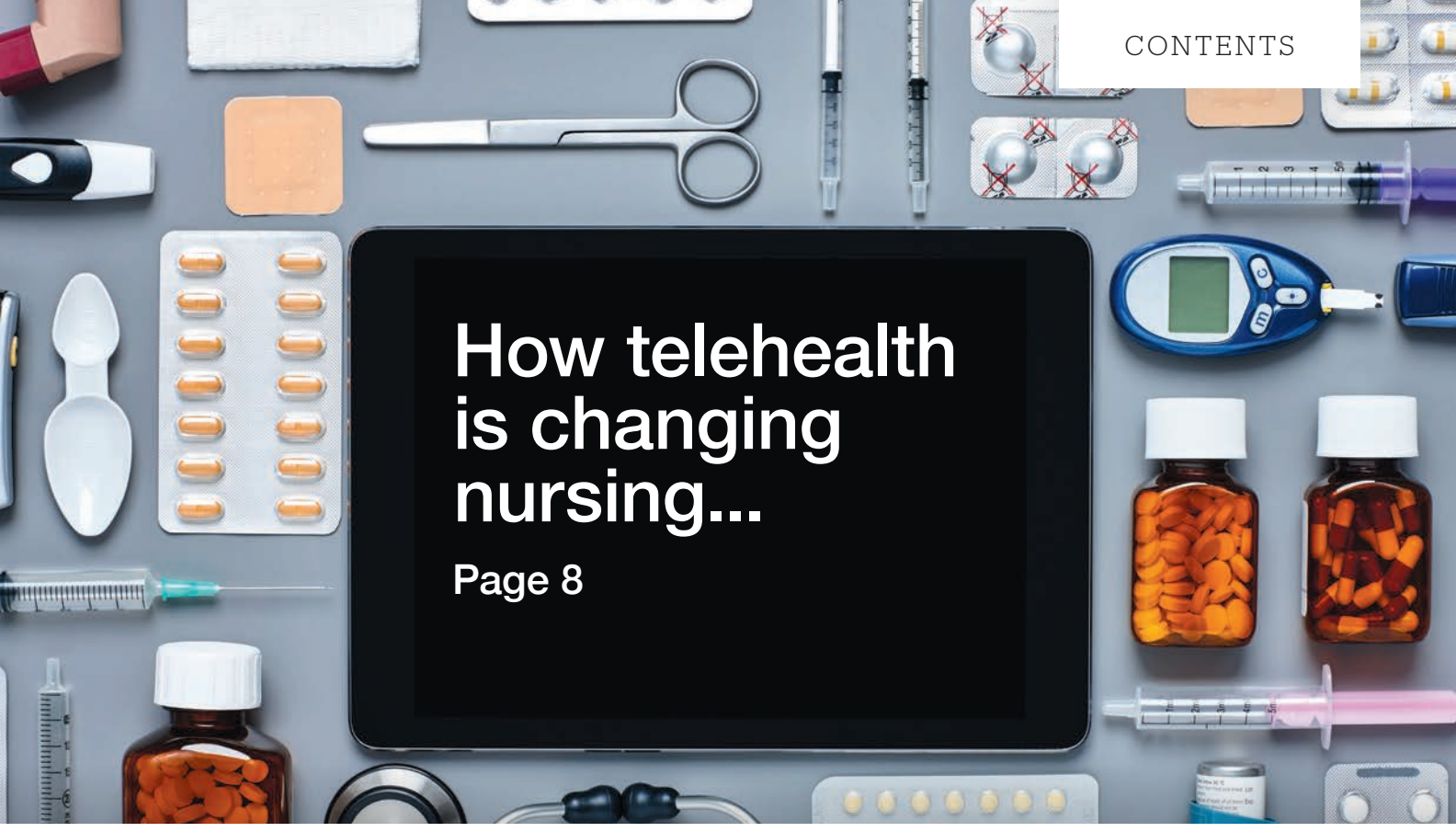

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# IN FOCUS

As we approach the end of our first year in this biennium, I would like to take time to reflect on some of the success WSNA has had this year as well as take the time to personally thank a few of the WSNA members who have contributed to our success.

WSNA's first Regional Nurses Association was successfully created in February of this year. This happened because members in Districts 1, 9 and 16 wanted to be more of a resource to the WSNA members who lived in their communities. They knew if they came together, shared resources and focused their work on the things that were of value to the membership, they would accomplish this goal. The three districts were disbanded, and regional bylaws were created and sent to the members for approval. The new organization, Northwest Region Nurses Association, was overwhelmingly approved.

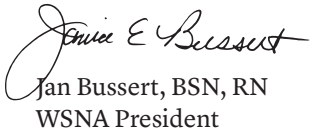
My thanks go out to Sally Herman, who took the lead in this work with valuable support from regional leaders Neva Wiederspohn, Aaron Lebovitz, Alex Dunne, Helen Behan and the many others who provided input into the decision and planning process.

We saw success in the 2018 legislative session (see our legislative report on page 62 of this issue). WSNA leaders went to Olympia to tell their stories, testify before the legislature and make a difference. There is great satisfaction found in stepping up and speaking out. Many opportunities are available for all our members. Are you interested in legislative advocacy? Would you be interested in participating in candidate interviews, participating in political campaigns or attending legislative receptions? If so, please contact Natasha Skorupa, WSNA Political Action Specialist, at nskorupa@wsna.org for upcoming opportunities. A special thank you goes out to Justin Gill, who testified in support of our rest breaks bill (HB 1715), and to Martha Phillips, who testified in support of creating more training for sexual assault nurse examiners (HB 2101).

Yakima Home Health and Hospice local unit leaders were successful in their efforts to put patients before profits. These nurses routinely worked additional, unpaid hours to ensure their patients received the care that was needed. The court ruled in their favor, saying that nurses were routinely expected to work hours off the clock and awarding nearly $2.9 million in back pay. "This is a tremendous victory, not only for the nurses who were forced to work off the clock to give their patients the care they need, but for nurses across the state," said Julia Barcott, RN, Chair of WSNA's Cabinet on Economic and General Welfare. "It is really powerful to see what nurses standing together in unity can do for nurses and quality patient care – whether we're in the courtroom, at the bargaining table or in the legislature."

Are you interested in advocating for yourself, your colleagues and your patients by engaging in a variety of WSNA union opportunities? If so, please contact Tara Goode, Director of Organizing, at tgoode@wsna.org.

Lastly, my thanks goes out to ANA President Pam Cipriano who was quoted in ANA Smartbrief as saying, "Surveys have found about 25% of nurses have been physically assaulted at work and about 40% have been physically or verbally abused by patients or their families, and workplace violence appears to be increasing... We have been very clear that we believe the need to prevent violence is a true partnership between employers and their staff and it really starts with leadership."



Jan Bussert, BSN, RN
WSNA President

PHOTO: MERYL SCHENKER

**MAY 2018**

| | |
|---|---|
| **5** | Washington Center for Nursing 'Hats Off to Nurses' – Auburn |
| **6-12** | National Nurses Week |
| **8** | Inland Empire Nurses Association 'Annual Spring Gala' – Spokane |
| **10** | University of Washington 'Nurses of Influence' banquet – Seattle |
| **10** | King County Nurses Association 'Spring Banquet / Annual Meeting' – Seattle |
| **11** | Pierce County Nurses Association 'Annual Meeting, Silent Auction and Banquet of Laughter' – Tacoma |
| **11** | Nursing Care and Quality Assurance Commission meeting – Tumwater |
| **19** | WSNA Union Leadership Summit – Vancouver |

**JUNE 2018**

| | |
|---|---|
| **2** | WSNA Union Leadership Summit – Seattle |
| **4-5** | AFT Nurses and Health Professionals 'Professional Issues Conference' – Washington, D.C. |
| **10-11** | WSNA Union Leadership Summit – Chelan |
| **21-23** | American Nurses Association Membership Assembly – Washington, D.C. |

**JULY 2018**

| | |
|---|---|
| **13** | Nursing Care and Quality Assurance Commission meeting – Richland |
| **13-16** | AFT Convention – Pittsburgh, PA |
| **17-19** | Washington State Labor Council Convention |

**AUGUST 2018**

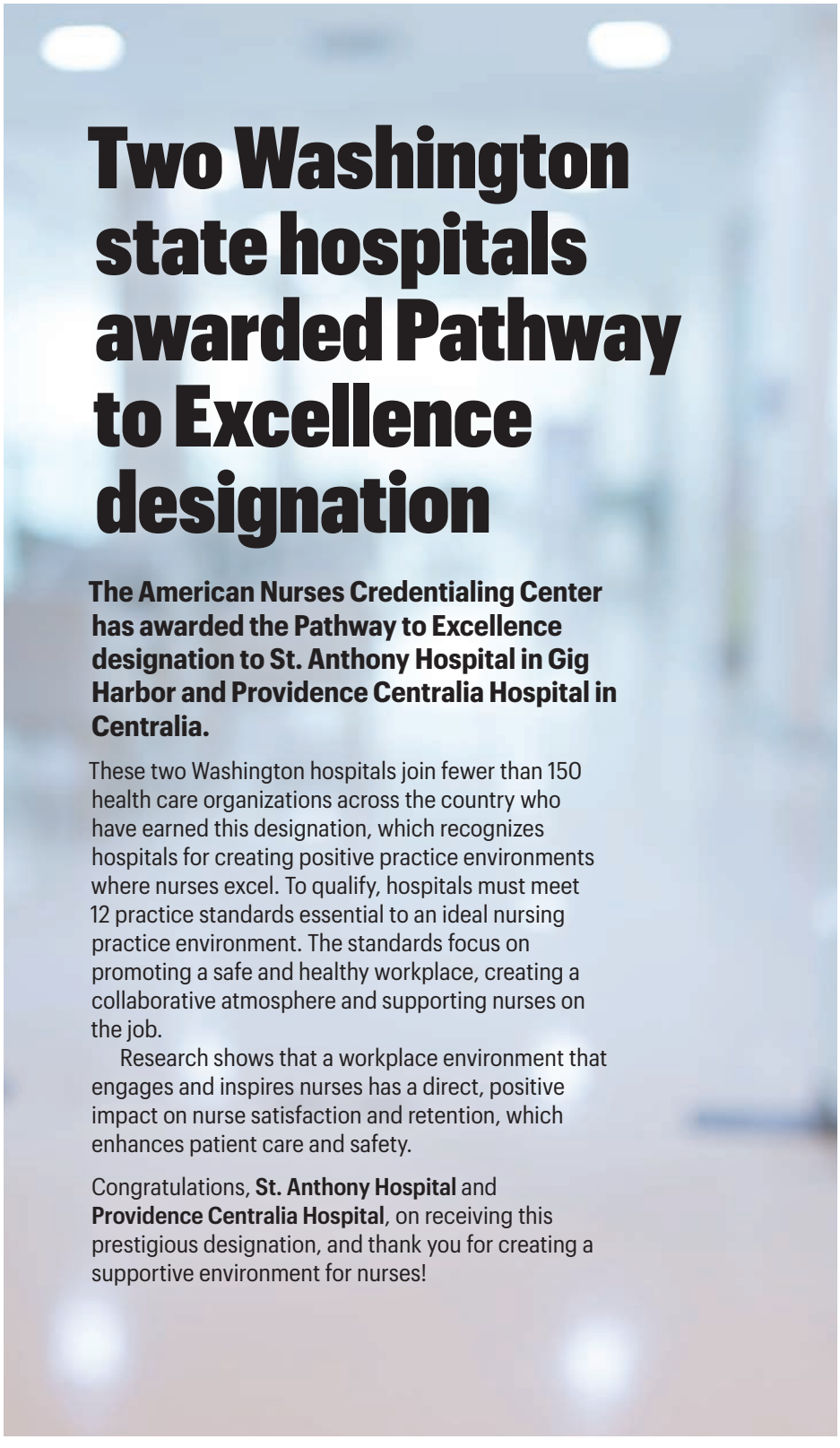
| | |
|---|---|
| **3** | WSNA Board of Directors meeting – Tukwila |

FOR MORE INFORMATION AND A COMPLETE AND UP-TO-DATE LISTING OF EVENTS, VISIT WSNA.ORG/CALENDAR.



# NEWS BRIEFS

For the most current nursing news and information, visit **wsna.org/news**.



## Two Washington state hospitals awarded Pathway to Excellence designation

**The American Nurses Credentialing Center has awarded the Pathway to Excellence designation to St. Anthony Hospital in Gig Harbor and Providence Centralia Hospital in Centralia.**

These two Washington hospitals join fewer than 150 health care organizations across the country who have earned this designation, which recognizes hospitals for creating positive practice environments where nurses excel. To qualify, hospitals must meet 12 practice standards essential to an ideal nursing practice environment. The standards focus on promoting a safe and healthy workplace, creating a collaborative atmosphere and supporting nurses on the job.

Research shows that a workplace environment that engages and inspires nurses has a direct, positive impact on nurse satisfaction and retention, which enhances patient care and safety.

Congratulations, **St. Anthony Hospital** and **Providence Centralia Hospital**, on receiving this prestigious designation, and thank you for creating a supportive environment for nurses!

PHOTO: ARISSU / ISTOCK

## Healthy Nurse, Healthy Nation challenge continues

**After a highly successful first year,** the American Nurses Association's Healthy Nurse, Healthy Nation Grand Challenge continues in 2018, with new challenges every month.

Healthy Nurse, Healthy Nation is an initiative that connects and engages nurses, employers and organizations to improve health in physical activity, nutrition, rest, quality of life and safety.

The truth is, nurses are less healthy than the average American. Research shows that nurses are more likely to be overweight, have higher levels of stress and get less sleep. As the largest and most trusted health care profession, nurses are critical to the health of the nation, and the HNHN initiative was developed based on the idea that if all 3.6 million registered nurses nationwide increased their personal wellness, influencing their families, co-workers and patients to follow suit, we would live in a healthier nation.

To join, register at www.healthynursehealthynation.org. Then, take the health assessment survey and get a heat map of your health risks. Pick your focus areas, make a health commitment and participate in the health challenges. Challenges for the rest of the year will focus on hydration, civility, safety, stress less, healthy sleep, mental health and happiness.

HNHN's online community offers information and support to help you reach your goals.

PHOTO: PEOPLEIMAGES / ISTOCK

### How are you celebrating National Nurses Week?

The theme for 2018 National Nurses Week (May 6-12) is "Nurses: Inspire, Innovate, Influence." Within that, May 8 is designated as National Student Nurses Day and May 9 is National School Nurse Day.

We know there are celebrations happening across Washington. Let us know how you celebrated National Nurses Week and send your photos to newsletter@wsna.org.

## ANA declares 2018 the 'Year of Advocacy'

**As the largest group** of health professionals in America, and consistently the highest ranked in terms of ethical behavior by the public, nurses are in a unique position to influence the direction of both the profession and health care. Nurses advocate every day regardless of role and setting. ANA wants to recognize the numerous examples – for individual/groups of patients, self, colleague(s) and the profession as a whole; locally, nationwide or globally.

Therefore, ANA has declared 2018 as the "Year of Advocacy." Throughout the year, ANA will feature examples of members advocating for patients and the profession in various roles and settings, hosted on the RNAction.org website and distributed through various ANA digital and social media channels using the hashtag #BedsideAndBeyond.

April through June, ANA will focus on "nurses influencing elected officials." July through September ANA will focus on "nurses get out the vote!"

How are YOU are making a difference at the #BedsideAndBeyond? Have you spoken up for patient-focused process changes? Contributed to revising workplace policies? Served on a committee or board? Called, emailed or met with elected officials?

Share your advocacy story with ANA at wsna.to/ANA-YOA.

## Washington is third most unionized state in the nation

**Washington state gained** 45,000 union members last year, according to the U.S. Bureau of Labor Statistics. In total, an estimated 584,000 Washington state residents belonged to labor unions in 2017. With those gains, the state's union membership level increased from to 17.4 percent in 2016 to 18.8 percent last year.

These gains make Washington the third most unionized state in the country, following New York and Hawaii.

The Bureau of Labor Statistics' January report showed that union members earn higher wages, with median weekly earnings of $1,041 compared to $829 for nonunion. With union wages averaging 25 percent higher than nonunion wages, full-time union members make more than $54,000 per year on average, which is $11,000 more than nonunion workers.

**SAVE THE DATE!** **2019 Convention** May 1–3, 2019

# NEWS BRIEFS

## WSNA-AFT nurses provide health screenings to students in St. Croix

**WSNA members Julia Barcott and Renata Bowlden** travelled to the island of St. Croix in April as part of an AFT assistance project. During the weeklong trip, April 8-14, AFT nurses provided thousands of hearing and vision screenings to students on the island, which is still recovering from hurricanes Irma and Maria that hit the Virgin Islands last September.

"We're up at 5 a.m. and back to the room around 5:30 p.m.," Barcott said.

Among the many stories of children helped, some stand out as making a big difference in the life and learning of the students.

"Yesterday (April 11), we screened a 1st grade boy that was held back because he failed," Barcott said. "Ended up we found out he was basically deaf and wasn't hearing hardly anything, so now he'll be getting hearing aids. On Tuesday, my sister did a vision exam on a teenager who couldn't see the eye chart. She had broken her glasses years ago. We put glasses on her and all of us started clapping and crying because she could read! She was so excited."

The trip was part of AFT's comprehensive assistance to the Virgin Islands, which has included help for teachers and school staff and shipments of books and school supplies, which were given to students across the Virgin Islands.

Left: Julia Barcott (wearing glasses) with another volunteer and several children in St. Croix.

## DOH adds third option to birth certificate

On Jan. 27, the **Department of Health began allowing people to change their sex designation on Washington birth certificates to "X,"** adding a third option to birth certificates.

Things to know about the new rule:

- The rule adds "X" as an approved sex designation as an option.
- Adults making a request no longer require medical attestation.
- The list of licensed health care professionals who can attest to the gender change for minors is expanded, including: psychologists, advanced social workers, independent clinical social workers, marriage and family therapists and mental health counselors.
- Minors must have a written consent of their parent or legal guardian and an attestation by a licensed health care professional to change their sex designation.

For more information, visit wsna.to/DOHsexDesignation.

## Online Nurses' Health Study 3 looking for participants

**The Nurses' Health Study 3** is continuing to recruit male and female nurses and nursing students from across the United States and Canada. Investigators at the Harvard TH Chan School of Public Health and Brigham and Women's Hospital, a Harvard Medical School affiliate, are asking nurses born on or after January 1, 1965 to join the study. Their goal is to recruit 100,000 nurses for this new study. The study is conducted entirely over the internet.

The goal of the Nurses' Health Study 3 is to investigate how lifestyle factors (including diet, exercise, birth control, pregnancy, work exposures, etc.) during people's 20s, 30s, 40s and 50s can influence both their health later in life and the health of their children. Over 230,000 nurses are already participating in the first and second phases of the Nurses' Health Studies. Information about these studies can be found at www.nurseshealthstudy.org.

WSNA endorses the Nurses' Health Study 3, and we encourage you to consider participating in this long-term study and inviting others to participate. Your contribution can help identify important nutritional, lifestyle and biological factors that could lead to optimal health.

Visit nhs3.org for more information and to join the study.

## ANA Enterprise selects new CEO

On April 12, **ANA Enterprise announced the appointment of Dr. Loressa Cole as its new Chief Executive Officer (CEO).** She assumes the role on May 7, 2018.

As CEO, Dr. Cole, DNP, MBA, RN, FACHE, NEA-BC, will provide strategic leadership and have responsibility for the operating activities of the Enterprise including management of staff and implementation of programs for the American Nurses Association (ANA), American Nurses Credentialing Center (ANCC) and American Nurses Foundation.

Dr. Cole has served as chief officer and executive vice president of ANCC since 2016. Previously, she held chief nursing officer and chief operating officer positions within the Hospital Corporation of America's (HCA) Capital Division. While Chief Nursing Officer at LewisGale Montgomery Hospital, she led the hospital to attain ANCC Magnet® recognition.

"Dr. Cole brings proven leadership as a seasoned health care executive and as the current Executive Vice President of ANCC," said ANA President Pamela F. Cipriano, PhD, RN, NEA-BC, FAAN. "She demonstrates the vision, creativity, passion for nursing, and strong business acumen to leverage the strengths of ANA's entities to enhance and grow the Enterprise."

## Global Impact seeks health care professionals for international summer program

**Health care professionals and members of the community are invited to participate in Global Impact,** a Seattle Colleges service learning program presented in partnership with Seattle area medical, education and service organizations.

Since 2005, local teams have paired with teams from the host country to provide clinics and health education services and to work on sustainable infrastructure projects that contribute to the overall health of rural communities.

Global Impact is sponsoring three summer programs in 2018:

**Peru Quest: Aug. 19 – Sept. 2**
Location: Cuzco region

**Magical Morocco: Aug. 19 – Sept. 2**
Location: Agadir and surrounding communities

**Discover Laos: Aug. 20-31**
Location: working in villages 1-2 hours from Luang Prabang

Programs costs participants $1,999 plus airfare. Details at seattlecolleges.edu/globalimpact.

## ANA Enterprise appoints new chief operating officer

On Jan. 3, **Gregory J. Dyson joined ANA Enterprise as its new chief operating officer.**

Dyson will serve on the Executive Leadership Team. He will provide strategic leadership and have responsibility for the operating activities to support the business entities, including oversight for information technology, human resources/organizational development, the office of general counsel and the Enterprise executive office.

Dyson is an accomplished senior executive who brings more than 20 years of progressively higher leadership and management responsibility, most recently as senior vice president and chief operating officer of ICMA Retirement Corporation, Washington, D.C., a $53 billion plan administrator and retirement services provider to state and municipal employers throughout the U.S. As COO of ICMA-RC, he was responsible for strategic plan development and leadership and oversight of corporate operations. Among his many accomplishments, he championed a multiyear, multimillion dollar investment to upgrade ICMA-RC's technology infrastructure and implemented an Enterprise Risk Management function.

Dyson earned a bachelor's degree at Ohio Wesleyan University, Delaware, Ohio and an MBA from The Darden School, University of Virginia in Charlottesville. In 2015, he received the National Leadership Award from the National Forum of Black Public Administrators.

PHOTO: WPA POOL / GETTY IMAGES

## Global nursing campaign launched with Duchess of Cambridge

**Feb. 27 marked the launch of Nursing Now, a three-year global campaign run in collaboration with the International Council of Nurses and the World Health Organization.** The Duchess of Cambridge, Kate Middleton, is the official patron of the effort and spoke at the launch.

Nursing Now aims to improve perceptions of nurses, enhance their influence and maximize their contributions to ensuring that everyone everywhere has access to health and health care. The campaign will run to the end of 2020 – the 200th anniversary of Florence Nightingale's birth and a year when nurses will be celebrated worldwide.

Middleton's interest in supporting the campaign stems both from the vital work she has seen front-line health care staff provide in other charity work and from the example of nurses in her family. Both her grandmother and great grandmother worked as volunteer nurses.

"You care for us from the earliest years, you look after us in our happiest and saddest times and for many, you look after us and our families at the end of our lives," Middleton said. She noted that in some places in the world, nurses are the only qualified health care professionals in their communities and that to keep pace with the rising global demand, an additional 9 million nurses would be needed by 2030.

Nursing Now has set the following goals to be achieved by the end of 2020.

1. Greater investment in improving education, professional development, standards, regulation and employment conditions for nurses.
2. Increased and improved dissemination of effective and innovative practice in nursing.
3. Greater influence for nurses and midwives on global and national health policy, as part of broader efforts to ensure health workforces are more involved in decision-making.
4. More nurses in leadership positions and more opportunities for development at all levels.
5. More evidence for policy and decision makers about: where nursing can have the greatest impact, what is stopping nurses from reaching their full potential and how to address these obstacles.

# How telehealth is changing nursing

## Telemedicine is changing the health care delivery landscape and the nurse's role in providing care.

**IN THIS SECTION,** we look at the emergence and evolution of telehealth and the many ways technology is being used to bring specialty care to underserved patients outside of major medical centers. We also bring you perspectives from CNA and the Nurses Service Organization about potential risks associated with telehealth and strategies to enhance clinical, operations and technical processes associated with telehealth. Finally, we share stories from nurses around the state who are using telemedicine to better serve patients through emergency department stroke care, lung cancer screenings, neurological exams at a distance, telepsychiatry and more.

**We hope you find this information useful and that you take advantage of the 1.0 CNE available based on the content here** (more details on page 18).

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# Nurses advancing telehealth services in the era of healthcare reform

*By Joelle T. Fathi, DNP, MN, BSN, RN, ANP-BC, Hannah E. Modin, MHA, B.A. and John D. Scott, MD, MSc, FIDS A*

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Limited health resources and providers in some American communities exacerbates health disparities (Williams, 2007). Progressive development and sophistication of communication and technology, coupled with demand for novel approaches to care, positions nurses to collaborate and address health disparities in these communities through deployment of telehealth technology. Telemedicine, meaning "healing at a distance" (Strehle & Shabde, 2006, p. 956), is increasingly viewed as a mechanism to deliver more efficient and patient-centered healthcare services to individuals who face barriers to access care.

Delivery of healthcare by means of Information and Communication Technology (ICT) sources is varied, and references to this are commonly used interchangeably. Terms used to describe these services, such as telemedicine, e-health, telehealth, and even mobile health, can be confusing until the construct and meaning of telemedicine is more clearly understood.

The Institute of Medicine (IOM) simply describes telemedicine as "...the use of electronic information and communications technologies to provide and support health care when distance separates the participants" (IOM, 1996, p. 1). Telehealth offers the opportunity to deliver care to a diverse array of underserved populations, including those in rural (National Conference of State Legislatures, 2016), urban, and suburban communities. Modalities and sophistication of telehealth technology have evolved over time, and uses of telehealth in the United States will likely continue to change with the demographics and healthcare needs of the country.

## Emergence of telehealth in America

**BEGINNING WITH** the invention of telephonic capability, the concepts and benefit of telemedicine were conceived in 1905 by a Dutch physiologist who utilized the telephone for transmission and monitoring of cardiac sounds and rhythms (Bashshur, Shannon, Krupinski, & Grigsby, 2013; Strehle & Shabde, 2006). The theoretical use of the television for delivery of bi-directional medical care first surfaced in 1924 on the cover of Radio News (IOM, 1996). This was represented in a novel depiction of a doctor, on the screen of a radio, assessing the health of a listener child, through the screen.

The 1940s brought transmission of radiography over telephone circuits between cities in Pennsylvania separated by 20 miles (Gershon-Cohen & Cooley, 1950). Given the potential need for healthcare delivery at a distance, as Americans began traveling to outer space, it was not surprising that the National Aeronautics and Space Administration (NASA) utilized some of the first closed circuit televisions for telemedicine (LeRouge & Garfield, 2013). Soon thereafter, Lockheed Missiles and Space Company and the Kaiser Foundation International partnered to pioneer a remote monitoring system (Gruessner, 2015), known as Space Technology Applied to Rural Papago Advanced Health Care, to provide care for the Papago Indian Reservation in Arizona (Cushing, 2015), a medically underserved rural area. While these first approaches were experimental, and not solely tested in the traditional medical setting, current advancements in technology now drive new opportunities for nurses to deploy telehealth technology in the future (Fong et al., 2011).

Today, patients may be a ferry or car ride away, or many miles from the nearest major medical center, critical access hospital, or primary care provider. All scenarios can result in healthcare delivery service gaps and barriers to access urgent or non-urgent healthcare; contributing to risk for disease and death. Video conferencing and other telehealth methods promote the opportunity to ensure timely care that is efficient, safe, and patient-centered. These outcomes cannot be accomplished without a cadre of nurses and other healthcare professionals.

Providers are increasingly looking to telehealth as a viable care delivery model for the future, and the adoption of certain telehealth technology and delivery of services is on the rise (HimSS Analytics, 2016). Concurrently, growth in technology and changes in consumer behavior are generating younger, technologically savvy patients, who represent diverse populations (Powell, Chen, & Thammachart, 2017). These patients demand efficient ambulatory care at the tap of a finger, driving advances in mobile health technology to provide health education and services via mobile devices (National Conference of State Legislatures, 2016). As one of the most widespread professionals with high level skills, nurses across America are called to action to determine how to leverage informatics and technology in the transformation of care delivery to improve the nation's health with high quality, cost efficient, and convenient care (Sensmeier, 2011).

## Modalities of telehealth services

**MORE RECENT** technologic advancements and wireless communications have catapulted telehealth services and the possibilities for nurses to participate in delivery of remote care (Fong et al., 2011; LeRouge & Garfield, 2013). Understanding the modalities and options for telehealth is important to determine precise means of implementation. Telehealth services are conducted in a variety of ways depending on the location of the patient

(end user), intended delivery of services, and various means for interaction with patients and healthcare providers (Fong et al., 2011). Direct and indirect telehealth services commonly deployed include synchronous, asynchronous, mobile health and ehealth, and remote monitoring. This section provides a brief overview of each of these services with select examples and literature support, and describes education of healthcare providers through Project ECHO (Extension for Community Healthcare Outcomes) and eConsult.

**Synchronous telehealth**

Synchronous telehealth communication is defined by a live, face-to-face interaction between a patient and healthcare professional or between healthcare professionals, in consultation, via audio-video conferencing. In this traditional healthcare setting, patients check in to a clinic in their area equipped with a video cart that allows for bi-directional interaction between the patient and healthcare provider and a camera with zoom capability (Ferguson, 2006; Verhoeven, Tanja-Dijkstra, Nijland, Eysenbach, & van Gemert-Pijnen, 2010). The cart may be equipped with Bluetooth enabled digital and peripheral equipment (e.g., stethoscope, otoscope, or ophthalmoscope with camera capability) to use for more sophisticated physical examination and evaluation (Fong et al., 2011). Synchronous visits are typically facilitated at the originating site (where the patient is located), commonly by a nurse trained as a telepresenter. The telepresenter uses the equipment to examine the patient for a provider offering healthcare services from a distant site (Wechsler, 2015). Synchronous visits enable assessment, diagnosis, and treatment in hospital or clinic settings, and facilitate nurse to patient education.

Critical access hospitals with limited resources can benefit from prompt, synchronous consultation by a neurologist, in the event a stroke is clinically suspected and timely treatment with thrombolysis is critical. Telestroke services are those wherein synchronous assessment of the patient by a neurologist occurs. Telestroke services have increased prompt access to specialized care with improved rates of evidence based care and interventions (Cutting, Conners, Lee, Song, & Prabhakaran, 2014).

Synchronous telehealth models improve convenience, access, and efficiency of care by offering walk-in telehealth services. Synchronous telehealth models improve convenience, access, and efficiency of care by offering walk-in telehealth services. One study (Neufeld & Case, 2013) compared the same services at walk-in telehealth clinics and scheduled, in-person mental health medication visits (staffed by nurse practitioners and medical doctors). The in-person clinics had noted significant no-show rates and incurred the expense of long distance travel by staff. This study demonstrated that the walk-in telehealth clinics provided significantly shorter wait times and more open access for initial and routine follow-up psychiatric visits, with more reliable utilization of the clinic time (Neufeld & Case, 2013).

Another area of success is continuity of care in the transition of chronically ill patients from hospital to home during an acute phase of illness, including synchronous visits with nurses upon discharge. In a mixed methods study (Day, Millner, & Johnson, 2016), patients received various devices for self-monitoring and video-conferencing. This study observed use of telehealth equipment by nurses to monitor self-care, coaching, and supervision of patients during an acute exacerbation of a chronic illness. In telehealth interactions with nurses and remote monitoring, patients became more involved in self-care; understood the time to report symptoms or a change in health (sooner rather than later); and reported a perceived mastery of their self-care. Competent and effective utilization of telehealth technology and equipment by nurses in provision of healthcare can positively impact patients (Day et al., 2016).

**Mobile health or eHealth**

Mobile health or eHealth is another example of synchronous telehealth wherein healthcare visits are initiated and conducted on patient personal computers and mobile devices or smart phones, from the patient's preferred location, instead of the traditional clinical setting. This form of synchronous consultation with healthcare providers, including nurse practitioners, is convenient for delivery of urgent care services and growing in popularity. Psychiatric care via a smartphone (telepsychiatry) highlights the benefits of healthcare delivery to high-risk patients in serious need of psychiatric services. The convenience of mobile healthcare breaks the barriers of transportation issues and need for caregiver accompaniment, and transcends symptoms and conditions like agoraphobia, factors which often isolate patients and prevent access to psychiatric care (Powell et al., 2017).

**Asynchronous telehealth**

Asynchronous telehealth communication represents contact that is not face-to-face, but in real time, by way of email, internet, text messaging (Verhoeven et al., 2010) or as 'store and forward' wherein information is sent and picked up or responded to at a later date. Most commonly supporting medical care in a non-urgent setting, this modality has been utilized for years in the radiology space where radiologic films are uploaded for review at a later date (Agrawal, Erickson, & Kahn, 2016). Another example of this utility is the assessment of dermatologic conditions by way

of uploaded digital photos or other patient data (Ferguson, 2006; Wade, Karnon, Elshaug, & Hiller, 2010).

**Remote telemonitoring**

Remote telemonitoring is a well-established means to monitor various conditions and associated data, including cardiac monitoring for those who suffer heart failure, or general monitoring of chronic diseases. In a study of over 3000 patients in the United Kingdom, researchers demonstrated that patients with diabetes mellitus, heart failure, or COPD had a nearly 50% reduction in one year mortality and 18% fewer hospitalizations when using a simple home monitoring device, compared to those who did not (Steventon et al., 2012).

An example of telemonitoring in the acute care setting is the recording of vital signs, continuous electrocardiogram tracing, and hemodynamic values in the Intensive Care Unit (Fuhrman & Lilly, 2015) and transmitting this clinical information to the teleICU. Critical care medicine experts then interpret the data in real time and assist the originating/remote site with clinical decision making. This type of monitoring is utilized in health systems to promote efficiency and quality (e.g., reduce waste, deliver evidence based standards of care) and decrease redundancy, such as costly positioning of equipment and professionals in community or critical access hospitals. In one study across 15 states that included 100,000 patients, researchers found that patients in the teleICU group had a 16% and 26% lower risk of hospital and ICU mortality, respectively (Lilly et al., 2014).

**Project ECHO and eConsults**

In contrast to the above programs, which provide direct consultations to patients, Project ECHO increases knowledge amongst primary care nurse practitioners, physician assistants, and primary care physicians through synchronous, audio-video conferencing for professional education from academic centers and specialists to primary care providers (PCP) in remote areas. This initiative, developed by Dr. Sanjeev Arora at the University of New Mexico School of Medicine, illustrates how technology can be used to train nurses at all practice levels in core specialty knowledge (Arora et al., 2007). Participants reported less professional isolation, greater job satisfaction, and more confidence in managing complex chronic diseases (e.g., hepatitis C; Arora et al., 2010). Through Project ECHO not only do patients receive expert assessment and care, but nurses can also receive bonus training in remote locations where educational resources may be limited.

eConsults are similar to Project ECHO in that the consultative exchanges are between PCPs and specialists. However, it differs in that consultations are asynchronous and not part of a larger conference. In this model, the PCP sends a professional consult request regarding a patient with a specialty problem, and, at a later date, the specialist returns expert information to the PCP (Davis et al., 2015). This is especially helpful to ensure timely care for patients who would otherwise have long wait times to see a specialist, or perhaps where it is impossible to see a specialist, depending on geographic location. In summary, both Project ECHO and eConsults help PCPs develop core specialty knowledge crucial to care delivery in the present and along the patient care continuum, and improve convenience and access to patients who require specialty care.

## Quality, means, and cost of healthcare delivery

**HEALTHCARE VALUE** has been defined as the health outcomes achieved, divided by each dollar spent (Porter, 2010). In the current era of value-based care, intentional design of high quality clinical care delivery models are targeted to achieve better patient outcomes. Provision of high-value care is a major priority for all stakeholders, including consumers who are patients; purchasers represented by employers and individuals; and healthcare systems as suppliers of healthcare. The IOM has identified the necessity and utility of technology to achieve better outcomes, stating "...information technology must play a central role in the redesign of the health care system if a substantial improvement in quality is to be achieved" (IOM, 2001, p. 16).

There are many conversations and mandates around delivering high quality care, but understanding what constitutes quality, and what is meant by 'high quality', is essential to making effective changes in care delivery. Nine years before the Patient Protection Affordable Care Act ([ACA], 2010) was passed, The Institute of Medicine and Committee on Quality of Health Care in America (IOM, 2001), outlined a roadmap that succinctly listed essential achievements and quality aims to strive for in order to improve the health of Americans. The recommended initiatives (pp. 39-40) described care that is:

1. Effective – ensuring that care delivered is evidence based with proven efficacy
2. Efficient – minimizing waste of resources (equipment, supplies, ideas, and energy)
3. Safe – prevention of harm or injury from the healthcare delivered
4. Timely – harmful delays in care delivery are avoided
5. Patient centered – patient's needs, preferences, and values are respected and upheld
6. Equitable – no variance in the quality of care delivered to all

In the current healthcare climate, and within healthcare organizations, significant attention is placed on these quality aims. The Agency for Healthcare Research and Quality (AHRQ) cites

the importance of these six domains of healthcare quality, and promotes the framework as a way for consumers to understand the meaning of quality (AHRQ, 2016). The American Hospital Association built the quality aims into its policy and advocacy agenda (American Hospital Association, 2017). If quality aims are actively integrated into direct clinical care, they possess the potential to greatly contribute to the timely delivery of safe and quality care, at good value, in a patient-centered way with the intent to mitigate health disparities, wherein all stakeholders win. Telehealth offers the opportunity to support achievement of quality aims, addressing barriers to care through innovative means and leveraging the proliferation of technology in an increasingly mobile-friendly and technology-centric population.

## Need for telehealth services

**WITH THE OVERARCHING GOAL** to meet healthcare demands of Americans, it is essential to understand who is in need, and could benefit from healthcare via telehealth. In 2017, the United States (U.S.) population is estimated at over 300 million, (Index Mundi, 2017b; U.S. Census Bureau, 2017) and is increasingly represented by minority populations and older adults (Index Mundi, 2017a). Diversity will continue to grow, with a projected minority population to exceed 50% of the total U.S. population by 2043 (La Veist, 2005; U.S. Census Bureau, 2017). More than ever healthcare providers will be required to offer culturally sensitive and patient centered care with consideration for ethnic, social, and cultural backgrounds. Concurrent with the surge in minority populations, the country is aging rapidly with 53.8 million current Medicare beneficiaries (National Committee to Preserve Social Security and Medicare, 2017). This number will continue to trend upward and likely demand development of innovative solutions for care, especially for patients with chronic conditions.

Changing national demographics and geographic dispersion of populations generates significant opportunities for telehealth technology. Occupying 3.8 million square miles, America is one of the largest countries in the world (Nationmaster, 2017), and 72% is categorized as rural territory (U.S. Department of Agriculture, 2017a). This percentage represents 42 million people in rural America (U.S. Department of Agriculture, n.d.) with considerably higher rates of unemployment and poverty compared to their urban counterparts, and with 25% of families (with children) in deep poverty (U.S. Department of Agriculture, 2017b).

Determinants of health, including level of education, socioeconomic status, and geographic isolation in relation to healthcare services, may keep many Americans at risk for suboptimal health outcomes (HealthyPeople.gov, 2017). With challenges to connect with healthcare resources, these populations, especially those in rural and medically underserved areas, remain at higher risk for health disparities and poorer health outcomes (Marmot & Wilkinson, 2006; Williams, 2007). Telehealth may offer a new opportunity to provide essential healthcare services to these underserved communities.

## Policy considerations

**GIVEN THE POTENTIAL** of telehealth, especially with rapidly developing ICT and established need for services, policy considerations are important to continue the evolution of quality, accessible services. Just as important is the need for nurses to become informed and support initiatives in telehealth in this era of health care reform. This section will discuss telehealth policy considerations such as the demand for providers; the role and contribution of nurses; challenges and feasibility of delivery and reimbursement; and future considerations.

### Policy impact on demand for providers

With the intent to create a healthier population, the ACA (2010) established provisions that incentivize patients to access primary care and preventive health services (Davis, Abrams, & Stremikis, 2011). Calling for the elimination of out-of-pocket costs for preventive services such as cancer screenings and annual wellness physicals, the legislation placed new pressures on an already stressed primary care network across the country. Coupled with increasing numbers of insured individuals, this has resulted in a greater demand for primary care providers (Heisler, 2013).

Many rural areas especially lack reasonable numbers of and appropriate ratios of health professionals (e.g., primary and dental care, mental health) to persons offer reliable access to safe and quality healthcare. Such areas are identified as Health Professional Shortage Areas (HPSAs) (Heisler, 2013). This shortage of healthcare professionals significantly determines access to healthcare, or lack thereof, and thus the health of communities. Professional isolation for healthcare providers in these remote HPSAs also poses a serious challenge. Telehealth provides a unique opportunity to address these shortages and effectively provide care to patients and support to providers, primarily nurses and doctors, in areas of provider and resource constraints. This shortage of primary care providers is well documented, and the deliberate inclusion of nurses as a solution is a natural conclusion to continued calls for innovation to meet health needs of all patients.

### Nurses as critical partners in telehealth services

Nurses are educationally and professionally prepared to provide a broad scope of skills and services across the continuum of healthcare (Bleich, 2011). The nursing workforce has doubled since 1980, and is now the largest contingency in the U.S. healthcare workforce (Committee on the Robert Wood Johnson Foundation Initiative, 2011) with 3.6 million registered nurses (McMenamin, 2016). This number includes 208,000 nurse practitioners, who are board certified to deliver specialty services and primary care (American Association of Nurse Practitioners, 2017) with a similar scope of practice as primary care physicians (Bleich, 2011).

There is an unending need for healthcare professionals, including nurses, to initiate appropriate and timely use of telehealth services to ensure Americans receive the care they need. Providers must collaborate to strengthen the infrastructure of clinical practice; delegate tasks to broaden the spectrum of caregivers; and develop care delivery pathways and models in telehealth to

address quality and reimbursement requirements. Collaborative practice is key to building effective healthcare teams (Joel, 2013); improving delivery and experience for patients via telehealth technology services; and optimizing efficiencies of healthcare.

Nurses are often the only consistent, frontline healthcare providers present in communities; critically positioning them to support all aspects of the telehealth continuum, with the greatest impact on patient care. As clinicians, educators, researchers, advocates of policy, and as transformational leaders, nurses need to practice at the fullest extent of their education and training in order to derive their professional potential for all involved. Nursing practice, at its full scope, must include continued reform to develop and deliver telehealth services.

## The intersection of telehealth and healthcare reform

THE 2009 American Recovery and Reinvestment Act included billions in funding to update healthcare IT systems, research, and facilities (LeRouge & Garfield, 2013). The National Broadband Plan, in 2010, identified and directed funds for further development and use of information technology by expanding the infrastructure for high speed internet access aiding in the establishment of telemedicine and remote monitoring (Federal Communications Commission, 2010; The White House: President Barack Obama, 2016). In 2010, the ACA became a driver of healthcare delivery and payment reform, and aspects of the legislation focused on improving care quality, value, transparency, and health information technology.

Telehealth is a means to achieve many aims of healthcare reform, particularly goals to improve value and deliver affordable care with high quality outcomes, while reversing rising healthcare costs (Rosenfeld, 2015). In the Accountable Care Organization (ACO) model, a product of the ACA, health systems are responsible for the care of a defined population, which requires seamless cooperation of multiple facilities and providers across the care continuum. The ACO model creates an ideal testing environment for novel models of care delivery like telemedicine, focused on better coordination and efficiency (National Advisory Committee on Rural Health and Human Services, 2015).

In the Centers for Medicare and Medicaid Services (CMS) Comprehensive Care for Joint Replacement (CCJR) program, hospitals are financially responsible for quality and cost of the entire care episode for Medicare beneficiaries receiving hip and knee replacements, including 90 days post discharge. As part of the CCJR program, CMS waived certain geographic reimbursement requirements for telehealth, encouraging the use of telehealth to care for patients during the episode of care, especially as they transition out of the hospital (CMS, 2017; mHealth Intelligence, 2016).

Now, value-based programs including the Medicare Access and Chip Reauthorization Act (MACRA), which will replace Meaningful Use in 2017, and the Delivery System Reform Incentive Payment Program, openly invite expansion of virtual services as a means to provide timely and cost-effective care (Becker's Health IT & CIO Review, 2016). The new payment tracks under MACRA will affect over 700,000 clinicians in 2017, including payments for nurse practitioners, clinical nurse specialists, and certified registered nurses (Advisory Board, 2017).

## Challenges and feasibility of delivery and reimbursement

INCREASINGLY, healthcare providers are driving innovation with intent to deliver care, promote wellness, and keep people healthier in new and cost effective ways, such as telehealth. However, there remain many evolving and unresolved challenges of telehealth, such as the determination of permissible practice environments; ethical considerations; licensing and credentialing; and interstate compact agreement statutes. Patient privacy and information security are other concerns. For example, telehealth provision must adhere to Health Insurance Portability and Accountability Act (Public Welfare, n.d.) requirements and always ensure patient privacy. This may require extra steps for providers (e.g., entering a business associate agreement) to ensure protection of patient health information (Center for Connected Heath Policy, 2017b). Services rendered electronically may be vulnerable to hackers and other security breaches, requiring the utilization of software encryption features and advanced protocols for security (Telehealth Resource Centers, 2017b).

Engaging in telehealth, in practice, also depends on identifying specific services that can be rendered; practical development and implementation; and determination of the feasibility of reimbursement. Reimbursement for telehealth services varies amongst Medicare, Medicaid, and private payers (Center for Connected Heath Policy, 2017a; Robert Wood Johnson Foundation, 2016). In 1997, Medicare was one of the first payers to acknowledge and promote reimbursement for telehealth services as part of the Balanced Budget Act (Telehealth Resource Centers, 2017a). However, Medicare has coverage restrictions for telehealth services, and traditionally only reimburses synchronous telehealth services for designated rural and underserved areas.

Expansion of reimbursement for other telehealth services has been slower amid concerns it will incentivize an increase in unnecessary utilization and drive Medicare expenses up (Galewitz, 2016). In 2000, The Benefits Improvement and Protection Act expanded Medicare coverage for telehealth, and today CMS only reimburses for a select number of services, and restricts payments to specific areas (Telehealth Resource Centers, 2017a). Although Medicare has covered some iteration of telehealth services for two decades (National Advisory Committee on Rural Health and Human Services, 2015), fewer than 1% of Medicare beneficiaries use it (Galewitz, 2016). Nurses have a critical opportunity to promote acceptance and adoption of telehealth services, advocate for nonrestrictive telehealth benefits, and educate patients on the care available through telehealth.

Medicaid reimbursement for telehealth is administered by respective states, and as of January 2016, 48 states provide some form of Medicaid reimbursement for live video telehealth services

with drastically fewer states providing Medicaid coverage for store-and-forward and remote monitoring (Center for Connected Heath Policy, 2015). Medicaid reimbursement for live video is more prevalent in most states, rather than reimbursement for store-and-forward and remote patient monitoring (Telehealth Resource Centers, 2017c).

Individual states are able to establish requirements for private payers, mandating coverage for telehealth services (National Conference of State Legislatures, 2016). As of 2016, 32 states had a private payer legislative policy in place (National Conference of State Legislatures, 2016). A study reviewing hospital adoption of telehealth (Adler-Milstein, Kvedar, Bates, 2017) found that uptake of telehealth is directly impacted by state policies on reimbursement and licensure. States with private payer reimbursement for telehealth, and particularly policies requiring payment parity, were associated with a greater number of hospitals choosing to adopt telehealth technologies (Adler-Milstein et al., 2017). Such policies drive reimbursement for telehealth services, including payment parity, where legislative policy require payers to reimburse at the same rate for the same services provided in person or via telehealth (Center for Connected Heath Policy, 2015). Payment parity encourages healthcare systems and providers to deliver telehealth services, and allows providers to make necessary investments in infrastructure to support new approaches in care delivery.

### Nurses as key contributors and informants

As noted previously, the 2010 landmark IOM report strongly recommended an increased role for nurses in the transformation of healthcare. This report outlined a future in which nurses work at the top of their license and training, achieve higher levels education through improved education systems, and work as partners with other healthcare professionals, including physicians. The report called for effective workforce planning and better data collection and information infrastructure (Bleich, 2011). Fostering essential interest and uptake of telehealth services by healthcare professionals, including nurses, demands integration of telehealth curriculum and practical training into academic programs (Ferguson, 2006). Such curriculum will enhance nurses' ability to demonstrate proficiency to conduct telehealth visits and advocate for such services through health policy.

The Josiah Macy Jr. Foundation (2016) published recommendations for the increased role of nurses in primary care. Given current stresses on the primary care system, new practice models that include nurses in critical roles are needed to meet demand and achieve the Institute for Healthcare Improvement (IHI) Triple Aim of improved patient experience, health of populations, and per capita cost of healthcare (IHI, 2016; Josiah Macy JR Foundation, 2016). An advanced role for nurses, and redesign of primary care practices, can provide an opportunity for nurses to participate and actively lead telehealth integration in the future.

As telehealth continues to move from theory to practice, legislation that ensures comparable reimbursement and favorable conditions for practice of telehealth services will be critical. This telehealth legislation remains a significant need in healthcare reform. Such health policy cannot occur unless healthcare providers partner with local government officials, and actively drive telehealth initiatives. Advocacy and awareness of critical legislation is also important, such as the Nurse Licensure Compact which allows nurses a multistate license to practice (National Council of State Boards of Nursing, 2017) Without this legislation, telehealth becomes an expensive venture requiring licensure in each state where telehealth care is delivered. As key informants on the front line of clinical healthcare, nurses should not underestimate the power of their individual and collective voices to advocate for changes to health policy in their practice states.

### The future for telehealth

In 2017, amid rising pressure of increasing health insurance costs, breakdowns in state health insurance marketplaces, and working to fulfill a campaign promise, Republicans introduced legislation to move towards repeal and replacement of the ACA. The House of Representatives voted to pass the American Health Care Act in May of 2017. The bill now moves to the Senate. For now, the ACA remains in place, but the long-term future of this legislation remains unknown. The extent to which the law will be modified or overhauled, and how healthcare coverage will be financed in the future, remains a highly polarized, partisan issue.

Meanwhile, advancements in telehealth policy continue to emerge. In spring 2017, a bipartisan bill was introduced to the U.S. Senate to expand Medicare coverage of telehealth services. The bill is aimed at increasing access for rural patients, however, opponents raise concerns regarding the potential for increased utilization, leading to greater overall Medicare costs (Arndt, 2017). Akin to the fate of healthcare reform, the future of the bill is yet to be determined in the politically charged and polarized environment of Washington DC.

## Conclusion

Telehealth policy aligns with current reform efforts that increasingly focus on healthcare value... It is certain that we need to meet care demands for our patients and raise the bar in delivery of quality and effective healthcare to the nation. Telehealth policy aligns with current reform efforts that increasingly focus on healthcare value, a deviation from the traditional fee-for-service model that incentivizes volume of services rendered. Videoconferencing and other ICT advancements aid in moving toward a value-based future, and thus in achieving the IHI Triple Aim of better health, and better care, at lower costs (IHI, 2016).

Healthcare reform is an ongoing process. As the market continues to expand, nurses can and will be excellent champions for telehealth. It is essential for nurses to undertake the critical advocacy task of identifying an opening opportunities to reach patients in the communities they reside through telehealth. In doing so, nurses will close healthcare delivery gaps and reduce health disparities by stepping forward and utilizing the breadth of their skills to adapt, adopt, and implement telehealth resources and services as commonly accepted, mainstream methods of care delivery. ■

## ERRATA NOTICE

The number of nurses reported in this article at 2.6 is incorrect. The correct number is 3.6 million as cited in the document, ANA's Nurses by the Numbers (McMenamin, 2016). This article was amended on August 16, 2017 to include the correct number and citation. The sentence referring to 220,000 advanced practice nurses was also amended to read 208,000 nurse practitioners who are board certified to deliver primary care to more accurately reflect nurse practitioners as a category of advanced practice registered nurses.

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## Action in the legislature

Two telemedicine bills of note passed this legislative session.

**Telemedicine Collaborative**
SB 6163 extends the duration of the Collaborative for the Advancement of Telemedicine to Dec. 31, 2021, with a final policy report due to the legislature on Dec. 1, 2021.

**Telemedicine Payment Parity**
SSB 6399 directs the Collaborative for the Advancement of Telemedicine to review the concept of telemedicine payment parity and develop recommendations on reimbursing for telemedicine at the same rate as if a provider provided services in person for certain treatments and conditions. The Collaborative is also charged with designing a training program to teach health care professionals about telemedicine and proper billing.

Read more about these bills in our Legislative Session Report, on page 62.

## Telehealth initiatives and resources

The Washington State Telemedicine Collaborative is comprised of members who represent stakeholder groups who have interest and experience in the development and implementation of safe and responsible telehealth technology and services that advance and extend telehealth in Washington state, including through the means of health policy. To learn more about the goals and mission of the Collaborative you may visit: wsha.org/policy-advocacy/issues/telemedicine/washington-state-telemedicine-collaborative.

The American Nurses Association (ANA), Department of Health Policy, recently convened a Connected Health/Telehealth Professional Issues Panel. This steering committee is comprised of 15 nurses from across the nation with telehealth practice experience and varied backgrounds including business, informatics, law and leadership. This steering committee is tasked with updating the ANA's 12 Core Principles on Telehealth. This work is in close partnership with the Telehealth Advisory Committee (nurses) through online discussions, research, and direct feedback as the Principles are updated with a target completion by autumn 2018.

### NATIONAL TELEHEALTH RESOURCES

**The Center for Connected Health Policy**
cchpca.org

**American Telemedicine Association**
americantelemed.org

**Telehealth Resource Centers**
telehealthresourcecenter.org

## Free continuing education hour available

1.0 CNE credit

Because of the wealth of information provided in the telehealth section of this issue of The Washington Nurse, you can earn 1.0 CNE contact hour.

To receive your CNE contact hour, complete this test and submit your answers at https://wsna.to/WANurseSpring2018. Use code '1908' to access the online test.

**Limited health resources and health care providers in some American communities exacerbates health disparities:**

A: True
B: False

**Choose the factor(s) that contribute to acceptance of telehealth services as a viable care delivery model:**

A: Technologically savvy patients
B: Growth in technology
C: Changes in consumer behavior
D: Adoption of telehealth technology
E: All of the above

**Telemedicine, meaning "healing at a distance", is increasingly viewed as a mechanism to deliver more efficient and patient-centered health care services to individuals who face barriers to access care:**

A: True
B: False

**Choose the telehealth communication method(s) that represent a live, face-to-face interaction between a patient and health care professional:**

A: Telephonic
B: Synchronous
C: Asynchronous
D: Mobile health
E: B and D

**Project ECHO, a synchronous consultative exchange of knowledge from academic centers to remote areas, may occur between:**

A: A nurse practitioner and specialist
B: A primary care physician and specialist
C: A physician assistant and specialist
D: A and C
E: A, B and C

**Nurses are educationally and professionally prepared to provide a broad scope of skill and services across the continuum of health care:**

A: True
B: False

**Choose the current challenges facing telehealth:**

A: Determination of permissible practice environments
B: Licensing and credentialing
C: Capable camera equipment
D: Interstate compact agreement statutes
E: A, B and D

**Nurses have an opportunity to promote acceptance and adoption of telehealth services, advocate for nonrestrictive telehealth benefits and educate patients on the care available through telehealth:**

A: True
B: False

**Choose the entity who administers Medicaid reimbursement for telehealth services:**

A: Respective state
B: Health care system
C: Patients
D: Senators
E: Government

**Health care policy is a critical driver in the advancement and adoption of telehealth:**

A: True
B: False

# Nurse "telepresenters" provide efficient care with a human touch

***By Kathleen Cuff Daman, MN, BSN, RN***
*Telehealth Clinical program manager, Swedish Medical Group*

Kathleen Cuff Daman

It feels as if there are daily changes occurring in the health care world. With the onslaught of medical insurance challenges, soaring health care costs and subsequent belt tightening, health care is charged with finding ways to save while providing the same high-level of care.

Despite these shifts, nurses are tasked with providing the same high level of care with fewer resources and are often the human touch point for our patients, which is why the introduction of technology into health care is seen as both a blessing and a curse. Technology allows us to provide better monitoring and oversight, but potentially decreases the human touch and personal care that patients desire and need. As health care evolves, Telemedicine relies on nursing to deliver safe, quick and efficient care while ensuring that the patients know they are the No. 1 priority.

One particularly successful program developed at the facility in which I work, is the TeleLung Cancer Screening program. This program was developed to provide access to a nationally and internationally renowned Lung Cancer screening program to a geographically remote area in Washington state, Port Angeles on the Olympic Peninsula. The program follows the rigorous U.S. Preventative Services Task Force (USPSTF) guidelines for lung cancer screenings and through Telehealth provides excellent service to this remote locale. Both sides of the camera are supported by nurses, both the DNP in Seattle and the BSN in Port Angeles. A collaborative approach to providing high-quality and personalized care to this population has been well received by the patients and is a source of pride for all involved.

On the patient side, nurses "present" the patient to the provider, utilizing the "Telepresenter" term. The role of Telepresenter was initially developed over 20 years ago as a mechanism to assist the provider in evaluating or "presenting" the patient in those areas of the country where physician resources were stretched or nonexistent and the patient population was spread across a large geographical area. Coupling technology with this role allowed the patient to stay locally (particularly important when travel conditions were impacted by weather, etc.) while receiving the care that they needed from their provider.

Training nurses to the role of Telepresenting includes clinical and technical workflows along with specifics about examination needs. Where the nurse Telepresenter is involved is on the patient side, the Telepresenter educates the patient to the technology, HIPAA compliance and encryption mechanism. During the consult, the Telepresenter ensures the provider is introduced and aware of all in the patient's room and then assists the provider in any requested assessments, using any peripheral technology as indicated.

Feedback from staff in facilities that have adopted telemedicine and the role of Telepresenter has been overwhelming positive as they readily see benefit to their community and their practice. Staff appreciate working with providers who are well versed in the technology and collaborative in working with the nurses, assuring an efficient process for patient evaluations and/or admissions.

The role of nursing within Telemedicine is compatible and completely sup-

PHOTO: COURTESY OF KATHLEEN CUFF DAMAN

ports our patient-centered care model. Delivering high-quality health care where it is not currently available, whether due to geographical obstacles, finances, lack of specialized providers or transportation barriers, via Telemedicine enables health care providers to improve patient outcomes. With the support of the American Academy of Ambulatory Care Nursing (AAACN) and the American Nurses Association (ANA), nursing has the capability to change the landscape through supporting varying modes of care delivery with technology assistance. I would challenge the nursing practice to be open to new modes of delivery, with our continued focus of patient-centered care and advocacy.

Comments below from Telepresenters working with hospitalists in a southwest Washington hospital provide examples of how Telemedicine is perceived and accepted. ■

**"When you wake up an on-call doctor in the middle of the night you may get some backlash. But the [tele] hospitalists are great... you know they are there and awake."** — Janiece Zauner, MSN, NP

**"The TeleHospitalist vs. at night home doc has been great since starting it here at MGH. I am able to reach the doctor in a timelier manner. The doctor can beam in and re-evaluate a situation at any given notice. I feel like I have more back up. It has been great."** — Laura B.-RN MSP

**"I love Dr. C. I had a patient that was not doing so well overnight. I spoke with Dr. C., she listened to me. Orders changed to fit the situation, and when results were back she listened. Dr. C. had the patient transferred to a higher level of care quickly in the middle of the night. Before the TeleHospitalist this situation would have taken three to four times longer waiting for the hospitalist to come in from home. I feel our patients have definitely benefited from this service."** — Barb P.-RN ICU

**"When describing how the TeleHospitalist system works to our patients prior to the admission exam, I sometimes get the odd look from the elderly patients. 'What do you mean the doctor is not here?' After demonstrating the equipment that will be used, they now seem more intrigued about what is going to happen. Many times during the exam with the doctor or at least after the exam many have said 'this is so cool, I can't wait to tell the grandkids I actually talked to a doctor over the computer and they were so nice'."** — Nathan P-RN House Supervisor


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# Bringing subspecialists to rural patients via telehealth

*By Ninette D. Swanson, BSN, RN*

Ninette Swanson

Living on the North Olympic Peninsula has many benefits: gorgeous mountain and water views, a very temperate climate and many ways to promote healthy living.

Easy access to sub-specialized health care is not one of those benefits. The North Olympic Peninsula is rural with a medium-size rural hospital and two Critical Access Hospitals, which are unable to employ subspecialists and offer all the specialties typically available in urban areas. The trip back and forth to Seattle for medical appointments is a full-day commitment.

This area also has a significant percentage of Medicare and Medicaid-eligible citizens with limited incomes and access to transportation. Patients requiring disease-specific specialists often need to travel three hours each way to the metropolitan areas of Seattle to receive care.

Through the Telehealth program offered by Olympic Medical Physicians in partnership with Swedish Health Services, patients get access to the Swedish Movement Disorders Clinic as well as the Swedish Lung Cancer Screening/Thoracic Surgery Clinic. Telehealth visits are scheduled for one day each week, alternating between TeleMovement (neurology visit for Parkinson's disease and essential tremor) and TeleLung (lung cancer screening and perioperative thoracic surgery) visits.

Telehealth presenting is the sparkle to my work week. It gives me the opportunity to use my assessment skills and work closely with the patient and family to ensure a meaningful provider visit. When I am not working with Telehealth, I am an office nurse triaging patient concerns, refilling medications and performing simple procedures like injections and changing urinary catheters.

To prepare for this role, I spent a day shadowing each Swedish Telehealth provider face to face in Seattle so that I could synchronize my assessment skills to match what they would find, as if my hands were theirs. I am using skills that would have remained dormant in my regular job duties.

For Telehealth, I am using a cart containing a computer, monitor, remote microphone and web camera as well as accessories to be used during the exam. These accessories include an exam camera with several lenses and a Bluetooth-enabled stethoscope.

For the TeleMovement visits, I use the exam camera to allow the remote provider to assess patient's gait and balance. The rest of the neuromuscular assessment involves me being the hands of the remote provider, evaluating the patient's tone, fine and gross motor skills.

For TeleLung visits, the Bluetooth-enabled stethoscope is used for cardiac and pulmonary assessment. The remote provider

PHOTO: SELINA PEIKERT SHEARER

wears a similar stethoscope and is able to hear heart and breath sounds as if the patient were in his office. The camera is used to visualize eyes, mouth, hands, feet and incision lines (for the postoperative patients.) The technology enhances the amount of information the remote provider can obtain about the patient's clinical condition.

One patient stands out from all of the visits: RP, a 45-year-old male who lives 30 minutes from our clinic, was seen through the TeleLung program after his second spontaneous pneumothorax due to severe emphysema. He was still smoking and was told that if he wanted surgery to help his condition, he needed to quit. His first visit was to initiate a smoking cessation program and evaluate his status after his hospital stay. His second visit was 10 days after lung volume reduction surgery. He had been smoke free for two months and tolerated surgery well. It is unlikely that he would have survived without the services provided through Telehealth as he was unable to access the specialized services and frequent follow-up visits that would have been needed if they were in Seattle.

Postoperative visits after thoracic surgery, such as hiatal hernia repair or lobectomy, via Telehealth have significant value for the well-being of the patients. These patients are usually weaker and unable to tolerate six hours of travel time for a 15-minute physician visit in the office.

Most patients seen in our clinic live less than 30 minutes away. They be seen by the remote provider, assessed, have next steps planned as part of the Telehealth visit, and are home again within two hours. Patients can be seen more frequently if needed as the hurdles of travel time and costs to receive care are much smaller.

For patients with advanced Parkinson's disease, being dependent on others for transportation, requiring assistance to ambulate and often having cognitive changes, the Telehealth visit addresses those challenges by making the provider available in a quiet, relaxed setting. As one TeleMovement patient said to me recently after his first Telehealth visit, "I received a more comprehensive visit via Telehealth than I would have if I traveled all the way to Seattle and met with the doctor face to face."

Presenting myself confidently to the patient and family eases anxiety and encourages a positive Telehealth experience. I am pleased that Telehealth has become part of my skill set and that I can help provide this important service for patients who might find it difficult, even impossible, to receive that kind of care. ■

ED staff work with telestroke neurologist to perform a NIHSS during a "code stroke."

# Telehealth gives busy ED a partner in acute stroke care

*By Mary Linares BSN, RN, ED and Lisa Shumaker BSN, RN, SCRN Stroke Program Coordinator nurse*

Mary Linares

Lisa Shumaker

Providence Regional Medical Center in Everett is a 530-bed regional referral center with Level II trauma designation located in Snohomish County. We have a very busy Emergency Department seeing 250-275 patients per day, or approximately 90,000 patients annually. Our Code Stroke process started in 2010, and we have had more stroke alerts every year. In 2017, we activated 600 "code strokes" in ED and about 10 percent occurred in inpatient areas. Of the patients with acute stroke activations, 20 percent are cared for by Telehealth consultation. Neuro-hospitalists work 12 hours, from 7 a.m. to 7 p.m., and respond to all areas for stroke alerts. From 7 p.m. to 7 a.m., we use Telestroke with neurologists from the Swedish Medical Group Inpatient Neurology Team.

The American Stroke Association recommends that care be instituted rapidly and that protocols improve the care of stroke patients. We have stroke algorithms for the Emergency Department and Inpatient areas for both day and night shifts and treated 700 patients with a stroke in 2017.

With a Telestroke neurologist consulting via audio-video conferencing technology, the Emergency Department has a partner in the care of acute stroke patients. Via Telestroke that neurologist can examine the patient, speak to staff and family, recommend treatments, view imaging scans, write orders and assist the staff in providing care. The care that is needed quickly is lifesaving IV Alteplase and/or clot retrieval. The world of stroke care expanded in the past year with the results of two trials that showed clot retrieval can be done in carefully selected stroke patients in a greatly expanded timeframe, which is up to 24 hours after symptom onset.

For the RN, the skills involved with Telestroke are very similar to when neurology is on-site. However, Telestroke requires certain technical and troubleshooting skills. For the patient to receive the best care, the monitor setup must be optimal. RN education is provided in the use of the technology and assisting the provider with remote neuro exams.

It is also very important to be well versed in the NIH Stroke Scale. One must be very comfortable with the NIHSS and do it well in order to best assist the remote neurologist in their examination

PHOTO: WENDY FAGAN PRMCE MEDIA

of the patient. A critical care RN responds to each code stroke and this RN usually performs the NIHSS scoring. In the interest of time, the Telestroke patients have a completed computerized tomography (CT) scan prior to the neurologist's examination. During the day, on-site neurologists triage some code strokes. ED will always defer to their judgment. With code strokes at night, we utilize the on-call Telestroke neurologist and run a code stroke over the Telestroke cart. Nurses need to rely on their strong neuro assessment skills and be comfortable with patient advocacy to be effective in the Telestroke environment.

The following vignette, told by Mary Linares, ED RN, demonstrates the high quality, expert care that the team is able to deliver quickly with the help of Telestroke:

> ED receives a medic call of a possible code stroke. EMS reports new dysarthria, aphasia, dizziness, vomiting and ataxia. Patient's last seen normal was tonight at 23:00. An internal ED Code Stroke is called. Patient arrives at 23:20. The medics with the patient are met in the stroke alcove, right at the ambulance bay doors. Here, an ED MD quickly evaluates the patient's deficits, history and risk factors. Simultaneously, the ED RNs enter stroke orders, obtain venous access and draw labs, which are handed over to the ED lab tech for immediate processing. These labs include an iStat creatinine, which takes just a few minutes to result. The ED MD decides to proceed with the code stroke. The patient is stable and so proceeds directly to CT with two RNs via the EMS gurney. This entire process takes less than five minutes.
>
> While the patient is on the CT table receiving their non-contrast head CT, the lab calls to report that the creatinine is WNL, so a CT Angiogram head is also ordered and performed immediately after the non-contrast study. During this time, the ED pharmacist is checking in with the team to discuss the likelihood of giving TPA. At the same time, the ED technician is setting up the Telestroke monitor in the patient's room.
>
> When the imaging is complete and the patient moves to their ED room, the ED MD is already there and the Telestroke monitor is set up so that the remote neurologist has the fullest view possible of the patient's bed. The ED MD and the neurologist have already spoken by phone. Now the neurologist performs a full NIHSS of this patient, with assistance from the on-site staff. The NIHSS is 6. There are no contraindications to TPA, so it is ordered. Pharmacy delivers the bolus and infusion within 10 minutes, and the TPA is started. The patient's time in ED is just 49 minutes.
>
> Meanwhile, the CTA head shows a retrievable clot. This same neurologist seeing the patient via Telestroke viewed scans and recommends clot retrieval. Serial NIHSS scores improve from 6 to 4 prior to clot retrieval.

Telestroke providers working with on-site providers and nurses complete a team that provides high quality, expert stroke care no matter what time of day or night an emergency occurs. Our staff are familiar with stroke symptoms are able to call for consultation, making Telestroke very valuable for patient care. ■

# Telehealth camera eliminates distance between patient and physician

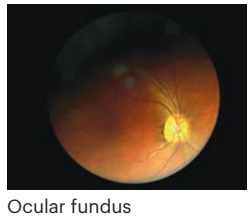
*By Un Jeoung Back, BSN, CCRN*

Un Jeoung Back

As many of us do, I wear multiple hats in my job. I am a hospital nursing supervisor, IV nurse, house float PRN nurse, transporter and Telehealth nurse. I am a proud nurse working at Swedish Hospital, Issaquah Campus.

We do not yet have enough of a patient population to necessitate a neurologist or psychiatrist 24/7. However, with Telehealth, it is as if we have those specialists a button click away.

As a nurse, I am a big part of the Telehealth service. For example, this becomes evident with Teleneuro, where my role starts before the consultation begins by explaining and preparing the patient and the family for the session. During the session, I become the hands of the neurologist by helping with neurological assessment as needed, including NIHSS and taking fundus oculi pictures. With Telehealth service, we can utilize different lenses to take various pictures, such as the ocular fundus, which not only allow the consulting neurologist to see it instantly, but also allows us to upload the picture to the patient's electronic chart.



Ocular fundus

The most rewarding experience I had with Telehealth was utilizing Telestroke. With an acute stroke case, the narrow window in which a patient can receive a thrombolytic is usually three hours from the last known normal time. By the time a patient is brought in to the emergency department, some of that precious time is already spent and the window gets even narrower. Therefore, the ability to establish an instant connection between the physician, patient, family and care team maximizes the chances for a satisfactory outcome.

Unlike Skype, Telehealth provides encrypted images with a secure two-way, online system for patient privacy. It has a built-in camera, which can zoom in so close that the physician is able to see the patient's pupil reaction to light. The enhanced speaker/microphone, along with the screen, allows the Telehealth session atmosphere to be as if the patient and physician are present in the same room in that moment. In addition to Teleneuro and Telestroke consultation, we frequently utilize telemedicine for Telepsych and Telesocialwork consultation. Therefore, as you can imagine, the use of Telehealth is infinite. Without a doubt, it will be a big part of our future global health system and I am very proud to be a Telehealth caregiver. ■

# Expanding access to mental health care through telemental health

*By Cara Towle, MSN, MA, RN*

Cara Towle

Nurses are ideally positioned to take on many different functions in telemental health and integrated care and play an important role in providing and increasing access to mental health care even — and sometimes especially — in remote and underserved areas of our region. Nurses are an increasingly essential part of the telemental health team at the University of Washington.

The Psychiatry Consultation and Telepsychiatry (PCAT) program partners with community hospital-based doctors, nurses and social workers to provide inpatient, "hospital-to-hospital" telepsychiatry services. UW psychiatrists provide "curbside" (provider-to-provider advice) consultation, as well as more formal consultations using real-time, interactive video interviews with patients who are admitted to a med-surg hospital bed but who are in need of mental health services, or for evaluation of "single bed certification" patients. UW psychiatrists find that nurses are vital to the success of this program, especially with detained patients. In many instances, it is actually more important to get input from the nurse than from the patient: nurses often have the most patient care contact and can share keen observations that help inform the consulting psychiatrist. Moreover, the safety of the patient and the safety of the staff are priorities for the hospital, and a quick huddle that includes psychiatry and nursing is an effective way to address these issues.

The UW Psychiatry and Addictions Case Consultation series (UW PACC) is a weekly CME-accredited telehealth program designed to develop a regional peer learning and support network for treating mental health and addictions, ultimately leading to better patient care. Using interactive video, UW faculty offer a short didactic presentation, followed by highly interactive clinical case discussions with PACC participants from locations throughout Washington. Several of the key PACC participants are nurses and ARNPs in primary care settings caring for patients experiencing complex mental health issues, and they generously contribute to this case-based learning format. Not surprisingly, they also frequently impart valuable insights about patient care, especially in rural and remote locations, and often share information about regional resources.

Finally, PCAT and the UW AIMS Center are beginning to combine expertise in Collaborative Care and telepsychiatry in order to provide access to better mental health care for more remote and underserved populations. Collaborative Care is a model of integrated behavioral health care that enhances "usual" primary care by adding two key services: care management support for patients receiving behavioral health treatment and regular psychiatric inter-specialty consultation to the primary care team. In some cases, such as in the UW Neighborhood Clinics and at some Community Health Centers, telepsychiatry complements the Collaborative Care model, allowing for the distant psychiatrist to interact directly with the patient when needed. Nurses serve a key liaison role, helping to identify patients who could benefit from a telepsychiatry visit, managing the patient through the telepsychiatry process and telepresenting. Another example of Collaborative Care + Telepsychiatry is an innovative new project in a frontier area of the WWAMI (Washington-Wyoming-Alaska-Montana-Idaho) region where resources are extremely scarce. The model uses a centrally-based specialty team comprised of a psychiatrist consultant as well as a central care manager and LCSW, both of whom work closely with nurses at the patient site to co-manage patients using telepsychiatry. Nurses are crucial to this model. Based at the patient site, nurses provide services in person with the patient and maintain a continuous relationship with the patient, as well as a collaborative, integrated relationship with the distant psychiatrist and care manager/LCSW. ■

## Opportunities for further training

The Healthier Washington Practice Transformation Support Hub, University of Washington AIMS Center and partners are hosting an **'Integrated Care and the Expanding Role of Nurses'** training workshop in Spokane, May 22, 2018. This free, one-day training is designed to help current nurse care managers in integrated care settings or those interested in this role learn key tools, principles, evidence and skills for supporting whole-person care. Continuing Nursing Education credits available to eligible providers.

For more details: waportal.org/integrated-care-and-expanding-role-nurses-training-workshop-0.

Twelve psychiatric ARNPs will join the inaugural year of the **Community-Based Integrated Care Fellowship** commencing March 2018. This yearlong program is designed for psychiatric providers seeking additional training to deliver integrated care in community-based settings and includes focused work on telepsychiatry. Modeled after employed MBA programs, the fellowship is structured as an employment-friendly program with flexible scheduling, including a self-paced distance learning component and quarterly in-person specialized skills work sessions. Tuition is free for Washington state providers. Applications will be accepted for the second cohort of this program starting in early summer.

For more details: ictp.uw.edu/programs/community-based-integrated-care-fellowship.

### Additional resources

- UW Psychiatry and Addictions Case Conference (UW PACC): ictp.uw.edu/programs/uw-pacc
  We invite and encourage participation in UW PACC, offered at no cost to participants.
- UW Psychiatry Consultation and Telepsychiatry program: wsna.to/UWtelepsychiatry
- UW AIMS Center: aims.uw.edu

# Telestroke means better outcomes for Skagit Valley patients

***By Jessica Bell, MSN, RN, CEN, ACNS-BC***
*Director, Emergency Services, Skagit Valley Hospital*

Jessica Bell

A 75-year-old longtime local resident was helping with a remodeling project in a Mount Vernon church last year when suddenly he couldn't move his right side or utter a sound. Luckily, the church's pastor was nearby and immediately called 911. With that call, this man was rushed to Skagit Valley Hospital in Mount Vernon, where staff had been alerted to his condition by emergency medical personnel in the field and were ready to care for him. He was quickly greeted by the ER stroke team and moved to the CT suite to make sure his brain did not show any signs of bleeding. Satisfied there was none, the ER team consulted with their telehealth partners at Swedish Neuroscience Institute in Seattle, administered brain-saving medication and transferred this man to Seattle where a clot blocking blood flow to a large part of his brain was removed. A week later he was home, walking and back to his life.

The RN face of this program is Lisa Rodgers-Potter. She is an ED CNS who works to ensure the hospital stroke program is second to none. A nurse for more than 30 years, Lisa works with stroke patients and the nursing staff who care for them both in the ED and in Skagit Valley Hospital. Rodgers-Potter moves quickly between the nurses and doctors taking care of a patient with stroke symptoms, reminding them of the best placement for an IV, urging them get to CT quickly and ensuring the correct blood tubes are drawn. She works with nurses and local EMS crews to ensure that patients are receiving expert nursing care, all the while making sure that the patient and their family are included in the conversation.

Skagit Valley Hospital has been part of a telehealth stroke program since 2012, when Swedish Neuroscience Institute partnered with the Mount Vernon hospital, making it one of the first partnerships for telemedicine outside of the Swedish system. Patients with recent stroke symptoms trigger a well-oiled system that includes a quick trip to CT, labs and a physician exam. Once a stroke is identified, a neurologist at Swedish is contacted, either by video or by phone to review the case and make a decision on whether to give tPA, a medication that helps to dissolve clots. This whole process, from the time a patient comes in the ER door until the medication is started, can take as little as 35 minutes. "Our goal is to give the medication in less than 45 minutes," Rodgers-Potter said. At that point, consultation with neurology determines whether the patient is admitted at Skagit Valley Hospital or takes a trip to Swedish Medical Center in Seattle for more definitive care, including possible retrieval of a clot.

Patients who are admitted at Skagit Valley Hospital are closely followed by Rodgers-Potter, Skagit Regional Health neurologists and hospitalists and by nursing staff in the inpatient units. Having the telemedicine relationship has allowed state-of-the-art care, including clot retrieval, within a short time frame. It means that appropriate patients go to Seattle and that more patients can stay in their own community, close to family and friends, while receiving excellent care. Not every patient is appropriate for tPA and Skagit Valley Hospital admits more than 200 people each year with stroke symptoms. Being part of a regional system of care improves outcomes for every patient and provides a resource for the community, from the EMS and the ER to outpatient rehab and a support group for families and caregivers.

From left to right: Morgan Hendricks, ED Charge RN, Lisa Rodgers-Potter, Stroke Coordinator and ED CNS, Kyle Allenbrand, ED tech, Amy Richards, ED Charge RN, Marlene Coello, RN, Wendy Graignic, RN and Lauralee Riske, RN.

Quality for the program is carefully measured, with each patient's trip through the hospital carefully followed while they are here and after they leave. Once a month, stroke cases that were part of the telehealth program, are reviewed by Skagit Regional Health neurologists and RNs and their counterparts at Swedish. The telestroke equipment is used so that meetings are in real time and in a conversational tone that builds relationships, making it easy to pick up the phone whenever a question arises. Building these relationships widens the safety net for the region's patients and the resources for hospital employees.

Meanwhile, just four days after his stroke, our 75-year-old patient was able to go home, regaining his strength and dexterity a little bit every day. ■

From left to right: Kevin O'Brien, MD, FAHA, Jennifer Beckman, MSN, ARNP, CHFN, Alice Chang, MSW and Darla Fagan, MSN, RN.

# Project ECHO connects community providers with heart failure experts

*By Susan Pambianco, ARNP*

Susan Pambianco

The Northwest Heart Failure Collaborative (NWHFC): Project ECHO is a bimonthly telehealth education series for health care professionals and students in the WWAMI region (Washington, Wyoming, Alaska, Montana and Idaho). The goal of the series is to elevate heart failure care in rural and medically underserved regions by providing accessible education on evidence-based practices. The "hub-and-spoke" format connects community providers with advanced heart failure experts and is based on the Project ECHO education and clinical care model (Extension for Community Healthcare Outcomes) developed at the University of New Mexico. Our heart failure Project ECHO is unique in that it is hosted by an interprofessional panel of clinicians (MD, ARNP, MSW, PharmD, etc.) As an advanced practice nurse, my role on the panel is to contribute my professional expertise and philosophy of care.

The NWHFC launched in May 2016 and has held 40 webinars to date. Over 70 percent of registered participants have identified themselves as nurses, advanced practice nurses or nursing students. Practice sites of participants have spanned from community clinics and regional hospitals in the rural settings of Montana, Washington, Idaho and Alaska to large clinic systems and academic institutions in urban settings. Feedback from annual surveys have been positive, with the majority of respondents noting the webinar series has provided them with knowledge that they have been able to apply to their practice, reduced their professional isolation and has improved professional satisfaction. Nearly 95 percent of survey respondents said they would recommend the NWHFC to a colleague.

The webinars have also been a useful tool when precepting students. The archive of webinars is available online, and students can view them in preparation for and throughout their clinical rotation. Feedback from students on this new resource has been overwhelmingly positive. Often, the webinar will highlight a patient case which prompts discussion amongst the webinar attendees. Recently, we had a case presentation on a patient with Takotsubo cardiomyopathy. Although this is a rare etiology of heart failure, it was interesting to discuss the distinguishing features that are important to consider when evaluating patients with chest pain and new heart failure symptoms. Overall, the NWHFC experience has served to enhance education for community providers, students and health care workers in multiple disciplines. ■

Find the archive of Project ECHO webinars at NWHFC.org.

# **TELEMEDICINE:** RISK MANAGEMENT ISSUES, STRATEGIES AND RESOURCES

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Telemedicine is the practice of electronically connecting geographically discrete health care facilities and providers. It encompasses numerous methods and technologies, ranging from traditional store-and-forward data applications, commonly utilized in diagnostic review and interactive exams, to innovative "telepresent" methods, including robotic surgery and emergency services consultations. Among other uses, telemedicine applications permit:

- **Patients/clients in underserved rural areas** to enjoy improved access to quality care, and state-of-the-art settings.
- **Practitioner networks** to collaborate via shared electronic medical records, digital imagery and data files.
- **Specialty providers** to communicate with (or "tele-assist") primary care practitioners in diagnostic tasks, leading to enhanced outcomes, shorter treatment periods, decreased use of unnecessary drugs and reduced costs.
- **Emergency department personnel** to video-link with trauma specialists for instant access to life-saving information and support.

While telemedicine/telehealth (TMH) can foster efficiency and convenience, its reliance on continuous, real-time transmission of data over computer networks also creates risk. At every step of the process, adverse events may occur, including diagnostic errors, technical glitches, and patient/client privacy and security violations.

This edition of Healthcare Perspective outlines strategies designed to enhance clinical, operational and technical processes associated with the provision of TMH. National standards are cited throughout this resource, serving as policy templates in the following key areas: network security, confidentiality, quality improvement, informed consent, record maintenance and technical support.

## SECURITY

### Safeguard patient/client data on computer networks and during transmission

Secure transmission of clinical information requires effective safeguards at every point in the process, i. e., within the transmitting facility's network, over the transmission medium and at the distant site. Whether data are sent by satellite, through the Internet or over a virtual private network (VPN), the following security measures, among others, should be established and implemented:

**Authentication** enables authorized users to enter the system and access data via such means as log-in passwords, biometric scans, voice pattern samples and smart cards. Authentication procedures also permit system administrators to verify specific users and their means of interface. Outside access should be limited to those networks that fulfill organizational security requirements.

**Patient/client identification** uses patient/client integration profiles to promote accurate verification at multiple sites. These profiles enable the cross-referencing of patient/client identifiers either from multiple domains or from a central patient/client information server.

**Data control** ensures that patient/client information is stored and transmitted in a confidential manner through the creation of a VPN, use of encryption technology and/or file anonymization software. An increasing number of medical systems also require digital signatures to verify that data have not been modified by an unauthorized user. Encryption measures also should extend to stored data on portable devices or removable media, as theft and loss of laptops, tablets, smartphones, discs and USB flash drives are a leading source of data breaches.

**Data tracking** offers an audit trail of all exchanges involving medical information, permitting the system administrator to verify who has used the system and/or accessed patient/client data. Related monitoring technologies help identify and protect against technical glitches and hacking.

**Protected access systems** safeguard telemedicine applications on wireless networks. A variety of security mechanisms may be used to provide both logical and physical restrictions, including firewalls and antivirus software that detects malicious programs and activity.

## PATIENT/CLIENT CONFIDENTIALITY

### Draft a disclosure protocol to ensure compliance with privacy regulations

Privacy is a paramount concern when transmitting electronic data.

Unauthorized network access, hardware tampering and interception of data may violate privacy requirements imposed under HIPAA, as well as other governing federal and state laws and regulations.

Both TMH partners should implement a disclosure protocol incorporating the following practices:

- **Obtain written permission** from the patient/client before transmitting any protected health information.
- **Require all staff involved in TMH to execute confidentiality agreements**, including contract and vendor personnel.
- **Allow only designated professionals to disclose health related information**, such as the telepresenter and consulting and referring practitioners.
- **Mandate HIPAA training for staff and providers**, covering such topics as information security, common sources of breaches and consequences of protocol noncompliance.
- **Transmit patient/client data on an as-needed basis** and monitor staff for inappropriate access to protected health information.

The privacy obligations of health care practitioners extend to the environment where interactive consultations occur. The following provisions can help safeguard patient confidentiality:

- **Ensure that the patient/client is aware of and grants approval for all personnel participating in consultations**, including the telepresenter.
- **Place a conspicuous sign on the exam door**, notifying others that a consultation is in progress.
- **Prohibit the use of unauthorized cameras and cellular telephones in the examination room**, using a signed consent agreement if necessary.
- **Schedule TMH sessions in a designated area that is suitably enclosed and private**, rather than in an administrative suite or other public space.

## QUALITY IMPROVEMENT

**Measure outcomes for clinical care and technical support**

Delivery of high-quality TMH services depends upon systematic monitoring and ongoing improvement of key processes. The following basic measures can help business owners more effectively compile, evaluate and report on meaningful care-related data.

**Outcome measurement** offers practitioners useful information about how well a TMH program is functioning, including further refinements that may be needed. Indicators should capture clinical, efficiency and satisfaction outcomes, including:

- Patient/client complication and morbidity rates.
- Compliance with provider performance criteria.
- Diagnostic accuracy.
- Adherence to clinical protocols.
- Referral rates.
- Patient/client satisfaction levels.
- Cost per case.
- Delays in accessing consultations, referrals or specialty providers.
- Average waiting times.

**Standardized clinical protocols**, properly implemented, can enhance quality and efficiency. By outlining a step-by-step process, protocols help improve consistency of care and performance of staff, and also ensure that test results are delivered in a timely, accurate and confidential manner. For interactive consultations, protocols minimally should advise providers on how and when to:

- Schedule a consultation.
- Arrange for a consulting room.
- Set up necessary equipment.
- Establish network connections.
- Prepare and advise the consulting provider, patient/client and telemedical presenter.
- Document consultation findings.
- Secure and back up required data.
- Prepare reports.
- Inform patients/clients and other providers of test results.

The American Telemedicine Association has promulgated a variety of practice guidelines (http://hub.americantelemed.org/resources/telemedicine-practice-guidelines). In addition, the Telehealth Resource Center provides information on protocol development (www.telehealthresourcecenter.org/toolbox-module/creating-protocols).

**Incident reporting** helps providers identify and respond to patient/client complications or other adverse events that may arise during telemedicine care. Providers should be instructed to document occurrences and forward reports promptly to the appropriate individual per written policy. A thorough, timely review of events helps foster a culture of accountability and continuous improvement.

**Regular equipment testing and maintenance** helps prevent potential technical and user problems. Equipment should be suitable for diagnostic and treatment uses, readily available when needed and fully functional during clinical encounters. Safety guidelines should specify who is responsible for maintenance. Utilize checklists or logs to facilitate documentation of post-installation testing, pre-session calibration, and ongoing quality checking of audio, video and data transmission capabilities.

**Satisfaction surveys** capture vital data regarding patient/clients and provider perceptions of the TMH program, as well as utilization patterns and the overall quality of TMH care. Surveys also can reveal unexpected barriers to care, including accessibility issues and cost. Sample survey formats for telehealth encounters are available at https://healthit.ahrq.gov/sites/default/files/docs/survey/telehealthpatientsatisfactionsurvey_comp.pdf and www.techandaging.org/Telehealth_Patient_Satisfaction_Survey.pdf.

## TRAINING

**Employ interactive teaching modules to ensure key competencies**

Staff training should focus primarily on learning the skills necessary to conduct consultations and other TMH services smoothly and efficiently. At a minimum, training sessions should aim to enhance the following competencies:

- **Communication skills,** including video presentation content, organization and etiquette.
- **Understanding the scope of services** that can be provided using TMH methods.
- **Proficiency with the technology system in use**, as well as the physical environment.
- **Knowledge of operational protocols and procedures**, updated as necessary.
- **Ability to respond to equipment malfunctions** and manage unexpected occurrences.

Optimally, staff should begin with separate training sessions at the originating and distant sites, then progress to mock joint

procedures before advancing to real-time provision of care. A wide variety of training modules is available, serving a range of procedures and existing proficiency levels. The Telehealth Resource Center offers guidance on developing a training strategy (www.telehealthresourcecenter.org/toolbox-module/developing-training-strategy), as well as answers to commonly asked questions concerning training of TMH providers (www.telehealthresourcecenter.org/toolbox-module/training).

## INFORMED CONSENT

**Disclose risks unique to the practice of telemedicine**

Patient/client consent is always required prior to participation in TMH services. Providers often use existing consent and documentation processes for store-and-forward consultations. For more invasive procedures, a separate consent form is preferable, encompassing the following information:

- Names, credentials, organizational affiliations and locations of the various health professionals involved.
- Name and description of the recommended procedure.
- Potential benefits and risks.
- Possible alternatives, including no treatment.
- Contingency plans in the event of a problem during the procedure.
- Explanation of how care is to be documented and accessed.
- Security, privacy and confidentiality measures to be employed.
- Names of those responsible for ongoing care.
- Risks of declining the treatment/service.
- Reiteration of the right to revoke consent or refuse treatment at any time.

In addition, clearly convey to the patient/client the inherent technical and operational hazards that may impede communication with the distant site or otherwise prevent prompt, accurate diagnosis of patient/client conditions. These include:

- **Fiber-optic line damage, satellite system compromise or hardware failure**, which could lead to incomplete or failed transmission.
- **File corruption during the transmission process**, resulting in less than complete, clear or accurate reception of information or images.
- **Unauthorized third-party access**, which may lead to data integrity problems.
- **Natural disasters**, such as hurricanes, tornadoes and floods, which can potentially interrupt operations and compromise computer networks

Consent form documentation becomes part of the patient/client health care information record and is customarily maintained at the originating site, where the patient/client receives routine care. Sample telemedicine informed consent forms are available from the American Telemedicine Association at https://thesource.americantelemed.org/resources/telemedicine-forms.

## RECORD MAINTENANCE

**Create and retain formal patient/client care records for all TMH encounters**

Telemedicine sessions should be as thoroughly documented as all other patient/client encounters, with both partners to the TMH agreement contributing to the process. According to the American Health Information Management Association, TMH records minimally should include:

- Patient/client name.
- Patient/client identification number at originating site.
- Date of service.
- Referring practitioner's name.
- Consulting practitioner's name.
- Provider organization's name.
- Type of evaluation to be performed.
- Informed consent documentation.
- Evaluation results.
- Diagnosis/impression of providers.
- Recommendations for further treatment.

The use of standardized intake and consultation forms can help providers achieve compliance with documentation parameters.

Templates, such as those available from the American Telemedicine Association, offer staff a clear and consistent documentation format for evaluations and consultations (https://thesource.americantelemed.org/resources/telemedicine-forms).

Facilities also must select acceptable media for record keeping, such as electronic files, hard copy and/or video or audiotape. Protocol routinely dictates that the originating site retains files and images, providing the distant site with access to data when needed. Record retention policies should comply with professional standards, federal and state laws and regulations and the reimbursement requirements of public and private payers.

Health care business owners can help streamline the archiving process by assigning "lifespans" to patient/client data and medical documents stored in computer memories, based on such factors as last date of patient/client treatment, provider access requirements and record retention policies. For many organizations, data are maintained on a locally designated and protected server, with replication servers backing up files in the event of a disaster, computer problem or other type of business interruption.

## TECHNICAL SUPPORT

**Implement a robust, high quality telecommunication system**

Interactive TMH encounters depend upon a reliable and secure telecommunication system. Connections are of the utmost importance and should support business-grade videoconferencing with clear sound. Available options range from portable video conferencing units to large screen, high-definition consoles. Relying on the basic Internet for connection, rather than a private network dedicated to health care applications, may compromise quality and interfere with effective diagnosis or treatment.

TELEMEDICINE / TELEHEALTH

## Frequently asked questions

As the reach of telemedicine services expands, questions arise regarding the permitted scope of practice, licensure requirements and HIPAA compliance, among other regulatory-based inquiries.

The questions and responses below provide basic information to practitioners and are intended to serve as a catalyst for further inquiry into the federal and state regulatory framework for telemedicine/telehealth (TMH).

**What qualifies as TMH?**

TMH involves the use of electronic communications and information technology to deliver health-related services at a distance, typically in real time. States have different laws concerning when and how TMH may be practiced, so it's important to check state statutes, regulations and policies, as well as state licensure boards regarding practice limitations before initiating services. In addition, the Centers for Medicare & Medicaid Services provide information on the scope of Medicare telehealth services.

**Who can provide care via TMH?**

It is essential to verify with the relevant state professional licensing board the practitioners who can legally practice TMH. Depending on the state, authorized practitioners may include physicians, clinical nurse specialists, nurse practitioners, physician assistants and licensed counselors and therapists, among others.

**Is a patient/client relationship established with TMH?**

A patient/client provider relationship is established via TMH in the same manner in which it is established in an in-person office/hospital setting.

**Is it necessary to secure a license in both states with delivering TMH across state lines?**

Some states require practitioners who practice TMH to be licensed in the state where the patient/client is located, and abide by the licensure and practice requirements of that state. Before embarking on interstate TMH, practitioners must review the state practice act of the state where the patient/client resides. If a state practice act is silent regarding TMH, or published opinions or interpretations regarding the subject of licensure have not been issued by recognized sources, then potential TMH practitioners should contact their state professional licensing board for clarification with respect to interstate practice and their licensure status. Certain states also have entered into interstate compacts, creating a new pathway to expedite the licensing of a practitioner seeking to practice in multiple states. For additional information, check the respective state licensing board to determine if the state has joined a compact.

**Should a special consent-to-treat form be utilized when performing TMH?**

Obtaining a patient's/client's consent to TMH services is an essential step in the care process, and is a recommended best practice of the American Telemedicine Association. A general consent-to-treat form lacks specificity regarding the potential benefits, constraints and risks unique to TMH, including equipment failures and privacy and security breaches. In addition, a general form is lacking in standard language regarding patient/client rights and responsibilities relating to TMH. See section "Informed Consent: Disclose Risks Unique to the Practice of Telemedicine" for a link to sample TMH consent forms.

**Does a practitioner need to abide by HIPAA regulations?**

TMH services must comply with the same HIPAA-related rules and regulations at the federal and state levels, as well as business policies, that apply to the delivery of in-person services. Practitioners should be conversant with the HIPAA Breach Notification Rule and technology encryption requirements. In the case of interstate practice, if requirements for privacy, security and informed consent differ between states, practitioners are encouraged to follow the most restrictive laws and regulations.

Health care business owners can streamline the equipment selection process by compiling a list of general requirements and technical specifications for videoconferencing systems, ancillary devices and post-purchase support needs. Choices are generally guided by imaging needs, existing infrastructure and budgetary realities.

Regardless of the specific equipment selected, TMH systems should:

- **Comply with all relevant laws**, regulations and codes regarding patient/client safety and technical requirements.
- **Provide redundant systems** to help ensure uninterrupted network connectivity.
- **Utilize connections exclusively designated for telemedicine**, rather than local networks, which may be incompatible with TMH image transmission and archiving applications and/or lack sufficient bandwidth.
- **Permit networks to connect** through existing firewalls.

It also is necessary to accommodate the physical and environmental demands of TMH operations. Patient/client rooms must be sufficiently spacious to allow at least six feet between the patient/client and the camera operator. In addition, adequate HVAC capabilities and accessible infection control supplies – such as antibacterial wipes, sterile plastic sleeves for probes and camera lens disinfectant are essential to patient/client safety.

As with any new venture, successful implementation of a telemedicine program requires careful planning and collaboration by multiple stakeholders, both inside and outside the business. The strategies presented in this resource can help health care business owners initiate and maintain a high quality TMH program, which maximizes efficiency and convenience while minimizing associated risks. ■

#WeRepSeattle

# 2018 HOME SCHEDULE

## MAY

**STORM INTO S.T.E.M.**
PRESEASON GAME - TUESDAY, MAY 8 | NOON

**OPENING NIGHT** PRESENTED BY SWEDISH
SUE BIRD BOBBLEHEAD GIVEAWAY - SUNDAY, MAY 20 | 6PM

FRIDAY, MAY 25 | 7PM

STORM INTO COLLEGE NIGHT - TUESDAY, MAY 29 | 7PM

**KELSEY PLUM RETURNS TO SEATTLE**
CAREER FAIR - THURSDAY, MAY 31 | 7PM

## JUNE

SUNDAY, JUNE 10 | 4PM

TUESDAY, JUNE 12 | 7PM

**DADS AND DAUGHTERS NIGHT**
JEWELL LOYD BOBBLEHEAD GIVEAWAY - FRIDAY, JUNE 15 | 7PM

TUESDAY, JUNE 19 | 7PM

**PRIDE NIGHT**
FRIDAY, JUNE 22 | 7PM

THURSDAY, JUNE 28 | 6PM

**REIGNSTORM NIGHT**
BIRD & RAPINOE POSTER GIVEAWAY - SUNDAY, JULY 1 | 4PM

## JULY

**CELEBRATE SEATTLE BASKETBALL NIGHT**
BREANNA STEWART BOBBLEHEAD GIVEAWAY - SUNDAY, JULY 8 | 4PM

**KIDS DAY**
TUESDAY, JULY 10 | NOON

SATURDAY, JULY 14 | 6PM

**BHA NIGHT** PRESENTED BY SWEDISH CANCER INSTITUTE
TEDDY BEAR TOSS - FRIDAY, AUGUST 3 | 7PM

## AUGUST

**STORMFIT NIGHT** PRESENTED BY KAISER PERMANENTE
TEAM POSTER GIVEAWAY - FRIDAY, AUGUST 17 | 7PM

**FAN APPRECIATION NIGHT**
SUNDAY, AUGUST 19 | 4PM

# Patient's "Do Not Resuscitate" tattoo sparks debate

*By John A. Musacchio, Esq.*

Article originally published in the February 2018 ANA - New York Nurse newsletter. Reprinted with permission.

I recently became aware of a case study involving a terminally ill patient who had the words "DO NOT RESUSCITATE" tattooed across his chest. This case is so fascinating and has sparked such a large ethical debate that I am compelled to write about it in this quarter's newsletter (I will refer to the tattoo at issue as the "DNR tattoo" throughout this article).

**The facts**

To summarize the facts, as reported by several news outlets, the 70-year-old patient had presented to a Florida emergency department in an unconscious state with the inability to communicate his wishes. He apparently had no identification and the medical team had no way to reach his family members in an emergent fashion. When his providers saw the words "DO NOT RESUSCITATE" together with what appeared to be the patient's signature tattooed across his chest, they were faced with the difficult decision of whether they should honor the patient's apparent end-of-life directive, or if they should disregard it and take the usual heroic measures to save the patient's life, as they would do for any other patient who did not have a properly executed DNR, health care proxy or living will.

Initially, the medical team chose to disregard the tattoo. However, they eventually brought in an ethics team, who instructed the providers to honor the DNR tattoo. The medical team stopped taking heroic measures, and the patient died shortly thereafter.

**The legal landscape**

In the November 2017 ANA New York Nurse Newsletter, I provided information about patients' advance directives – health care proxies and living wills. These documents are typically created to express people's wishes involving life-sustaining treatment, and should be used in the event that the person becomes incapacitated or unable to express their wishes at the time care is being provided to them.

To be properly executed and effective, these documents should typically be signed by the patient in the presence of two (2) witnesses, whose names and, often, contact information are provided on the documents. There are many reasons for having these documents properly witnessed, including to indicate that the person making the advanced directive was of sound mind at the time of executing the document, that the person was not coerced or unduly influenced and to identify other individuals to contact in case a question arises regarding the validity of the patient's directive.

**Should the DNR tattoo's message have been followed?**

Patient advocacy is often at the top of a nurse's list when providing patient care, as it should be. Following a patient's wishes is certainly one of the most important forms of patient advocacy. While many medical providers would be quick to say that this type of tattoo should be followed, we need to dig deeper to determine what is truly in the patient's best interest.

To me, the answer comes down to being able to sufficiently prove the patient's true wishes. The courts have the job of balancing the importance of upholding people's wishes while protecting people from fraud and undue influence. That is why many states, including New York, require people to go through certain formalities when creating documents such as wills, health care proxies, powers of attorney, etc. In New York, for instance, the courts do not recognize the validity of "holographic" (handwritten) wills, except if made by a member of the US Armed Forces during his or her active duty. Therefore, courts in New York will generally disregard a handwritten will, since it does not meet the required formalities.

Also, unlike a typical health care proxy or living will, the DNR tattoo in this case does not include the names or attestation of any witnesses and certainly was not notarized. The use of witnesses and notarization are the usual, time-tested methods of proving that the person was of sound mind at the time he or she made the decision about his or her future health care needs. If there is ever a question as to the validity of the incapacitated patient's prior instruction, a health care provider or court can ask the witnesses. In the case of the DNR tattoo, however, there were no identifiable witnesses for the providers to ask.

Another important consideration is that most legally enforceable documents can be revoked by the person making them. For instance, if a person changes his or her mind about the wishes specified in a living will, health care proxy or do not resuscitate order, he or she can simply revoke that document and it will no longer be effective. By contrast, it is much more difficult to "revoke" a tattoo – having a tattoo removed is a costly, painful, and time-consuming process. While those same facts may on one hand suggest the strength of the patient's dedication to having a

particular wish carried out, it also could be argued that the patient may have changed his mind and just didn't have a chance to get the tattoo removed. We don't know when the patient got the tattoo – it may have been a week before he presented, or it could have been many years or decades earlier.

Since this tattoo does not have any of the traditional safeguards, it raises important questions, such as: 1) Was the patient of sound mind when he got the tattoo? 2) Was the patient unduly influenced by someone who had an interest in his estate? 3) Was the tattoo made against his will? 4) Did the tattoo still accurately represent the patient's wishes at the time he presented?

There is a presumption with properly executed documents following the required legal formalities that the patient's wishes are accurately described in those documents, and therefore should be carried out. Since none of those safeguards were present with this particular patient's tattoo, it is hard to determine whether the tattoo's message is enforceable and binding.

Importantly, it has been reported that the medical facility searched for, and found, this particular patient's formally executed DNR, which had previously been filed with the Florida Department of Health, before the ethics committee made the final decision to discontinue its life-sustaining treatment.

### Good practices

Review your employer's policies and procedures

Become familiar with the published guidelines in your area of practice

Ask your supervisor for guidance

Follow your supervisor's instructions

Attempt to find proper documentation of the patient's wishes

**What are we to do?**

The best definitive answer I can give is that people should make their wishes known by using traditional, properly executed and witnessed written documents, such as DNRs, living wills and health care proxies, which have been found by the courts to be valid. Medical providers should typically follow the directions specified in those documents. However, it would not be good practice for a medical provider to rely solely upon a patient's tattoo, without the support of any legally valid documents, in making the decision to let a patient expire.

As always, when a provider is unsure what to do, he or she should ask for guidance from a supervisor or other department leader. Nurses should also be familiar with their facilities' internal policies and procedures with regard to the use of patients' advance directives. And if you ever find yourself facing some form of discipline, you should speak directly with an experienced attorney to discuss your options. ■

WASHINGTON PERSPECTIVE

## DNR tattoo not a good idea

*By Seth Rosenberg, JD, MSW*

There was recently a case in Florida involving a man who tattooed "Do Not Resuscitate" together with what appeared to be his signature on his torso. That act has generated a national debate over the sufficiency of the request.

In Washington, that request would likely not be honored. There are several problems with the tattooed DNR. First, it really does not allow for changes to be made over time. For example, how would the person revoke the instruction? Second, directives in Washington state require either a doctor's signature (in the case of a POLST) or witness signatures and notarization (in the case of a health care directive.) Without those third-party signatures, a treating physician would not know if the request is current, whether the person was of sound mind when he tattooed the order or whether the tattoo was freely requested.

In conclusion, such a tattoo would likely only confuse issues of care once seen. It would likely not be effective in getting what the client wants.

Seth Rosenberg, JD, MS.W., practices law in Seattle, with a focus on professional licensure defense.

**References**

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Henderson, Cydney, "Florida man's 'Do Not Resuscitate' tattoo creates ethical dilemma for doctors" USA Today, December 5, 2017.

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**About the author**

John A. Musacchio is an associate attorney with the law firm Towne, Ryan & Partners, P.C., which has five offices in Upstate New York and a sixth office in Bennington, Vermont. In addition to defending nurses in professional discipline matters, John also assists clients with estate planning, Medicaid planning, criminal and DWI defense, labor and employment law, personal injury matters, real estate transactions, business law and litigation in all of these areas. He has been selected to the Upstate New York Super Lawyers Rising Stars list in 2015, 2016 and 2017.

John serves on the New York State Bar Association's Committee on Disability Rights, as Secretary of the Capital Region Italian American Bar Association and as Co-Chair of the New York State Trial Lawyers Association Young Lawyers Committee, Capital Region division.

John can be reached by telephone at (518) 452-1800 and by e-mail at john.musacchio@townelaw.com.

# HEALWA: Your on-call library

*By Christina Pryor, MLIS*
*Assistant Director and Community Health Education Coordinator*

Do you know that as a nurse registered in Washington state you have access to an online resource library? The Health Evidence Resource for Washington State, or HEALWA, gives you access to the highest quality information in the shortest amount of time for the very best care. It costs you nothing to sign up. This remarkable resource is already paid for with a small portion of your state licensing fees, so for less than the price of a single journal article you have an entire medical library at your fingertips.

HEALWA gives you access to:

- Thousands of full-text journals to keep you up-to-date in your field
- Constantly reviewed and updated databases such as DynaMed Plus and MEDLINE
- Evidence-based articles and practice guidelines
- A toolkit tailored to nursing practice
- Printable patient handouts
- Free Continuing Nursing Education credits

### How to sign up for HEALWA

Signing up for HEALWA is easy! Just complete the following steps to receive your HEALWA username and password:

**1.** If you haven't already done so, update your contact information with the Department of Health to include an email address.

**2.** Using a web browser, go to healwa.org and click on the "Getting Started" webpage. Select the option to create a UW NetID. Then enter your Last Name and Credential Number.

**3.** Then HEALWA emails you a username and password and you are ready to start exploring the HEALWA resources!

Once registered, HEALWA users have access from anywhere, anytime whether on a computer or a mobile device. Simply visit healwa.org and click the "Log In" link located on the upper left corner of the screen.

### Earn one free CNE contact hour

You can now earn one free CNE contact hour just by learning about HEALWA. On the first Tuesday of each month, HEALWA offers a free one-hour workshop. This webinar demonstrates how to register for the HEALWA website, how to navigate the portal and presents basic information about the HEALWA collection. Registration is required and more information can be found on the HEALWA website under "News."

Christina Pryor

Kathryn Vela

### Need help or have questions about HEALWA?

Our goal at HEALWA is to help nurses and other medical professions across Washington state have affordable, anytime, online access to current, authoritative clinical information and educational resources. If you need assistance with learning how to navigate the resources or have questions about HEALWA, contact us at 206-221-2452 or at healwa@healwa.org.

If you need help using HEALWA or have any questions, contact Christina Pryor (cnpryor@uw.edu), Assistant Director for HEALWA at the University of Washington or Kathryn Vela (kathryn.vela@wsu.edu), Health Sciences Outreach Librarian at Washington State University Spokane.

You can also follow HEALWA on Facebook and Twitter.

Stay tuned for future HEALWA articles featuring helpful tips and hints about how to get the most information from your On-Call Library.

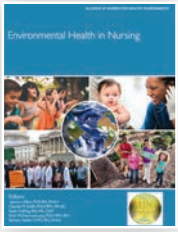
## Bachelor of Science in Nursing preparation emerging as mandated entry level for nursing practice

The value of a culture of safety, sound care delivery and quality outcomes as priority aims for health systems and practicing health care providers are not new concepts. The ever-evolving health care environment and more recent shifts in reimbursement for health care services have placed an emphasis on quality outcomes and pressures for all involved to optimally perform, including nursing. Furthermore, research data continues to demonstrate measurably improved quality outcomes with increasing levels of nursing education i.e., the higher the education level in nurses, the better the outcomes.

Given this climate and evidence-based knowledge and outcomes that meet the goals for all stakeholders, there is strong argument to press the nursing profession toward higher thresholds of acumen through higher levels of academic preparation. Indeed, the American Nurses Association and others have adopted requirements of higher levels of education for nurses to qualify for nursing certifications and for health systems in achieving Magnet Recognition as a Center of Excellence with a minimum of 50 percent of their nursing staff BSN prepared or higher.

Health systems are responding with proactive plans that facilitate opportunities for education and sign-on agreements that enter nurses into a commitment to achieve baccalaureate training within a specified time frame.

This trend is now extending into the health policy and legislative arena as evidenced by the recent "BSN in 10" legislation that passed in New York State and mandates associate and diploma nurses finish a baccalaureate program in nursing within ten years of their initial licensure. This trend has implications across the continuum of nursing education, workforce development and practice and is one WSNA will continue to track closely.




## The Alliance of Nurses for Healthy Environments awarded 2017 AJN Book of the Year Award

In December, the Alliance of Nurses for Healthy Environments' e-textbook, "Environmental Health in Nursing" (2016), was awarded first place in the environmental health category by the American Journal of Nursing.

AJN recognized 2017 Book of the Year Award winners in 19 categories encompassing various aspects of nursing practice. These awards serve as a way to acknowledge high-quality publications among the nursing profession. "Environmental Health in Nursing," published by ANHE and edited by Jeanne Leffers, PhD, RN, FAAN, Claudia M. Smith, PhD, MPH, RN-BC, Katie Huffling, RN, MS, CNM, Ruth McDermott-Levy, PhD, MPH, RN, and Barbara Sattler, DrPH, RN, FAAN, is an evidence-based, peer-reviewed and open-access textbook for nurses and other health professionals that offers essential information on environmental health topics.

The textbook is freely accessible online at envirn.org/e-textbook and is divided into nine units, including topics such as toxic chemicals, climate change and environmental health nursing advocacy and research. In this publication leading environmental health nursing experts have joined together to share their knowledge, expertise and experiences.

The Alliance of Nurses for Healthy Environments is currently working on a second edition of the online textbook. If you'd like to author a chapter please contact Katie Huffling at katie@enviRN.org or 240-753-3729.

The Alliance of Nurses for Healthy Environments is the only national nursing organization focused solely on how the environment impacts human health. The mission of ANHE is to promote healthy people and healthy environments by educating and leading the nursing profession, advancing research, incorporating evidence-based practice and influencing policy. Learn more at enviRN.org.

# Nursys requirements and nursing data surveys

**The National Council of State Boards of Nursing** (NCSBN) is a national, not-for-profit organization comprised of boards of nursing from 50 states and the District of Columbia; Washington state's Board of Nursing (the Nursing Care Quality Assurance Commission – NCQAC) is an active member of the NCSBN.

The NCSBN and NCQAC exist to protect the public's health and welfare by assuring that safe and competent nursing care is provided by licensed nurses. As the comprehensive source of nursing licensure statistics for the U.S. and in order to track nursing as a workforce, NCSBN is partnering with their member state Boards of Nursing, including Washington state, to collect demographic data that pertains to licensed registered nurses. Beginning January 1, 2018, NCQAC requires all nurses enroll with Nursys at the time of application for a new nursing license or licensure renewal.

Nursys fulfills the following purposes:

- Allows you or an employer to verify the status (active/inactive) of your nursing license(s), the status of your practice privileges and the status of any disciplinary action by a participating board of nursing.
- Provides an e-notification when you are due to renew any nursing licenses you hold and provides a central place to review your license(s).
- Collects demographic data via Nursys for the purposes of national and state workforce tracking.

As the comprehensive source of nursing licensure statistics for the U.S. and territories, the NCSBN collects demographic data via Nursys for the purposes of national workforce tracking. The demographic/national workforce tracking data that you will be asked at the time of enrollment in Nursys is:

> Gender, race/ethnicity, primary zip code, membership status of a collective bargaining unit, language(s) spoken fluently, nursing degree at time of initial licensure, nursing school attended and year of graduation, all nursing related degrees and credentials, which country originally licensed in, year of initial nursing license, active status as an Advanced Practice Nurse (APN), which states licensed as an APN, employment status as a nurse and typical hours worked.

The NCSBN is a strong resource for nurses. For more information about Nursys and other topics you may visit: www.ncsbn.org/nursys.

### 2018 National Sample Survey of Registered Nurses

The U.S. Department of Health and Human Services last conducted research and published the National Sample Survey of Registered Nurses in 2008 (to see the report go to bhw.hrsa.gov and search for "registered nurse").

This research and publication provides up-to-date information about the status of registered nurses and nurse practitioners in the U.S., is the primary source of data on the nursing workforce and is integral in describing the registered nurse population at the national and state level. The 2018 National Sample Survey of Registered Nurses (NSSRN) is now underway and being sent to over 100,000 nurses in the U.S. by the U.S. Census Bureau. It will update the 2008 data, with a target publication date of January 2019. Nurses' participation in these surveys supports work that enhances nursing workforce advocacy.

**Note:** The Department of Health working with Washington State Office of Cyber Security and the NCSBN are serious about protecting your security and privacy. These entities have sophisticated defense systems in place to detect, block and respond to cyber-attacks.

# Hall of Fame

## Presenting the 2018 inductees into the WSNA Hall of Fame

**IN MARCH,** WSNA inducted six outstanding leaders into the Washington State Nurses Hall of Fame. All have pioneered new pathways for registered nurses through their outstanding vision, determination and achievements throughout their careers. The 2018 Hall of Fame honorees join 65 nurses and leaders inducted into the Washington State Nurses Hall of Fame since its inception in 1996.

WSNA created its Hall of Fame to recognize the dedication and achievements of Washington state registered nurses who have made significant lifetime contributions to the profession of nursing.

Each inductee has demonstrated excellence in the areas of patient care, leadership, education, public service, nurse advocacy, heroism, patient advocacy or clinical practice. Their contributions have value to nursing beyond the inductee's lifetime, and their demonstrated excellence has made a difference in the health and social history of Washington state.

They are our heroes. Congratulations to all of the 2018 inductees.

**Continued page 38.**

# Debbie Brinker, MSN, RN, CNS

**In her four decades as a nurse, Debbie Brinker's work has contributed** to the wellbeing and advancement of patients, students and the nursing profession. She has cared for children as a pediatric nurse, held leadership positions at the state and national level and shaped the careers of hundreds of students. Her mentorship, leadership and passion for the profession have rippled across the globe.

Brinker received her Bachelor of Science in Nursing from the University of Washington and her Master of Science in Nursing as a Pediatric Critical Care Clinical Nurse Specialist from the University of California in San Francisco. She began her nursing career in Seattle as a staff nurse in the Pediatric Intensive Care Unit at Children's Hospital. Her work as a pediatric and critical care nurse has taken her from Washington state to the United States Air Force Hospital in Homestead, Florida, from Upstate New York to California's Central Valley.

Brinker settled in the Inland Empire in 1992 and worked for 13 years as a clinical nurse specialist in the PICU at Deaconess Medical Center.

In 2002, Brinker joined the faculty of the Washington State University College of Nursing, where she currently serves as Clinical Assistant Professor and Assistant Dean for Clinical Affairs. Her teaching experience includes pediatrics and professional development and leadership education.

Brinker's commitment to growing the future generation of nurses with a spirit of inquiry, quest for research and application of evidence in practice are invaluable. She gives all her students a solid foundation to lead and contribute with team members in achieving a culture of health. In recognition of her teaching excellence, WSNA gave Brinker the Nurse Educator Award in 2013.

In 2017, she became the first College of Nursing faculty member to receive the WSU President's Distinguished Teaching Award for Instructors and Clinical Faculty. In announcing the award, the University said, "Her teaching philosophy of 'engage and transform' is manifested in her research publications, positive student evaluations and affirming feedback from clinical site partners." Brinker also has been honored by the WSU College of Nursing with both a Faculty Service Award and Undergraduate Faculty Award.

Brinker's passion for supporting nursing students goes beyond WSNA. She also has served as the faculty advisor for the Nursing Students of Washington State for more than five years, where she has mentored students in leadership roles. She has acted as keynote speaker at the NSWS Convention on the topic of how to prepare an effective resume to get a nursing job. Brinker regularly brings busloads of students from the Spokane area across the state to Olympia for WSNA's Nurse Legislative Day, impressing upon her students the importance of advocating for nursing practice and health care issues on behalf of all those in Washington state.

In addition to her teaching and mentoring, Brinker has stepped forward as a leader at both the state and national level. She is a national past president of the American Association of Critical-Care Nurses. Currently, Brinker serves as president of the Washington Center for Nursing, the statewide nursing workforce center, and is deeply committed to meeting WCN's mission of supporting a healthier Washington by engaging nurses' expertise, influence and perspective and by building a diverse, highly qualified nurse workforce to meet future demands. As the vital link to central and eastern Washington, Brinker has been critical to WCN's work to establish a diversity mentoring program in Yakima, raise awareness of implicit bias in Spokane and create a rural health advisory committee. None of these initiatives would have happened without her.

Brinker is also a member of the Leadership Washington Nursing Action Coalition, the statewide interprofessional effort that leverages nurses' expertise to improve and transform the health care system. Responding to the alarming shortage of clinical placement experiences and clinical faculty to teach nursing, Brinker joined the Action Now! effort to improve nursing education. In that role, she is working with stakeholders to ensure the state has more residency and preceptorship programs for nursing students and new graduates in all settings.

From bedside nursing, to teaching and mentoring to leadership at the state and national level, Brinker's work and dedication has influenced countless patients and students, and will continue to have a lasting impact on the nursing profession and the health of our communities.

# David Campbell, JD

**Although not a nurse himself, David Campbell has spent decades** advocating for WSNA-represented nurses. His commitment to RNs is unwavering. Through his work, he has improved working conditions for nurses and addressed patient safety concerns in every possible legal venue: in court, at arbitrations, during contract negotiations and in the legislative arena. The advances Campbell has made for WSNA and the nursing profession will be felt for decades to come.

Campbell graduated from the University of Washington School of Law in 1983 and has been zealously advocating for labor unions and the workers they represent ever since. He is principal partner at Schwerin Campbell Barnard Iglitzin & Lavitt, LLP, where his experience includes major federal and state litigation, collective bargaining, proceedings before the National Labor Relations Board, organizing campaigns, strikes, contract administration and arbitrations. Campbell is also an adjunct professor at both the University of Washington School of Law and the Seattle University School of Law, where he teaches labor law and negotiation.

The work Campbell has done with WSNA to compel hospitals to give nurses rest and meal breaks has gone all the way to the State Supreme Court, with precedent-setting wins for nurses. The impact of this work cannot be overstated. This successful legal strategy, with Campbell as the primary facilitator and lead counsel for WSNA, has had a deep and abiding impact on nurses' rights to receive rest breaks and get compensation for breaks that are denied.

Rest and meal breaks are essential to reduce fatigue on the job and ensure that nurses can safely and consistently provide the highest quality care for their patients.

It started in 2007 with the lawsuit WSNA filed against Sacred Heart Medical Center in Spokane on behalf of the 1,600 nurses WSNA represented there, arguing that nurses deserved pay for the thousands of rest breaks they had been denied. WSNA v. Sacred Heart Medical Center, decided by the State Supreme Court in 2012, established the right to overtime pay for missed rest breaks and expanded the right to rest breaks for nurses. This groundbreaking decision created a financial penalty for hospitals' failure to provide breaks and initiated a cascade of legal wins around the state.

In 2010, WSNA filed four additional lawsuits, on similar grounds, against Good Samaritan Hospital, Tacoma General Hospital, Evergreen Hospital Medical Center and Holy Family Hospital in Spokane.

In 2011, WSNA reached a significant settlement agreement with Evergreen Hospital resulting in improved timekeeping and recordkeeping requirements, appropriate pay for missed breaks and entitlement to full, uninterrupted breaks.

In 2013, WSNA reached a major settlement agreement requiring that MultiCare, owner of Tacoma General and Good Samaritan, adopt mechanisms, policies or practices to assure nurses are completely relieved of patient care duties during rest breaks.

In 2015, in an arbitration case enforcing its settlement agreement with Tacoma General, WSNA won a landmark award compelling MultiCare to abandon its "break buddy" system, which continued to leave nurses on call during breaks and doubled patient care loads, often beyond safe limits, for nurse "buddies" providing coverage. WSNA is currently defending the arbitration award in the Ninth Circuit Court of Appeals.

In 2016, WSNA reached a settlement with Franciscan Health-St. Joseph Medical Center in a lawsuit brought the year before on behalf of 1,200 nurses for denial of rest breaks, meal breaks and overtime pay. The settlement agreement provided $5 million in back pay to nurses for missed breaks and put an end to intermittent breaks at St. Joseph in Tacoma through commitments to implement block rest breaks across the hospital and to create 26 FTE new, dedicated break-relief nurses.

The cascade of successes continues. This year, home health and hospice nurses at Yakima Regional Medical and Cardiac Center were awarded nearly $2.9 million in back pay for the significant number of hours they had been forced to work off the clock.

Taken together, Campbell's legal efforts on behalf of WSNA have set new standards on rest and meal breaks for nurses. His novel utilization of the Minimum Wage Act to compel overtime pay for nurses who missed breaks set a precedent that other attorneys have successfully utilized to win stronger rest break policies and compensation for missed rest breaks across the state.

In the legislative arena, Campbell has acted as counsel and advisor on many bills including nurse staffing laws. He has worked with WSNA's legislative staff to lobby the Washington State Department of Labor & Industries regarding guidance on rest breaks and mandatory overtime.

Campbell has been a force at the bargaining table as well, negotiating on behalf of WSNA to win huge contractual gains for nurses. From securing wage increases to improving staffing language and resisting employer attempts at takeaways, Campbell has fought tirelessly to achieve major contractual victories that have improved working conditions for nurses. Among his accomplishments, Campbell was lead negotiator in the late 2016 contract victory at MultiCare Tacoma General Hospital that, for the first time in Washington state, established unit-specific nurse-to-patient ratios in a collective bargaining agreement.

The contractual, legislative and litigation-based wins Campbell has achieved have set high standards for working conditions, nurses' rights and patient care that WSNA-represented nurses will enjoy for decades to come. Whether arbitrating to enforce nurses' contractual rights or taking legal battles all the way to the State Supreme Court, Campbell has dedicated his career to championing WSNA's members and improving working conditions and patient safety for nurses throughout the state

# Hilke Faber, MN, BSN, RN

**Hilke Faber is an exemplary nurse advocate, and has been throughout** her career. From being on the front lines of tough hospital contract negotiations, to pushing forward the role of the nurse practitioner in the state legislature, to advocating for residents of nursing homes to igniting a passion for political action in her fellow nurses, advocacy is a thread that runs through her career.

Faber has been an active member of the Washington State Nurses Association since her graduation from the University of Washington School of Nursing in 1965, serving on numerous councils and committees. She has also been actively involved in the King County Nurses Association.

As a staff nurse, Faber walked the halls of all hospitals covered under the Seattle Area Hospital Council contract to collect resignation letters from nurses during the 1967-68 contract negotiations. This huge mass resignation effort worked, ending in a new contract with wage increases.

Faber assisted with the successful passage of the expanded Washington State Nurse Practice Act in 1973, which included a new definition of nursing and provided for the expanding role of nurses in advanced practice roles. In the face of opposition from the medical and hospital associations, WSNA was able to demonstrate the valuable contributions of the nursing profession to health care and the need for more flexibility in existing nurse practice laws to meet the health care needs of underserved populations. Washington became the first state in the nation to recognize the advanced practice nurse as an "independent" provider.

Faber also lobbied for third-party coverage for nursing services and passage of 1975 legislation mandating that all commercial carriers reimburse for nursing services in Washington state. She also was instrumental in obtaining funds from Medicare for nurse practitioner services in rural areas of the state.

Faber contributed greatly to continuing education for nurses in Washington. She assisted in development of the WSNA Continuing Education Recognition Program, which was adopted as a voluntary CE program by the WSNA House of Delegates in 1974. This effort led to a Continuing Education Recognition Program for all nurses in the state and passage of legislation in 1978 mandating CNE requirements for re-licensure in nursing practice. Faber brought her considerable experience in continuing education to the role of education program specialist on staff at WSNA from 2004 to 2015.

Faber's many accomplishments speak to her commitment to giving vulnerable populations a voice through policy, advocacy and leadership as a registered nurse. In 1975, she was appointed by Mayor Uhlman to the Seattle Women's Commission, which advises the Mayor, City Council and city departments. As vice-chair, Faber used her position as a registered nurse to address issues affecting women such as health, housing, homelessness and domestic violence.

Much of Faber's career was devoted to raising the voice of and improving care for those in long-term care facilities. In 1976, Faber became the first appointed Nursing Home Ombudsman for Seattle-King County, a role she filled until 1983. The program Faber developed and directed served over 15,000 nursing home residents, their families and friends.

Faber also provided leadership in the passage of major nursing home reform legislation both statewide and nationally, including a Resident Bill of Rights and the Long-Term Care Resident Rights Law. She was instrumental in gaining passage of the federal law removing chemical and physical restraints from nursing home residents.

Faber served on the Board of Directors of the National Citizens Coalition for Nursing Home Reform and on the Long-term care committee in the American Academy of Nursing; she was admitted as a fellow because of her work creating the first Ombudsman Program for Seattle-King County.

In 1984, Faber founded the Washington State Nursing Home Resident Councils, a statewide nonprofit membership organization comprised of nursing home resident councils with the goal of bringing the voice of the resident into the state and national public policy debate. She recruited, trained and supported residents from 12 different nursing facilities to serve on the Board of Directors.

From 1992 to 2001, Faber was a Health Representative to the AARP West Region, working with regional and state teams of volunteers and staff in five states to develop, implement, coordinate and evaluate health and long-term care consumer education, advocacy and community service projects.

In addition to her advocacy on behalf of nurses and long-term care residents, Faber has shared her experience and passion for advocacy by mentoring nurses and helping them get involved. She was an early member of PUNCH, Politically United Nurses for Consumer Health, which was the forerunner of WSNA-PAC, and her advocacy continues to this day. Faber is a trustee of the WSNA-PAC and a member of the Washington Senior Citizens Lobby and the League of Women Voters. She also lectures at the University of Washington School of Nursing.

Faber's many awards and recognitions include the King County Nurses Association Nurse of the Year in 1976, admission as a fellow with the American Academy of Nursing in 1980 and the Resident Councils of Washington Recognition Award in 2012.

# Judy Huntington, MN, RN

**In her five decades as a nurse, Judy Huntington has worked as a staff** nurse, nurse manager, policy advocate, educator and union leader. She has shaped national and state health policy, led effective coalitions and built the Washington State Nurses Association into a vibrant, powerful voice for nurses. On so many levels, Huntington has had a lasting impact on the profession of nursing and the work lives of nurses.

Huntington served as Executive Director of the Washington State Nurses Association for nearly 19 years. During that time, she built the organization's finances, more than doubled membership and presided over remarkable policy and contract gains for nurses in Washington state. During her tenure, WSNA's advocacy efforts on behalf of nurses and patients were remarkably successful, with numerous new laws and rules enacted to protect nurses and ensure patient safety. WSNA is the leading voice and advocate for registered nurse in Washington state thanks largely to Huntington's leadership.

But Huntington's influence on the nursing profession and health care policy started long before her time as WSNA's Executive Director and goes far beyond Washington state. From local unit leadership at Seattle Children's Hospital to leading health reform efforts at the American Nurses Association in Washington, D.C., Huntington has been a fierce advocate for nurses and patients throughout her career.

Even before her graduation from the University of Washington School of Nursing in 1968, Huntington threw herself into union work. When she was working as a student nurse at Seattle Children's Hospital the summer after her junior year, she signed on to the mass resignation in 1967, joining the staff nurses in their fight for a fair contract.

Huntington went on to work at Seattle Children's for 13 years, as a staff nurse, head nurse and supervisor.

In 1971, Huntington served as chair of the Seattle Area Hospital Council nurses negotiating team. By that time, nurses were legally allowed to strike, and after a packed meeting where Huntington urged them to do so, nurses voted to go out on strike. The Seattle Area Hospitals settled less than three hours before the strike was set to begin.

Huntington served in a variety of leadership roles at the local, state and national levels of WSNA, the ANA and the National Federation of Nurses, including President of WSNA from 1979 to 1983. She is also a founding member of the Washington State Nurses Foundation and the WSNA Political Action Committee, serving as Chair from 1974 to 1976.

For more than a year, from May 1983 through August 1984, Huntington was called upon to serve as WSNA's Interim Executive Director. It was a fairly short interim, but it was long enough for Huntington to file WSNA's first lawsuit after she learned that Seattle Area Hospitals had agreed to limit wage increases in all of their contracts.

Huntington earned her Master of Nursing degree from the University of Washington in 1985. While in graduate school, she worked part-time at St Cabrini Hospital, where she later worked for three years as director of hospital strategic planning.

Throughout her career, Huntington has been active in public policy and political action. In 1983, she was among the founding members of the Washington State Committee for Affordable Health Care, a coalition of leaders in health care, business and public policy responsible for crafting and successfully lobbying for passage of the Washington State Basic Health Plan.

In 1989, Huntington moved to Washington, D.C., to become Director of the ANA Division of Governmental Affairs, where she directed the ANA lobbying and political action agenda. She spearheaded the creation of Nursing's Agenda for Health Care Reform, a seminal effort that became the nursing profession's official platform during the 1992-1994 national debate on health care reform and put nurses on the health reform map. She also represented ANA on the National Leadership Coalition for Health Care Reform from 1990 to 1994.

Huntington went on to direct the ANA Department of Field Services and the Center for Labor Relations and Workplace Advocacy and to direct the Office of Strategic Planning, where she was responsible for overall association strategic planning, program development and for development of the award-winning ANA Website, NursingWorld.org.

In 1999, Huntington returned to Washington state as Executive Director of WSNA. She also served as Executive Director of the Washington State Nurses Foundation, Vice-President of the Washington Center for Nursing, member of the Executive Board of Directors of the Washington Health Foundation and a Vice President on the Executive Board of the Washington State Labor Council.

Huntington also was a leader in bringing together nurse educators, nurse executives and nursing unions to form the Washington Center for Nursing, which is charged with developing a comprehensive solution to address nursing workforce issues, including the nurse shortage and diversity in the profession.

Over the years Huntington has served as adjunct faculty at several universities. In December of 1998, Judy was awarded an Honorary Doctor of Science degree from Kent State University for her work in health policy and advancing distance learning through electronic communications and development of the Online Journal of Issues in Nursing (OJIN), an international, peer-reviewed nursing journal jointly sponsored by Kent State University and the ANA.

Huntington's numerous awards and honors include University of Washington School of Nursing Distinguished Alumni award in 2008, the Mary Mahoney Professional Nurses Organization Anne Foy Baker Award in 2015, the ANA Distinguished Membership Award in 2016 and the King County Nurses Association Shining Star Award in 2017.

Huntington's impact on WSNA, on ANA and on the nursing profession has been incredible and indelible.

# Karen Matsuda, MN, BSN, RN

**Karen Matsuda has served as a public health nurse, a school nurse,** an educator, a federal regional nurse trainer and Director of the Washington State Family Planning Program. She spent 23 years with the U.S. Public Health Service's Federal Region X, where she progressed to the highest levels of responsibility and decision-making in the administration.

Throughout her career, Matsuda has been dedicated to improving population health and pushing for advanced practice nurse training, both of which have made a tremendous impact on Washington state, as well as Alaska, Idaho, Oregon and the nation. Matsuda's contributions and excellence across all areas of patient care, leadership, education, public service, nurse advocacy, heroism, patient advocacy and clinical practice have made a lasting impact on patients and the profession of nursing.

Matusda earned her Bachelor of Science in Nursing from Seattle Pacific University in 1968 and her Master of Nursing Administration from the University of Washington 10 years later. She completed Women's Health Care Nurse Practitioner training from the Harbor/UCLA School of Medicine in 1973.

Matsuda began her nursing career as a public health and visiting nurse with the Seattle-King County Department of Public Health, where she provided home visits and worked in the Maternal and Infant Care, Children and Youth and Family Planning clinics. She went on to work as a school nurse, a Nurse Educator/Nurse Practitioner with Planned Parenthood of Seattle-King County and as a Health Services administrator for Title X family planning programs in the Washington State Department of Social and Health Services. She was a consultant and trainer for women's health and family programs for a decade before joining the U.S. Public Health Service, Region X, where she worked in progressively responsible positions for the next 23 years.

Advocacy for high quality patient care, especially for communities of color and families of lower income has been a prominent theme of Matsuda's entire nursing practice career. Her work included special initiatives related to women's health, minority health, family planning and reproductive health, HIV/AIDS, viral hepatitis prevention, children and adult immunizations and tobacco control.

As a senior-level health official for Federal Region X, Matsuda had a major influence on patient care throughout Washington state, as well in the other Region X states of Alaska, Idaho and Oregon. She was one of the first to promote Patient Flow Analysis to reduce patient wait times, firmly believing that providing high quality, yet efficient care was beneficial to the many clients who relied on public clinics because of lower socioeconomic status. A new idea at the time, it has now been widely incorporated in the Northwest.

While individual-level patient care has always been her principal focus, Matsuda has worked on a variety of broad-reaching health policy platforms to address population-level health. Early in her career as a public health nurse in the Seattle-King County Department of Public Health, she authored the first infertility guidelines for clinic protocols at SKCDPH and designed the first portable birth control kit for public health nurses to use during patient home visits.

Matsuda's exceptional ability to recognize health trends, conceptualize policies and adapt them to state-level priorities, along with her poise and articulate style, were recognized in her promotion to the highest level of management in the U.S. Public Health Service's Region X. She was the first nurse ever to be named its Deputy Regional Health Administrator. For three years she served as Acting Regional Health Administrator, which made her the most senior ranking federal public health official for the states of Washington, Alaska, Idaho and Oregon.

Matsuda worked throughout her career to advance educational and career opportunities for nurses and professionals of color. She established a fellowship in the Region X office that led to new, expanded education and prevention for the Tobacco Free Campus Initiative at higher learning institutions nationwide. She also helped establish an HIV-AIDS program consultant position in Federal Region X that advanced the careers of many professionals of color.

Matsuda served as a Clinical Instructor with the University of Washington School of Nursing's Department of Family and Child Nursing for over 13 years, working with both master's and postdoctoral students. She had special interest in mentoring students from underrepresented populations and guiding them through career development even after they completed their academic program.

Among her many honors and awards, Matsuda has received the Distinguished Alumnus award from the University of Washington School of Nursing, selection into the Seattle Pacific University Alumni Hall of Fame Honor Roll and honors from numerous community organization for her advocacy for nurses and modeling excellence.

Matsuda has been a strong advocate for nurses over her entire professional career. She has had a lifetime of extraordinary performance in roles serving local, state and federal levels, representing the nursing profession with distinction.

# Barbara Van Droof, MN, ARNP

**In her long nursing career, Barbara Van Droof has worked as an** educator and an advocate, with a special interest in elderly patients, long-term care and end of life with dignity. She has acted as an advisor and curriculum developer on behavioral health issues such as mental illness, substance abuse, working with angry behaviors in clients and families and caring for the person with AIDS. She has served WSNA and numerous other nursing organizations at the local and national level to advance the interests of patients and the profession of nursing.

Van Droof earned her nursing diploma from the Presbyterian St. Luke's Hospital School of Nursing in Chicago in 1960. She went on to the University of Washington to earn her Bachelor of Science in Nursing in 1965 and her Master of Nursing in 1972. She completed post-Master's work to become an ARNP in Adult Nursing in 1994.

Van Droof has been a member of WSNA since 1962. Her interest and expertise in adult care is evident in the many positions she has held with the association. In 1979 she was elected chair of the WSNA Gerontology Interest Group, and she went on to serve with the group in various capacities into the 1980s. She served on the WSNA Bylaws Committee from 1986 to 1990 and on the Legislative Committee from 1988 to 1990. In 1992, Van Droof traveled to Olympia and Washington, D.C. to speak in committee meetings about issues related to older adults, elder abuse and end of life.

Beginning in 1970, Van Droof served on the faculty at Shoreline Community College for more than 37 years, most of that time as a full-time professor. She continually worked to enhance the curriculum and engage students in meaningful experiences. She integrated palliative care concepts into the curriculum and involved students in co-leading volunteer groups in adult day health and outpatient mental health settings. Van Droof tutored many students and was especially successful with non-native speaking students, including RNs from outside the U.S., to successfully complete psychiatric nursing for NECLEX.

With a Workforce and Economic Development grant award from Shoreline Community College, Van Droof completed a two-year project in 2005 on dietary technicians, health care information technicians, medical laboratory technicians and associate degree nurses that led to forward-thinking curriculum development to meet the needs of the current and future workplace.

In addition to her work at Shoreline Community College, Van Droof taught Master's level advanced assessment and clinical skills in the nurse practitioner program at Seattle Pacific University for four summers, between 2002 and 2006.

Her research, training and curriculum development included working with Western Washington University to develop, present and evaluate conferences as mandatory statewide continuing education courses for DSHS adult service workers and supervisors on "Working with vulnerable adults: chronically mentally ill, abused older adults, persons who misused alcohol and developmentally disabled adults." The pioneering curriculum was used to increase the standard of care and improve self-confidence in DHSH social service workers.

Van Droof was a longtime member of the National League for Nurses, a national organization for faculty nurses and leaders in nurse education, and served the state organization, Washington League for Nursing as president from 1998 to 2004. As part of that work, Van Droof in 2001 sponsored a nursing summit to develop a strategic plan for nursing education in Washington state. Work from that summit and meetings of nurse leaders led to creation of the Washington Center for Nursing in 2003.

Both before and during her time as a nursing professor, Van Droof worked as a staff and charge nurse in numerous facilities in intensive care units, in-patient specialty units and public health. After she received her ARNP certification, she worked in long-term care for 10 years at Cascade Vista and Evergreen Vista convalescent centers.

In 2007, Van Droof joined the board of the Peoples' Memorial Association, a non-profit organization specializing in dignified death planning, education and care that reflect the client and families' values and resources. In her five years on the board, Van Droof facilitated a reorganization of PMA, helped sponsor a national convention in Seattle in 2010 and lectured on benefits of PMA membership to facilitate education on pre-planning funeral and memorial options such as green burials. She served on the national board of the Funeral Consumers Alliance from 2011 to 2014.

Van Droof was given the Shoreline Community College Women's Center Woman of the Year award in 1989 and was selected as the King County Nurses Association Nurse of the Year in 2002. ■

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# VICTORY

## Yakima Regional home health, hospice nurses win nearly $2.9 million for hours worked off the clock

*By Ruth Schubert*
*WSNA Communications Director*

Home health and hospice nurses at Yakima Regional Medical and Cardiac Center won $2.895 million in damages Feb. 14, after Yakima County Superior Court Judge Blaine Gibson ruled that that the hospital acted "knowingly, willfully, and with the intent to deprive" the nurses of pay for their hours worked and their missed meal breaks.

The court ruled that because Yakima Regional's state wage law violations were knowing and intentional, the nurses should be awarded twice the amount of back pay that they were denied. These damages for willful violations were awarded under RCW 49.52, which is a protective measure to assure payment to employees of wages they have earned.

"As nurses, we will not be deterred in giving our patients the care they need and deserve," said Dan Campeau, RN, one of the nurses involved in the lawsuit. "Employers must be held accountable and nurses deserve to be paid for hours worked."

The Washington State Nurses Association filed the lawsuit on behalf of Yakima Regional home health and hospice nurses in April 2015. The ruling is the latest in a string of legal victories WSNA has won seeking to ensure our members get their breaks — and when they don't, that employers pay them for the hours worked. Other cases include WSNA v. Sacred Heart Medical Center, decided by the State Supreme Court in 2012, which established the right to overtime pay for missed rest breaks and expanded the right to rest breaks for nurses.

Favorable lawsuit settlement agreements that included provisions for better record-keeping, and policies and procedures to ensure nurses receive breaks were reached with Evergreen Hospital in 2011; with MultiCare, owner of Tacoma General and Good Samaritan, in 2013; and with Franciscan Health-St. Joseph Medical Center in Tacoma in 2016. The St. Joseph Tacoma settlement provided $5 million in back pay to nurses for missed breaks and put an end to intermittent breaks through commitments to implement block rest breaks across the hospital and to create 26 FTE new, dedicated break-relief nurses.

In the Yakima Regional case, evidence at the trial showed that Yakima Regional managers routinely paid nurses for eight hours of work a day, knowing that the nurses were regularly working additional hours to give patients the care they needed, complete required documentation and coordinate care with doctors and pharmacists.

Yakima Superior Court Judge Gibson ruled that "overwhelming evidence" proved that Yakima Regional broke state law when it forced its home care nurses to work substantial amounts of uncompensated time off the clock between April 21, 2012 and Aug. 31, 2017.

In evidence presented, nurses said they were told by management that they wouldn't be paid for additional work, like charting and coordinating care, or for care given to patients beyond their scheduled eight-hour shift.

Nurses said that, given the nature of their work, such as when a patient could be nearing the end of their life or might have a setback that required additional time and attention, it was nearly impossible to fit their work into a rigid schedule and patient visit load. They were given virtually no flexibility regarding hours worked and were denied paid hours necessary to spend more time with a patient and family, even though they would never walk away from a patient in need, and to perform necessary charting relating to that patient care.

Nurses who fought for pay for all hours worked were reprimanded. "I can't tell you how many times I was called in to my administrator's office and yelled at, screamed at," one nurse testified. At one point she was told, "if I didn't like it I could find another job." After complaining that she was tired of working overtime for free, another nurse testified she was told "you could turn in your resignation by email."

Judge Gibson also ruled that the home care nurses were denied uninterrupted half-hour meal breaks, to which they are entitled by state law, on at least 90 percent of the days they worked long enough to be entitled to a meal break. The judge noted that to ensure that their patients received needed care in a timely way, and to complete all work required for each home health or hospice patient visit, including charting, the nurses had to work through their meal breaks, including regularly taking telephone calls from physicians and pharmacists, because delaying those calls was not in the patients' best interest. Otherwise, the judge noted, the nurses would end up "playing phone tag" while their patients suffered.

"This is a tremendous victory, not only for the nurses who were forced to work off the clock to give their patients the care they need, but for nurses across the state," said Julia Barcott, RN, Chair of WSNA's Cabinet on Economic and General Welfare. "It is really powerful to see what nurses standing together in unity can do for nurses and quality patient care — whether we're in the courtroom, at the bargaining table or in the legislature." ■

Negotiating team members at University of Washington Medical Center (back row, left to right) Anita Stull, Henry James, Teresa Wren and (front row) Trish Nilsen and Miko Robertson.

## UW per diem nurses join WSNA

On March 2, representatives from the University of Washington Medical Center and the Washington State Nurses Association met for the first negotiating session for a new collective bargaining agreement for per diem nurses, who recently became part of the bargaining unit represented by WSNA.

Approximately 165 per diems working at UWMC officially became represented by WSNA on Dec. 29, 2017, when the Public Employee Relations Commission ruled that they should be part of the existing bargaining unit. WSNA is represented in negotiations by per diem RNs Miko Robertson and Trish Nilsen; classified RNs Teresa Wren, Harry James and Anita Stull; attorney Dave Campbell and WSNA Nurse Rep Ed Zercher.

WSNA and the per diem nurses at UWMC worked for nearly two years to bring this about. Per diem RNs first asked WSNA to be allowed to join the union in 2015 after seeing an active WSNA membership at UWMC stand in solidarity and speak with a loud voice to get a great contract, which was ratified in January 2016. That same month, WSNA filed a unit clarification petition with PERC to allow the UWMC per diem RNs to join WSNA. UWMC fought against this and, unfortunately, PERC's ruling did not allow per diems to automatically be allowed to be a part of the bargaining unit with the classified RNs.

In Spring 2017, during contract bargaining with UWMC, WSNA proposed that the UWMC per diem RNs be allowed to join WSNA and be considered during those contract negotiations. UWMC rejected this proposal. Consequently, WSNA went back to PERC and filed a second unit clarification petition.

A favorable ruling came at the end of the year, giving per diem RNs at UWMC a strong, union voice in their wages and working conditions.

A second negotiating session was held on March 13, with an additional session scheduled in April. ■

# PROUD WSNA UNION MEMBERS ARE SPEAKING UP!

Across the state, proud nurses are speaking up and standing up for their union. Join them! Learn about threats to our union, share your story and recommit to WSNA at wsna.org/union-strong.

## I can't imagine being a nurse and not being a member of the local union.

**Steve Connelly, RN**
Overlake Hospital Medical Center, Bellevue

I was originally licensed in Louisiana in 1994. I worked for multiple hospitals in the Baton Rouge area until I became so dissatisfied in 2011 that I accepted a travel contract to Seattle, and I have been here since that time.

The issue that caused many nurses a great deal of dissatisfaction, is that there is no advocate between the nursing staff and management, because Louisiana is a right-to-work state. There is no level of protection from management from harassing employees, employees can be fired at any time for any reason and there are no negotiations for better salary or better work environments.

Truthfully, I at first bristled at the thought of paying my union dues, but when I learned all the benefits that I received because of my union membership, I became a loyal supporter of the union. My relationship with the union has been a very rewarding experience, and I can't imagine being a nurse and not being a member of the local union.

## When we are all involved in our union, we achieve better wages and working conditions for nurses, which means better care for our patients.

**Cheryl McDaniel, BSN, RN**
St. Luke's Rehabilitation Institute, Spokane

I care for patients rehabilitating from brain injuries and have worked as a nurse for 20 years. I have worked in both union and non-union hospitals, so I know the difference having a union makes.

WSNA gives us a structure and a voice to raise concerns and problems specific to nursing with hospital administration. Over the years, we have gotten more support as nurses in the form of having nurse managers on each floor, getting more creative and appropriate staffing, adding the charge nurse position and offering better precepting and support for new nurses.

When we are all involved in our union, we achieve better wages and working conditions for nurses, which means better care for our patients.

## I am proud to be a WSNA member – together we're strong!

**Joyce Makori, RN**
Kindred Hospital, Seattle

I have been a nurse for over 10 years and I have worked in Washington and Ohio.

The hospitals I worked for in Ohio had no unions, and we had to rely on the administration to make decisions regarding our welfare at work. In fact, my last hospital paid the same hourly rate to all the nurses who worked in my unit. Experience didn't count and wasn't rewarded. We really didn't have a say on anything that affected us. The administration made the rules and we were expected to play by them or leave. This was frustrating to us! Good thing, I was only there for 2½ years.

It's nice to belong to a professional organization because you're in the same situation with the other members that you can learn from. The WSNA representatives are nurses, so they understand us best. WSNA is the nurses' voice. When we come together, we're more powerful than if we said or did the same things individually.

It's hard to do, but through being actively involved with WSNA, we've made progress improving our work conditions. For example, work assignments are manageable and acceptable to an extent. Any raises that we've received or will receive will be a result of WSNA members coming together to negotiate, and WSNA staff is always there advising us. This is our organization and it's always nice to know that we have each other's back.

I am proud to be a WSNA member, together we're strong!

## More nurses getting involved in WSNA means more power.

**Harry James, RN**
University of Washington Medical Center, Seattle

I've been a nurse at the University of Washington Medical Center for over 30 years, and I have been on a lot of bargaining teams. I know from experience that it's so important for members to stand together and show unity to gain more benefits and keep the ones that they have. The number of nurses that get involved and show support makes an absolutely critical impact for the management to listen to the nursing staff.

At one point, management wanted to implement mandatory call house-wide for all nurses. Because we stood together and said "NO" we were able to fight off this proposal that would have been terrible for the nurses. It is only when we stand united that we can best advocate for our patients and ourselves; otherwise, we are one voice lost in the wind.

# Threat to our freedom in Washington

**BIG MONEY AND CORPORATE CEOS** are attacking workers' rights at the U.S. Supreme Court and in Congress. Here in our state, the Freedom Foundation is leading the fight against our interests and our freedom. Funded by outside groups and monied interests, they are working against our efforts to improve health benefits and working conditions. They oppose funding for public employee contracts and lobbied against paid sick leave.

For more than 100 years, WSNA has been fighting for better working conditions, improved wages and respect for registered nurses and the care we provide. In a changing health care environment, we have stood together for our patients.

Extremist groups like the Freedom Foundation don't care about working people, fair wages and safe working conditions. They don't care about high quality patient care. Their goal is to pay lower wages, reduce benefits, lower safety protections at work and take away our freedom to join together in unions.

| **Our union** – Patients before profits | vs. | **Freedom Foundation** – Profits before people |
|---|---|---|
| Fights for fair wages to keep up with cost of living and enhance recruitment and retention | | Fights against funding public employee contracts |
| Defends our employment rights | | Opposes collective bargaining |
| Supports strong families and healthy communities | | Opposes paid sick leave |
| Is transparent and member-run | | Hides funding by wealthy special interests |
| Advocates for worker power | | Opposes union rights |
| Represents more than 18,000 nurses around the state | | Represents extremist out-of-state political groups and corporate foundations |

HURRICANE BLIZZARD EARTHQUAKE
FLOOD TERRORIST ATTACK TORNADO
VOLCANO NATURAL DISASTER

# Be prepared for the unexpected.

Get a WSNA emergency preparedness kit.

## 'First Responder' kit

~~MSRP $74.95~~
**Member price $55**

**Sling bag**

(16) Datrex **emergency drinking water pouches**

Datrex packet of 18 **food bars**

84" × 52" **thermal blanket**

(2) Air-activated 12-hour **body / hand warmers**

**AM/FM radio**

**Hygiene pack:**
(1) tissue packet, (3) moist towlettes, (1) biohazard waste bag, (1) n-95 dust mask, (2) sanitary napkins and (1) zip baggie

(3) **Trash bags**

(2) **12-hour light sticks**

(2) **Zip baggies**

**Flashlight** with two D cell batteries

Hooded **poncho**

Deck of **playing cards**

(1) Pair **leather palm gloves**

**First aid pack**:
(3) 2" × 2" gauze pads, (1) 5" × 9" abdominal pad, (10) plastic strip bandages, (1) roll Kendall tape, (3) antiseptic towlettes, (2) antibiotic ointments, (1) pair vinyl gloves and (3) alcohol wipes

**Whistle**

### BILLING ADDRESS

Name

Address

City

State Zip

Phone

### SHIPPING ADDRESS

☐ Same as billing address

Name

Address

City

State Zip

### YOUR ORDER

LINE 1 **NUMBER OF KITS** ( _____ × $55) _____

LINE 2 **SHIPPING** ($12.50 per kit) _____

LINE 3 **SUBTOTAL** (line 1 + line 2) _____

LINE 4 **TAX** (subtotal × 10%) _____

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# WSU alum advocates for nursing, patient care across Washington

The past president of Nursing Students of Washington State has advocated for patients at WSNA's Nurse Legislative Day and has accepted a job at Kadlec Regional Medical Center in Richland.

*By Maegan Murray*
*WSU Tri-Cities*

**ADAM HALVORSEN KNOWS** that providing the best possible patient care is crucial in the health field, which is why he is using his degree in nursing from Washington State University Tri-Cities to advocate for better care for patients and for his nursing colleagues across the state.

Halvorsen got involved in advocating for nursing policy as a student at WSU Tri-Cities. Little did he know his efforts would lead him to become the WSU College of Nursing Outstanding Undergraduate Student this fall.

"It's been an amazing ride so far," he said. "I've been very humbled by this profession and by my incredible colleagues, and I'm excited to see where it leads me."

### Inspired by service

Halvorsen's passion for service grew out of his start in the military. The day after 9/11, he signed up for the U.S. Marine Corps and spent four years active-duty with time in Okinawa, Japan, as well as through a tour in Iraq.

"Sept. 11 happened and on Sept. 12, I signed up," he said. "I saw a need and I went for it. My core philosophy is service. I believe in service to others before self."

After he left the armed forces, Halvorsen continued his career in service in two jobs: as an emergency management technician for Medstar Ambulance and as a firefighter for the Gallup Fire Department in Gallup, New Mexico. He enjoyed those roles, he said, but he wanted to be a part of the long-term care and recuperation of his patients, rather than just being a part of their initial care in his emergency care roles.

"The thing with nursing is you don't see a person at their height of being – you see people at their base," he said. "To be able to be allowed in that moment of their lives and to try to have a positive impact, it is a blessing to be able to do that."

He enrolled in the WSU Tri-Cities nursing program, which is where he was introduced to opportunities that would allow him to use his passion to better nursing and patient care for Washington state.

### Leadership in nursing

In addition to the hands-on training he received from his experienced professors and instructors in the WSU Tri-Cities nursing program, Halvorsen received the opportunity to take on leadership roles within several state nursing organizations.

He served as president of Nursing Students of Washington State. His experience at WSU also led him to serve as part of the Washington State Nurses Association, as well as attend a national conference through the National Student Nurses' Association. Through these affiliations, Halvorsen had the opportunity to provide input on association policy, expand communication efforts through video, as well as generally advocate for his peers and future colleagues in nursing.

Last year, Halvorsen also joined his WSU peers to represent WSU at Nursing Day at the Capitol in Olympia, which allowed him to interact with prominent government figures to advocate for patient care and speak publicly about the importance of nursing education and the nursing profession.

Halvorsen said he hadn't initially planned on getting involved with these types of leadership roles or that it would

lead him earning the WSU College of Nursing Outstanding Undergraduate Student award.

"I honestly didn't expect it, but I'm honored to represent my incredible peers for the work we have accomplished together," he said.

**Future as a nursing leader**

Halvorsen said the primary reason behind his activism in the nursing field is that he is able to have a positive impact, not only on the current state of health care, but also its future.

"If we could get more students interested in being proactive, not only in policy, but in their communities, we could have a much better impact in nursing, compared with what we think our limits are as student nurses," he said. "Washington has amazing potential – we have a lot of schools and students out there. There's an amazing opportunity to grow nursing and help people."

After graduating this fall, Halvorsen now has the opportunity to exude even more leadership through his role as a director for the National Student Nurses Association where he is also head of the ethics and governance committee for the organization. Additionally, he has accepted a position as a full-time nurse in the cardiac department of the Kadlec Regional Medical Center.

After spending a few years as a full-time nurse, he plans to obtain his doctorate of nursing practice. He hopes to use his career experience and academic credentials to continue with advocacy work and volunteer opportunities. His long-term goal is to work with the American Nursing Association to develop and refine nursing policy.

"It's been incredible experience so far, both through my education with incredible professors at WSU, in addition to what I've been able to participate in through state and national organizations," he said. "I hope to keep having an impact in nursing so that everyone can benefit."

Halvorsen said he couldn't have accomplished his feats without the mentorship he received from the the nurses at WSU, WSNA and those within the NSNA.

"Their guidance and leadership has taught me so much that I will continue to use throughout the rest of my career," he said. ■

This article is reprinted with permission of the Washington State University College of Nursing.

# Our trip to support fellow PeaceHealth nurses in Ketchikan

*By Mary Katz, RN, and Ben Katz, RN*
*Nurses at PeaceHealth Southwest Medical Center in Vancouver*

On Saturday, Feb. 17, 2018, we flew to Ketchikan, Alaska to show support for our fellow PeaceHealth nurses who were negotiating their new union contract. It was a great opportunity to connect with nurses from another PeaceHealth hospital that work and live under very different conditions than ourselves.

We were greeted by a couple nurses from Anchorage who were members of the Alaska Nurses Association (AaNA). They had come down to show support and solidarity to the nurses in Ketchikan as well. We met up with a group of people at the busiest intersection in Ketchikan to hold an informational rally — mind you that there is only one main intersection in Ketchikan. There were people from various organizations and unions, including the local nurses from Ketchikan, local teachers, as well as people from the local maritime union, all out on the street in the cold to show support for the nurses.

The nurses in Ketchikan need our support to receive a fair contract. One of the biggest issues that they are facing is their rate of pay, which is currently the lowest of all the PeaceHealth facilities, and is well below the current cost of living in Ketchikan. They also have difficulty with nurse retention, leading to higher utilization of agency and travel nurses, which costs the organization millions of dollars.

Having this opportunity to connect with the people in Ketchikan really was wonderful to see how a small town can come together to support each other. As nurses, we all face similar struggles and need to support each other no matter where we are at geographically. In the past, we have received support from PeaceHealth in Bellingham during negotiations, which helped to reach a contract agreement quickly. All the support that they have received in Ketchikan has appeared to have paid off as they were able to reach a tentative contract agreement in late February. ■

# Recently settled contracts

| | Wage increases | | Other gains |
|---|---|---|---|
| **Morton / Lewis County Hospital**<br>Morton | 1st year<br>2nd year | 5%<br>4.5% | › Signing bonus for RNs $1,900 and LPNs $634 (both prorated to FTE)<br>› Evening shift differential increased from $2.50 to $2.75 per hour<br>› Charge nurse premium increase to $2.75 per hour<br>› Standby rate increased from $3.50 to $4.00 per hour. Nurses living more than 10 miles from the hospital have 60 minutes to report, rather than the current 30 minutes<br>› Clarified work day language<br>› Improved low census standby language<br>› Enhanced staffing language<br>› OR staffing and coverage committee developed |
| **Northwest Hospital and Medical Center**<br>Seattle | 1st year<br>2nd year<br>3rd year | 4% (steps 1-19) and 2.5% (steps 20-30)<br>3%<br>3% | › Added steps 22, 24,26, 29 and 30<br>› Ratification bonus $700 per nurse (prorated to FTE)<br>› New float premium of $1.50 for non-float pool nurses who float<br>› BSN premium of $1.00 per hour worked<br>› Improved shift differential language<br>› $200 per nurse per year for educational expenses (prorated to FTE)<br>› Enhanced staffing committee language<br>› All newly hired and nurse transferring to a new unit shall be assigned a preceptor |
| **PeaceHealth St. John Medical Center**<br>Longview | 1st year<br>2nd year<br>3rd year | 3.25%<br>3%<br>3.25% | › New step 32 added 1.5% above step 30<br>› Enhanced staffing committee language<br>› Contractual commitment to staff to permit nurses to receive meal and rest breaks, use PTO, nurses will not receive patient loads above the matrix except in emergent circumstances and charge nurses will not carry full patient load if can be avoided<br>› Work schedules will be in six-week cycles<br>› Improved low census language<br>› Increase charge nurse pay<br>› Hours worked in call back will count as a shift for the purpose of rest between shifts premium |
| **PeaceHealth United General Hospital**<br>Sedro Woolley | 1st year<br>2nd year<br>3rd year<br>4th year | 3%<br>3%<br>3%<br>3.5% | › New step 32 added 6% above the current last step<br>› Enhanced language regarding safe staffing committee<br>› Increase certification differential to $1.10 per hour<br>› Increase preceptor pay to $1.50 per hour<br>› Establishment of a health benefits committee |
| **Snohomish Health District**<br>Everett | 1st year<br>2nd year<br>3rd year | 2.6%<br>2.75%<br>2.75% | › Full-time nurses to receive an additional $370 monthly toward dependent insurance coverage if it is chosen (prorated to FTE)<br>› On-call stipend increased to $25 per day, and 10-minute minimum pay for each call taken<br>› Numerous enhancements to sick leave<br>› Improved language regarding travel on work time<br>› Enhanced work week language |

## WSNA UNION Leadership Summits

The WSNA Union Leadership Summits bring a day of education and strategy to a city near you. Get ready to talk with other nurses about:

**Safe Staffing** – How to make the 2017 Staffing Law work for you in your facility.

**Workplace Violence** – Learn more about what types of violence nurses face and how you can help create a safer work environment in your facility.

**Attacks on Worker Rights** – Learn about the movement to silence your voice in the workplace and how you can stop it.

Our discussions will include education, strategy discussions and networking with other RNs in your community. You will walk away with tools to make a difference and earn 6 CNEs.

**May 19**
**Teamsters 58, Vancouver**

**June 2**
**Good Shepherd Center, Seattle**

**June 10 and 11**
**Campbells Resort, Chelan**

**Sept. 8**
**Red Lion (Columbia Center), Kennewick**

**Sept. 30 and Oct. 1**
**Campbells Resort, Chelan**

**Nov. 3**
**Skagit Casino, Mt. Vernon**

In conjunction with Leadership Summit events on Sept. 8 and Sept. 30, we are holding 'Nurses Speak' – a meet and greet with state legislators and legislative candidates!

**Visit www.wsna.org/leadership for more details and to register.**

# 2018 NURSE APPRECIATION DAY

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## SUNDAY, MAY 6
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- Receive a Mariners scrub top when you purchase through this special offer (while supplies last).

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Deadline to purchase tickets:
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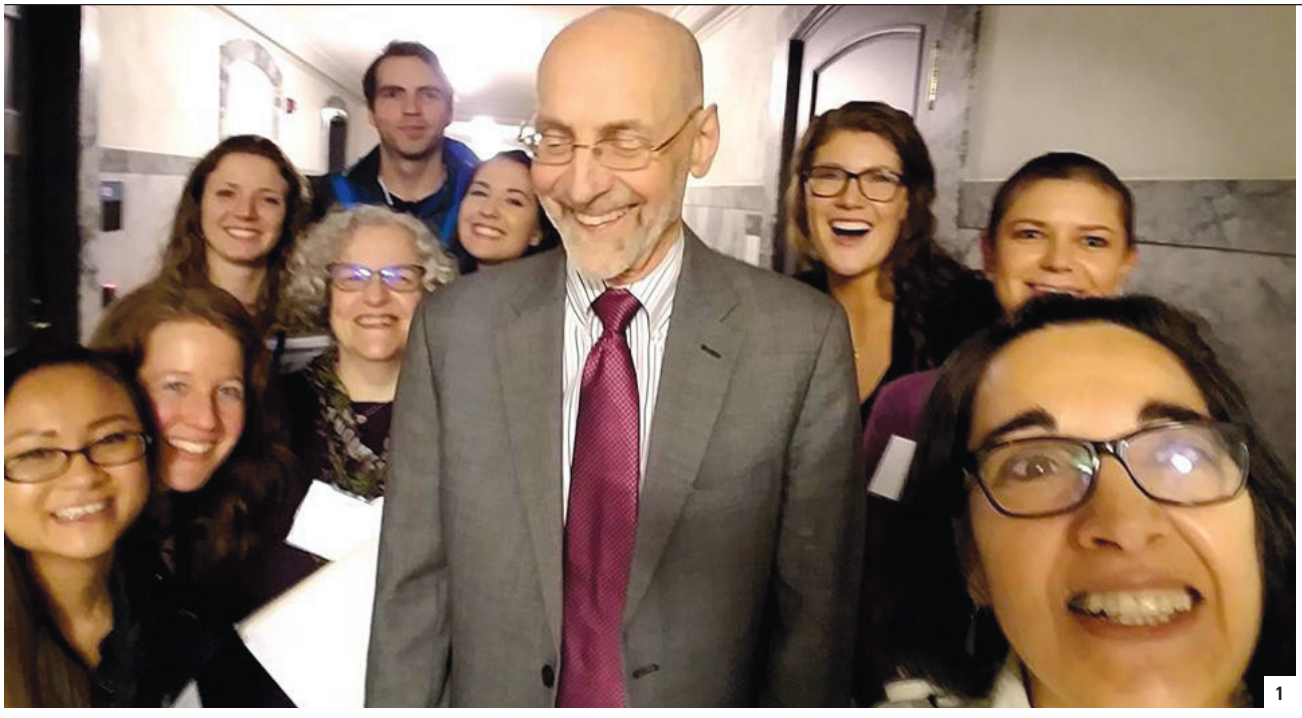

# WSNA IN OLYMPIA

## **2018 ADVOCACY CAMP** AND **NURSE LEGISLATIVE DAY**

This legislative session, 600 nurses and nursing students gathered at the state capitol on January 22, for Nurse Legislative Day. Governor Jay Inslee provided the keynote address, and WSNA honored four legislators for their work during the 2017 legislative session. After a morning training, nurses met with legislators in the afternoon to advocate for #Breaks4Nurses.

Nurse Legislative Day followed on the heels of WSNA's Advocacy Camp and Legislative Reception which took place in Olympia on January 11. Sixty-six nurses and nursing students braved wild weather and closed mountain passes to join WSNA for a deep dive on 2018 legislative priorities and training on how to advocate for issues that impact nurses and patients.

**1** Rep. Larry Springer (D-45) meets with nurse constituents.

**2** Rep. Mike Volz (R-6) meets with Spokane nurses and nursing students.

**3** The Legislative and Health Policy Council presents a panel discussion on nursing's top legislative issues for 2018.

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**4** More than 600 nurses and nursing students gather to learn and to share their stories with their legislators.

**5** Speaker of the House Frank Chopp (D-43) talks with nurses.

**6** Gov. Jay Inslee delivers the keynote address.

**7** Sen. Hans Zeiger (R-25) receives a Legislative Champion Award from WSNA and the School Nurse Organization of Washington (SNOW) for his sponsorship of the School Nurse Supervision bill which passed in 2017.

**8** Rep. Eileen Cody, RN, (D-34), one of four legislators to receive WSNA's 2017 Legislative Champion Award, meets with nurses from her district.

## 2017 Legislative Champion Awards

At the 2018 Nurse Legislative Day, WSNA presented four Legislative Champion Awards to lawmakers who championed pro-nurse legislation during the 2017 session. This year's awards went to:

**Senator Ann Rivers (R-18)** for her work to shepherd HB 1714, the Safe Nurse Staffing bill, through the State Senate.

**Representative Eileen Cody (D-34)** for sponsoring and championing HB 1714, the Safe Nurse Staffing bill that passed the legislature in 2017.

**Senator Hans Zeiger (R-25)** was honored jointly by WSNA and the School Nurse Organization of Washington (SNOW) for his sponsorship of the School Nurse Supervision bill, which passed the legislature during the 2017 session.

**Representative Larry Springer (D-45)** was also honored by WSNA and SNOW for his sponsorship of the School Nurse Supervision bill, HB 1346, which passed the legislature last year.

# LEGISLATIVE SESSION REPORT 2018

**THE LEGISLATURE ADJOURNED SINE DIE** on March 8, the last day of the 2018 regular session. It was a fast and furious short, 60-day session as the legislature worked to pass policy bills and a supplemental operating budget, updates to the 2017-19 budget for the second year of the biennium.

Thank you to every nurse who advocated for the legislature to pass House Bill 1715, which would mandate uninterrupted meal and rest breaks for nurses and would close the mandatory overtime loophole. We made a huge grassroots push — and a lot of noise — during the final weeks of session, trying to move this bill to the Senate floor. While we were successful in moving this bill the farther through the process than in past years, ultimately time ran out before this bill could be voted on by the full Senate. That said, our 2019 campaign for rest breaks starts now (see article on page 64)!

Despite the disappointing outcome on House Bill 1715, some other major policy wins deserve celebration – such as the passage of House Bill 1047, which creates the nation's first statewide Secure Medicine Return program, and House Bill 2101, which seeks to increase the availability of Sexual Assault Nurse Examiners (SANEs). The expansion of the Washington State Opportunity Scholarship program, through House Bills 2143 and 1452, will offer new education funding pathways for future nursing students.

Please read on for summaries of WSNA's budget priorities and policy bills of interest.

# BUDGET PRIORITIES

The legislature passed its final 2018 supplemental operating budget on March 8. The final budget was largely good for health care and for WSNA's budget and policy priorities – making strong investments to address the opioid epidemic and providing new opportunities for health care scholarships through the Washington State Opportunity Scholarship program. Public Health – Seattle & King County received an additional $3 million to prevent and respond to Communicable Disease, the state's Secure Medicine Return program received funds to begin program design work and the Bree Collaborative was funded to identify best practices for mental health services regarding patient mental health treatment and patient management.

| WSNA priority | Budget amount | Description |
|---|---|---|
| **Nursing education funding: scholarship match** | $4.336 million | Funding for the expected state match requirements for the Washington State Opportunity Scholarship program (added advance degree health professions in policy bill). |
| **Nurse education funding: expand scholarship opportunities** | $500,000 | Pursuant to HB 1452, funding is provided for anticipated state match requirements due to expanding the WSOS program to students pursuing a two-year certificate and degree programs. |
| **Public health funding: King County communicable disease prevention and response** | $3 million | Funding for King County to address the prevention and response to communicable diseases, including zoonoic and emerging diseases and chronic hepatitis B and hepatitis C. |
| **Address the opioid crisis: data tracking** | $996,000 | Funding is provided for DOH to (1) establish a statewide electronic emergency medical services data system for licensed ambulances and aid services to report and furnish patient encounter data, (2) distribute knowledge-based identity verification for the prescription monitoring program, health care supplies through hub and spoke community-based public health programs, and (3) perform |
| **Address the opioid crisis:increase medicaid medication assisted treatment rate** | $6.156 million | Funding is provided to increase the Medicaid Medication Assisted Treatment (MAT) rate for opioid use disorder to match the Medicare rate to encourage more providers to treat patients with opioid use disorder. |
| **Address the opioid crisis: hub and spoke expansion** | $4.630 million | The "hub and spoke" model is a term used to describe a specific treatment network model used to provide care for individuals with opioid use disorders. Funding is provided to create an additional four hub and spoke networks. |
| **Address the opioid crisis: Naloxone distribution** | $864,000 | Unobligated federal block grant funds are appropriated to support efforts to increase access to opioid reversal medications. |
| **Address the opioid crisis: tribal opioid reduction grants** | $1.5 million | Unobligated federal block grant funds are appropriated to provide grants to tribes to reduce opioid use through prevention and expansion of treatment. |
| **Address the opioid crisis: medication assisted treatment tracking tool** | $1.3 million | Unobligated federal block grant funds are appropriated to develop and implement a capacity tracking tool for medication-assisted treatment providers. |
| **Secure medicine return: drug take-back program** | $1.120 million | Unobligated federal block grant funds are appropriated to support agency efforts to encourage individuals to return unused prescription drugs to designated sites for safe disposal. |
| **Access to mental health services (Volk Decision): Bree Collaborative Workgroup** | $40,000 | Funding to create a workgroup at the Bree Collaborative to identify best practices for mental health services regarding patient mental health treatment and patient management. |

# Our 2019 rest breaks campaign starts now

**DESPITE A DISAPPOINTING ENDING** this year, nurses and other health care workers made a huge grassroots push during the 2018 session. Hundreds of nurses called their legislators, wrote postcards, posted on social media and sent thousands of emails asking lawmakers to pass HB 1715. We made strong progress, despite being up against tough opposition.

Hospitals continue to oppose the Rest Breaks bill – saying it will cost too much to hire break relief nurses and that they want to retain the "flexibility" to cover nurse staffing shortages by assuming nurses will work through breaks and by assigning mandatory overtime for non-emergency situations.

But while hospitals have far, far more paid lobbyists than nursing organizations like WSNA, we have you! With 17,000 WSNA members around the state, we have the power to make legislators listen if we all step up.

## *What can I do?*

**You can set us up for success in 2019 by engaging in these five activities now!**

Email your State Senator and express your disappointment that this bill was not voted on in the Senate – ask that the Senate pass a bill in 2019.

Donate to WSNA-PAC and help us thank legislators who stood with nurses and patients – and hold accountable those that did not. Donate at wsna.org/pac/donate.

Get involved in elections. Nearly every member of the legislature is up for re-election this year; volunteer for your legislator's campaign and talk with her or him about the importance of rest breaks.

Tell us your story. How do missed meal and rest breaks impact your patient care? How do missed breaks impact the nurses around you – are they burned out? Do you know a nurse whose missed breaks have contributed to a decision to leave the profession? Email your story to: stories@wsna.org.

Meet with your legislator. WSNA will be meeting with legislators over the remainder of 2018. Please let us know if you would like to join us for a meeting with your legislator! Email: nskorupa@wsna.org.

# POLICY PRIORITIES

## Rest Breaks DEAD

The rest breaks bill was WSNA's top priority for 2018 and made it through all but the last step of the legislative process — the furthest the bill has progressed. HB 1715 passed the House with bipartisan support, 56-42. In the Senate, the bill was heard and passed by the Senate Health Care Committee — a huge thank you to WSNA-PAC Board member Ingrid Anderson, RN, for testifying. Another resounding thanks goes to WSNA Legislative & Health Policy Council member Justin Gill, BSN, RN, ARNP, who testified in the Senate Ways & Means Committee. Before the bill passed out of Ways & Means, it was amended with language that would have exempted health care facilities with collective bargaining agreements addressing meal and rest breaks. This amendment was unacceptable, and we worked on a fix to this language on the Senate floor; however, this bill was not brought to the Senate floor prior to the final cutoff.

House: passed, 56-42 Senate: not pulled to Senate floor for vote

## Surprise Billing (Medical Debt) DEAD

HB 2114 would ensure that patients receiving care in an emergency room or in-patient/out-patient surgery would be charged the in-network insurance rate, even for providers who may be out-of-network. WSNA testified in support of this bill in the Senate Health Care Committee.

House: passed, 72-26 Senate: not pulled to Senate floor for vote

## Secure Medicine Return PASSED

With the passage of ESHB 1047, Washington is the first state in the nation to adopt a Secure Medicine Return program that will be available to every resident of the state. This bill requires manufacturers that sell drugs into Washington state to operate and pay for a drug take-back program to collect and dispose of prescription and over-the-counter drugs from residential sources. Counties that currently have secure medicine return programs can continue to run their own programs for 12 months after an approved statewide program begins operating. WSNA is a longtime supporter of a statewide approach, and we are thrilled that this victory will help reduce access to unwanted and unused medications.

House: passed, 84-12 Senate: passed, 49-0

### Opioid Prevention and Treatment DEAD

HB 2489 was Governor request legislation to enhance community prevention and treatment of opioid use disorder. This bill requires state agencies to: increase access to evidence-based opioid use disorder treatment services; promote coordination of services within the substance use disorder treatment and recovery support system; strengthen partnerships between opioid use disorder treatment providers and their allied community partners; expand the use of the state prescription drug monitoring program; and support comprehensive school and community-based substance use prevention services. It also requires that agencies administer state purchased health care programs to: (1) Coordinate activities to implement this act and the state interagency opioid working plan; (2) Explore opportunities to address the opioid epidemic; and (3) Provide status updates as directed by the joint legislative executive committee on health care oversight to promote legislative and executive coordination.

House: passed, 98-0 Senate: not pulled to Senate floor for a vote

### Washington State Opportunity Scholarship Program (Advanced Degree Health Professions) PASSED

E2SHB 2143 adds advanced degrees (graduate and professional degrees – service obligation required) in health professions to the Washington State Opportunity Scholarship program, a public-private partnership to fund scholarships in STEM (science, technology, engineering and math) fields.

House: passed, 94-3 Senate: passed, 48-1

### Washington State Opportunity Scholarship Expansion (Professional-Technical Certificates and Degrees) PASSED

HB 1452 expands the Washington State Opportunity Scholarship program to students pursuing professional-technical certificates and degrees. It also allows students who are ineligible for federal student aid to file a state financial aid application to meet scholarship renewal requirements.

House: passed, 98-0 Senate: passed, 48-1

## OTHER BILLS OF INTEREST

#### NURSING

### Sexual Assault Nurse Examiners PASSED

SHB 2101 requires the Office of Crime Victims Advocacy to develop best practices that local communities can use to create more access to Sexual Assault Nurse Examiners and to develop strategies to make Sexual Assault Nurse Examiner training available without requiring nurses to travel unreasonable distances or incur unreasonable expenses. Thank you to WSNA member Martha Phillips, BSN, RN, SANE, for testifying in support of SHB 2101.

House: passed, 98-0 Senate: passed, 48-0

### Hospital Privileges for ARNPs and PAs DEAD

SHB 2264 was championed by ARNPs United with support from WSNA. It requires health care facilities to collect information from physician assistants (PAs) and advanced registered nurse practitioners (ARNPs) before granting or renewing clinical privileges. It allows a hospital or facility to rely on the decision of a distant site hospital to grant or renew privileges when granting or renewing privileges for a PA or ARNP providing telemedicine.

House: passed, 97-0 Senate: died in Senate Rules Committee

#### TELEMEDICINE

### Telemedicine Collaborative PASSED

SB 6163 extends the duration of the Collaborative for the Advancement of Telemedicine to Dec. 31, 2021. The Collaborative is required to submit its final policy report to the legislature on Dec. 1, 2021.

House: passed, 98-0 Senate: passed, 48-0

### Telemedicine Payment Parity PASSED

SSB 6399 directs the Collaborative for the Advancement of Telemedicine (Collaborative) to review the concept of telemedicine payment parity and develop recommendations on reimbursing for telemedicine at the same rate as if a provider provided services in person for treatment of diabetes mellitus, stroke, mental health conditions, opioid dependence and chronic pain and to review methodologies for reimbursement of telemedicine services. The Collaborative must also design a training program to teach health care professionals about telemedicine and proper billing. Recommendations must be reported to the Legislature by Dec. 1, 2018.

House: passed, 98-0 Senate: passed, 47-0

## HEALTH CARE

### Charity Care and Notice Requirements PASSED

SSB 6273 requires hospitals to provide notice of charity care policies in specific areas of the hospital, on the hospital's website and on all billing and collection documents. It requires hospitals to develop standardized training programs on the hospital's charity care policy and the use of interpreter services and to provide regular training for appropriate staff.

House: passed, 98-0 Senate: passed, 49-0

### HIV Testing PASSED

SB 6580 repeals a specific prohibition against HIV testing without consent and a list of exceptions to that prohibition, as well as the requirement that clinicians employ "opt-out" HIV screening for patients age 15 through 65 years and for all pregnant women; and repeals the prohibition against health care providers using the fact that a person has declined an HIV screening as a basis for denying services or treatment other than the HIV screening.

House: passed, 96-2 Senate: passed, 47-1

## OCCUPATIONAL AND ENVIRONMENTAL HEALTH

### Perfluorinated Chemicals in Food Packaging PASSED

2ESHB 2658 conditionally restricts the inclusion of perfluoroalkyl and polyfluoroalkyl chemicals in specific applications of food packaging beginning as early as 2022, pending the outcome of an alternatives assessment to be completed by the Department of Ecology by Jan. 1, 2020.

House: passed, 56-41 Senate: passed, 30-17

### Presumption of Occupational Disease for Certain Hanford Employees PASSED

SHB 1723 creates a presumption for Hanford nuclear site workers that certain enumerated diseases and conditions are occupational diseases, for the purposes of industrial insurance coverage. This bill applies to employees, contractors and subcontractors who worked on the site at the 200 east, 300 west, 300 area, environmental restoration disposal facility site, central plateau or the river corridor locations for at least one 8-hour shift while covered under the state's industrial insurance laws. The presumption applies to the following diseases and conditions: respiratory disease; beryllium sensitization and acute and chronic beryllium disease; heart problems, experienced within 72 hours of exposure to fumes, toxic substances or chemicals at the site; certain cancers as specified; and neurological disease.

House: passed, 74-12 Senate: passed, 35-14 Governor: signed into law March 7

## STUDENT LOAN TRANSPARENCY AND ACCOUNTABILITY

### Student Opportunity, Assistance and Relief Act PASSED

3SHB 1169 addresses student education loan debt, the repeal of statutes regarding professional license or certificate suspensions, private student loan default and exemptions for bank account and wage garnishments. The repeal of provisions allowing suspension of a professional license due to student loan default includes nursing licenses.

House: passed, 80-16 Senate: passed, 48-0

### Student Loan Bill of Rights PASSED

E2SSB 6029 creates the Student Education Loan Advocate to provide assistance to student education loan borrowers who file complaints. It requires student loan servicers to obtain a license from the Department of Financial Institutions (DFI) to operate in the state and permits the DFI to establish fees. The bill also requires servicers to comply with various provisions regarding assessing and crediting fees; account information and dispute requests; acquiring, transferring and selling servicing rights; and reporting information. It prohibits third-party student loan modification servicers from various practices that may misrepresent the student loan situation or encourage a borrower to do something counterproductive to their situation; and requires the Washington State Institute for Public Policy to study student loan authorities who refinance student loans.

House: passed, 87-11 Senate: passed, 35-13

### Protections and Fairness in Student Loan Disbursement Process PASSED

HB 1499 creates requirements applicable to postsecondary institutions that use third-party servicers or financial institutions to disburse financial aid refunds to students. It requires the Washington Student Achievement Council to have rules ensuring that contracts between institutions and third-party servicers or financial institutions are in the best financial interest of the students and meet other criteria.

House: passed, 98-0 Senate: passed, 49-0

# ASSOCIATION OF ADVANCED PRACTICE PSYCHIATRIC NURSES

WSNA also provides lobbying services for the Association of Advanced Practice Psychiatric Nurses (AAPPN). This session, AAPPN actively supported bills related to mental and behavioral health – many of which have been delivered to the Governor for signature.

## CHILDREN'S MENTAL HEALTH

### Student Mental Health PASSED

2SHB 1377 specifies the roles and duties of school counselors, social workers and psychologists. Requires first-class school districts to provide a minimum of six hours of professional collaboration time per year for school counselors, social workers, and psychologists that focuses on recognizing signs of emotional or behavioral distress in students, beginning in the 2019-20 school year.

House: passed, 64-34 Senate: passed, 43-3

### Children's Mental Health Services Consultation Program PASSED

SSB 6452 directs the Health Care Authority to convene stakeholders and submit a recommendation to the Legislature and the Children's Mental Health Workgroup by Dec. 1, 2018 regarding: an alternative funding model for the Partnership Access Line (PAL), a telephone-based child mental health consultation system; and, a strategy to ensure that expanded PAL services do not duplicate existing Managed Care Organization requirements. It creates a two-year pilot program between UW and Seattle Children's to create PAL for Moms and Kids – a hotline to help parents and providers with child mental health referrals.

House: passed, 97-0 Senate: passed, 48-0

### Improving Access to Mental Health Services for Children & Youth PASSED

E2SHB 2779 reestablishes the Children's Mental Health Work Group through the year 2020. It allows provider reimbursement for supervision and partial hospitalization and intensive outpatient treatment programs; and directs the Health Care Authority and the Department of Children, Youth and Families to develop strategies for expanding home visiting. It directs an advisory group to make recommendations regarding parent-initiated treatment. This bill also requires the delivery of mental health instruction in two high school pilot sites.

House: passed, 88-10 Senate: passed, 48-0

## BEHAVIORAL HEALTH

### Improving the Behavioral Health of People in the Agricultural Industry PASSED

2SHB 2671 establishes a task force to review options to improve the behavioral health status of agricultural workers and reduce suicide risk. It establishes a pilot program related to behavioral health and suicide prevention in the agricultural industry based upon task force recommendations.

House: passed, 98-0 Senate: passed, 48-0

### Outpatient Behavioral Health PASSED

ESSB 6491 makes changes to the assisted outpatient mental health treatment standard, criteria and process. Makes changes to less restrictive alternative treatment services. It allows for the revocation of less restrictive alternative treatment orders entered on assisted outpatient behavioral health treatment commitment grounds. Beginning April 1, 2018, this bill authorizes a court conducting a review of a designated crisis responder's decision not to detain a person under the Involuntary Treatment Act to order a person to involuntary outpatient treatment.

House: passed, 92-5 Senate: passed, 48-1

## MENTAL HEALTH – LEGAL AND LAW ENFORCEMENT

### Child Forensic Interviews and Child Interview Digital Recordings PASSED

ESHB 2700 exempts audio and video recordings of child forensic interviews that depict or describe allegations of child abuse, child neglect or exposure to violence from the Public Records Act except by court order upon a showing of good cause and notice to the child's guardian. Requires that audio and video recordings of child interviews disclosed in criminal or civil proceedings are subject to a protective order unless the court finds good cause that the interview should not be subject to such order; a violation of this order is subject to a civil penalty up to $10,000.

House: passed, 96-0 Senate: passed, 49-0

### Mental Health Field Response PASSED

HB 2892 creates the mental health field response team grant program, administered by the Washington Association of Sheriffs and Police Chiefs, to assist local law enforcement agencies with establishing and expanding mental health field response capabilities, focused on treatment, diversion and reduced incarceration time. The bill requires the Washington State Institute for Public Policy to conduct a study on whether the program improves outcomes of interactions with persons experiencing behavioral health crises.

House: passed, 97-0 Senate: passed, 48-0

### Commitment Hearings by Video PASSED

SSB 6124 allows for participation in commitment hearings by video. At an Involuntary Treatment Act hearing, the petitioner, the respondent, any witnesses and the presiding judicial officer may be present and participate either in person or by video, or by any equivalent technology, provided that all parties must be able to see, hear and speak, and attorneys must be able to use exhibits or other materials. Witnesses may provide testimony telephonically. The court determines video participation and may consider if the individuals alleged mental illness affects their ability to perceive or participate by video. The respondent's counsel shall be in the same location as their client unless otherwise requested by the respondent or their counsel.

House: passed, 97-0 Senate: passed, 46-2

# SCHOOL NURSE ORGANIZATION OF WASHINGTON (SNOW)

NOTE: SNOW also supported the children/student mental health bills listed in the preceding AAPPN section.

WSNA also provides lobbying services for the School Nurse Organization of Washington (SNOW). This session, SNOW monitored a number of bills that impact student health and readiness to learn.

## HUNGER-FREE STUDENTS

### Breakfast After the Bell: Student Meals & Nutrition PASSED

2ESHB 1508 requires qualifying high-needs schools, beginning in the 2019-20 school year and until June 30, 2028, to offer breakfast after the bell (BAB) programs to students. It specifies that BAB participation is considered instructional time if required conditions are met. It directs the Joint Legislative Audit and Review Committee to conduct and complete an analysis of BAB programs by Dec. 1, 2026; and authorizes the OSPI to coordinate with the Washington State Department of Agriculture to promote new and existing regional markets programs, including farm-to-school initiatives and small farm direct marketing assistance. The bill also authorizes the OSPI to award grants to school districts to collaborate with community-based organizations, food banks and farms or gardens for reducing high school dropout occurrences through farm engagement projects.

House: passed, 87-8 Senate: passed, 43-5 Governor: signed into law March 7

### School Meal Payment: Hunger-Free Students' Bill of Rights PASSED

ESHB 2610 prohibits schools and districts from taking action directed at a student under the age of 15 to collect unpaid school meal fees and from stigmatizing a student who cannot pay for a school meal. It requires school districts to notify parents or guardians of the negative balance of a student's school meal account no later than 10 days after the account has reached a negative balance; and it requires the OSPI to collect, analyze and promote to school districts and community-based organizations best practices in local meal charge policies. It requires schools and districts to improve systems to identify homeless students, students in foster care, runaway students and migrant students to ensure that each student has proper access to free school meals; and, at least monthly, to directly certify students for free school meals if the students qualify because of enrollment in assistance programs. It requires schools to annually distribute applications for free and reduced-price meals to student households and to, if necessary, provide related language assistance to parents and guardians.

House: passed, 69-29 Senate: passed, 31-17

## MEDICATIONS IN SCHOOLS

### Opioid Medications in Schools DEAD

HB 2390 allows K-12 schools to obtain, maintain and administer opioid overdose medication through a standing order from a health care practitioner for the purpose of assisting a person at risk of experiencing an opioid-related overdose, and it may be administered by: school nurses, designated trained school personnel, and health care professionals or trained staff located at a health care clinic on public school property or under contract with the district. A person or entity is not subject to civil or criminal liability for their lawfully authorized actions related to opioid overdose medications or the outcomes of their lawfully authorized actions if they act in good faith and with reasonable care. If a student is injured or harmed due to the administration of opioid overdose medication that a health care practitioner has prescribed and a pharmacist has dispensed to a school, the practitioner and pharmacist may not be held responsible for the injury unless he or she acted with conscious disregard for safety.

House: passed, 79-19
Senate: died in Senate Health & Long-Term Care Committee

### Medical Marijuana in Schools DEAD

HB 1060 allows a parent or guardian to administer marijuana for medical use by a minor, who meets state law requirements, on school grounds, aboard a school bus or while attending a school-sponsored event out of view of the general public, and if the administration is not by smoking or other means of inhalation. School districts may not inquire into the type of medication or product that parents or guardians administer to their children, in accordance with state law, while on school grounds, on a school bus, or attending a school-sponsored event and may not deny parents or guardians access to their children for this purpose.

House: passed, 67-27 Senate: died in Senate Rules Committee

# 2018 legislator voting record

As part of its endorsement process, the WSNA-PAC Board reviews the voting records of candidates currently serving in the Legislature, or incumbents. The 2018 Legislator Voting Record was developed based on priority bills that WSNA supported during the 2018 state legislative session. Not all WSNA priority bills were voted on in both chambers, which is why the bills lists differ from Senate to House. As the voting records below indicate, most nursing issues have bipartisan support in Olympia.

## Bill

1. HB 1047
2. HB 1715
3. HB 1715 - Senate Labor & Commerce Committee
4. HB 1715 - Senate Ways & Means Committee
5. HB 2114
6. HB 2114 - Senate Health & Long Term Care Committee
7. HB 2114 - Senate Ways & Means Committee
8. HB 2143
9. HB 2489
10. HB 2489 - Senate Health & Long Term Care Committee
11. HB 2489 - Senate Ways & Means Committee

## Vote

✓ **Yes**

✗ **No**

E **Excused**

| Senator | District | 1 | 3 | 4 | 6 | 7 | 8 | 10 | 11 |
|---|---|---|---|---|---|---|---|---|---|
| Angel, Jan (R) | 26 | ✓ | | | | | ✓ | | |
| Bailey, Barbara (R) | 10 | ✓ | | ✗ | ✗ | ✗ | ✓ | ✓ | ✓ |
| Baumgartner, Michael (R) | 6 | ✓ | | | | | ✓ | | |
| Becker, Randi (R) | 2 | ✓ | | ✗ | ✗ | ✗ | ✓ | | ✓ |
| Billig, Andy (D) | 3 | ✓ | | ✓ | | ✓ | ✓ | | ✓ |
| Braun, John (R) | 20 | ✓ | ✗ | | | | ✓ | | ✗ |
| Brown, Sharon (R) | 8 | ✓ | | ✗ | | ✗ | ✓ | | ✓ |
| Carlyle, Reuven (D) | 36 | ✓ | | ✓ | | ✗ | ✓ | | ✓ |
| Chase, Maralyn (D) | 32 | ✓ | | | | | ✓ | | |
| Cleveland, Annette (D) | 49 | ✓ | | | ✓ | | ✓ | ✓ | |
| Conway, Steve (D) | 29 | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Darneille, Jeannie (D) | 27 | ✓ | | ✓ | | ✓ | ✓ | | ✓ |
| Dhingra, Manka (D) | 45 | ✓ | | | | | ✓ | | |
| Ericksen, Doug (R) | 42 | ✓ | | | | | ✓ | | |
| Fain, Joe (R) | 47 | ✓ | | ✗ | ✗ | ✗ | ✓ | ✓ | ✓ |
| Fortunato, Phil (R) | 31 | ✓ | | | | | ✓ | | |
| Frockt, David (D) | 46 | ✓ | | ✓ | | ✓ | ✓ | | ✓ |
| Hasegawa, Bob (D) | 11 | ✓ | ✓ | ✓ | | ✓ | E | | ✓ |
| Hawkins, Brad (R) | 12 | ✓ | | | | | ✓ | | |
| Hobbs, Steve (D) | 44 | ✓ | | | | | ✓ | | |
| Honeyford, Jim (R) | 15 | ✓ | | ✗ | | ✗ | ✓ | | ✗ |
| Hunt, Sam (D) | 22 | ✓ | | ✓ | | ✓ | ✓ | | ✓ |
| Keiser, Karen (D) | 33 | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| King, Curtis (R) | 14 | ✓ | ✗ | | | | ✓ | | |
| Kuderer, Patty (D) | 48 | ✓ | ✓ | | ✓ | | ✓ | ✓ | |

| Senator | District | 1 | 3 | 4 | 6 | 7 | 8 | 10 | 11 |
|---|---|---|---|---|---|---|---|---|---|
| Liias, Marko (D) | 21 | ✓ | | | | | ✓ | | |
| McCoy, John (D) | 38 | ✓ | | | | | ✓ | | |
| Miloscia, Mark (R) | 30 | ✓ | | | | | ✓ | | |
| Mullet, Mark (D) | 5 | ✓ | | ✗ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Nelson, Sharon (D) | 34 | ✓ | | | | | ✓ | | |
| O'Ban, Steve (R) | 28 | ✓ | | | | | ✓ | | |
| Padden, Mike (R) | 4 | ✓ | | | | | ✓ | | |
| Palumbo, Guy (D) | 1 | ✓ | | ✓ | | ✓ | ✓ | | ✓ |
| Pedersen, Jamie (D) | 43 | ✓ | | ✓ | | ✓ | ✓ | | ✓ |
| Ranker, Kevin (D) | 40 | ✓ | | ✓ | | ✓ | ✓ | | ✓ |
| Rivers, Ann (R) | 18 | ✓ | | ✗ | ✓ | ✗ | ✓ | ✓ | ✓ |
| Rolfes, Christine (D) | 23 | ✓ | | ✓ | | ✓ | ✓ | | ✓ |
| Saldaña, Rebecca (D) | 37 | ✓ | ✓ | | | | ✓ | | |
| Schoesler, Mark (R) | 9 | ✓ | | ✗ | | ✗ | ✓ | | ✗ |
| Sheldon, Tim (D) | 35 | ✓ | | | | | ✓ | | |
| Short, Shelly (R) | 7 | ✓ | | | | | ✓ | | |
| Takko, Dean (D) | 19 | ✓ | | | | | ✓ | | |
| Van De Wege, Kevin (D) | 24 | ✓ | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Wagoner, Keith | 39 | ✓ | | ✗ | | ✗ | ✓ | | ✓ |
| Walsh, Maureen (R) | 16 | ✓ | | | | | ✓ | | |
| Warnick, Judy (R) | 13 | ✓ | | ✗ | | ✗ | ✓ | | ✓ |
| Wellman, Lisa (D) | 41 | ✓ | | | | | ✓ | | |
| Wilson, Lynda (R) | 17 | ✓ | ✗ | | | | ✓ | | |
| Zeiger, Hans (R) | 25 | ✓ | | | | | ✓ | | |

| Representative | District | Pos. | 1 | 2 | 5 | 8 | 9 |
|---|---|---|---|---|---|---|---|
| Appleton, Sherry (D) | 23 | 1 | ✓ | ✓ | ✓ | ✓ | ✓ |
| Barkis, Andrew (R) | 2 | 1 | ✓ | ✗ | ✗ | ✓ | ✓ |
| Bergquist, Steve (D) | 11 | 2 | ✓ | ✓ | ✓ | ✓ | ✓ |
| Blake, Brian (D) | 19 | 2 | ✓ | ✓ | ✓ | ✓ | ✓ |
| Buys, Vincent (R) | 42 | 2 | ✓ | ✗ | ✗ | ✓ | ✓ |
| Caldier, Michelle (R) | 26 | 2 | ✓ | ✗ | ✓ | ✓ | ✓ |
| Chandler, Bruce (R) | 15 | 1 | ✗ | ✗ | ✗ | ✓ | ✓ |
| Chapman, Mike (D) | 24 | 1 | ✓ | ✓ | ✓ | ✓ | ✓ |
| Chopp, Frank (D) | 43 | 2 | ✓ | ✓ | ✓ | ✓ | ✓ |
| Clibborn, Judy (D) | 41 | 2 | ✓ | ✓ | ✓ | ✓ | ✓ |
| Cody, Eileen (D) | 34 | 1 | ✓ | ✓ | ✓ | ✓ | ✓ |
| Condotta, Cary (R) | 12 | 1 | ✗ | ✗ | ✓ | ✓ | ✓ |
| DeBolt, Richard (R) | 20 | 1 | ✓ | ✗ | ✓ | ✓ | ✓ |
| Dent, Tom (R) | 13 | 1 | ✗ | ✗ | ✓ | ✓ | ✓ |
| Doglio, Beth (D) | 22 | 2 | ✓ | ✓ | ✓ | ✓ | ✓ |
| Dolan, Laurie (D) | 22 | 1 | ✓ | ✓ | ✓ | ✓ | ✓ |
| Dye, Mary (R) | 9 | 1 | ✗ | ✗ | ✗ | ✓ | ✓ |
| Eslick, Carolyn | 39 | | ✓ | ✗ | ✗ | ✓ | ✓ |
| Fey, Jake (D) | 27 | 2 | ✓ | ✓ | ✓ | ✓ | ✓ |
| Fitzgibbon, Joe (D) | 34 | 2 | ✓ | ✓ | ✓ | ✓ | ✓ |
| Frame, Noel (D) | 36 | 1 | ✓ | ✓ | ✓ | ✓ | ✓ |
| Goodman, Roger (D) | 45 | 1 | ✓ | ✓ | ✓ | ✓ | ✓ |
| Graves, Paul (R) | 5 | 2 | ✓ | ✗ | ✓ | ✓ | ✓ |
| Gregerson, Mia (D) | 33 | 2 | ✓ | ✓ | ✓ | ✓ | ✓ |
| Griffey, Dan (R) | 35 | 1 | ✓ | ✗ | ✗ | ✓ | ✓ |
| Haler, Larry (R) | 8 | 2 | ✓ | ✗ | ✗ | ✓ | ✓ |
| Hansen, Drew (D) | 23 | 2 | ✓ | ✓ | ✓ | ✓ | ✓ |
| Hargrove, Mark (R) | 47 | 1 | ✓ | ✗ | ✓ | ✓ | ✓ |
| Harmsworth, Mark (R) | 44 | 2 | ✓ | ✗ | ✗ | ✓ | ✓ |
| Harris, Paul (R) | 17 | 2 | ✓ | ✗ | ✓ | ✓ | ✓ |
| Hayes, Dave (R) | 10 | 2 | ✓ | ✗ | ✓ | ✓ | ✓ |
| Holy, Jeff (R) | 6 | 2 | ✓ | ✓ | ✓ | ✓ | ✓ |
| Hudgins, Zack (D) | 11 | 1 | ✓ | ✓ | ✓ | ✓ | ✓ |
| Irwin, Morgan (R) | 31 | 2 | ✓ | ✗ | ✗ | ✓ | ✓ |
| Jenkin, Bill (R) | 16 | 1 | ✗ | ✗ | ✗ | ✓ | ✓ |
| Jinkins, Laurie (D) | 27 | 1 | ✓ | ✓ | ✓ | ✓ | ✓ |
| Johnson, Norm (R) | 14 | 1 | ✓ | ✗ | ✓ | ✓ | ✓ |
| Kagi, Ruth (D) | 32 | 2 | ✓ | ✓ | ✓ | ✓ | ✓ |
| Kilduff, Christine (D) | 28 | 2 | ✓ | ✓ | ✓ | ✓ | ✓ |
| Kirby, Steve (D) | 29 | 2 | ✓ | ✓ | ✓ | ✓ | ✓ |
| Klippert, Brad (R) | 8 | 1 | ✗ | ✗ | ✗ | ✓ | ✓ |
| Kloba, Shelley (D) | 1 | 2 | ✓ | ✓ | ✓ | ✓ | ✓ |
| Kraft, Vicki (R) | 17 | 1 | ✗ | ✗ | ✗ | ✓ | ✓ |
| Kretz, Joel (R) | 7 | 2 | ✓ | ✗ | ✗ | ✓ | ✓ |
| Kristiansen, Dan (R) | 39 | 1 | ✓ | ✗ | ✗ | ✓ | ✓ |
| Lovick, John (D) | 44 | 1 | ✓ | ✓ | ✓ | ✓ | ✓ |
| Lytton, Kristine (D) | 40 | 1 | ✓ | ✓ | ✓ | ✓ | ✓ |
| MacEwen, Drew (R) | 35 | 2 | ✗ | ✗ | ✗ | ✓ | ✓ |
| Macri, Nicole (D) | 43 | 1 | ✓ | ✓ | ✓ | ✓ | ✓ |

| Representative | District | Pos. | 1 | 2 | 5 | 8 | 9 |
|---|---|---|---|---|---|---|---|
| Manweller, Matt (R) | 13 | 2 | ✗ | ✗ | ✓ | ✓ | ✓ |
| Maycumber, Jacquelin (R) | 7 | 1 | ✓ | ✗ | ✗ | ✓ | ✓ |
| McBride, Joan (D) | 48 | 2 | ✓ | ✓ | ✓ | ✓ | ✓ |
| McCabe, Gina (R) | 14 | 2 | ✓ | ✓ | ✓ | ✓ | ✓ |
| McCaslin, Bob (R) | 4 | 2 | ✗ | ✗ | ✗ | ✗ | ✓ |
| McDonald, Joyce (R) | 25 | 2 | ✓ | ✗ | ✓ | ✓ | ✓ |
| Morris, Jeff (D) | 40 | 2 | ✓ | ✓ | ✓ | ✓ | ✓ |
| Muri, Dick (R) | 28 | 1 | ✓ | ✗ | ✓ | ✓ | ✓ |
| Nealey, Terry (R) | 16 | 2 | ✓ | ✗ | ✗ | ✓ | ✓ |
| Orcutt, Ed (R) | 20 | 2 | ✓ | ✓ | ✓ | ✓ | ✓ |
| Ormsby, Timm (D) | 3 | 2 | ✓ | ✓ | ✓ | ✓ | ✓ |
| Ortiz-Self, Lillian (D) | 21 | 2 | ✓ | ✓ | ✓ | ✓ | ✓ |
| Orwall, Tina (D) | 33 | 1 | ✓ | ✓ | ✓ | ✓ | ✓ |
| Pellicciotti, Mike (D) | 30 | 1 | ✓ | ✓ | ✓ | ✓ | ✓ |
| Peterson, Strom (D) | 21 | 1 | ✓ | ✓ | ✓ | ✓ | ✓ |
| Pettigrew, Eric (D) | 37 | 2 | ✓ | ✓ | ✓ | ✓ | ✓ |
| Pike, Liz (R) | 18 | 2 | E | ✗ | ✓ | ✓ | ✓ |
| Pollet, Gerry (D) | 46 | 1 | ✓ | ✓ | ✓ | ✓ | ✓ |
| Reeves, Kristine (D) | 30 | 2 | ✓ | ✓ | ✓ | ✓ | ✓ |
| Riccelli, Marcus (D) | 3 | 1 | ✓ | ✓ | ✓ | ✓ | ✓ |
| Robinson, June (D) | 38 | 1 | ✓ | ✓ | ✓ | ✓ | ✓ |
| Rodne, Jay (R) | 5 | 1 | E | ✗ | ✗ | E | ✓ |
| Ryu, Cindy (D) | 32 | 1 | ✓ | ✓ | ✓ | ✓ | ✓ |
| Santos, Sharon Tomiko (D) | 37 | 1 | ✓ | ✓ | ✓ | ✓ | ✓ |
| Sawyer, David (D) | 29 | 1 | ✓ | ✓ | ✓ | ✓ | ✓ |
| Schmick, Joe (R) | 9 | 2 | ✓ | ✗ | ✗ | ✓ | ✓ |
| Sells, Mike (D) | 38 | 2 | ✓ | ✓ | ✓ | ✓ | ✓ |
| Senn, Tana (D) | 41 | 1 | ✓ | ✓ | ✓ | ✓ | ✓ |
| Shea, Matt (R) | 4 | 1 | ✗ | ✗ | ✗ | ✗ | ✓ |
| Slatter, Vandana (D) | 48 | 1 | ✓ | ✓ | ✓ | ✓ | ✓ |
| Smith, Norma (R) | 10 | 1 | ✓ | ✓ | ✓ | ✓ | ✓ |
| Springer, Larry (D) | 45 | 2 | ✓ | ✓ | ✓ | ✓ | ✓ |
| Stambaugh, Melanie (R) | 25 | 1 | ✓ | ✓ | ✓ | ✓ | ✓ |
| Stanford, Derek (D) | 1 | 1 | ✓ | ✓ | ✓ | ✓ | ✓ |
| Steele, Mike (R) | 12 | 2 | ✓ | ✗ | ✓ | ✓ | ✓ |
| Stokesbary, Drew (R) | 31 | 1 | ✓ | ✗ | ✗ | ✓ | ✓ |
| Stonier, Monica Jurado (D) | 49 | 2 | ✓ | ✓ | ✓ | ✓ | ✓ |
| Sullivan, Pat (D) | 47 | 2 | ✓ | ✓ | ✓ | ✓ | ✓ |
| Tarleton, Gael (D) | 36 | 2 | ✓ | ✓ | ✓ | ✓ | ✓ |
| Taylor, David (R) | 15 | 2 | ✗ | ✗ | ✗ | ✗ | ✓ |
| Tharinger, Steve (D) | 24 | 2 | ✓ | ✓ | ✓ | ✓ | ✓ |
| Valdez, Javier (D) | 46 | 2 | ✓ | ✓ | ✓ | ✓ | ✓ |
| Van Werven, Luanne (R) | 42 | 1 | ✓ | ✗ | ✗ | ✓ | ✓ |
| Vick, Brandon (R) | 18 | 1 | ✓ | ✗ | ✗ | ✓ | ✓ |
| Volz, Mike (R) | 6 | 1 | ✓ | ✓ | ✓ | ✓ | ✓ |
| Walsh, Jim (R) | 19 | 1 | ✓ | ✗ | ✓ | ✓ | ✓ |
| Wilcox, J.T. (R) | 2 | 2 | ✓ | ✗ | ✗ | ✓ | ✓ |
| Wylie, Sharon (D) | 49 | 1 | ✓ | ✓ | ✓ | ✓ | ✓ |
| Young, Jesse (R) | 26 | 1 | ✓ | ✗ | ✓ | ✓ | ✓ |

# IN MEMORIAM

## Mary Brown, RN

**BELOVED WIFE,** mother, grandmother and great-grandmother, Mary L Brown, passed away on Saturday, March 10, 2018 at her home in Yakima at the age of 80. Mary was born on July 1, 1937, to Herald and Shirley Hall in Portland, Oregon.

She graduated from Everett High School in 1955. Following graduation, she attended Saint Elizabeth School of Nursing, where she obtained her degree as a registered nurse. She furthered her education in Coronary Care and Electrocardiography attending both Seattle University and the University of Washington. She was chosen to be Washington State Representative on the National Cardiovascular Nursing Council. She also served on the State Nursing Education Committee. Mary worked at Central Memorial Hospital as an Assistant Director of Nurses until she was forced to retire in 1974, due to her diagnosis with multiple sclerosis. She was proud when she was able to serve as a wife, mother and professional.

While attending school, Mary met her future husband, Bill Brown. They married on May 29, 1959 in Everett, Washington. Together they had three children and made their home in Toppenish, Washington. Mary enjoyed being involved with her children's activities and continued that passion with her grandchildren. Her sweet smile and kind heart will be greatly missed.

Mary is survived by her husband of 59 years, Bill Brown, daughter, Debbie Soliz of Yakima, son, Randy (Gail) Brown of Zillah and daughter, Tammy (Steve) Bangs of Toppenish. She is also survived by her twelve grandchildren and numerous great-grandchildren.

She is preceded in death by her father, Herald Hall, mother, Shirley Hall and brothers, Jim Hall and Sonny Hall.

## Gerald Gifford, RN

**GERALD GIFFORD,** who served for many years as the WSNA Local Unit Chair at the Spokane Veterans Home died on January 16 in Spokane.

Gerald was born in Olympia in 1967. He served as a Wildland Firefighter for the Washington State Department of Natural Resources, enjoyed delivering pizzas, and managed and called Bingo for many years. After becoming a registered nurse, Gerald worked for over 20 years in nursing, including 15 years at the Spokane Veterans Home.

He was a devoted Seahawks fan, avid fisherman and loved coaching his sons. Gerald was a loving husband, father, brother and son. He is survived by his wife of 32 years, Gilda Gifford; four sons, Santos (Krystal), Gerald Jr., Alek and Mason; and grandchildren Jaidyn and Mateo. He was preceded in death by his mother, Francine Champagne; brother, Guy Gifford III; and many family members and friends.

## Ruth Marilyn Porter, RN

**RUTH PORTER** passed away on April 4, 2018. Ruth was born in Seattle on May 27, 1926 then moved with her mother, Crescent Adams, to Butte, Montana as a young child. She spent her childhood in Butte as well as White Sulphur Springs, MT. During the Great Depression years Ruth, her mother and stepfather, Dave Adams, worked to survive, including capturing rattle snakes for sale. Ruth even played the piano in a family-run saloon at 12 years old. She babysat a young child who turned out to be Evel Knievel, the daredevil motorcyclist. She graduated from Butte High School.

When WW II broke out Ruth came back to Seattle and enrolled at Seattle College, later named Seattle University, in the Cadet Nursing program. She would have become an Army nurse, but the war ended. At Seattle U. she met a young Navy veteran, Robert J. Porter, attending college on the GI bill. They married shortly thereafter. They settled in Seattle, then the Angle Lake community and finally in Burien. They were married for 69 years at her passing.

Ruth worked as a nurse and worked on and off at Virginia Mason Hospital in Seattle for 30 years. She may have helped bring you into life as a nurse supervisor in the maternity ward or helped save your life when she worked with the Medic One cardiac team in its early years.

Her interests included boating in the Salish Sea with Bob and their cat in Canadian and U.S. waters. They kept a boat in Des Moines for many years. She and Bob traveled the world in their later years. Her interest in history and literature enriched their experiences greatly. She was very involved and supportive of Bob in the Early Ford V8 Car Clubs. They could be seen together in any of several cars from the 1930s and 40s at picnics and rallies.

Her greatest love was her family. She is survived by her husband, Bob, and her children: John, Mike, Marilyn, Paula Porter Hopkins and Rob Porter; 12 grandkids and 10 great grandkids. She was and always will be the guiding light and glue that has kept them all together. Gone before her are her daughter Kathleen (Porter) Walker and Kathleen's daughter Carrie (Walker) Bookless.

## Mary Lynne Short, MBA, RN

**MARY LYNNE SHORT** passed away on January 28 after a brief battle with pneumonia.

Beloved sister, wife, mother and grandmother, Mary Lynne Short was born on May 22, 1938 in Minneapolis, Minnesota to Arna Berseng Wood and Jack L. Wood.

Her father worked for Northwest Airlines, which sent the family to Japan towards the end of the United States' occupation of that country. Her sister Pam was born in Japan and both learned to speak Japanese as children. They stayed in Japan until Mary Lynne's senior year in high school when they returned to the U.S. and settled in West Seattle for her senior year. This experience had a profound impact on her as she learned at an early age the cost of war and that that peace and understanding were essential.

Mary Lynne attended nursing school at the University of Washington. She was destined to be a nurse; her mom and aunts spoke frequently of how she nursed, cared for and bandaged almost any doll, animal or person from a very young age. While in nursing school, she met Dr. Denis Stafford Short, who was in medical school, and they married on June 17, 1960 in Seattle. They began their life together by moving to Richmond, Virginia so Denis could complete his residency. They had three children: son Patrick Michael, born in Richmond, and their twin daughters, Mary Beth and Laurie Lynne, born in El Paso, Texas.

After several moves around the United States, the family returned to Seattle in 1974, where Mary Lynne's career in geriatric nursing began. She became a Director of Nursing, Administrator and Consultant and started the first hospital-based skilled nursing facility in Washington. She was greatly respected by doctors, families, patients, owners, state surveyors and several geriatric associations. During this time, Mary Lynne was active in WSNA.

She was a member of the American Association of University Woman and cared deeply about the education of girls so they could reach their full potential. She was also a member of the Order of the Eastern Star, where she encouraged girls in the International Order of the Rainbow for Girls. Later in life, Mary Lynne joined the Daughters of Norway and the Red Hat Society.

Mary Lynne is survived by her husband, Denis; son Mike (Crystal); twin daughters Laurie and Mary Beth; grandchildren Spencer and Elizabeth; her sister, Pam LaBrie (Buster); aunt Ruth Broman, as well as many nieces, nephews and cousins from the Bergseng, Broman and Short families. Her laughter, humming and joyous attitude have left this world and Heaven is all the brighter.

## Janet Stanek, BSN, RN

*Obituary by Charlie Hickenbottom and friends*

**JANET STANEK,** 58, a resident of Wenatchee, passed quietly in her home Saturday, February 24, 2018.

Janet was raised on a dairy farm near Wonewoc, Wisconsin. Childhood friend Sharon Jindrick recalls "growing up in the country where we lived not far from each other. We spent our summers meeting up and riding our bikes around the countryside as well as having sleepovers. We went to County Corners School for our elementary years before transferring to school in Hillsboro." Sister Kris recalled that Janet graduated from Hillsboro High School in 1977 and was Salutatorian of her class.

College chum Ann Schlice remembers Janet attended college in LaCrosse, Wisconsin and graduated from Viterbo University with a BSN (bachelor of science in Nursing) in 1981. Her first nursing position was at St. Michael's Hospital in Stevens Point, Wisconsin.

Work colleague and long-time friend Ginny Heinitz recalls that in 1982, "Janet was one of many 4-year

BSN prepared nurses from the Midwest that were recruited by Central Washington Hospital, now known as Confluence Health. Midwest nurses were hired for their Midwest hard work ethic. She had the very best work ethic that was equally complemented with a gentle and determined soul. She believed in finishing a job and finishing it well, for the benefit of the patient. No amount of effort was ever too much.

"Janet first worked on the surgical floor and then transitioned to ICU. In 1987, she transitioned to the Home Health and Hospice department, and there she remained until 2015 when she retired. She was a strong and creative patient advocate, with a specialty focus on wound care as a National Certified Wound Care nurse. The patients who were placed in her care received exceptional nursing intervention, all while softly, yet steadfastly Janet cared and comforted their needs with the utmost compassionate respect. Her strength to detail, and analyzed research for the patient's needs, exceeded others in the field. As a caveat, she often was acknowledged by the annual review board standards of care in Home Health and Hospice for her exceptional care and attention to detail. She exceeded all expectations in critical and analytical thinking and attention and compassionate care for the patient. Her greatest gift, however, was not only meeting the rigorous standards, but doing so with a gentle soul and spirit for others. Her long-term colleagues in nursing remember her calm demeanor, all while balancing meticulous care and advocacy for the patient. She was the calm waters in the hurricanes at work."

Marc Dilley remembers Janet's early years in Wenatchee, a decade before Charlie showed up in Wenatchee. "Janet, Freeman Keller and I participated in licensed bicycle racing through the United States Cycling Federation (USCF). I was never formally introduced to Janet, but I knew her by reputation: She was one of the young, hot (as in FAST) women racers, new to our club (the Wenatchee Valley Wheelmen) and a force to be reckoned with. I remember quite distinctly what set Janet apart from her female contemporaries. They were mostly loud and raucous, and like us guys, could get pretty mopey after a loss. In contrast, Janet was always of even temperament, keeping her cool, always the good sport, an exemplar for the rest of us. I remember doing a race or two in the Yakima area and in King County somewhere. Janet always did quite well as I recall. Of the three types of bike races "on road" (as opposed to track racing), Janet was best at the Time Trial. This best suits the racers who have very strong legs, whereas road races favor hill climbers and criterions favor bike handling skills. And Janet had by far the strongest legs of any female racer."

Holly Dunham-Wheeler was one of Janet's contemporaries on the bike racing team. Holly remembered "Janet always having a smile on her face and you could tell she enjoyed working out hard on her bike. Janet was quiet, but you would be mistaken if you thought she was shy because she was always ready for a fun bike adventure. I remember her pride when she got a new race bike and how she treated it like her baby!"

Through the 80s and 90s, Janet participated several times in Wenatchee Valley's Ridge to River relay. There was always a team that wanted Janet to ride the bicycle leg of the event.

Charlie arrived in Wenatchee in 1992 and by the mid-1990s Janet and Charlie became a couple. We married July 17, 1999 and remained a strong couple throughout the years. Janet micro-managed her vacation schedule to align with the vacations that Charlie enjoyed with his teaching career. When Janet was at home in the evening completing her paperwork ("charting"), Charlie would work the kitchen duties. We hiked, cross-country skied, scrambled and climbed rock together. My database was perused and I found that 126 times we had reached high points in the hillsides adjacent to Wenatchee. We skated-skied over 2,000 miles together. We did 1,316 rock climbs together. We stayed busy having fun.

Charlie retired in 2011 and within the next couple of years Janet twice nursed Charlie after hip-replacement surgeries done about a year apart. He never in all his imagination would have thought that eventually he would take over the nursing when Janet was the patient. Janet retired in 2015 and we had a memorable month-long road trip to the mid-west. It was the retirement that we had imagined, camping along the way and touring various rock climbing and hiking locales along the I-90 corridor.

But by late in 2015 the retirement bubble burst when Janet started having some urinary issues. At first it was easily put aside as a urinary tract infection, but during the winter Janet was diagnosed with bladder cancer. Chemotherapy during spring, 2016 proved ineffective. Summer of 2016 Janet underwent a massive surgery, having the cancerous growth excised from her urinary and reproductive organs. An "Indiana pouch" was created from tissue from her digestive system and Janet forged on, with urine drained at her discretion from her abdomen via tubing. By fall, 2016 Janet was back to hiking, but imaging showed metastatic cancer involvement in her lung. Winter/Spring, 2017 Janet underwent immune therapy with optimism, but the treatments did not shrink any tumors. Summer/fall Janet twice went into the hospital due to empyema infections in her lungs. We wondered if she would ever get a break?

Janet gained strength for a bit and traveled to the Washington D.C. area in mid-October to be part of a cancer research group. She was one of a hundred that participated with all costs borne by a research foundation. Janet had become an expert on bladder cancer and probably knew more than most urologists. Janet continued to search for promising clinical trials that might provide a cure to cancer, but meanwhile cancer spread to her cervical spine. Christmas 2017 was spend in the hospital as Janet underwent surgery to shore-up a neck with plates and rods that was slumping with cancer involvement. Janet's final attempt to enter a clinical trial in mid-January 2018 included finding out through imaging that cancer had spread to her hips/pelvis and into one leg. Janet declined from there, beginning hospice service in our home in late January, and passing on February 24, 2018.

Mary Jo Bendickson remembers Janet being "true to her Czechoslovakian heritage. She loved crafting. She created beautiful hand stamped cards for friends and relatives, spending hours in the flow of creation to design just the right card for the person who would receive the gift and the occasion it represented. Crafting jewelry became a part-time hobby as well. She enjoyed taking classes creating fun wearable art. Her fingers, wrists, earlobes and neckline were adorned with artisan jewelry. Apple Blossom time in Wenatchee meant gathering with friends to visit the craft show. She enjoyed perusing the many wonderful booths and sitting in the sun for a relaxing lunch. The common thread through all of her crafts including a longtime tradition of a Christmas cookie party. Friends gathered to enjoy each other and the sweet things life has to offer."

Margareta Dilley recalls "a lovely memory of Janet is how much all our dogs adored her. Even our super shy cat who was extremely wary of all strangers was won over by Janet's gentle patience and magic touch." Janet touched us all with her kindness and will be sorely missed. Good bye, Janet, I will love you always.

Janet is preceded in death by her parents Raymond J. Stanek and Dorothy (Herbeck) Stanek, brother Bernard Stanek, sister Kathy Hynek, nephew Benjamin Stanek. Survived by her husband Charles Hickenbottom, whom she married July 17, 1999. Survived by siblings Ramona (Cal) VanKirk, Michael (Nancy) Stanek, Tony (LaDonna) Stanek and Kris (John) Pastor. Survived by Charlie's mom Patricia Baker and Charlie's brothers, Gary (Kathy Boland) Hickenbottom and Paul (Marianne Baker) Hickenbottom. Survived by sister-in-law Patty Stanek and brother-in-law Randy (Michele) Hynek. Survived by numerous nephews and nieces on both sides of the family.

## Leta Tarrell, RN

LETA TARRELL passed away on June 28, 2017. Leta was born to Richard and Ila Mae Howard on December 11, 1950, in Sacramento, California. She graduated from Grant High School in 1969. She married Charlie Tarrell, the love of her life, in 1973 and graduated from Biola College in 1974. She was a much-loved pastor's wife serving churches in Fairbanks, AK, Winston, OR, and Lynden, WA.

Leta worked as a nurse in doctors' offices, hospitals and in public health. While working for the Snohomish Health District, Leta was active in WSNA, including serving as the Local Unit Chair for a couple of years.

But her greatest love was raising and loving her two sons, Ben and Chuck, and watching her grandchildren grow. Through the best of times and the worst of times her faith in Jesus Christ never wavered. She is survived by her husband Charlie; her two sons, Ben (and Sunny) and Chuck (and Tatum); her grandchildren Caden, Saylor, Lucy and Daisy; her siblings Norman, Gary and Shirley; and many nephews and nieces and their children. ■

# Welcome new WSNA staff

## Gloria Brigham, EdD, MN, RN
Education Director

Gloria Brigham joined WSNA as Education Director in March. She is a registered nurse who is passionate about learning. She believes in the value of relevant, evidence-based guidance to improve care quality, safety and experience — for the patient and for the health care team. With over 25 years of experience in education, safety and risk management, Gloria has worked in health care and in higher education, locally and at the national level. She serves as clinical faculty for the University of Washington, Tacoma and enjoys the opportunity to mentor students during fieldwork placement.

Gloria started her career as a nursing assistant at Burien Terrace Nursing Home. She earned a Bachelor of Science Degree in Nursing from the University of Washington, Seattle and worked as a bedside nurse in medical/surgical and critical care at Mt. Diablo Hospital in CA. After returning to the Pacific Northwest, Gloria joined St. Francis Hospital and was instrumental

in developing the Franciscan multihospital model for delivery of education and registered nurse residency programs. In 2010, Gloria earned a Master of Nursing from the University of Washington, Tacoma and in 2016 a Doctoral Degree in Educational Leadership. Most recently, Gloria was the CHI Division Director for Risk Management Operations and holds a CPHRM certification.

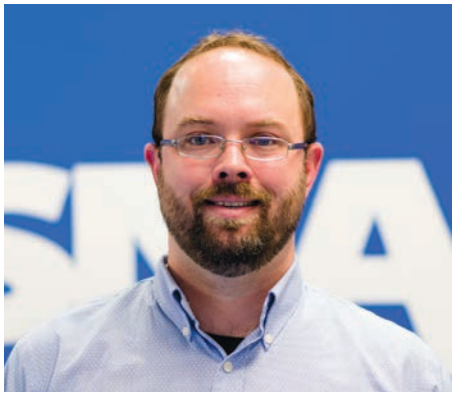
Gloria is excited to join WSNA to serve nurses in Washington. She states, "With the many changes in the health care industry, registered nurses are uniquely positioned to drive improvement in safe, quality care delivery. Utilizing strategies to effectively transfer education from the classroom into clinical practice is essential. We must collaborate to establish best practices that comply with regulatory requirements and are reasonable, achievable and sustainable over time."

## Josh Brown, JD
Director of Membership and Digital Transformation

Josh became the Director of Membership and Digital Transformation in January after working with the WSNA as a consultant for over two years.

As a consultant, Josh worked with a wide variety of organizations including Microsoft, Visa and Hewlett-Packard. His work focused on helping organizations use technology to improve their business processes, meet compliance challenges and reach customers more effectively. Most recently, Josh led the team that designed and implemented WSNA's new membership database and the MyWSNA portal.

A native of California, Josh received a degree in the Operations Management and Information Systems from Santa Clara University in 2004 and a law degree from the University of Oregon in 2010.



Josh has a family background in health care — his mother was an EKG technician and his grandmother put in the first patient processing management system at St. Mary's Medical Center in Long Beach, California — and so is pleased to be using his expertise to benefit nurses. "Nurses are in the forefront of your experience with health care in private practice or a hospital setting," he said.

Josh added, "I am excited to work with the team at WSNA to provide service and value to a membership that has doubled in the last ten years, and I am eager to use technology to continue to meet the needs of the current membership and to help WSNA scale for future growth."

Josh lives in Tacoma and can be found chasing his toddler around when not fixing bugs or building systems.

PHOTOS: BEN TILDEN

DISTRICT 1

# Northwest Region Nurses Association

### Three districts combine to form Northwest Region Nurses Association

In late January, members of three WSNA districts voted to join together as a new, regional district, the Northwest Region Nurses Association. Leaders in the districts, which cover Skagit, Island, San Juan, Snohomish and Whatcom counties, wanted to consolidate their efforts so they could offer more continuing education, events and other activities of interest to nurses in the region.

Every member of WSNA who lives and works in the five-county area is automatically a member of the Northwest Region Nurses Association, including both union and non-union members. WSNA districts are not involved in collective bargaining, and the Local Unit structure and officers where nurses in the region work are unaffected by this change.

Like other districts of WSNA, the Northwest Region Nurses Association will offer a more local way for all members to learn, network and support future nurses. The region is in the process of electing new officers and planning activities for the year ahead.

DISTRICT 2

# King County Nurses Association

So far, 2018 has been a busy time for KCNA, with a number of well attended and very well received continuing education programs (see below). Now we look forward to summer and an opportunity to begin planning for next year!

### 2018 continuing education programs to date

- **Trauma-informed Nursing and Human Trafficking**, with Kelly Martin-Vegue, RN, MSW. Kelly spoke about trauma-informed response principles, local and national resources, and opportunities for advocacy.
- **Ethics and Health Equity**, with Doris Boutain, PhD, RN, PHNA-BC, Anne Poppe, PhD, MN, BSN, BA, RN, and Christine Prenovitz, MSW, E-RYT. The seminar explored issues in upscaling social justice practice, easing moral distress and mindfulness.
- **District Meeting: Conversations with the new WSNA Executive Director**, with Sally Watkins, PhD, RN. This session included updates on current WSNA activities and legislative initiatives in 2018.
- **Health Care Ethics Discussion: Henrietta Lacks and Beyond**, with Bridget Carney, PhD, RN, health care ethicist. Bridget led a discussion of the book "The Immortal Life of Henrietta Lacks" and related bioethical issues.

### Annual Meeting and Spring Banquet

We are looking forward to this popular event – celebrating nurses and nursing – scheduled for May 10 to coincide with National Nurses Week. This year, KCNA is celebrating 115 years of support and advocacy for the profession. Participants will: honor the 2018 recipients of Shining Star nurse awards, meet this year's scholarship recipients (18 at $3,000 each) and enjoy silent and live auctions (100% of proceeds to the scholarship fund).

Not able to attend this event? If you would like to support deserving nursing students through the KCNA Scholarship Fund, make your tax-deductible donation on-line at kcnurses.org. Thank you!

The Bouffants won the coveted Most Team Spirit award at PCNA's 5th Annual Bowling Tournament.

DISTRICT 3

# Pierce County Nurses Association

Pierce County Nurses Association is off to a great start for 2018!

### Fundraising!

Our 5th Annual Bowling Tournament on Saturday, Feb. 24 was a great, fun-filled afternoon with fellow nurses while helping raise money for nursing students. When combined with additional donations, we've raised over $2,000 for nursing scholarships! Save the date for next year's PCNA Bowling Tournament – Saturday, Feb. 23, 2019.

### Education events!

Each year, PCNA hosts two main education events. Our Spring 2018 education event, The Opioid Epidemic, was held at Jackson Hall on Saturday, March 24. Visit our website, www.piercecountynurses.com, and 'like' us on Facebook to stay up to date about all our education events. Do you have a topic suggestion for a future education event? Email us at office@piercecountynurses.com.

### Career fairs!

PCNA seeks to support future nurses by attending career fairs at local high schools as well as attending student nurse meetings at local colleges. We're always looking for members to join us at these events. Email us at office@piercecountynurses.com to be added to our volunteer email list.

### Get involved!

PCNA is led by a fun, welcoming group of nurses who serve as officers and directors. We encourage you to come to a board meeting, see how things work and get more involved. Email us at office@piercecountynurses.com for times and locations of upcoming board meetings. Thank you for everything you already do, and we look forward to getting to know you better!

# Your support for tomorrow's careers

Your contributions to the Washington State Nurses Foundation support the academic advancement of outstanding nursing students. WSNF awards nursing scholarships that provide financial assistance to qualified students currently enrolled in a community college, baccalaureate or advanced degree nursing program in Washington state.

Since 1997, The Washington State Nurses Foundation has awarded $193,500 in nursing scholarships.

Congratulations to the following students who have been awarded scholarships by the Washington State Nurses Foundation.

**ACADEMIC YEAR 2018-2019**

| | |
|---|---|
| Associate ($1,500) | **Luu Phan** (Highline College), **Karina Paul** (Clark College) and **Krysta Hess** (Whatcom Community College) |
| Baccalaureate ($2,000) | **Allison Walter** (Gonzaga University) and **Hem Acharya** (Washington State University) |
| Masters ($2,000) | **Marit Knutson** (Seattle Pacific University) |
| Doctoral ($1,500) | **Bridgett Chandler** (Seattle University) |
| Judy Huntington Scholarship Fund ($2,000) | **Ingrid Anderson** (Gonzaga University) |
| Deo Little Scholarship Fund ($2,500) | **Sophia Cima** (Seattle University) |

**ACADEMIC YEAR 2017-2018**

| | |
|---|---|
| Associate ($1,500) | **Amanda Crist** (South Puget Sound Community College), **Michelle Simmons** (Lower Columbia College), **Amy Ingermason** (Clark College), **Lauren Spicer** (South Puget Sound Community College) and **Grace Mason** (Boise State University) |
| Baccalaureate ($2,000) | **Alyssa Freeland** (Northwest University – Buntain), **Rebecca Sellner** (Gonzaga University) and **Katelyn Cordes** (WSU/Whitworth University) |
| Masters ($2,000) | **Brien Basrett** (Seattle University), **Jeremy King** (Seattle University) and **Anne Laird** (Seattle University) |
| Deo Little Scholarship Fund ($2,000) | **Shaylene Page** (Seattle Pacific University) |

wsnf
WASHINGTON STATE NURSES FOUNDATION

The primary goal of the Washington State Nurses Foundation is to advance our profession and facilitate nursing's contribution to the health of the community. WSNF was established in 1982 to award grants and nursing scholarships, and to support educational advancement for the future of nursing. Contributions to WSNF are tax-deductible and are used for the clinical, literary, scientific and educational advancement of the nursing profession.

wsna.org/wsnf

## WSNA BOARD OF DIRECTORS

### Member observer attendance at meetings

#### Policy

All WSNA Cabinet, Councils, Committees and Board of Directors meetings shall be open to members to attend as observers, except when discussion involves the following (which will be in executive session):

1. Legal matters
2. Personnel matters
3. Grievances
4. Appointments, e.g. cabinet, councils, committees, official representatives
5. Matters pertinent only to the members of the group in session

#### Guidelines for attendance for members

Members attend with observer status as space allows and:

1. An observer of WSNA open meetings establishes prior to entrance into the meeting that he/she is current WSNA member who is not violating the WSNA Policy on Dual Unionism (see WSNA bylaws).
2. May participate in discussion when requested to do so by the chairholder.
3. Shall adhere to Board policy that release of information is through official channels of communication.
4. Attend at their own expense.

#### Criteria for determining attendance when limited space available

Members will accumulate points to be seated as observers based on the following:

1. First time attendance – 2 points
2. WSNA cabinet, council or committee member – 1 point
3. Local unit chair – 1 point

#### Communicating

Members will be informed of policy-related topics by:

1. Publishing of the open meeting policy in the Washington Nurse annually.
2. Publishing meeting dates in each Washington Nurse, the WSNA website and with dates subject to change.
3. Agenda indicating which portions of the meeting will be executive session.

***Approved by the WSNA Board of Directors Executive Committee, Oct. 6, 2017***

## New members

DISTRICT 1

### Northwest Region

Lisa M. Adam
Amber R. Anderson
Barry R. Antler
Jessi Ayers
Kayleigh M. Banks
Mikhail Barabanshchikov
Jessica T. Barbra
Becky L. Baumann-Steinhilber
Julie A. Bielau
Jennifer L. Border
Jade A. Borseth
Alexis J. Boz
Linda K. Bradley
Alyssa M. Brown
Steven L. Caporgno
Elizabeth C. Carlson
Rosaleen M. Carlson
Amy E. Chesbrough
Ashley M. Chess
Jenna K. Christopher
Suzanne M. Cochran
Adrienne M. Colson
Theresa W. Conner
Heather M. Coon
Julie A. Dean
Bonnie J. Decker
Rachel E. Demers
Cora L. Dubrow
Nathaniel W. Dufour
Heather N. Finney
Tomeka N. Franklin
Jesse D. Franks
Gretchen L. Geroux
Amy S. Gibson
Ashley D. Gillam
Jason L. Goodman
Ray L. Gould
Karen L. Griffith
Dorothy M. Hale
Lisa R. Harper
Monica D. Harrison
Heidi C. Hauenstein
Ashley R. Heilig
Timothy W. Herlickson
Claudia E. Hernandez
Dylan C. Hicks
Marci M. Holm
Sunny Hwang-Oras
Kristyn Irving
Cara C. Jacques
Amber Jones-Radcliffe
Anna D. Jordan
Harriet M. Kimori
Kay M. King
Kaci M. Korthuis
Katsura Kurayama
Cindy A. Laue
Martha Florentina M. Lee
Rosalie A. LeVee
Julie K. Malone
Mary T. Malone
Wesely C. Marion
Jonathan S. Mauk
Erika Mer
Terra E. Merwin
Claire B. Milnes
Staci L. Nakanishi
Sadie M. Nelson
Cheryl J. Nelson
Debra A. Northey
Laura L. O'Neil
Jui-Ting Peng
Anne M. Pequignot
Tiffany S. Pillman
Elaine N. Poore
Brian P. Prince
David E. Proffitt
Craig T. Pruitt
Micheline J. Ray
Thorkild S. Rosenvinge
Ginger L. Ross
Paul R. Ross
Sarah A. Rush
Julie A. Samms
Laura J. Savage
Beverly J. Selga
Elizabeth K. Sica
Sophie S. Siemion
Jean M. Staben
Alanna W. Steele
Sandy L. Steiger
Kristin S. Stevens
Marie E. Storms
Alba A. Suarez
Evelyn M. Syverson
Summer A. Tryon
Claire G. Villalanti
Stephanie L. Wahlgren
Craig M. White
Leanna J. Wilcox
Amy K. Williams
Rebecca M. Williams
Ryan T. Willis
Miriam R. Witt

DISTRICT 2

### King County

Jadamae S. Agoo
Shannon E. Akers
Cayla M. Alexander
Anita G. Alkire
Juli A. Allard
Tami C. Allen
Anna An
Christie L. Anderson
Natalie Anderson
Patricia G. Anderson
Welcom D. Ang
Ephrem M. Asfaw
Meklite F. Asfaw
Merlyn B. Asprec
Meilssa A. Avila
Katlyn A. Ayres
Hannah S. Baggett
Hailee M. Barnes
Audrey Bauer
Ana C. Bebec
Ashley M. Beeson
Patience Bekoe
Fitsum G. Belay
Samara A. Benezra
Emily C. Berreth
Alexis N. Boersma
Emily L. Boline
Rachel N. Bonnie
Natalya V. Boshaw
Tatiana Bostan
Cathleen M. Bozek
Michael W. Bratsch
Emma M. Breen
Emma D. Brenner
Gloria J. Brigham
Grant P. Brogger
Maureen E. Brooks
Laura L. Broustis
Czarina U. Brown
John D. Brown
Melanie L. Brown
Lindsay W. Brownlee
Erika L. Buechler
Marilu L. Bumgardner
Andrew J. Burzo
Sophie T. Buu
Brenda H. Campbell
Hannah R. Cantrell
Michael J. Carey
Christy L. Carlson
Nicole M. Caron
Bryanne A. Cassidy
Joanna B. Cerar
Susan S. Chan
Jorge I. Chang-Bocanegra
Wai S. Chum
James A. Churgai
Geanina L. Ciobanu
Natalie L. Cleek
Holly V. Closs
Kirsten M. Coddington
Paul R. Cookson
Amy Corin
Chelsea A. Cramer
Amanda J. Crandall
Chelsea E. Cullom
Lindsey E. Dandridge
Stacey J. Dao
Lily R. Dashtestani
Laura H. Decker
Lauren N. DeDore
Katrina L. DelRosario
Catherine Dennis
Hannah K. Depew
DeAnne S. Dey
Erin D. Dijulio
Pa C. Dimalanta
Jessica Dowler
Leah Dragotti
Sandra H. Draper
Lindsay E. Eagle
Janelle M. Eliason
Janette M. Eligino
Gillian E. Estrada
Tigist A. Fantai
Ashley J. Feerer
Xiaoli Feng
Nikkea M. Ferrin
Samantha J. Frerichs
Katherine S. Fritz
Alexandria R. Fryling
Noveshien Galang
Fallon N. Gallagher
Stacy K. Gallagher
Tamica M. Gant
Shaunda L. Gardner
Chandra K. Gates
Ludmila Gaydamachuk
Kathryn A. Geren
Cody M. Gibo
Olivia M. Gilge
Poonam Gill
Jaime L. Ginsey
Barbara A. Goebel
Robyn H. Gomez
Katie N. Goss
Kelsey M. Grant
Christina E. Griffin
Jannae E. Groeneweg
Jade Y. Gunnarson
Rosemary Hadcox
Jonathan D. Halldorson
Megan W. Hamlin-Fry
Lee A. Harper
Nico E. Hartwell
Ellen Charity S. Hegenauer
Ashley K. Heikes
Elaine S. Henriksen
Diane E. Hickey
Sunny A. Hillsberg
Barbara Hintzen
Anne M. Hirsch
Briana T. Hodson
Chelsea J. Hoffman
Elizabeth M. Hoffman
Sherrise Holland
Summer D. Hopkins
Connie L. Huang
Minyu Huang
Courtney M. Huffman
Elhan A. Jama
Jason Jernigan
Angela L. Jimenez
Juliana D. Johnson
Jason B. Jordan

Joel T. Kalpinski
Minseok Kang
Heather N. Kays
Neda M. Kazempourmatanagh
Amanda Kelley
Mattie R. Keltner
Brad W. Kennedy
Kara Kiesz
Clare M. Kilker
Andreia H. Kim
Christine Y. Kim
Eunha L. Kim
James S. Kim
Jordan G. King
Coreen A. Klein
Erin E. Kotzenmacher
Marion E. Kresslein
Claire E. Krizan
Amanpreet K. Labaana
Elizabeth A. Langlitz
Danielle N. Laskey
Kristi M. Leahy
Frieda M. Lehn
Karen J. Lemker
Sarah M. Leong
Sarah J. Lim
Katherine B. Linville-Wellman
Carolyn A. Livingston
Maria Cecilia A. Lopez
Stephanie Louie
Amielle J. Love
Jemimah Lwanga
Heather E. Maharrey
Kelsey A. Mandel
Erik K. Marks
Emily A. Martin
Sarah J. Matlack
Ranna Mae G. Mayhan
Kelly M. McCastland
Jessica S. McComber
Roxanne R. McCurry
Monica L. McLain
Chelle V. McMonigle
Karen A. Medina
Ashley A. Meek
Kristin J. Mellein
Cristian Mendoza
Taylor A. Metcalf
Kellie E. Miller
Madison P. Miranda
Brittany H. Moore
Krista L. Moran-Hodge
Yolanda M. Morris
Kimberly J. Morrison
Cassidy Napier
Colleen E. Neece
Aya L. Neuville
Bich Tram N. Nguyen
Judy T. Nguyen
Ibra Niane
Donnianne M. Noble
Amanda K. Norgaard
Amanda J. O'Neal
Cecilia A. Oforji
Katherine E. Oshita
Marian V. Oswald
Neil Alan E. Padalhin
Jenny A. Parker
Paige E. Parker
Debora C. Pascan
Frances P. Pathuis
Megan C. Pauling
Jennifer L. Pease
Elizabeth M. Pendergrass
Heather K. Pereira
Jessica R. Perry
Audrey G. Peter
Eric B. Peterson
Joanne E. Peterson
Louise M. Peterson
Elitah R. Petty
William R. Phare
Kathrina V. Phimviengkham
William T. Pierce
Belinda J. Plunkett
Severine L. Pons De Vier
Eric L. Prado
Amanda K. Profitt
Kiera W. Quinlan
Susan Ra
Marija D. Radulovic
Meghan N. Ramirez
Heather E. Rathod
Karen L. Ray
Anna M. Reed
Meredith L. Reilly
Nalani A. Rininger
Amber J. Robinson
Karen E. Robinson
Lauren C. Robinson
Amy E. Rollins
C. Jeanne Ronk
Emily P. Rowen
Evanne C. Sager
Thomas C. Sampson
Erica Sanchez
Lois A. Schipper
Emily S. Schlabra
Keri M. Schrimshaw
Jessica C. Schuldt
Amy E. Schweitzer
Alexandria Y. Serwold
Evelyn Y. Shao
Chitra Sharifian
Ioulia S. Shenk
Jingxin Shi
Jessica M. Simon
Steven C. Simpkins
Isatou Sinera
Victoria A. Singsaas
Christie L. Skelton
Michelle K. Smigaj
Brandi J. Smith
Caleb M. Smith
Kristi M. Smith
Larry T. Smith
Jennifer K. Southall
Meghan E. Sparks
Julie T. Spink
Denise R. Spisso
Kyle C. Stanton
Judith Stein
Alicia R. Stemmler
Hanna J. Stockelman
Jacob R. Stollenwerk
Katherine E. Strand
Megan E. Strom
Danae L. Swartz
Brandy L. Tallman
Monica Tamborero Fernandez
Jennifer A. Taylor
Shielisse D. Te
Tanesha Tekola
Cynthia L. Tellefson
Asmeret Tesfalem
Evan C. Thomas
David R. Thompson
Gurinder K. Thoohan
Dorothy Tokarz
Annelisa B. Tornberg
Paige R. Torres
Hien T. Tran-McGuire
Thuy N. Truong
Abraham T. Tsegaye
Gary E. Turnage
Jessica J. Turver
Anna R. Ursino
Ester Valencia
Sara E. Van Natta
Robyn M. Van Velthuyzen
Roberta R. Wagner
Kristina N. Wang
Claire M. Warbis
Teresa M. Ward
Rachel M. Weinand
Jessica L. Wenner
Kevin R. Wilhelmsen
Breanne A. Williams
Kurvin G. Williams
Lindsay R. Williamson
Christina M. Wimmer
Elizabeth J. Witter
Desiree L. Wood
Fransisca F. Worang
Li Zhang
Kamlah G. Zughni

DISTRICT 3

### Pierce County

Kylie A. Adams
Sahra Y. Adan
Lisa A. Agcaoili
Corina L. Allen
Rhowin D. Amadeo
Michael P. Anderson
Sharleeta D. Austin
Alexis C. Axford
Amy L. Bakalarski
Erin E. Barnes
Kelly R. Barron
Kaitlyn A. Bassler
Clinton E. Berreth
Elisha A. Bigayan
Oluwadamilola Bolonduro
Irina Bolotnyuk
Marvin Jhorell D. Bontigao
Kayla A. Brogden
Ryan L. Buttrick
Gladys C. Cadiz
Constance M. Cales
Kimberly Anne C. Camacho
Roseanna R. Camacho
Carolyn M. Capell
Lyndie M. Carboni
Celia M. Carrasquillo
Amy Chan
Alexandra M. Chang
Joan Cheptum
Kay A. Clarke
John Arvin F. Clavecillas
Brooke E. Clover-Owens
Taran C. Cobb
Tessa L. Cockrum
Grace W. Collins
Emily A. Cook
Maryann J. Cox
Melissa W. Cutting
Kristen A. Daily
Andrew J. Davis
Laura Deuel
Dayna L. Devereaux
Tammy L. DeVito
Monica A. Dolfi
Maria April Domer
Maria L. Douglas
Jenna D. Duque
Andrea R. Edwards
Anna V. Ellersick
Chelsea N. Engelhardt
Stina L. Farrow
Morgan J. Fox
Brittney J. Gagne
Kathleen A. Galapon
Ericka A. Galindo
Greta M. Ganley
Roxane S. Garcia
Amy M. Gocha
Lourdes Marie N. Grau
Hailey E. Grimm
Daniel V. Guama
Dixie A. Harvey
Abdi I. Hassan
Beth M. Hastert
Tiffany M. Heiges
Meghan Hepp
Samantha Hernandez-Cartagena
Sherie M. Hess
Walter R. Hill
Sharilyn C. Hoefs
Paul V. Hua
Haley S. Hughett
Kelsay L. Irby
Florence T. Isaguirre
Esther M. Jaime
Lauren E. Janssen
Richelle Anne G. Jaspe
Manjinder Kaur
Viktoriya Kazimirets
Alicia B. Ketterer
Simranpreet K. Khosa
Sarah Kim
Corey K. Kime
Liliya S. Kruk
Hellen W. Kungu
Alyssa M. Kuwik
Katala M. Lach
Kathryn A. Ladner
Kelly Lagervall
Rose M. Laporte
Mimbouabe Lare
Vivian L. Latham
Alexandra T. Lawrence
Blaine Robert C. Lee
Irina A. Lisitsyn
Jennifer M. Livermore
Michael R. Long
Jamie L. Loudenback
Adriana C. Loya Ferguson
Jennifer L. Lukins
Christina L. MacDowell
Shelby L. Maginn
Ruthy Rhea S. Mamerto
Jordyn A. Mandery
Bryce R. Markey
Krista A. Markovic
Queenie M. Marquinez
Christopher C. McCall
Marjorie T. McDaniel
Tania M. McGuffey
Rochelle D. McKay
Sarah J. Meier
Adrienne E. Milam
Maryanne W. Mirie
Megan J. Moore
Rebecca L. Mulkey
Anna Munns
Rehemah N. Nabunya
Lavena M. Narvaiz
Racquel L. Navarro
Mary W. Ndugire
George M. Ngugi
Monicah E. Ngugi
Tina Nguyen
Arisa F. Nogler
Valene Nicole Ocampo
Cecilio E. Ocbian
Laura L. Ohman
Shauna-Lynn Orallo
Sergey V. Osadchy
Alaine Nicole Pareja
Caryl L. Parkinson
Lucia L. Patrick
Hannah F. Pekarek
Lyn Rochelle M. Perosi
Barbara A. Perry
Bethany D. Perry
Erin N. Peters
Jeffrey D. Peterson
Taya M. Peterson
Kristin M. Phillips
Illene L. Plaster
Giesleydi N. Portelles
Margaret K. Post
Sean N. Powell
Monique A. Presutti
Melissa A. Prime
Trudy A. Rader
Jennifer M. Reinhardt
Larra A. Reyes
Claudelle Ridore
Rachel N. Robinson
Roksoliana M. Rohovyy
Chelsey A. Roos
Lindzey K. Rubio
Stephanie J. Ruddell
Melissa M. San Filippo
Carol A. Schroeder
Naomi Seale
Pio M. Seria
Kristopher M. Sheldrake
Alison R. Sipe
Clarice G. Siy
Cynthia M. Skidmore
Cynthia H. Smith
Alexis L. Snyder
Casey A. Sprague
Saudah N. Ssemakula
Hilary E. Stallings
Kimberly R. Steffens
Christina B. Stephens
Ruby R. Stocking Siagkris
Heather A. Storm
Bryanna M. Stowers
Elizabeth Strauss
Anna Kristina S. Swanson
Sinalyn A. Tagata
Tatiana Templeman
Christopher L. Thao
Mandie M. Thompson
Allison L. Thomson
Tuyen N. Tran
Julia M. Tripp
Jessica G. Tsosie
Susanne L. Urabeck
Sumiko L. Vandenberg
Suzanna M. Velichko
Kellie E. Veltung
Elysia R. Villa
Karen G. Viscaya
Edward D. Vizcaino
Caroline L. Walsh
Dustin D. Wannamaker
Michelle N. Webster
Julia M. Weisser
Colleen P. Wherry
Dustin B. Williams
Malerie A. Wilson
Samuel A. Woldemariam
Sarah M. Wood
Sarah N. Wooley
Maria E. Workman
Amanda J. Wurts
Dean K. Young

DISTRICT 4

### Spokane / Adams / Lincoln / Pend Oreille Counties

George Aguilera
Lee M. Ayers
Fatima M. Baldridge
Kim P. Benton
Taylor R. Berdar
Briana N. Bobrik
Aleigha D. Brandt
Julie A. Brockbank
Chelsea L. Burright
Kari L. Carbajal
Shannon M. Carey
Davina I. Carr
Channing M. Collette
Trevor N. Cooper
Kristin A. Curl
Emil J. Daily
Brooke M. Daly
Breanne R. Denlinger
Tawny R. Duncan
Tammy L. Durham
Alyssa N. Egland
Katerine J. Elvir Santos
Kramer S. Erb
Delaney K. Fisher
Kathleen B. Gallegos
Sarah A. Gumm
Amber L. Haney
Janna I. Haun
Hailey M. Heilman
James T. Henry
Lisa M. Heston
Lara M. Jarrett
Brittni C. Jones
Nitsuh E. Kebede
Maureen A. Kohler
Lilia S. Kopets
Elizabeth A. LaBella
Angela M. Livingston
Tamara K. Loe
Tamara L. MacIlroy
Alyssa M. McElroy
Erica J. McNeel
Ryanne L. Millard
Daniela Montes
Kayla N. Moorman
Vicki J. Morrison
Amanda R. Nelson
Courtney L. Peterson
Kelci J. Quinn
Diana M. Rambow
Miranda B. Roberts
Maurya R. Robinson
Marco A. Rudas-Garcia
Alexander R. Rumann
Amy L. Shaver
Aubrey A. Spear
Jeanette R. Spreadborough
Kayla R. Stan
Jacquelyn N. Starr
Karina S. Sutker
Walter S. Sutton
Kortney L. Thornburg
Alexis R. Traver
Benjamin E. Verbil
Linda L. Walker
Aaron L. Walsdorf
Dylan M. Ward
Sheree H. Webb
David M. Wellman
Kaitlin E. Wendt
Brittanee D. Wheeler
Rachel M. Wieker
Angela R. Zigarlick
Kathryn L. Zink

DISTRICT 5

### Walla Walla / Columbia Counties

Jillian M. Burton
Renee G. Clark
Nikolaus Cortez
Sandra Cuellar
Tuesdee Gies
Jashay Lua
Elizabeth A. Salgado Cantrell

DISTRICT 6

### Yakima City / North Yakima

James A. Allen
John J. Allen
Samantha Argo
Tanya D. Britt
Lorrie T. Carter
Jessica S. Garcia
Susan K. Gleeson
Cheryl M. Hoffee
Jeffrey D. Holdeman

DISTRICT 7

### Chelan / Douglas / Grant Counties

Emma Anderson
Julie A. Becker
Kristy M. Bir
Brittney M. Blinkinsop
Joy Dawe
Kerry S. Finerty
Paul Fuller
Diany C. Godoy
Coventry O. Jankowski
Samantha J. Jerome
Meghan E. Johnson
Keith Krejci
Jennifer J. Lane
Taleah R. Lankhaar
Katie A. Lewing
Rochelle E. Long
Emily E. Lumpkins
Rylee J. Marboe
Rachel A. Meier
Lesley A. Moses
Allison B. Neher
Abeth K. Okall
Nicholas D. Sells
Secrett Simmons
Kaitlin Spurbeck
Noah R. Stearns
Shelley R. Story
Iris A. Tiemersma
Martha Von Reis
Alina F. Wabaunsee
Sara M. Walker
Ashlee N. Wallach

## New members

DISTRICT 8

### Grays Harbor

Meta J. Bray
Daryl D. Brown
Angila L. Lake
Brenda L. Seelye
Belinda M. Spahn
Richard K. Thompson
Bailey N. Walczak

DISTRICT 10

### Wahkiakum / Cowlitz Counties

Jason T. Escudero
Irina A. Goldinov
Bethany L. Madden
Stephanie W. Nelson
Breanna D. Osborn
Monica M. Richards

DISTRICT 11

### Clark / Skamania Counties

Tatetum R. Allison
Rachel M. Barham
Adam B. Bartle
Debora L. Bozich
Jerome D. Crawford
Benjamin R. Cupelli
Raissa S. Garcia
Ciera R. Hawkins
Emilee B. Kent
Paige R. Lewis
Tenzing Lhamu
Nicholas X. Luisi
Carly A. Mackay
Mortuma J. Murry
Erin N. Oberstaller
Ron D. Olsen
Elizabeth A. Osborn
Gerry R. Poitras
Yvonne E. Quashie
Megan E. Richey
Dalton M. Ries
Shelby P. Schleis
Karly A. Schriever
Hsin-Yi Sung
Lisa M. Yadon

DISTRICT 12

### Clallam / Jefferson Counties

Amy D. Scott

DISTRICT 13

### Thurston County

Mary L. Zozaya-Monohon

DISTRICT 14

### Whitman County

Tara L. Styhl

DISTRICT 15

### Benton / Franklin Counties

Sheena R. Anderson
Kassandra P. Baxter
Tracy A. Bowers
Mary A. Brownlee
Alejandra G. Chong
Jessie M. Crandell
Kelsi L. Duncan
Rachael L. Fisher
Mehgan P. Gray
Mahin T. Hackler
Rachel M. Jones
Theresa H. Kallsen
Baylee M. Keith
Sara K. Kindelspire
Rebecca A. Malawy
Terin L. Pratt
Diana M. Reyes
Elvia S. Rojas
Debra L. Strait
Bailey G. Walthers
Jacklyn A. Wegers
Sarena D. Wright

DISTRICT 17

### Kitsap County

Christopher J. Chin
Melinda Hamilton
Crystal E. Heggie
Tameka S. Hullen

DISTRICT 18

### Kittitas County

Agnes M. Komorowski
Ronald Reda
Crystal J. Weyand

DISTRICT 98

### All other counties

Lisa A. Bartlett
Amy J. Blair
Nora C. Consulta
Michelle D. Fetkenhour
Janet G. Fry
Mayte Garza
Heidi J. Irwin
Kelly A. King
Pamela L. Logalbo
Jody M. Shively
Amanda R. Tisai
Morgan N. Waldeck

## Membership information

## If you are currently a member and have had a change in your employment situation...

Please complete a Change of Information Form or email your changes to membership@wsna.org. The Change of Information Form is available on the WSNA website under "Membership," or you can contact the WSNA Membership Department at 800-231-8482 or 206-575-7979 to request one.

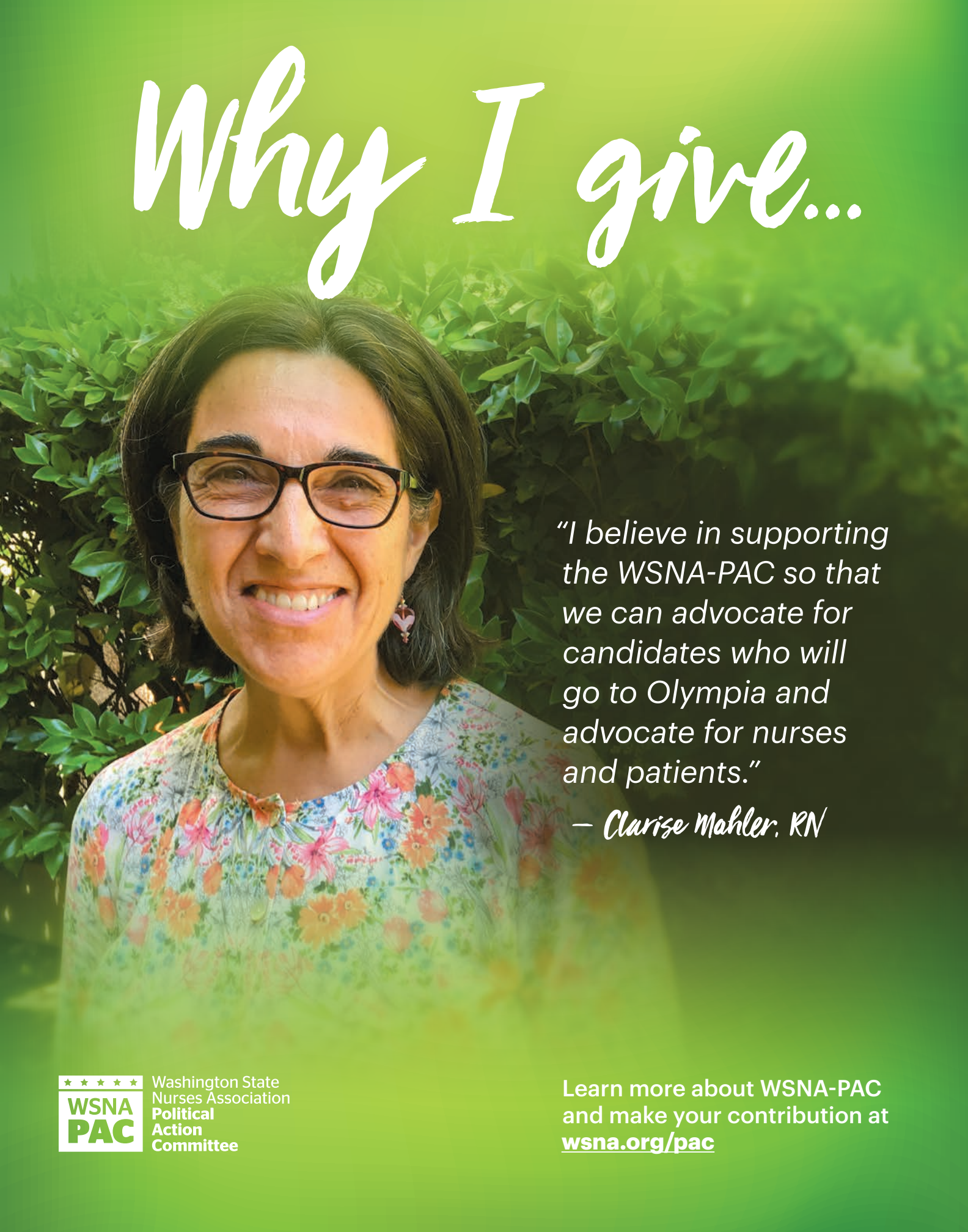
**Please note:** It is the member's responsibility to notify WSNA in writing of any changes in address, employer, FTE status, layoff or leave of absence. Write to: Membership – Washington State Nurses Association, 575 Andover Park West, Suite 101, Seattle, WA 98188.

**Notice of Washington State Nurses Association policy regarding nonmembers employed under WSNA collective bargaining agreements**

Federal and state labor laws recognize the right of unions in Washington to enter into collective bargaining agreements with employers that require employees, as a condition of employment, either to join the union (and thereby enjoy all of full rights and benefits of membership) or to pay fees to the union (and thereby satisfy a financial obligation to the union without enjoying the full rights and benefits of union membership). Regardless of the wording of the "union security" agreement, employees represented by the Washington State Nurses Association for purposes of collective bargaining and covered by a union security agreement are not required to become full members of WSNA, and are required only to choose either to be members of WSNA or pay fees to it. Employees who choose to become members of the Washington State Nurses Association pay WSNA dues and receive all of the rights and benefits of WSNA membership. Employees who either decline to become members of WSNA or who resign from WSNA membership may pay "agency fees" to cover their share of the cost of representation, and thereby satisfy any applicable union security obligation. WSNA has negotiated union security agreements, which have been ratified by the democratic vote of the affected employees and which require that all employees must either join the union or pay fees to the union, in order to ensure that each employee who is represented by WSNA pays a fair share of the cost of that representation. Such union security agreements strengthen WSNA's ability to represent employees effectively in collective bargaining, contract enforcement and grievance administration, while eliminating "free riders" who enjoy the benefits of a WSNA contract and representation without contributing their fair share of the union's expenses for negotiating, administering and enforcing the contract. Through the collective bargaining process, nurses represented by WSNA achieve higher wages, better benefits, fairness in the disciplinary procedure, and enhanced respect for their skills and professionalism. These improvements, won through collective bargaining, enhance the terms and conditions of working life for all employees, and allow them to better provide for themselves and their families. Only WSNA members enjoy all of the full rights of WSNA membership. Only WSNA members have the right to attend local unit meetings and speak out on any and all issues affecting their workplace, WSNA and its members; the right to participate in the formulation of WSNA policies; the right to have input into WSNA bargaining goals and objectives, and to serve on WSNA negotiating committees; the right to nominate and vote for candidates for WSNA office, and to run as a candidate for WSNA office; the right to vote on contract ratification and strike authorization; the right to participate in the WSNA general assembly; and the right to participate in the American Nurses Association and the American Federation of Teachers.

Agency fee payers are those who choose not to be full members of WSNA but who pay their share of WSNA's expenses for negotiating, administering and enforcing the contract with their employer by payment of agency fees. They thereby fulfill any applicable union security financial obligation to WSNA under the terms of any collective bargaining agreement between their employer and WSNA. Agency fee payers forfeit valuable rights and benefits of WSNA membership. Agency fee payers give up their rights to have input into the affairs of WSNA, the organization that represents them in dealings with their employer concerning wages, hours of work, health and retirement benefits, disciplinary matters, and other terms and conditions of employment. Any WSNA member who chooses to become an agency fee payer (and thereby forfeit his or her WSNA membership rights) may resign at any time from WSNA by submitting a written notice of resignation from WSNA membership, which becomes effective upon receipt by WSNA. Agency fee payers should submit to WSNA an Agency Fee Payer Application Form, which is available upon request from WSNA. Agency fee payers are required to pay fees equal to their share of WSNA costs germane to collective bargaining, contract administration and grievance adjustment. WSNA automatically reduces the fee charged to agency fee payers by the amount attributable to expenditures incurred for WSNA activities that are not related to its responsibilities as representative for purposes of collective bargaining. In our most recent accounting year, 6.6% of WSNA's total expenditures were spent on activities unrelated to collective bargaining representation. Any non-member who is financially obligated to WSNA under a union security agreement may inspect the audit report of WSNA expenditures at a reasonable time and place upon written request to WSNA. Any non-member who disagrees with the amount of the agency fee may file a written challenge with WSNA, which must state the basis for the challenge. For members who resign their membership during the calendar year, challenges must be made within 30 days of the postmark of the notice regarding their change in status from members to agency fee payers. For non-members, challenges must be made during the 30 day period after the postmark of WSNA's written notice of the new calculation for agency fees that take effect on Jan. 1 of each year. Such challenges shall be decided by an impartial arbitrator appointed by the American Arbitration Association pursuant to its Rules for Impartial Determination of Union Fees. Any challenges must be submitted to WSNA, ATTN: Agency Fee Challenges, 575 Andover Park West, Suite 101, Seattle, WA 98188. It is recommended that any challenges submitted be sent by certified mail, but certified mail is not required.

# Why I give...



*"I believe in supporting the WSNA-PAC so that we can advocate for candidates who will go to Olympia and advocate for nurses and patients."*

*— Clarise Mahler, RN*

WSNA PAC
Washington State Nurses Association **Political Action Committee**

**Learn more about WSNA-PAC and make your contribution at wsna.org/pac**

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