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DNA Reporter

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The mission of the Delaware Nurses Association is to advocate for the interest of professional nurses in the state of Delaware. The Delaware Nurses Association is dedicated to serving its membership by defining, developing, promoting and advancing the profession of nursing as an art and science. Quarterly publication direct mailed to approximately 12,000 RNs and LPNs in Delaware.

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Guest Editor

Dianitza V. Runser, MSN, RN

Dianitza V. Runser

Dianitza is a native from the Republic Panama who relocated to the United States 26 years ago. She is a graduate of Delaware State University where she obtained her baccalaureate degree in nursing science. Dianitza graduated in 2009 from Wesley College with her Master of Science in Nursing degree. She is currently attending Chatham University for her Post-Master Certification as a Nurse Educator. At the same time, Dianitza is completing a Post-Masters Certification for the Genrontology Clinical Nurse Specialist at Wesley College. Presently, she works at Wesley College as a full time instructor of nursing. Dianitza is a former employee from Bayhealth Medical Center where she worked in different units including medical surgical, intensive care, intermediate care, endoscopy, and dialysis. She also worked at Polytech High School as a nurse assistant clinical supervisor and liaison. Dianitza is a member of the National Association of Hispanic Nurses (NHAN) and the president elect of the Delaware Hispanic Nurses Association. She is an active member of the Hispanic parish at the Holly Cross, Catholic Church where she volunteers in various activities. Dianitza is a member of Sigma Theta Tau and currently holds the vice president position for the Tau Beta Chapter at Wesley College. For three consecutive years, Dianitza has traveled to Guatemala where she co-teaches a study abroad course for undergraduate nursing students that focuses on ethnography, culture, and health. Dianitza is also a member of the Lecture and Cultural Arts committee at Wesley College. Dianitza can be reached at Dianitza.Runser@Wesley.edu

Issues related to Transgender (TG) health disparities are an emergent topic in healthcare. As nurses, we are the most trusted profession, and we represent vulnerable populations through advocacy. Furthermore, nurses are the voice of those marginalized and stigmatized by the inequalities of an

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Executive Director's Column

Sarah J. Carmody, MBA

Sarah Carmody

It's 2018 and I am excited for what's in store for DNA in the coming months. DNA welcomes new Board of Directors members who took office in the fall. The new DNA President-Elect is Gary Alderson, Chris Otto is Secretary, Jon Leeking is Treasurer, and Terry Towne and Felisha Alderson are members of the Nominating Committee. Thank you to all who offered their expertise and time to run for office!

In the coming months, DNA will be implementing the decisions from the BOD Retreat that was held in January. The Board will focus on our policy agenda, organizational structure, and membership engagement. If you have any comments or suggestions, my email is always open. Please contact me at sarah@denurses.org

As of this writing, the DNA Spring Conference is scheduled for April in Dover with a location to be determined. The focus of this conference is safety with topics that include bioterrorism and active shooter safety. Please check the DNA website for additional details.

Voting for Delaware Today Top Nurses closes February 5th. This program provides opportunity for all nurses regardless of practice to be recognized for their contribution to the nursing profession and patient care. The 2018 celebration of Top Nurses will be held at the Bella Vita at Cavaliers Country Club on May 17, 2018. I hope that you will join DNA and Delaware Today magazine for this celebratory event! Information on tickets and sponsorship can be found on the DNA website.

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existing healthcare system. Advocacy in nursing practice involves taking a stand to ameliorate the political, socio-economical, and educational issues that affect the health outcomes of vulnerable individuals (Selanders & Crane, 2012). In addition, advocating for the vulnerable requires learning about the population and the factors contributing to their health disparities (Selanders & Crane, 2012). This edition of the *DNA Reporter* presents health discrepancies among TG individuals; thus, opening the window of opportunity for Delaware nurses to take actions in advocating for this vulnerable population by learning about issues that the general TG community faces.

As nurses, we must learn to provide cultural-competent care to patients without stigmatizing, or alienating individuals in the community. An extensive literature exists as evidence of the frequency mistreatment, discrimination, and stigmatization to TG people from healthcare providers (Cornelius & Whitaker-Brown, 2017). On the other hand, current research points out that healthcare providers are not knowledgeable enough when caring for TG people; therefore, hindering the willingness for TGs to seek care (Poteat, German, & Kerrigan, 2013). As a result, many Transgender people face exposure to health disparities that endanger their physical, emotional, and psychological wellbeing.

Health disparities associated with TGs require team work and collaboration from all angles of healthcare. Nurses must engage and be at the frontline of defense to advocate for TG people. The contributing authors in this edition of the DNA Reporter bring a comprehensive approach to inform Delaware nurses about current issues affecting the TG population and efforts to help decrease discrepancies related to the care of TG persons. I would like to thank the contributing authors for standing up and providing extensive, informative articles on current issues affecting TG people, a topic often overlooked, and to Denise Morris and Patsy Stark for sharing their original groundbreaking research in reference to a conceptual model when caring for Transgender people.

In the first article, I will discuss issues regarding the overall lack of knowledge on communicating and improving clinical practice for TG people. The second article written by Denise Morris, EdD, MSN, RN in collaboration with Patsy (Pat) Stark, BSN, RN, CHPN will explore and introduce a conceptual framework deemed necessary for nurses to provide delivery of care without assumptions. The third article written by Margaret McElligott, MSN, RN presents the increase rate of suicide amongst TGs due to discrimination matters and lack of acceptance in society. The fourth article written by Brian Wharton, MSN, BSN, RN will be a discussion regarding homelessness among transgender youth and the consequences that influence the development of risky behaviors encountered by this vulnerable population. The final article written by Shari Tenner, MSN, RN will explain issues that create barriers for cancer screenings among Transgender people; consequently, presenting specific cancer screenings to provide better preventive care to TGs.

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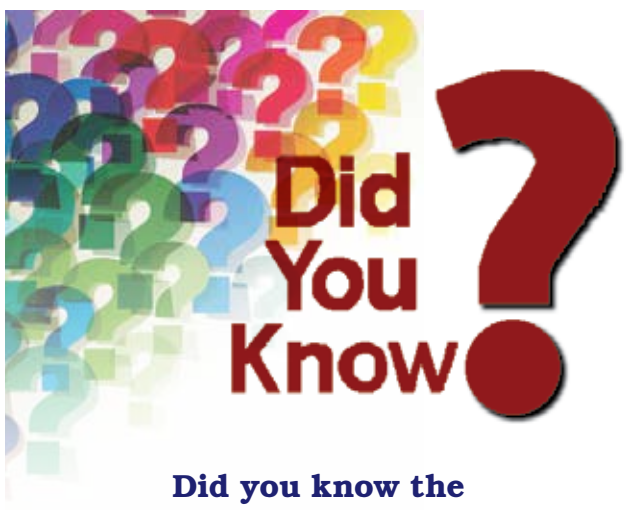

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- Maintain and strengthen nursing's role in client advocacy for consumer safety and quality healthcare

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Managing Editors
William T. Campbell, Ed.D, RN
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The *DNA Reporter* welcomes unsolicited manuscripts by DNA members. Articles are submitted for the exclusive use of T*he DNA Reporter*. All submitted articles must be original, not having been published before, and not under consideration for publication elsewhere. Submissions will be acknowledged by e-mail or a self-addressed stamped envelope provided by the author. All articles require a cover letter requesting consideration for publication. Articles can be submitted electronically by e-mail to Sarah J. Carmody, MBA @ sarah@denurses.org.

Each article should be prefaced with the title, author(s) names, educational degrees, certification or other licenses, current position, and how the position or personal experiences relate to the topic of the article. Include affiliations. Manuscripts should not exceed five (5) typewritten pages and include APA format. Also include the author's mailing address, telephone number where messages may be left, and fax number. Authors are responsible for obtaining permission to use any copyrighted material; in the case of an institution, permission must be obtained from the administrator in writing before publication. All articles will be peer-reviewed and edited as necessary for content, style, clarity, grammar and spelling. While student submissions are greatly sought and appreciated, no articles will be accepted for the sole purpose of fulfilling any course requirements. It is the policy of DNA Reporter not to provide monetary compensation for articles.

President's Message

Leslie Verucci, RN, MSN, CNS, CRNP-A, APRN-BC

Leslie Verucci

Belated but **Happy New Year.** I hope all of your dreams are filled this year and you are able to keep those resolutions. I have no willpower so never make resolutions as I know I will not keep them. My goal is to become more active in providing more engagement opportunities for our members. I am so glad to congratulate the new Board of Directors for 2018 – DNA President-Elect Gary Alderson, Secretary Chris Otto, Treasurer Jon Leeking, and Nominating Committee members Terry Towne and Felisha Alderson. It is going to be a fun and exciting year. We had a retreat in January to look at what our goals and plans are for the upcoming months. We hope to add more for our members and encourage involvement. We as a group are being asked to be more involved in Community Issues and will need volunteers to assist with this as we move forward. If you have an interest in being involved with your state organization, please contact the office for more information.

I am also asking you to think about the nurses you work with and some of the amazing things they do everyday for our patients and the community in which they work. Delaware Today Voting closes February 5th so consider nominating one of your colleagues. The awards ceremony will be held on May 17th at the Cavalier Country Club Bella Vita Room. We always have a great turn out and watching the winners' faces when their names are announced is a gratifying experience for all. Delaware Today does such a great job in recognizing and celebrating the nursing profession.

I want to thank the editors of this edition for the great information they have provided us in the care of the transgender community. Being culturally competent can create a challenging time with patients, but learning all we can will make the visit and the care we provide safer and more holistic.

To the advanced practice providers, the State Of Delaware has created a new Delaware Prescription Monitoring Program (PMP) software. Your existing Delaware PMP account has automatically been transferred into the new software system.

You can access the Delaware PMP by:

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- Clicking the 'Reset Password' button on the homepage.
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- Once you have reset your password, you will be logged into the system.
  - If prompted, update your demographic information.
  - To request patient reports, please review the How to Make a Request Guide.

Additional instructions for use of the new Delaware PMP can be found after log-in by clicking the Training section in the top menu.

Note that the old website, https://depdm-ph.hidinc.com/, is no longer available. If you have any questions or concerns, please contact support directly at 855-263-6401. Technical assistance is available Monday - Friday; 8:00 am - 5:00 pm ET.

For policy questions, you may contact the Delaware State Administrator at (302) 744-4518.

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Left to right: Felisha Alderson/Nominating Committee, Chris Otto/Secretary, Gary Alderson/President-Elect, and Jon Leeking/Treasurer

Caring for Transgender Individuals: Improving Nursing Practice

Dianitza Runser, MSN, RN

See Guest Editor for complete bio on page 1

Several months ago, I attended a Transgender (TG) support group with the assumption that all TG people look and dress according to the gender with which they identify. I came to the meeting prepared to share a health promotion activity that I considered would be beneficial to the group. I realized that evening, how unprepared I was to contribute, and how unfit I was to even attempt disseminating *"my plan."* After that experience, I have embarked on the journey to become an advocate for the TG population in Delaware. I have realized how few available resources exist to support the healthcare needs of the TG population. The aim of this article is to raise awareness about the narrow knowledge on the clinical management and cultural insight of this vulnerable population from a nursing perspective. Barriers to provide cultural sensitive and competent care for TGs is due to the lack of a broader knowledge on Transgender people (Lim & Brown, 2014). Another area in nursing needing attention to better care for TGs is the development of clinical guidelines specific for nurses (Zunner & Grace, 2012). Nurses also need to stand-up and participate in research that ameliorates communication practices, preventive services, and the effects of treatments for TGs (Levitt, 2015). Learning and keeping an open mind about the unique needs of TGs will strengthen advocacy and improve nursing practices for this population.

Transgender health is an emerging concern among healthcare professionals; however, the worries about the lack of knowledge regarding transgender care poses challenges to healthcare providers (Poteat, German, & Kerrigan, 2013). Ameliorating better communication practices begins by learning specific terminology to help nurses address the TG patient respectfully (Zunner & Grace, 2012). The word transgender, for instance, means that the person does not identify with the sex given at birth (Bostock-Cox, 2016). The term cisgender means that individuals are not Transgender and use their biological sex (Mesics, 2015), and the term male to female (MTF) [trans-woman] means a male self-identifying as female or the term female to male (FTM) [trans-man] means a female self-identifying as a male (Aramburu Alegria, 2011). In order to establish a trusting relationship, healthcare providers (HCP) must address TG persons by the name and pronoun that TG persons prefer (Poteat et al., 2013). Further, differentiating between gender identity in which the TG person identifies with being a man, a woman, or neither, differs from gender dysphoria when there is incongruity between the physical and mental characteristics. In other words, the person looks female; however, mentally, the person knows he is male (Bostock-Cox, 2016). Improvement in communication practices with TG persons will promote a trusting relationship; hence, a safer environment for competent clinical practices (Poteat el al., 2013). Nurses must practice using the proper terminology when caring for TG people to demonstrate respect to TG people; therefore, TGs lessen their fear when seeking health, especially preventive services. Zunner and Grace (2012) stated that "thirty one percent of patients who felt disrespected by care providers delayed medical care" (p.63).

Above all, the lack of publication about transgender health in nursing articles (Carabez, Eliason, & Martinson, 2016), and the limited inclusion about TG in nursing education (Lim & Bernstein, 2012) lessen effective, cultural competent learning about the care for LGBT patients. Nursing students demonstrate negative attitudes and fear of HIV contamination when caring for these patients; therefore, nursing curriculum should include evidence-based learning about Transgender health to reduce the stigmatization that exist among future nurses (Lim & Brown, 2014). As cited by Aramburu Alegria (2011) "…, 10% of nursing students were found to have a basic level of knowledge…" when referring to the general lesbian, gay, bisexual, and Transgender LGBT population (p. 175). The TG population continues to grow with an approximation of 1.5 million people admitting being TG (Centers for Disease Control and Prevention [CDC], 2017). Including TG care in nursing education, at any level, nurse educators will help trace the future for improving better patient-centered-outcomes (Aramburu Alegria, 2011). Part of providing competent care to the TG population involves the initiative for the development of specific tools, such as collecting the health history and obtaining a physical examination focused on TG people (Wichnski, 2015).

Nurses must acquire competence in various issues that can affect the overall health of TG people. A holistic approach including biological, socioeconomic, spiritual, and mental health is imperative in order to provide comprehensive care to TGs. Of the estimated 700,000 (0.3%) identified TGs in the United States, many do not have health insurance nor preventive care (Wichnski, 2015). Other TG persons would rather not seek medical care due to derogative statements and stigma by healthcare providers (Wichinski, 2015). As previously mentioned, the physical characteristics of TG individuals differ from one another (Wichnski, 2015). Some TG persons do not take hormones, and others do not have surgery. On the contrary, some TG persons may have surgery with or without hormone therapy (Wichnski, 2015). Furthermore, some TG people may lack family support when disclosing their identified gender; consequently, they are faced with homelessness, lack of insurance, low-paying jobs, or unemployment (Cornelius & Whitaker-Brown, 2016). Jobless TG persons needing hormones recur to street suppliers; in addition, some TG people become hormone and illicit drugs suppliers themselves, thus being exposed to HIV, crime, and violence (Cornelius & Whitaker-Brown, 2016). The unfortunate reality is that young TGs who become homeless due to social rejection demonstrate negative behaviors such as drug addiction or becoming sex workers (Torres et al., 2015). Transgender youth face challenges for obtaining mental health services; as a result, they deal with mental distress, depression, social isolation, and suicidal behavior (Torres et al., 2015).

The complex care for TG persons needs standardization by designing policies and guidelines specific to the nursing profession; thus, updating the information with current research (Zunner & Grace, 2012). The World Professional Association for Transgender Health [WPATH] (2012) designed standards of care specific for TGs which guides primary care providers on developing better practices when caring for TG people. A gap in the literature, however, exists for the lack of specific nursing guidelines geared toward proficiently caring for TG persons. A comprehensive knowledge about all that involves caring for TG people will strengthen the provider-patient relationship; thereby, building a trusting, caring environment (Poteat et al., 2013). Nurses should be aware of the treatments prescribed to TG people, and the short-term and long-term effects of therapy the TG person may face (Bostock-Cox, 2016).

In conclusion, to provide culturally, sensitive care to TGs, nurses and other healthcare professionals should start by learning about issues affecting TG health and improve knowledge on the terminology, for better patient-nurse communication (Wichinski, 2015). Another venue is to improve positive attitudes among newer nurses about TG healthcare by the integrating TG culture and health in the nursing curriculum (Armburu Alegria, 2012). Further, familiarize oneself with available resources to learn more about caring for TGs, and the comprehensive care needed by this vulnerable population, including treatments, hormone replacement, and surgery. Thus, improving a trusting nurse-patient relationship for better outcomes of Transgender people.

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Care without Assumption: A Conceptual Framework for Transgender Nursing Care

Denise S. Morris, Ed.D, MSN, RN
Patsy Starke, BSN, RN, CHPN

Denise S. Morris

Denise received her Doctorate in Education from Wilmington University, her Masters in Nursing from Wesley College, and her primary nursing diploma from Beebe School of Nursing. She is currently teaching graduate nursing courses at Wesley College. A strong advocate for inquiry based education and active participatory learning, Denise involves students in research and evidence based practice in a variety of community and small group settings focused upon health promotion and wellness. Her professional interest focuses on vulnerable population health, the spirituality of caring in nursing, complementary and alternative healing, and promoting a culture of curiosity in nursing education. Dr. Morris has pending publications in the Journal of Holistic Nursing and The Clinical Nurse Specialist. In addition, she serves as a member of the Graduate Committee for Wesley College, and is a member of the American Nurses Association, the Delaware Nurses Association, the World Professional Association for Transgender Health (WPATH), the National Association for Clinical Nurse Specialists, and the American Holistic Nurses Association. Denise was recently honored with *Excellence in Teaching Award* for her contributions to nursing and health professions education. Denise can be reached at denise.morris@wesley.edu

Patsy Starke

Patsy was born in 1959 as William Patrick Starke. She is a 1996 graduate from the University of Delaware with a Baccalaureate of Science in Nursing and a minor degree in Biological Sciences. Patsy's focus in nursing has always been in the field of Community Health where she began her career providing migrant health care for Delaware's migrant population. She worked in the area of health promotion for Delaware Division of Public Health, and was instrumental in forging a partnership with the March of Dimes Folic Acid Coalition to develop strategies to promote folic acid, as a necessary vitamin in pre-conception health to aid in preventing neural tube defects in the early stages of fetal development. Along with the Folic Acid Coalition, a mascot named Folic Acid Man was created and Patsy became Folic Acid Man to attend community functions; thus, reaching Delawareans to promote the benefits of Folic Acid. Patsy received the Dr. Katherine Esterly Award for lifetime contribution to Perinatal Development in Delaware from the March of Dimes. Patsy has worked in the field of Hospice for the last 15 years, and is a Certified Hospice and Palliative Care Nurse (CHPN). Patsy began her Transition to her true self, as a Transgender Woman, in April of 2016, and she refers to that as her second birthday after a lifetime of struggles with her gender identity. Patsy now dedicates her life and nursing career to: End of Life Care, LGBT healthcare, mainly Transgender Health Care, and advocacy for LGBT equality issues. She is a proud member of WPATH, GLMA, SAGE, and HPNA. She is a prolific writer in poetry and short stories on Medium.com where she publishes her works.

Transgender individuals have been a part of world cultures historically, yet the support for the healthcare of such populations has only received attention in recent decades. The World Professional Association for Transgender Health (WPATH) published Standards of Care (7th edition) in 2012, which focused on the medical and psychological approaches that foster the highest quality of care for this vulnerable population (Coleman, et al, 2012). While these standards support an understanding of surgical, hormonal, cosmetic, and psychological care, it does not identify nursing care and nursing related etiologies for transgenderism.

Further, an extensive review of the literature offers few evidence based articles related to nursing care or nursing implication for transgender individuals. According to Berreth (2003), the dearth of literature regarding nursing care for the transgender person puts this population at risk for a plethora of problems associated with uniformed nursing care. For nursing to properly address the needs of this special population, it is incumbent upon nurses to conduct patient-centered research that is based upon the life experiences of the transgender that is grounded in a conceptual framework specific for nursing care and nursing education.

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Depression and Suicidality in the Transgender Community

Margaret O. McElligott MSN, RN

Margaret O. McElligott

Margaret earned her Baccalaureate (BSN) from The Catholic University of America, her Master of Science in Nursing (MSN) from Wesley College, and Certification in Simulation from Drexel University. Margaret has worked in many nursing specialties in various medical centers on the east coast and in the mid-west over her extensive career to include Hematology-Oncology at Christiana Care, Bone Marrow Transplant & Coronary ICU at George Washington University in Washington D.C., ICU Float Pool & Cardio-Vascular Lab at United Hospital in St. Paul Minnesota, Level II Trauma/ED at St. Mary Medical Center in Langhorne, PA, and Medical ICU at Bayhealth Medical Center in Dover, DE. She is currently a member of the Wesley College faculty as an instructor of nursing and the simulation coordinator. Margaret plans, coordinates and facilitates simulation for every clinical course with sophomore through senior nursing students. Margaret also serves as co-teacher for the Palliative Care & Field Study in Guatemala courses. This year she began teaching an Ethics in Healthcare course to Wesley College students. Margaret serves as the faculty adviser to the Delaware Student Nurses Association as well as Faculty Counselor to the Tau Beta Chapter of Sigma Theta Tau. Margaret can be reached by email at Margie.mcelligott@wesley.edu or at her office at (302) 736-2737.

Transgender individuals are part of a minority population which until recently was not familiar to the majority of society. Trangenderism is defined by the American Psychological Association (APA) as "an umbrella term for persons whose gender identity, gender expression or behavior does not conform to that typically associated with the sex to which they were assigned at birth" (n.d., para. 1). According to the APA, gender identity refers to an individual's internal sense of being male, female or something else.

It is difficult to quantify an exact number of transgender individuals in the United States for numerous reasons. For example, the U.S. Census Bureau and other government data collection agencies have not polled respondents for this information. However, a 2017 study by Meerwijk and Sevelius published in the *American Journal of Public Health* addressed this matter. Their study analyzed twelve population-based surveys from 2007 to 2015. Their findings suggested that approximately one out of 250 individuals in the United States identify as transgender. This represents 0.39% of the population or just under one million people. The authors noted that this figure is likely an underestimation because of the sensitivity of the topic, the broad context of transgenderism and other related factors.

For some transgender individuals, attaining self-acceptance is challenging as this is such a personal and relatively uncommon identity. Much research has been conducted on the psychological burden for many transgender individuals. Among this population, the rates of depression and suicide attempts and completions are considerable. This significant public health issue must be addressed with initiatives to improve the quality of life for members of the transgender community.

The National Transgender Discrimination Survey (NTDS) (2016) noted that 41% of transgender respondents reported having attempted suicide. This number compares to 1.6% of the general population in the United States who report having attempted suicide. Mustanski, Andrews and Pucket (2016) pointed out that the predictors of mental health issues for LGBT individuals are extensive:

> One of the most consistent predictors of mental health issues for LGBT individuals is experiencing discrimination, harassment and victimization, which LBGT youths experience disproportionately compared with heterosexuals and cisgender youth. For example, a study with a community-based sample of LGBT youths found that 94% had experienced some form of sexual orientation-based victimization. In addition, victimization has been associated with greater psychological distress (including symptoms of somatization and anxiety), depression, substance use, suicide attempts and PTSD. (p. 527)

Su et al. (2010) conducted a study that assessed an LGBT community in the Midwestern United States for the impact of transgender identity and the elevated odds of reported discrimination, depression and suicidality. The findings showed 53.9% of transgender respondents reported depression symptoms compared to 33.4% of non-transgender participants. The reported history of a suicide attempt was significantly higher in the transgender population over the non-transgender respondents, at 37.7% vs. 15.9%, respectively. Several variables were evaluated in this study, but the two most significant factors in relation to depression were reported discrimination and LGBT identity acceptance. There was a direct correlation between a higher occurrence of discrimination and depression symptoms, and an inverse correlation between identity acceptance and depression symptoms. The study indicated that the lack of societal acceptance, in addition to discrimination and stigma, can have a negative impact on the mental health of LGBT persons.

A secondary effect of this mistreatment may be a lower self-acceptance rate, which in turn could worsen depression symptoms. Nurses who work in a range of areas to support society could help to influence change, promote acceptance and understanding of the transgender experience, and improve the quality of life for LGBT community members and their families. Schools, hospitals, outpatient facilities, public health agencies and legislative committees could collectively address this serious issue to change lives.

Veale, Watson, Peter, and Saewyc (2014) conducted a study on mental health disparity in Canadian transgender youth. As part of the study, 923 transgender adolescents and young adults completed an online survey. The survey categories included gender identity, emotional distress, suicidality, self-harm and general mental health. The respondents were divided into two groups based on age; 14-18 years and 19-25 years. The survey results were compared to the British Columbia Adolescent Health Survey; a general population based study in which only 1% of the youth respondents self-identified as transgender. The findings of the British Columbia survey confirmed the hypothesis; that significant mental health disparity exists between transgender youth and both cisgender and LGB youth.

For the Canadian study, both age groups of transgender and non-binary males reported significantly higher rates of self-harm than their cisgender peers or the transgender females (Veale et al., 2014). A positive finding from the study indicated an improvement in the prevalence of self-harm in the older age groups of transgender participants of both sexes. The older age group of transgender males also reflected a decline in suicide ideation and attempts. These findings may be attributed to improved self-acceptance with age and life experience. The older, non-school age group would be able to select their social contacts, which may provide more acceptance and less discrimination, perhaps leading to an improved outlook and quality of life. This study validates the need for public health initiatives to support transgender youth and adults and optimize their mental health and potential in life. The transgender community, like all cultural groups, has a unique set of needs and expectations which society – and particularly the medical and mental health communities – must identify and become competent in addressing.

According to Haas, Rodgers, and Herman (2014) the *National Transgender Discrimination Survey of 2008,* identified negative experiences for transgender individuals who sought healthcare as a contributing factor to suicidality. Some 60% of respondents who interacted with a physician or healthcare provider who refused to treat them, because of their transgender or gender non-conforming status, had attempted suicide. These participants also reported avoiding and or postponing acute care for illness; as well as for preventative care because of disrespectful or discriminatory treatment by medical personnel.

Medical professionals have an ethical obligation to treat all patients with respect and dignity. The ethical principles of justice, autonomy, beneficence and non-maleficence are foundational in medical and nursing practice to ensure patients receive the benefits of the best health care practices to maximize both their quality of life and human potential. For vulnerable populations, including the transgender community, an ethical focus is especially important to guide health care providers in identifying and meeting their unique needs.

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EOE

Homeless LGBTQ Youth: Transgender Homeless are an Emerging Population

Brian Wharton, MSN, RN, CPEN

Brian Wharton

Brian earned his BSN and MSN from Wilmington University. He is a Certified Pediatric Emergency Nurse and is the current chairman of the Pediatric Resource Team at Christiana Care Level 1 Trauma Center in Newark, Delaware. Brian is an adjunct clinical instructor at Delaware Technical Community College. He is a member of the American Nurses Association, Emergency Nurses Association, and the Pediatric Trauma Society. He sits on the CPEN delineation study advisory board. Brian has an extensive background in working with children and adolescents in an acute psychiatric center prior to becoming an RN. He currently develops and conducts education on secondary traumatic stress and horizontal violence at CCHS and other institutions. Brian can be reached at bwharton@christianacare.org or at his personal email pedsrn2012@gmail.com

Imagine how amazing it would be to live in a world where no one was homeless! Unfortunately, homelessness in the United States is highly prevalent affecting millions of Americans. The youth populace serves as a large percentage of the overall homeless population. According to Ferguson and Maccio (2015), "More than 2 million youth, most aged 15 to 17 years old, are reported to be homeless in the United States, and 40% of these homeless youth are estimated to identify as lesbian, gay, bisexual, transgender, and queer/questioning" (p. 659). Once homeless, LGBTQ youth are an extremely underserved and vulnerable population that have to face the problems of being homeless compiled by the obstacles that are induced by their sexuality and identity. Nurses are on the frontline of healthcare; thus, having the greatest potential to positively impact the care and health of LGBT homeless.

Literature asserted that mental/physical abuse, sexual abuse, aging out of foster care, runaway, neglect, shame, guilt, depression, and rejection by peers and family are some issues that lead to homelessness in LGBTQ (Ferguson & Maccio, 2015). LGBTQ youth are more likely to be sexually abused, physically assaulted, discriminated against, and acquire a substance abuse issue than their heterosexual counterparts (Ferguson & Maccio, 2015). Homeless shelters are becoming more accepting of the LGBTQ homeless population and are taking proactive approaches in meeting this populations' needs (Henry, Rosenthal, Shivji, Watt & Associates, 2016). Homeless youth may or may not have access to appropriate healthcare depending on if they seek shelter or are in a non-sheltered environment such as living in a car, under bridges, or in another public area where the homeless population can gather. This becomes a major public health and nursing issue when attempting to assist these patients; therefore, policy makers, advocates, and researchers need to address how to meet the needs of the homeless LGBTQ youth (Ferguson & Maccio, 2015).

Delaware has a low homeless population where unaccompanied youth accounted for only 51 of the total 1,070 homeless that were reported in 2016 (Henry et al., 2016). The numbers are on the rise; thus, there is great potential for an escalation in this specific population due to the close proximity of two major cities and an increase in the LGBTQ youth community. Nurses should always be aware of the specific needs of the LGBTQ homeless population, and how their attitudes can impact LGBTQ individuals' perception of the care they are receiving. According to Kezelman (2016), "Many of those experiencing traumatic stress are inadvertently re-traumatized in systems of care which lack the requisite knowledge and training around the particular sensitivities, vulnerabilities and triggers trauma survivors experience" (p28). A trauma informed care approach can be beneficial in ensuring that the healthcare provider does not inadvertently place blame or guilt, and re-victimize the patient (Kezelman, 2016).

The LGBTQ homeless youth population will require specialized assessments and screenings. Transgender youth are an emerging homeless population that require assessments that are focused on their individual needs; however, accessing medical care can be a serious issue for this population leaving them without proper healthcare (Ferguson, 2015). It is imperative that they are seen by healthcare providers and full medical evaluations are completed and a psycho-social history is conducted to attempt to meet the needs of the patient (Klein & Nakhari, 2016).

Healthcare providers need to recognize that the transgender homeless population is growing, and there are distinctive risks associated with being homeless and transgender. A provider caring for transgender patients should acknowledge necessary medical assessments associated around the "transition" process, post-operative wound inspections, and medications needed to maintain health (Alegria, 2011).

This population is at a high risk for physical, emotional, and spiritual stress, and need specific treatment plans to address their needs (Klein & Nakhari, 2016). The nurse should always do a safety risk assessment and depression screening to ensure that the patient is mentally and physically safe. According to the National Alliance on Mental Illness (NAMI) (2017), "Often termed 'minority stress,' disparities in the LGBTQ community stem from a variety of factors including social stigma, discrimination, prejudice, denial of civil and human rights, abuse, harassment, victimization, social exclusion and family rejection" (p. 1). The NAMI (2017) stated that LGBTQ populations are more susceptible to mental health conditions, ideations of suicide, and are four times more likely to attempt suicide. Drug dependency and alcohol consumption are disproportionate issues of the LGBTQ population. Often used as coping mechanisms to deal with stress by providing the youth with a temporary break from reality, they are habit forming and discourage the youth from seeking treatment (Hunt, 2012).

According to Martinez and Kelle (2014), "LGBT sex trafficking is commonly overlooked and rarely reported by local and national governments… Due to the hidden nature of same-sex prostitution and the stigma associated with being LGBT…" (p.23). Victims of sex trafficking may endure physical trauma, mental abuse, and possible contraction of communicable diseases by often being forced into dangerous sexual acts. Communicable disease screening and treatment are imperative in reducing the devastating effects of these infections. Sex trafficking is a real problem with this population and is speculated to only increase in the near future (Martinez & Kelle, 2014).

The LGBTQ homeless are an underserved population that are vulnerable and require informed healthcare providers. There are great strides being made to serve this population and to meet their needs. As a nurse, it is imperative to remain aware of the obstacles that face LGBTQ homeless and to be proactive in their care. Remaining optimistic, empathetic, accessible, and compassionate as nurses do, will ensure that this population has an ally and will receive the support they deserve.

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Issues in Transgender Health Screening

Shari Tenner, MSN, RN

Shari earned a Diploma of Nursing from Ann May School of Nursing in 1979, completed her BSN at Drexel University 2010, and her MSN at Drexel University 2014 with an emphasis on nursing education and faculty role. Her experience lies in perioperative field of nursing. Currently Shari is the Director of Learning Resources for the BSN program at Wesley College in Dover Delaware working with nursing students for formative and summative skills education. Shari can be reached @ shari.tenner@wesley.edu

Shari Tenner

Internationally there is an estimated 25 million people who consider their sexual identity as that of transgender (TG) (Lowry & Vega, 2016). This incidence has been further categorized as 1:11,900 TG females (those who are biologically males but who identify as female) and 1:30,400 TG males (those who are biologically female but who identify as male). These statistics are obtained from the literature and are deemed low, as the collection of the data is difficult to obtain and is often incomplete (Dutton, Koenig, & Kristopher, 2008). It is understood the TG population (like the non TG population) will age, and those over the age of 50 will require age appropriate health care screening for cancer prevention and health promotion. Help is needed to navigate through the maze of healthcare providers to ensure the appropriate testing in a gender-accommodating manner.

While there is a scarcity of research on transgender health care, it is clear, equitable care is far from the norm. Barriers to healthcare for the TG population include but are not limited to: Gender identity discrimination, negative experiences with insensitive or inadequately educated providers or health care systems, lack of time, lack of finances, and/or availability to treatment centers. This unique population has distinctive issues associated with sexual health, reproduction health, and general health maintenance (Porsch, Dayananda, & Dean, 2016), which require culturally competent healthcare providers and treatment centers.

The focus of this writing is to discuss health promotion, disease prevention and cancer screening (see Table 1). What must be examined as well is the increased incidence of fear and psychological issues of the TG client. The sexual incongruence of the birth gender vs. the gender identity produces reluctance to seek care and screenings. For the TG client health care screening are often postponed until changes in health prompt treatment. Review of the literature provides alarming statistics of fear of care, discrimination and healthcare providers who are ignorant to needs of this client population. Cancer screening, while ostensibly important, may be postponed until illness presents due to other health issues associated with surgery and hormonal replacement (Vogel, 2014).

The Department of Health and Human Services (HHS) in section 1557 of the Affordable Care Act does provide minimal protection to the TG population under the umbrella of *protection of sexual discrimination* (Nelson & Vega, 2017). Additionally the American Society of Clinical Oncology Association recognizes the need for focused care for the TG population to reduce the "disproportionate cancer burden" seen in this community (Nelson & Vega, 2017, p.1). The Gay and Lesbian Medical Association concur recommending the adoption of policies and programs to assist TG clients. To date population specific health promotion and disease prevention paradigms within legislation do not exist. The outcome of current Federal law is unclear. While section 1557 of the HHS policy does prohibit denial of health care based solely on gender it does not clearly speak to TG issues (Nelson & Vega, 2017).

Culturally competent health care providers must look beyond their own vision of the transgender patient and provide safe holistic care. The Institute for Healthcare Improvement (IHI) provides a perfect framework with six guidelines to improve care: implement care safely (physically and emotionally), provide care effectively, make all care patient centered, timely screening and treatment, efficient and equitable care (Institute for Healthcare Improvement, 2017, page 1). Facilities should engage in training and reeducation and revision of intake forms and admission paperwork to streamline information gathering to make this process more accommodating. It is not enough to put the onus of care solely on the healthcare system. A working partnership must be firmly established between the TG community and the healthcare community so both communities are better served.

The goal is to have the TG client feel free to identify with the sexual orientation and gender role of their choice while obtaining care for the *biological* gender specific body systems to maintain health. The healthcare/insurance system must strive to accommodate the TG population by becoming less sex segregating and more sex integrating as gender and sexual identity do not necessarily remain fixed over the life span. More research is needed to identify needs of the TG population so integration into the healthcare system can meet the objectives of the IHI but more importantly to provide health promotion and disease prevention for this vulnerable population.

Table 1. Suggested Screening (Lindsey, 2014; Edmiston et al., 2016).

Screening	Female to Male	Male to Female
Breast/Chest Wall	Yes, especially with intact breast tissue. Following breast removal, ultrasound or MRI if traditional mammography is not feasible.	Yes. Risk factors for breast cancer include: estrogen progesterone therapy hormone therapy for 5 years or longer, family history of breast cancer, BRCA + testing, BMI of >35% or breast implants (Tongson et al., 2017).
Pap Smear	Yes, especially if an intact cervix remains, as well as a visual exam of the vaginal tissue for lesions.	No. Pap smear unnecessary however a visual exam of surgically created vaginal tissue for lesions.
Anal screening/ Colonoscopy	Yes, follow National Guidelines for colonoscopy.	Yes, Follow National Guidelines for colonoscopy.
Prostate/ PSA Screening	N/A	Yes. Digital rectal exam is necessary. PSA becomes unreliable due to androgen blocking hormone treatment.

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Care without Assumption: A Conceptual Framework for Transgender Nursing Care continued from page 5

Negative Outcomes

As holistic practitioners, nurses are positioned to explore these life experiences and to create a conceptual framework (McCabe, 1988). The absence of a framework to guide nursing in the provision of care that is without assumption can easily lead to unintended prejudices and discriminatory behaviors (McDowell, 2016). Examples of such unintended consequences are referring to the patient by non-preferred pronouns, room assignment by gender, gender insensitive assessment tools, HIPPA violations, assessment of high risk behaviors and potential negative outcomes such as suicide. A lack of curricular preparation in gender-affirming care creates additional barriers resulting in health inequities and adverse outcomes. According to Reisner et al. (2015), a community sample of transgender patients indicated a 24% incidence of discrimination which resulted in the postponement or delay in needed care. In addition, these patients screened positive for depression and other negative psychosocial symptoms. Grant et al. (2011) indicated key barriers to seeking healthcare included stigmatization, discrimination and fear of being refused care because of their gender status, and even verbal harassment and physical attack.

Lack of Knowledge

One key functional barrier to transgender care is the lack of provider knowledge without assumption. The current nursing curricula inadequately defines and addresses appropriate transgender care and may contribute to false thinking that may lead to heterosexism and homophobia (Zuzelo, 2014). In addition, the Transgender patient is forced to educate the nurse on the limited knowledge currently available for his or her care. Transgender people are already marginalized, feeling oppressed, grappling with social and healthcare disparities, and in need of medical attention, and now they must stop and educate the person they expect to help them (Biederman, 2016). This lack of knowledge will clearly affect the confidence level of the patient and prevent seeking care or withholding key information that supports informed decision making. Nurses can do better. Nurses want to know.

A Guiding Framework

Using a combination of the critical (Weaver and Olsen, 2006) and interactional paradigms (Gillis & Jackson, 2002) we created a model entitled "Care without Assumption" (see *Figure 1*). This model is grounded in key assumptions that nursing practice must move toward the elimination of social struggle and oppression in society, while fostering the examination of the phenomena through the eyes of the people experiencing it. The model aims to shift the paradigm for nursing to that of a gender transcendent world view. Nursing ontology is innately caring, therefore, to be a nurse, one is called to develop the full potential of caring expressed ethically and without bias. Like many nursing models the components include the nurses affect upon the patient domain, the systems domain, and the domain of nursing practice. It includes, however, suggested drivers that support inclusive gender neutral educational preparation, relationship building, self-assessment, process management, and a culture of ongoing research that will establish evidence based protocols and dispel the myth associated with transition. By using the framework, the nurse can move the domains and drivers along a continuum from Assumption to Non-assumption.

The use of such a framework will provide the foundational position for nursing practice and nursing education that might mitigate discriminatory actions and foster normalization of sexual diversity. Additionally, the Care without Assumption framework offers support for the creation of core competencies for transgender care, gender sensitive assessment tools, and a protocol of universal standards of interaction for nursing (Starke, personal communication, 2016). Nurses who use the framework will foster a culture of curiosity for research regarding inclusivity and embrace a world view of gender transcendence in nursing care. As with all models, additional research and testing is necessary.

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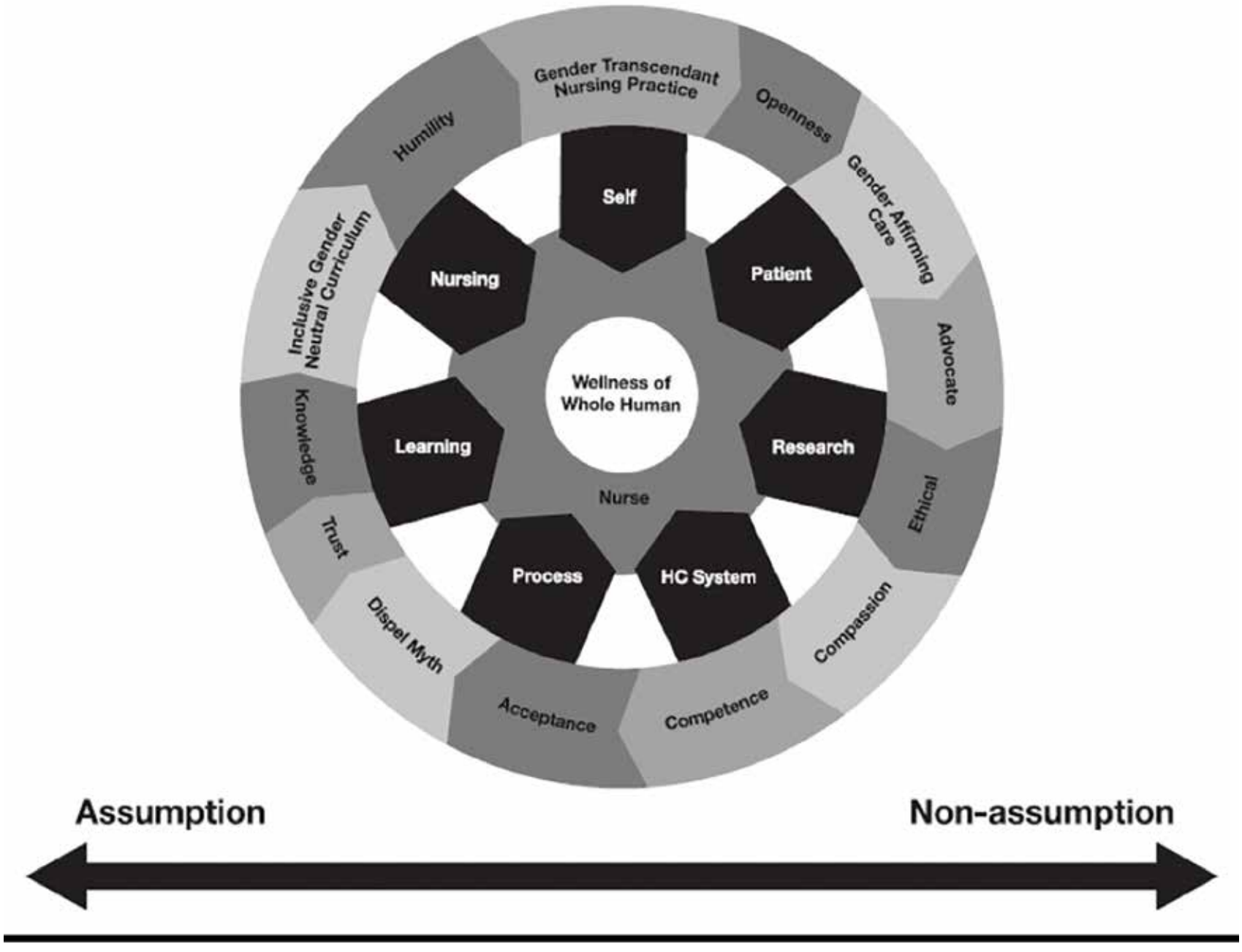

Figure 1. Care without Assumption Model. Nursing model conceptualizing a gender transcendent nursing world view. Source: D. Morris & P. Starke (2017) copyright pending. Used with permission.

How HIPAA[1] Allows Doctors to Respond to the Opioid Crisis

HIPAA regulations allow health professionals to share health information with a patient's loved ones in emergency or dangerous situations – but misunderstandings to the contrary persist and create obstacles to family support that is crucial to the proper care and treatment of people experiencing a crisis situation, such as an opioid overdose. This document explains how health care providers have broad ability to share health information with patients' family members during certain crisis situations without violating HIPAA privacy regulations.[2]

HIPAA allows health care professionals to disclose some health information <u>without</u> a patient's permission under certain circumstances, including:

- Sharing health information with family and close friends who are involved in care of the patient if the provider determines that doing so is in the best interests of an **<u>incapacitated or unconscious</u>** patient and the information shared is directly related to the family or friend's involvement in the patient's health care or payment of care.[3] For example, a provider may use professional judgment to talk to the parents of someone incapacitated by an opioid overdose about the overdose and related medical information, but generally could not share medical information unrelated to the overdose without permission.
- Informing persons in a position to prevent or lessen a **<u>serious and imminent threat to a patient's health or safety.</u>**[4] For example, a doctor whose patient has overdosed on opioids is presumed to have complied with HIPAA if the doctor informs family, friends, or caregivers of the opioid abuse after determining, based on the facts and circumstances, that the patient poses a serious and imminent threat to his or her health through continued opioid abuse upon discharge.[5]

HIPAA respects individual autonomy by placing certain limitations on sharing health information with family members, friends, and others without the patient's agreement.

- For patients with decision-making capacity: A health care provider must give a patient the opportunity to agree or object to sharing health information with family, friends, and others involved in the individual's care or payment for care.[6] The provider is not permitted to share health information about patients who currently have the capacity to make their own health care decisions, and object to sharing the information (generally or with respect to specific people), *unless* there is a serious and imminent threat of harm to health as described above.[7]

HIPAA anticipates that a patient's decision-making capacity may change during the course of treatment.

- Decision-making incapacity may be temporary and situational, and does not have to rise to the level where another decision maker has been or will be appointed by law. If a patient regains the capacity to make health care decisions, the provider must offer the patient the opportunity to agree or object before any additional sharing of health information.[8]

  For example, a patient who arrives at an emergency room severely intoxicated or unconscious will be unable to meaningfully agree or object to information-sharing upon admission but may have sufficient capacity several hours later. Nurses and doctors may decide whether sharing information is in the patient's best interest, and how much and what type of health information is appropriate to share with the patient's family or close personal friends, while the patient is incapacitated so long as the information shared is related to the person's involvement with the patient's health care or payment for such care.[9] If a patient's capacity returns and the patient objects to future information sharing, the provider may still share information to prevent or lessen a serious and imminent threat to health or safety as described above.[10]

HIPAA recognizes patient's personal representatives according to state law.

- Generally, HIPAA provides a patient's personal representative the right to request and obtain any information about the patient that the patient could obtain, including a complete medical record.[11] Personal representatives are persons who have health care decision making authority for the patient under state law.[12] This authority may be established through the parental relationship between the parent or guardian of an un-emancipated minor, or through a written directive, health care power of attorney, appointment of a guardian, a determination of incompetency, or other recognition consistent with state laws to act on behalf of the individual in making health care related decisions.

For more information visit: <u>https://www.hhs.gov/hipaa</u>

1. "HIPAA" refers to the Health Insurance Portability and Accountability Act of 1996 and, for purposes of this guidance, the HIPAA privacy and security regulations.
2. This guidance does not discuss the requirements of other federal or state laws that apply to individuals' health information, including the federal regulations that provide more stringent protections for the confidentiality of substance use disorder patient records maintained in connection with certain federally assisted substance use disorder treatment programs (42 CFR Part 2 implementing 42 U.S.C. §290dd–2). HIPAA does not interfere with other laws or medical ethics rules that are more protective of patient privacy.
3. See 45 CFR §§ 164.510(b)(1)(i) and 164.510(b)(3).
4. See 45 CFR § 164.512(j)(1)(i).
5. HIPAA still requires that a disclosure to prevent or lessen a serious and imminent threat must be consistent with other applicable laws and ethical standards. 164.512(j)(1). For example, if a state's law is more restrictive regarding the communication of health information (such as the information can only be shared with treatment personnel in connection with treatment), then HIPAA compliance hinges on the requirements of the more restrictive state law.
6. See 45 CFR § 164.510(b)(2).
7. See 45 CFR § 164.512(j)(1).
8. See 45 CFR § 164.510(b)(2).
9. See 45 CFR § 164.510(b)(1)(i).
10. See 45 CFR § 164.512(b)(2).
11. See 45 CFR § 164.502(g).
12. See *generally* HHS Office for Civil Rights *<u>Guidance on Personal Representatives</u>* (providing a chart which explains who must be recognized as a personal representative and the legal exceptions applicable to unemancipated individuals and abuse, neglect and endangerment situations).

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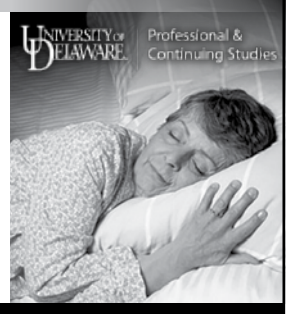

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Career Sphere

From the bedside to the boardroom: Are you ready to serve?

By Connie Mullinix, PhD, MBA, MPH, RN; AnnMarie Lee Walton, PhD, MPH, RN, OCN, CHES; and Diana Ruiz, DNP, RN, APHN, CCTM, CWOCN, NE-BC

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Use the skills you have—and learn new ones—to advance health care and your career.

You're educated and prepared to lead in safety and quality. You're at the bedside caring for patients and working to improve care. However, decisions about the allocation of resources for caregiving are made at the board level, and there's a dearth of nurses in board positions. Why?

A nurse's insights

The late nurse leader Connie Curran told the story of a nurse on a hospital board asking significant questions when financial cuts were needed. The proposed solution was to discontinue pharmacy services in remote parts of the facility during off shifts. The nurse board member asked, "Who would go to the central pharmacy when patients need medications in the middle of the night?" The answer: "The nurses." Her next question: "Who will do the nursing care while the nurse is transporting the medicines?" By the end of the conversation, the board realized that the proposed budget solution would actually increase costs.

Because of her intimate knowledge of bedside care delivery and her understanding of the relevant systems, this nurse board member prevented her hospital from making a costly mistake. Clearly, the nursing voice is critical at the board level to help hospitals make effective, financially viable and sustainable healthcare decisions.

What's stopping you?

So why don't nurses serve on hospital boards? Do policymakers not appreciate the value nurses can bring, or are nurses not stepping forward to join? If they're not stepping forward, is it because nursing culture is built on serving in the background? Or do nurses think they don't have the competencies needed for board service?

In *The Atlantic*, authors Kay and Shipman state, "Evidence shows that women are less self-assured than men—and that to succeed, confidence matters as much as competence." Most nurses are women, so Kay and Shipman's conclusions could easily apply to nurses who don't seek board positions.

However, findings of a recent study of board effectiveness showed that a greater number of women on a board results in better, more well-rounded decisions. One investment firm tracks the number of women on companies' boards and offers to invest funds in those that have more women and thus greater returns on investments. According to Joy and colleagues, "The correlation between gender diversity on boards and corporate performance can also be found across most industries—from consumer discretionary to information technology."

"In the video *Sentimental Women Need Not Apply: A History of the American Nurse*, producers Garey and Hott suggest that the first trained nurses were chosen because they were hard workers, stayed in the background, didn't call attention to themselves, and were subservient—hardly characteristics for board service. This history may have set the stage for nurses not seeking positions where their insights are needed.

Skills, skills, skills

For the benefit of patients and the financial health of hospitals and other healthcare organizations, boards need to harness the safety, quality, and evidence-based practice knowledge of nurses; nurses need to join healthcare agency boards. To achieve this national goal, nurses also need to become more aware of the skills they already possess that translate well into board service. For example, nurses are experts at communication and reading nonverbal cues. They're good at establishing relationships, making others feel comfortable, using data for decision making, and, as we're often reminded by the yearly Gallup Poll, perceived as honest and ethical.

Walton and Mullinix developed a list of board-readiness skills that can help you assess your ability to work successfully on a board. A single individual can't be expected to have all the skills, but you can check yourself against this list of overall competencies.

- Understand the difference between management and governance.
- Comprehend financial statements presented to board members each time they meet.
- Possess social etiquette proficiency for business conducted in social settings.
- Know Robert's Rules of Order so you can contribute to accomplishing the board's work.
- Bring influence and work to gain power.
- Possess negotiating skills.
- Speak comfortably in public.

Where are you strong and where do you need more refinement? If you're deficient in any area, don't let that stop you from serving; take the time to hone your skills. (See *Get ready to serve*.) Patients and healthcare organizations deserve your expertise at the bedside and in the boardroom.

Count and be counted

Ready to be counted as someone who wants to serve? Visit the national Nurses on Boards Coalition website (www.nursesonboardscoalition.org) and let boards know you want to serve. If you're already serving, you can help the Future of Nursing: Campaign for Action reach its goal of 10,000 nurses on boards by 2020 by visiting www.nursesonboardscoalition.org to make sure you're counted. Ultimately, nurses serving on boards provide a voice for and improve the health of their communities across the country.

The *nursing voice* is critical at the board level to help hospitals make effective, financially viable and sustainable healthcare decisions.

Connie Mullinix is an associate professor in the department of nursing at the University of North Carolina–Pembroke. AnnMarie Lee Walton is a postdoctoral fellow at the University of North Carolina Chapel Hill, School of Nursing. Diana Ruiz is the director of population & community health in the Medical Center Health System in Odessa, Texas.

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