The purpose of the AANP Fellows Program, in support of the mission and vision of the AANP, is to impact national and global health by engaging recognized nurse practitioner leaders who make outstanding contributions to clinical practice, research, education or policy.

FAANP FORUM DECEMBER 2020
IS DEDICATED
to
DR. LEE FORD
ON HER 100th Birthday
Happy Birthday with
Deep Gratitude and Love
from all NPs
Dr. Lee Ford

1943 - AIR FORCE CORPS

1965 - FOUNDED NP PROFESSION

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50 Year Celebration - 2015
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Dear Fellows,

What a year this has been. I sincerely hope that 2021 is more ‘normal’, and by that I mean calmer, healthier and with some hope of gathering together in person (not that video isn’t nice, but I’m rather tired of it!). I am going to miss seeing you in person at the winter meeting, but am still hopeful that a vaccine will allow us to gather in Anaheim in June. Here are some of the things the Fellows EC team have been up to over the past couple months:

**FAANP Winter meeting, 9 January 2021:** By now, you should all have received the final agenda for the 2021 Winter Meeting. I’d like to personally thank the winter meeting planning committee for all their hard work, creativity and flexibility as we tried to create something both fun and meaningful. The team consisted of: Frank Manole (Chair), Laurie Ann Ferguson, Maria Colandrea, Mary Anne Dumas, Meredith Heyde and Wendy Paracka (Janet Dubois, Diane Padden, Janice Bays and I played supporting roles). We look forward to hearing from Madrean Schrober our Loretta Ford Lecturer, and were delighted when Eileen O’Grady agreed to share some of her ideas about how to navigate these very stressful waters with us.

**Loretta Ford Birthday Celebration:** Immediately following the winter meeting, we will spend a half hour celebrating Dr. Ford’s 100th birthday with a series of short videos and photo montages (including a golf cart parade) followed by a short talk by Dr. Ford herself, so if you’re registered for the Winter Meeting, please plan to stay on from 2-2:30 to participate in that event.

**FAANP Mentorship program:** A small taskforce has been very busy talking about modifying/refreshing the Fellows mentorship program based on all your great ideas at last year’s Winter Meeting. This year, they’ll update you on their progress, and will also be asking you questions to get more clarity on some of your thoughts and ideas.

**And just a few reminders:** January 2021: Nominations will open for several key awards: Loretta Ford Award, Legacy Award and Honorary Fellows. Please put your thinking caps on for these.

February 2021: Nominations for elected FAANP offices will open.
Merry Christmas to ALL  
BEST WISHES FOR 2020

What a wonderful year with so many accomplishments by so many Fellows and Nurse Practitioners.

Message from Dr. Ford: “I've outlived most of our antagonistic forces, and we must now take advantage of the opportunities the pandemic brings all nurses, especially NPs, who have earned their 'freedom to practice to the extent of their preparation'. We've proven our worth and value! Very best wishes for a healthy, safe, productive and fulfilling 2021 and beyond. Lee”

With this issue of the Forum we will spotlight Dr. Lee Ford in our quarterly publication for her 100th birthday December 28, 2020. Loretta (Lee) C. Pfingstel Ford was born on December 28, 1920, in the Bronx (New York), the fourth of six children born to Joseph F. Pfingstel a European trained lithographer and artist and Nellie Williams. Her father was Austrian and her Mom was Irish. None of her siblings entered the health field. One wonders if anyone in her family visualized Lee as a future nurse and world leader in nursing and health care? As a child and young teenager, Lee dreamed of being a teacher. She graduated from high school at age 16 and was not old enough to be accepted by a college or a nursing school. She sought employment and was employed as a nurse’s aide and “learned the rudiments of care giving in the hospital, lived with nursing students, read all their books, and had a conversion to nursing as a career. “I loved taking care of people, hearing their stories, feeling with compassion their pain and problems, being invited into their world as they struggled to survive. Her siblings entered professions of sales executive, cosmetician, minister, and sales clerk. Lee entered nursing and made the following observation: “As I entered nursing school, I soon learned that the professional nursing curriculum included many aspects of teaching and learning, not only for myself, but for me as a teacher of patients and families. Through this circuitous route I became a teacher through my position as a Public Health Nurse (PHN). In that role, I was a teacher not only of patients, and their families, but also a teacher of the community and nursing students who cared for patients.”

She received a diploma in nursing in 1942 from the Middlesex General Hospital in New Brunswick, N.J., where she was a staff nurse. She was also employed by the Visiting Nurses’ Association in New Brunswick. She was commissioned an officer, A Second Lieutenant, in the U.S. Army Air Force in 1943. She wanted to serve overseas but because of her vision was stationed in the United States at a variety of military bases. After the war she moved to Boulder, Colorado working as a Community Health Nurse and pursuing her education. She joined the faculty at the University of Colorado. In 1965, she proposed the Nurse Practitioner profession and scheduled the first class. For the past 55 years Dr. Ford has supported and spoke for the Nurse Practitioner. She has attended and spoken at many meetings. She has received multiple awards, honorary doctorates, and recognition all over the world. She has published hundreds of articles and has promoted nurse practitioners throughout the world. She has been our leader role model and superhero for the past 55 years.

Lee, thank you for the monumental changes you made in health care and for the nursing role.

We proudly dedicate this FAANP Forum to you with deep gratitude, love, and honor.
Teaching NP Students Under Stress During the Pandemic

The effects of the COVID-19 pandemic on the overall well-being of graduate nurse practitioner (NP) students merit study. Many NP students work as registered nurses (RNs) in hospital intensive care units, and for the last nine months they have been providing care to patients with severe novel coronavirus infection, often without any extended time off for personal renewal. At the same time, they are desperately trying to concentrate on completing academic course work and clinical hours, and perhaps taking care of a family too. Life is on overload. When I asked students how they were managing these competing roles, many quickly volunteered, “I know I have PTSD,” “I feel numb,” “I don’t know how much more I can take,” “I am so tired,” “If another patient dies, I . . .” But a few squares on the Zoom screen housed faces with blank stares, as if I had not even spoken; these students I called by name for a response. I wondered whether they were so drained of physical and emotional energy that the effort to reflect on the current circumstances was too great. Seminar was in the evening and I knew the students had either worked all day in their regular RN positions, spent 6-8 hours at their clinical site, or had already been in front of a computer since the afternoon in other courses. My mind started churning. How would I facilitate learning during the semester for this group of students?

The pandemic has caused faculty to shift how they teach; even those faculty who were accustomed to teaching in fully online programs had to shift some strategies (Esterhuizen, 2020). Information technology (IT) teams and computer wizards can easily figure out the logistics of remote learning when given the personnel and resources they need. Multiple online resources are also available to faculty within and outside of their own university and through professional memberships and organizations (deTantillo & Christopher, 2020). With surges in the number of COVID-19 patients and “stay at home” orders, students found themselves without face-to-face camaraderie, frozen access to clinical sites, and frustration with systems where faculty were also overstretched. Much of what was happening with all the mandatory changes was beyond the control of schools of nursing. Faculty scurried to create alternative learning modalities and effect modifications in program requirements that were acceptable to accrediting, licensing, and credentialing bodies at state and national levels, to accommodate students who were nearing graduation. 2020 was a year of “Let’s see if we can make this work.”

During these challenging times, faculty must focus on humanity in teaching – being genuine, present, mindful, reflective, empathetic, compassionate, flexible, patient, and caring; all qualities faculty seek to foster in their students and subsequent graduates (Baverstock & Hulatt, 2020; Jacobson & Jeffries, 2018). An increased awareness of stressors and students’ reactions to them imposed by changes in their educational experiences and expectations and the pandemic should strengthen faculty success in teaching and learning. Students more than likely have little control over their work environments – difficulty social distancing, repeated exposure to patients infected with COVID-19, sick co-workers, availability of full personal protective equipment (PPE); forced modifications in infection control principles related to the use of PPE, particularly wearing N95 masks beyond levels of comfort and safety; resistance to public health measures by some, and numerous other influencing factors. Likewise, modified behaviors in their personal lives, such as wearing a mask or face covering in public,
more frequent hand washing or sanitizing, limitations on travel, and avoidance of social, even family gatherings has created additional stress. More than ever, it is important for students and faculty to support each other.

Aslan and Pekince (2020), nursing faculty researchers in Turkey, investigated nursing students’ perceived stress during the COVID-19 pandemic. Data were collected in April and May 2020 from 662 students (32.7% of total students), using a cross sectional design with the online administration (WhatsApp) of an informational form and the Perceived Stress Scale. The linear regression model created indicated that 29.3% of the total variance was determined by age, sex, watching the news, worrying about the risk of infection, and the curfew imposed by the government (over 65 and under 20 years). Higher perceived stress levels were found in younger nurses and in females. The curfew curtailed the social life of younger citizens. Although not statistically significant, nursing students in their first and last year of study had higher perceived stress. Authors interpreted these results by stating that females are more emotional than males, and that younger people had not yet developed as effective coping mechanisms as older individuals. Of course, the first year for nursing students was not what they had expected or prepared for and the 4th-year students were concerned about meeting graduation requirements. The authors do report appropriate limitations to the study. Although the sample in this foreign study was undergraduate nursing students, students’ perceptions might not be dissimilar to the perceptions of levels of stress experienced by NP students in the United States. This is just one study; thus, no conclusions can be made about the universe of nursing students; future studies with diverse student groups are warranted. Findings post pandemic might also be different.

Schools provide student services for mental health and stress reduction. These services have also been modified during the pandemic but faculty are generally kept well informed about services available at their schools to help students be successful academically. I proceeded through the semester by allowing time at each session for students to “vent” about anything, which usually revolved around work and school, providing what they termed a “safe environment” to discuss what they could not in other places or with certain individuals. They said these brief sessions helped them relieve some stress and anxiety, especially at the end of the day. Knowing they were all going through similar challenges and being able to say it aloud was therapeutic for them. I tried to listen attentively more than intervening with my thoughts (and analysis). We signed off Zoom with a smile and wave.

References


My recommendations this month include a recent article aimed at improving statistics reporting in nursing, and a new book by a sociologist in support of the nurse practitioner model of health care.

Few subjects are more off-putting than statistics, but fortunately there are many resources available to help anyone who is interested in having a greater comfort level with the topic. There are free online basic stats courses offered, including one at Stanford University, and there are almost too many medical and biostats textbooks to count. Despite this, basic and classic statistical methods continue to intimidate those who do not bat an eye at the most difficult clinical challenges. Recently, statistical reporting errors have become a hot topic. An article published in the September issue of Journal of Nursing Scholarship delves into one such error.

Wu and colleagues conducted a study of an assortment of 30 nursing science journals for the error of reporting $p = .000$. JAANP was not included in the journals sampled. Overall, the authors found an average error rate of 12.8% in reporting this $p$ value in the journals studied. The good news, I suppose, for us nurses is that other studies have identified the same mistake occurring at even higher rates in radiology, general medical, and veterinary journals.

What’s wrong with $p = .000$? The major problem the authors cite is that when testing an hypothesis, the researcher is calculating the probability of error and not establishing proof that the hypothesis is true, and a $p = .000$ reflects the absence of error. Statistical software that reports results out to three digits including .000 contributes to the belief that the value should be reported as calculated.

One reason the authors selected this error as the focus of their study was the instruction in the 6th edition of the APA style guide against using this $p$ value. You will note that page 180 of the 7th edition of the APA manual also instructs writers to report exact $p$ values to two or three decimal places, and to report $p$ values less than .001 as “$p=<.001$”. In other words, don’t report “$p=.000$”.

The authors point out that misuse or incorrect interpretation of statistics calls into question the quality of the research and may cause it to lose its importance. I found this article useful in improving my own skills in critically reviewing research and recommend it to you as well.

Reference

There are lots of articles promoting the nurse practitioner role, but few books. Two that spring to mind are Julie Fairman’s “Making Room at the Clinic”, a well-researched history of the NP movement, and Jeff Bauer's “Not What the Doctor Ordered”, a contemporary view of the economics and politics of medical practice in the United States including the medical monopoly in the marketplace. In 2020 we saw the addition of LaTonya Trotter’s “More than Medicine”, a study of the important, inclusive, and disruptive work of nurse practitioners. The author is a sociologist who became interested in our role when a friend returned to school for her NP degree and shared stories of some surprising things she was learning.

The author’s interest in this area as an outsider looking in started with informal conversations with NP students and grew into an ethnographic study conducted at a clinic for the medically underserved. Trotter followed a group of NPs for a full year, observing and interviewing them as they went about meeting many different needs of their patients. She used this material to point out the evolving landscape of advanced practice nursing and its impact on the practice of medicine as well as social work.

Trotter’s book is divided into three sections: the expanded terrain for nursing, the changed terrain for medicine, and the shrinking terrain for social workers. One of the key changes studied was the incorporation of what is traditionally thought of as social work into NPs’ nursing care due to multiple factors, including societal devaluation of social workers and the comfort level of many nurses in addressing the home and environmental needs of patients.

In her biographical sketch on the Vanderbilt University faculty pages, Trotter notes that her work “explores the relationship between changes in the organization of medical work and the reproduction of gender, racial, and economic inequality”. Trotter touches on each of these in “More than Medicine”, and it is clear that there will be a great deal more to say as our profession continues to evolve. This book is useful in helping NPs take a step back and see our profession from the outside in. In doing so, it provides support for challenging the sacred cows of our national medical industrial power structure.

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Under normal circumstances, this column would explore how results of the latest presidential election will likely affect the future of health care—something I’ve done every four years since 1976. My post-election forecasts have been generally consistent with subsequent changes in policy and practice, although I have tended to expect things to happen faster than they actually did.

My general approach to post-election analysis reflects the view of Murray Weidenbaum, a former chairman of the President’s Council of Economic Advisors: “The role of an economist is to dampen the enthusiasm of proponents of simplistic solutions.” Big changes promised by candidates almost never translate into actions by those elected. Evolution of the medical marketplace is decidedly incremental…and painfully slow. (For an excellent case study of the complexities of health reform, read the chapter on passage of the Affordable Care Act in President Obama’s new book.)

I wish I could forecast the impact of last month’s election, but I cannot say much of anything about its implications, except that anyone who claims to know is making a SWAG (silly wild-ass guess). Control of the US Senate—a critical variable—will not be known for at least another month, and transition to the Biden Administration will encounter lots of expected and unexpected roadblocks. Then there’s the out-of-control pandemic, which will continue to wreak havoc on the delivery system and population health for years to come. Add our overall economic crisis to the big picture, and the future could move in any number of unpredictable directions.

As a health futurist, I traditionally spend December and January updating information on the four key trends that historically shape the evolution of American health care: health sciences, technology, the economy, and politics. The overall situation is so uncertain at this time that almost nothing can be said about the last three items on the list for the foreseeable future. However, Covid-19 is solidifying a game-changing trend in scientific knowledge that defines how health professionals should approach patient care. The pandemic is revealing why precision medicine will become the new paradigm for 21st century health care.

Medical practice in the 1900s was firmly based on a “one-size fits all” concept of disease and treatment. (This is not a criticism of 20th century medicine. The new paradigm was made possible by technologies that only became efficient and effective over the past 20 to 30 years.) The medical system was designed to meet the acute care needs of individuals once they got sick or injured. It was curative. The new paradigm is preventive in comparison, managing the evolution of individual health problems so that they do not develop into conditions requiring hospitalization. It also recognizes social determinants of medical problems and factors them into the dynamics of successful care.
Precision medicine grew in popularity over the past 20 years, but some commentators have recently begun to raise questions about it. However, I contend that Covid-19 is proving the value of precision (i.e., individualized) medicine in ways that will redirect evolution of the health care delivery system once the pandemic dust settles. Clinical studies of the novel coronavirus clearly show that it is not one discrete disease which will ultimately be cured by a vaccine or drug. Consistent with the new paradigm, Covid-19 encompasses a variety of evolving organisms that express themselves in different ways in different types of patients. Treatments must be customized to individual patients; “one-size fits all” approaches won’t solve the problem for the population. The pandemic can only be managed successfully when health policy and delivery systems are reshaped accordingly.

As much as I am dispirited by today’s economic failures and political dysfunctions, I am optimistic that health professionals (not economists or politicians) will see that Covid-19 is sufficient reason to restructure American health care around the precision paradigm. Nurse practitioners are at least as well positioned as any other health professionals to be leaders in this revolution. AANP has a golden opportunity to help make it happen.

In closing, I can’t resist honoring Dr. Loretta Ford on her 100th birthday. She is a stellar example of a leader who revolutionized American health care with a new and better paradigm. Few of us will replicate her longevity, but all of us should emulate her commitment to defining a better path and sticking to it. She has significantly shaped my career, as explained in several previous columns for this publication and others. I wish I could be there to celebrate with her. Happy Birthday, Lee!!!

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The method for making these forecasts is presented in detail in my book, Upgrading Leadership’s Crystal Ball (New York: CRC Press, 2014).

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Why don’t we have a National Nurse? Seriously, why don’t we?

In a recent YouTube video by Thom Hartmann, entitled America Needs Nurses, Nurses Need Democracy, Mr. Hartmann opens with the statement, “In many ways, nurses are more important than doctors. And, I find it fascinating that we have a Surgeon General. We don’t we have a National Nurse!” So, why don’t we have a National Nurse? Seriously, why don’t we? In the video Mr. Hartmann interviews Teri Mills, MS, RN, CNE, President of the National Nursing Network Organization & 2019 Oregon Nurse of the Year, as she champions a movement to make the Chief Nursing Officer (CNO) of the US Public Health Service the National Nurse. Currently the CNO position is held by Rear Admiral Aisha K. Mix, who was appointed in October 2019. At present, the duties of the position consist of advising the Office of the Surgeon General as well as the US Department of Health and Human Services on nursing matters. Nurse Mills goes into great depth about the need for the National Nurse position, the legislation previously pending in both the Senate (SB696) and House (HR1597) related to the initiative, and the website in support of this effort (http://nationalnurse.org/). Since the bills did not pass this year, the effort has now shifted to asking President-elect Biden to immediately make this happen upon taking office.

And while the Chief Nursing Officer of the US Public Health Service is definitely a preeminent position the fact the office does not carry the recognition or responsibility of that of Surgeon General is emblematic of how nursing is viewed and functions in this country. Most nurses and nurse practitioners (NPs) would probably agree the above effort is long overdue, and certainly something that should happen during the 2020 Year of the Nurse, during a blistering pandemic, and as they risk (and sometimes lose) their lives on the frontlines. That this recognition has not happened before now raises questions. That it has not happened this year, of all years, raises even bigger questions. Why are so few nurses, and even fewer NPs, in pinnacle positions at the top of health care systems or in major positions that affect healthcare (i.e., political office)? Why is this happening, and what will it take to correct the situation?

Everywhere one might look systems who have anything to do with healthcare are almost entirely headed by non-nurses, non-NPs. For the most part, nurses tend to head nursing departments but not organizations. Even very large, very prominent international healthcare organizations have non-nurses in charge of nearly all preeminent offices. Doctors fill most of those elevated positions, which some might say is counterintuitive given there are two nurses for every one physician in the US and around the world (WHO, 2010). This is also somewhat odd since nurses are especially good at thinking about systems and coordinating care across departments and organizations. It is also odd since NPs have that same background, then have additional education on systems theory, leadership, project management, and finance in the DNP programs they attend. Additionally, few nurses or NPs hold political office, at any level. Whether the problem is internal (nurses/NPs not seeking top spots, running for office, or doing the groundwork that leads to those positions) or external (gender glass ceiling issues) depends on a variety of issues.

In 2014, out of a desire to understand why so few women serve as leaders in business and politics the Pew Research Center performed two surveys exploring attitudes about gender and leadership. Women and men were found to be virtually identical in leadership characteristics such as intelligence and innovation, with women considered to be even stronger in compassion and organization skills. They also found the reasons often ascribed to limiting position attainment, that is, lack of skill, lack of toughness, or work-life balance issues, were not the primary reasons for lack of success for women. The reasons, in descending order, were as follows: presence of a double standard for women, where women were expected to do more than male counterparts in order to move ahead professionally (external); corporate and electorate America is simply not ready to hire or elect women into leadership positions (external); family responsibilities are prohibitive in terms of time (internal and external); women do not have sufficient business/party connections (internal and external); and lastly, women are not considered tough enough (internal and external).
The surveys also looked at attitudes about women in certain industries. When asked if women would do a better job in hospital management 44 percent thought there would be no difference and 37 percent thought women would do a better job. When asked if women would do a better job in banking (business example) 47 percent thought there would be no difference and 29 percent thought women would do a better job. Obviously there is a disconnection between viewed abilities and what actually happens. While some of the barriers were internal, with women not feeling they could or should step into those positions, ALL of the about listed barriers were mostly external barriers, especially the ones most cited.

Naming a National Nurse would be a great step in the right direction for the profession. But, there are other things that would be helpful. In 2017, the International Labour Organization published a detailed guide to recognizing and mitigating workplace gender bias, available at https://www.ilo.org/wcmsp5/groups/public/---ed_dialogue/---act_emp/documents/publication/wcms_601276.pdf. Aside from a discussion of identifying and countering gender bias in performance evaluations, work assignments, and business norms, the report emphasized other efforts, such as leadership mentoring and leadership development programs. These last two have been initiatives offered by AANP and FAANP. There are also programs to get more women to run for office, such as the She Should Run program, available at https://www.sheshouldrun.org/the-community/, the IGNITE program, available at https://www.ignitenational.org/how_to_run_for_office, or Running Start, available at https://runningstart.org/?gclid=Cj0KCQiAzsz-BRCCARIsAnFgPPK9gvfnu0X_ImBEn=_lad7irFmXPgnE14-9TH9ZU5hMo2xDx_pwaAtsuEALw_wkB. Each year AANP takes the initiative to include program content on running for office at the annual Health Policy Conference. It was noteworthy, in searching for information for this article, one prominent page was sponsored by the American Bar Association on running for office (https://www.americanbar.org/groups/young_lawyers/projects/seat-at-the-table/political/). The page offered numerous links to information and programs for running for office, and not exclusively aimed at attorneys. At least two of the programs were aimed specifically at black women running for office, Higher Heights, available at https://www.higherheightsforamerica.org/, or Black Women in Politics, available at https://blackwomeninpolitics.com/. As an aside, why does AANP not do something similar, to encourage NPs to run for office?

In writing this article there were misgivings about concentrating on women in leadership, either in elected positions or corporate health positions, given both nursing and advanced practice nursing are no longer exclusively female professions in the US. However, the vast majority of both professions are female and, in all likelihood, the males in both professions experience some level of profession bias because they are nurses. Perhaps the day will come, as Sheryl Sandberg, the Chief Operating Officer for Facebook, states, “In the future, there will be no female leaders. There will just be leaders.” Maybe, for NPs, the day can come when they are the Chief Executive Officer, Chief Operating Officer, Chief Medical Officer, Secretary of Health and Human Services, or Minister of Health, and no one blinks an eye that they were a nurse.

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Membership Feature Column

Diane Viens DNSc, FAANP

Education: 1965 Diploma, Nursing, St Francis Hospital, Hartford, Connecticut
1972 BSN, University of Vermont, Burlington, Vermont
1974 MS, University of Colorado, Denver Colorado
1992 DNSc, University of San Diego, San Diego, California

Certifications: FNP-BC, ANCC

Short Bio: Dr. Viens received her diploma in nursing from St. Francis Hospital, Hartford CT in 1965. She received her BSN at the University of Vermont, in 1972, her MS at the University of Colorado in 1974, and a DNSc at the University of San Diego in 1992. She is certified as a family nurse practitioner. She taught at the University of New Mexico at Albuquerque where she was the director of the FNP program and division director. Beginning in 2002 she became an associate professor at the Yale University School of Nursing for seven years and worked as an NP at Back to Health in Branford, CT for nine years. She returned to New Mexico in 2009 and has been working part time for the University of New Mexico doing site visits for nurse practitioner students.

She was selected as a Fellow of the American Academy of Nurse Practitioners, 2003; President, NONPF, 2002-2004; Member, NONPF’s Committee on Clinical Hours in Dual Programs, 2002-2007; Member, NONPF’s Doctor of Nursing Practice Taskforce, 2000-2006; and Chair, Education Committee, National Organization of Nurse Practitioner Faculties, 1995-1999.

When did you become an NP? What was the motivation?

I became a nurse practitioner by accident. Prior to going back for my M. S., I was a hospital nurse and planned to become a clinical nurse specialist. During my program, I had to take some elective courses. At that time, the requirements for becoming an NP were somewhat “soft”. I took four courses over one year and became a nurse practitioner. My clinicals were in migrant health care in rural Colorado and that opened my eyes to the world of NP practice. I found that I liked being a nurse practitioner and never went back to hospital care. The opportunity was there and I took advantage of it. After graduating from my M. S. program, my first position was as a member of the undergraduate faculty in Wisconsin. I then went back to the University of Vermont and taught in their undergraduate program. During summers, I returned to Colorado and worked as a nurse practitioner in the migrant health clinic. There was no certification at that time but I took the examination when it became available from ANCC.

What experiences did you bring into the role?

Prior to returning for my masters, I worked as a hospital nurse in medical and surgical units for 8-9 years. I felt that was very helpful because there was no disease in primary care that I hadn’t seen or dealt with previously. Most importantly, I knew how to deal with people by then.
Did you experience any challenges? How were they resolved?

Early in the 1970s there were almost no restrictions for nurse practitioners working in rural areas. I worked on an island in the middle of Lake Champlain; we were the only health care available at the time. Physicians would call the pharmacy and provide overall approval for any prescriptions we wrote. The University of Vermont was easily accessible and willing to help if needed. The clinic was under the auspices of the Visiting Nurses Association. NPs provided care and ran the clinic for several years until the community decided that a physician needed to be in charge. The community wanted to have a provider who had hospital privileges. The five NPs were then let go.

When I think back to that practice in Vermont and compare it to my last practice in Connecticut, there are now more roadblocks to practice. In the early days, I never had to call insurance companies or seek prior approval for a treatment or medication.

Are there any experiences that you would like to talk about?

After obtaining my doctorate, I returned to New Mexico to teach family nurse practitioner students as well as directing the FNP program at the University of New Mexico in Albuquerque. I decided that I needed to be involved with the National Organization of Nurse Practitioner Faculties (NONPF). It was one of the best things I ever did. It made me a better educator and person. The leaders at the time, Cathy Gilles, Janet Allen, Pat Burns, Chuckie Hansen, Phyllis Zimmer as well as numerous others were so visionary. As a board member in 1993, Cathy Gillis, then President of NONPF, thought that I would be a good fit with the Education Committee. At the same time, NONPF was awarded a large grant to write pharmacology curriculum for NP programs and was asked to head this task force. We worked with many nursing, advanced practice nursing organizations and the National Council of State Boards of Nursing (NCSBN). This vetting process hashed out problems and issues and is still a process used today for NP guidelines and criteria.

I was also heavily involved with obtaining legislative approval for independent practice for nurse practitioner in New Mexico in 1993. I acted as an unofficial lobbyist meeting with legislators, physicians and community groups. We initially did not realize that we needed to bring in the insurance companies so that work had to be done later for reimbursement. Physicians were often asked by legislators if there was any reason why nurse practitioners could not practice independently and they could not come up with any valid reasons. On the day of the vote, we had the spectator gallery filled with NP students and the Speaker made the comment that he hoped it would pass because he might have one of the NP students caring for him some day. It has been smooth sailing ever since.

What was most challenging in your career/ most important?

One of my early challenges occurred when I came back to New Mexico as Director of the Nurse Practitioner Program. Since we were the first family nurse practitioner program in the state, one of my goals was to make the state aware of nurse practitioners and their scope of practice. I had to get involved politically. I traveled to many committees, hospitals and talked with nurses, legislators, physicians, citizens. I was a one-person lobbyist for nurse practitioner practice at the grass roots. It was very tiring but in the long run, rewarding.

Another challenge came later in my career when I worked at the Yale School of Nursing. I went from a state-run university program to a private institution. Cathy Gilles was the first outside dean and she recruited me to teach in and later coordinate the FNP program. National guidelines for NP education were just being introduced and change was difficult. I feel that I made good changes while I was there. Site visits were integrated, changes were made in the sequencing of courses, and more clinical application was integrated into theory based courses. I also practiced as a primary care provider in a chiropractic clinic. I ended up having a large case load and could integrate holistic care.
What was most challenging in your career/ most important? (continued from page 15)

Perhaps the most important aspect of my career came in the 1970s. I was teaching in the undergraduate nursing program at the University of Vermont and working in migrant health during the summers. The University of Vermont then started a certificate family nurse practitioner program. I was teaching in the program and went through the clinical program as well to be better prepared as a family nurse practitioner. My program in Colorado focused on adults. I then became Director of the Lake Champlain Island Clinic from 1980-1982. I left Vermont in 1982 but gained so much from that experience.

Another highlight of my career involved my time as President-elect and President of NONPF. I was President-elect in 2001; Lucy Marion was President. NONPF was deeply involved in discussions related to the DNP. In 2002, the Task Force for NP criteria for accreditation was formed. NONPF and AACN (American Colleges of Nursing) brought together all the advanced practice nursing organizations and met regularly. The NCSBN was also involved. It was the first time that we all heard different points of view of the different advanced practice groups. The Consensus Model emerged from those meetings.

Is there anything you would want to change?

I don’t think there is much I regret; maybe I’d be more tactful in some situations. But I was lucky that there was always someone in the wings keeping me in line. One never does anything alone; it takes many people and organizations working together to make changes. I have been very fortunate to work with such wonderful colleagues over the years.

What do you see as pivotal moments in the past years?

I have concerns for nurse practitioner education at this point. Previously everyone knew that educational institutions were putting out good practitioners. What I have witnessed is the softening of standards. NP education doesn’t seem “crisp” any more. I see site visits being replaced with objective structured clinical examination (OSCE) or are conducted via various modalities. I just don’t see how physical assessment can be done online. I am concerned that NP faculty may not have to practice and that clinical hours decrease. Schools are feeling pressure to fill spots and they are admitting people who should not be in the role. Accrediting associations are not doing enough to maintain quality of NP programs. There is a need for someone to step up to maintain standards of NP education and practice.

What advice would you give to new nurse practitioners?

I would advise new nurse practitioners to make sure they get satisfaction from their jobs and that they have a connection to their patients. It is a difficult job with little reward in the current health care system. The rewards for the NP come from connecting with patients. We need to advise nurse practitioner educators to infuse the concepts of nursing and the connection to patients. It is not just a job with a decent salary. The ANA recently published the revised Moral Code of Ethics. In today’s world, it is impossible for NPs to practice according to the code because organizations are telling the practitioners what to do. We need more than just passing certification exams. We need to examine what we are doing. We need, as a profession to examine our practice in this health care environment and continue to shape the nurse practitioner role.

What do you see as the role of Nurse Practitioners in the next 25 years?

If changes are not made, we will see nurse practitioners practicing like mini-docs, where there is an emphasis on production, not care. I am afraid that nursing as the main component of care will fall to the wayside.
Membership Feature Column

Joanne M. Pohl PhD, FAANP

Education:
Swedish Covenant Hospital, Chicago IL, 1964, Diploma
Southern Connecticut State College, New Haven CT, 1969, BS
Wayne State University, Detroit, MI, 1979, MSN
University of Michigan, Ann Arbor, MI, 1992, PhD

Certifications:
Adult Nurse Practitioner, American Nurses Credentialing Center
Adult Nurse Practitioner, Michigan

Short Biography:

Dr. Pohl is best known for her commitment to education, global health, community, vulnerable populations and nurse managed clinics. Her clinical experiences during her graduate program at Wayne State University became the driving force for her lifelong commitment to primary care and nurse-led care. She has worked in or opened nurse managed health centers while teaching throughout much of her career. The breadth of Dr. Pohl’s research includes family caregiving; tobacco cessation with vulnerable populations although she is best known for her funded research on outcomes of care, cost of care, community responses and student experiences in nurse-managed health centers. She was a faculty member at Wayne State University, Michigan State University and the University of Michigan. Dr. Pohl also served as the Coordinator of the Adult Nurse Practitioner and the Associate Dean, Office for Community Partnerships at the University of Michigan. Over the years, she was highly involved in policy work at the state and national levels related to the recognition of nurse practitioners and access to health care for the nation. In retirement, Dr. Pohl was appointed to the Washtenaw County Board of Health, MI from 2014-2019, and continues to have an impact on global nursing, focusing on Haiti. She is currently a member of the Board of the Haiti Nursing Foundation in the US, following a four-year term as president. She is assisting in developing a certified nurse midwife – family nurse practitioner graduate program in Haiti.

Dr. Pohl served on the Board of Directors of the National Organization of Nurse Practitioner Faculties (NONPF) from 1998-2002 and 2004-2008, serving as president from 2006-2008. She co-chaired the National Task Force Criteria Revision, a collaborative effort between NONPF and the American Association of Colleges of Nursing, 2015-2017. Honors include Distinguished Alumna, Wayne State University College of Nursing in 2018; First Awardee of the FAANP Loretta C Ford Award for the Advancement of the Nurse Practitioner Role in Health Care, 2012; Lifetime Achievement Award, NONPF 2011; Fellow of the American Association of Nurse Practitioners, 2010; Michigan Council of Nurse Practitioners President’s Leadership Award, 2009; Achievement in Research Award, NONPF, 2006; Outstanding Faculty Member Joint Award, Edward Ginsberg Center for Community Service and Learning, 2005; Fellow, American Academy of Nursing, 2000; Outstanding Nurse Practitioner Education Award, NONPF, 1998.

When did you become an NP? What was the motivation?

I became a nurse in 1964 and worked in Intensive Care at the University of Minnesota. I then moved to New Haven, CT, and worked in the emergency room. In the early 1970s, I thought that working in ICU and the ER had taught me much, but was not my life work. My motivation for pursuing graduate nursing education was to impact peoples’ lives before they got so sick. While in Minneapolis, I also taught at St. Mary’s Junior College and volunteered at the West Bank free clinic.
When did you become an NP? What was the motivation? (continued from page 17)

Through collaboration with Hennepin County Health Department, a Red Door Clinic, a sexually transmitted infection screening and treatment clinic opened across the street from the Hennepin County Hospital. The clinic was staffed by a medic from the Viet Nam war who would treat men and RN nurses who would examine and treat women. Together with a colleague, we proposed a job share position which after some discussion was approved and we were hired. We were taught how to perform pelvic exams and to screen for STIs and other GU infections. That experience had a huge impact on my interest in women’s health and my realization that I needed further education and certification. My colleague became a certified nurse midwife and I went on to become an adult nurse practitioner. I had initially considered becoming a CNM and maybe even an MD but I loved nursing and decided to continue that pathway. We then moved from Minneapolis to Detroit and I enrolled at Wayne State University. Most of my clinical experiences in that program were at the College of Nursing’s nurse-managed Primary Care Nursing Service at Detroit Receiving Hospital. It was a wonderful collaborative experience.

Public health nurses matched patients with a provider that was a physician or NP. The model of care was unique in that the Nurse Managed Clinic (NMC) was considered one option for primary care along with family medicine and internal medicine. The Chief Medical Officer, married to one of the NPs in the NMC fully supported and in fact championed that model of care. It was a very grounding experience in the 1980s in terms of what nurse led care could be in a most collaborative, interdisciplinary setting. I found that what I learned in the classroom was actually practiced in the clinical setting.

What experiences did you bring into the role?

When I was teaching at the junior college in Minneapolis, I found that I enjoyed teaching but needed more experience. When we moved to Detroit, I worked with Planned Parenthood in their Moms and Tots program and wanted to do more than my registered nurse license permitted. Experience had found me and I enrolled at Wayne State University in their Adult NP program to further my education.

Serving on the NONPF Board of Directors, then as President-Elect and President provided many opportunities to “sit at the table,” thereby impacting policy and changes at higher levels. It is important that as nurse practitioners have a larger and larger presence in primary care, nurse practitioners need to be given full practice authority. Over the past 6 years, we have been tracking the number of medical students matching in primary care residencies to the number of NPs graduating with primary care foci (e.g. Adult/Gero, FNP, PNP, WHNP). Over the past 6 years, the number of NPs in primary care has greatly increased and physicians moving into primary care has remained relatively flat.

Did you experience any challenges? How were they resolved?

When I enrolled in the adult NP program at Wayne State University (WSU), I was pregnant and caring for a young family. I was a part-time student over the next five years and with a traineeship, I was able to complete my studies. Following graduation from WSU, I accepted a position there that was 60% practice in the nurse managed clinic and 40% teaching. It was an ideal match between academia and clinical practice.

After completing my PhD, I was hired at the University of Michigan as an assistant professor to direct their Adult NP program. I brought the needed NP background as well as the newly acquired research focus from my PhD. I had to meet all the publication and research requirements for tenure and had tremendous support from the leadership. Dr. Ada Sue Hinshaw, Dean at that time, was interested in starting a nurse managed center and provided opportunities for me to develop the center and made sure I met the requirements for tenure. She was instrumental in helping me write grants and become principal investigator. I learned great appreciation for support in leaders who understood the importance of junior faculty being successful.
Are there any experiences that you would like to talk about?

While at Wayne State working as faculty and NP in the nurse managed center, I took a 4 month leave of absence to travel to the Philippines with my husband and two young children. We lived in a rural area. I taught in the local, rural college, worked with a family practice physician who worked out of his home, and also worked with the local health unit. I developed a vision of primary health care and primary care and what it meant for my practice. It helped me hone my assessment skills since there were few diagnostics available. It was a transformational experience for me. It made an incredible impact for me in relation to vulnerable populations. Since then, I have worked to ensure policy changes regarding insurance and vulnerable populations.

What was most challenging in your career/ most important?

Rather than challenging, I’d like to talk about what was most exciting in my career. I felt so fortunate to combine roles – policy, practice, research, teaching, administration. The ability to have so many experiences helped me play a significant role at many tables. One of the most recent memorable experiences was co-chairing the 2017 National Task Force Criteria Revision with Ruth Kleinpell. It was rewarding to be part of the big picture. It was a privilege to be part of moving the NP roles toward full practice authority, even if it continues. I am impressed with the upcoming generation of NPs. I feel privileged to be part of it.

Is there anything you would want to change?

I don’t know what I would change. I have few regrets. I would like to see policy move a little faster. I have learned to be patient, keep at it and not give up.

What do you see as pivotal moments in the past years?

My experience in the Philippines was most transformational for me. It took my teaching and practice at Wayne State University to a new level. I struggled a little with my decision to obtain my PhD because I didn’t want to lose my community and patient connection. I had to ask myself if I was selling my soul, but it definitely helped to have my doctorate when sitting at decision making/changing tables. It provided credibility and access to areas where I wanted to go, to issues I wanted to work on. Being able to combine teaching, practice, research, administration and policy work over the years was a real joy, if not a challenge. Working with patients, students, local universities, health departments, and national level organizations was an amazing opportunity and joy.

What advice would you give to new nurse practitioners?

That’s a hard one because things have changed so much. I would advise new nurse practitioners to look for passion in their practice and vocation. Primary care is different now and NPs need to find and impact the needed changes. I would advise to find joy and work at changing it if it’s not there at any level. We often talk about “career”, but for me I found my “vocation”. Vocation is where your soul’s joy and the world’s need meets. I was fortunate to be able to do that. For me it was working toward a health system in which primary care is available for everyone.

What do you see as the role of Nurse Practitioners in the next 25 years?

Nurse practitioners will increasingly become leaders in Primary Care and the national health care system. However, I’m a little worried that there may be a downward trend in NPs working or choosing primary care. We need to have a strong primary AND public health base as well. We need policies that support full practice authority for NPs along with a national health care plan. NPs need to be a major part of policy decisions. NPs will continue to be an essential part of the health care workforce team and no doubt a key component of the leadership of health care in this nation.
As we enter the holiday season in a different world, we can reflect on our history. This Thanksgiving Plymouth commemorated the landing of the Mayflower. This was a commemoration rather than a celebration and for the first time included indigenous people. Our story: 400 years of Wampanoag history (https://www.plymouth400inc.org/) offers a perspective not captured in our history books. We begin to understand the other side of history and gain new perspectives. This is occurring the first time in 400 years.

Black lives matter became a mantra with demonstrations and protests highlighting racial injustice. Unfortunately, with increased awareness the issues continue. The solution will not be easy and will require a long-term effort. As nurses and nurse practitioners we believe that all lives matter.

Although this year has presented challenges that we could not have imagined. The experiences are not new and can be found in published historical accounts of the pandemic of 1918. USA Today published an article of how Thanksgiving was celebrated amid the pandemic (https://www.usatoday.com/in-depth/news/nation/2020/11/21/covid-and-thanksgiving-how-we-celebrated-during-1918-flu-pandemic/6264231002/) . There were issues surrounding wearing masks, quarantines, lockdowns. Schools and business closed then opened then closed again amidst protests. Cases of flu and death continued to rise. Physicians were making house calls and there was an urgent call for nurses. There was an attempt to develop a vaccine however it was not known that influenza was a virus not a bacterium.

Fast forward to 2020. We are a global community with technological advances. We have access to news from around the world 24/7. We are connected by social media, on multiple fronts. This could have been an opportunity to combat Covid-19 on a global basis however this was not the case. With misinformation, masks and simple hygiene became a political statement with nonbelievers enjoying life in super spreader events while health care and essential workers risk their lives and go to extraordinary means to try to care for the population needs. Those trying to stop the spread continue to receive death threats and calls for individual rights abound. As vaccine becomes available in record time questions abound. Is it safe, how will it be distributed, who should receive it and how many will line up? Will misinformation continue or will the message be clear and consistent?

Since we have not learned from our history, will this be different? Will our experiences of today be lessons for the future or are we destined to repeat the past?

Think about how today will be portrayed in 400 years? This is an unprecedented time. All healthcare providers are experiencing a new reality. It will be years before we realize the impact the pandemic has on our profession. The AANP history committee sponsored a writing contest to capture some of the thoughts and feelings. We received a variety of heartfelt stories, poems and memoirs that will be archived. We are grateful that so many colleagues took the time to share their thoughts and experiences. The committee will be sponsoring another writing contest early 2021 to continue the momentum in capturing our feelings. Consider capturing this point of time in your legacy story.

Some of the stories mirrored the interviews seen in the news while others highlighted issues for the homeless, mental health and the future for the population who are not getting the primary care during this time. One story discussed the issues of immunizations. As our workforce ages providers may not recognize childhood diseases such as pertussis, polio, measles, and chickenpox. We heard what it was like to be an experienced nurse but new nurse practitioners on the frontlines. It will be years before we understand the toll this has taken on our healthcare workers and their families.
In the Medscape 2020 compensation report, (http: www.medscape.com) N=3294, 12% of nurses reported they retired earlier than planned. Peter Buerhaus is leading a two-year study on the effects of Covid-19 on the US workforce (http: www.montana.edu). It will focus on the settings, regional differences, impact on earnings, race, gender ethnicity and age. With many baby boomers retiring earlier than anticipated how will this effect the healthcare work force?

We continue to be a well-respected profession, but will the experiences of COVID-19 decimate our workforce? Will the experiences of nurses as heroes inspire a new generation to become nurses or will the personal demands be a deterrent? How long can nurses work, day and night in unsafe conditions without relief. Our hearts and prayers go out to those on the front lines and only hope they will inspire our future nurses to continue to bring change to our profession.

*****

SEASON’S GREETINGS FROM
FAANP FORUM COMMITTEE

MERRY CHRISTMAS

BEST WISHES FOR 2021
Every quarter we receive self-reported accomplishments by fellows. In this issue we are proud to recognize distinguished fellows who contributed much to advance the field of healthcare and or the professional role of nurse practitioners. Do you have an achievement you would like to share with us? Send to [https://www.surveymonkey.com/r/FAANPAchievements](https://www.surveymonkey.com/r/FAANPAchievements)

**CONGRATULATIONS!!**

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<tr>
<th><strong>Nanette Alexander, FAANP</strong></th>
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<tr>
<td><strong>Other:</strong></td>
<td>Became a shareholder in PrimeHealthCare and is among the first cohort of Nurse Practitioners in the provider owned multi-specialty corporation.</td>
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<tr>
<th><strong>Sherry Greenberg, FAANP</strong></th>
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<tr>
<td><strong>Recognition:</strong></td>
<td>Inducted as President of the Gerontological Advanced Practice Nurses Association (GAPNA) in September 2020.</td>
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<tr>
<th><strong>Laura G Leahy, FAANP</strong></th>
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<td><strong>Honor:</strong></td>
<td>Inducted as Fellow in American Academy of Nursing in October 2020.</td>
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<tr>
<th><strong>Colleen Leners, FAANP</strong></th>
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<td><strong>Appointment:</strong></td>
<td>To serve on the Friends of the National Institute of Nursing Research (FNINR) Board of Directors.</td>
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<th><strong>Bernadette Melnyk, FAANP</strong></th>
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<td><strong>Appointment:</strong></td>
<td>Named to an expert panel of the National Academies of Sciences, Engineering and Medicine to develop and disseminate tools to promote emotional well-being and resilience via cognitive behavioral therapy strategies. She was also appointed the inaugural Helene Fuld Health Trust Fund Professor of Evidence-based Practice at Ohio State.</td>
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<tr>
<td><strong>Election:</strong></td>
<td>Secretary/treasurer for the National Forum for Heart Fuld Disease and Stroke Prevention.</td>
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<tr>
<td><strong>Honor:</strong></td>
<td>Received the 2020 Ada Sue Hinshaw Award by Friends of the National Institute of Nursing Research (FNINR) for her sustained and substantive program of science.</td>
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Member News Column

Joyce Pulcini, FAANP


Vicky Stone-Gale, FAANP

Other: First Nurse Practitioner to be licensed by Florida State Board as an Autonomous Advanced Practice Nurse after the passage of autonomous practice legislation.


Kathleen P. Wilson, FAANP

Election: To serve as the Florida (North) State representative to AANP.

MAY 2021 BRING YOU UNIQUE AND HAPPY MEMORIES OF YOUR 2020 CHRISTMAS: EVEN GREATER IMPROVEMENTS TO HEALTH CARE; MORE PRIVILEGES FOR NURSE PRACTITIONERS; RENEWAL OF FACE TO FACE CONTACTS, CONTINUED AND GREATER ENFORCEMENT OF PREVENTION SKILLS AND PRACTICES, THE COURAGE TO FACE EACH NEW DAY AND CHALLENGE, AND THE HOPE AND FAITH FOR A BEAUTIFUL YEAR.
The Fellows Column is a recurring special feature of JAANP. Each column, written by an AANP Fellow, informs readers of:

- issues, trends, and factors impacting the NP role
- professional responsibilities and related strategies to promote stewardship of the NP role.

This broad purpose provides opportunities for Fellows to share their reflections on current issues, informed by their experiences, knowledge and expertise in NP practice, policy, research, and education. Fellows Column manuscripts should provide thoughtful, scholarly discussions of topics with informed synthesis and/or opinion of their topic. Manuscripts primarily written as clinical articles or research reports are not suitable for the column.

Fellows Column manuscripts are limited to approximately 1500 words and 10 references. They are submitted through the JAANP Authors Submission Site. In order for a manuscript to be considered as a Fellows Column, authors must select “Fellows Column” as the manuscript type during submission. Fellows Column manuscripts undergo peer review, although reviewers are aware of the authors’ identity.

Questions can be referred to members of the Fellows Column editorial review committee:

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<tr>
<th>Nancy Dirubbo, column editor</th>
<th>Pat Kelley, column reviewer</th>
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<tr>
<td>Mary Jo Goolsby, column reviewer</td>
<td>Gary Laustsen, column reviewer</td>
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<tr>
<td>Debra Hain, column reviewer</td>
<td>Leslie Taub, column reviewer</td>
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May your Holidays be filled with Blessings!
**Announcements**

**FAANNP Winter meeting, 9 January 2021**

**Loretta Ford Birthday Celebration:** Immediately following the winter meeting, we will spend a half hour celebrating Dr. Ford’s 100th birthday with a series of short videos and photo montages (including a golf cart parade) followed by a short talk by Dr. Ford herself, so if you’re registered for the Winter Meeting, please plan to stay on from 2-2:30 to participate in that event.

**AANP Seeks Next Vice President of Education and Accreditation**

Are you interested in leading AANP’s education and accreditation efforts and ensuring NPs have access to high-quality CE? AANP is seeking a qualified professional to serve as its Vice President of Education and Accreditation. If selected, you will direct the educational grant, CE and accreditation functions of the Association, overseeing and guiding the planning, development and implementation of departmental activities and programs to meet strategic goals. This position reports to the AANP Chief Operations Officer. The expected start date is April 5, 2021. (See job posting on web site).

**Reminders**

**AANP Open Access Award**

Two strategies in the latest AANP strategic plan include disseminating NP outcome data. As part of this initiative, researchers who are AANP members can now apply for funding so that their accepted manuscripts to a peer-reviewed, scholarly journal may become open access and available to a broader audience. **Learn more or apply here.**

FAANNP would like to acknowledge Fellows who are ill or who need a word or words from FAANNP. Please, notify Diane Padden (dpadden@aanp.org) or Liza ecechini@aanp.org.
FAANP OFFICERS AND COMMITTEES

FAANP Executive Committee

Chair – Diane Seibert, PhD, CRNP, FAAN, FAANP
Immediate Past Chair - Janet DuBois, DNP, FNP, PMHNP, FAANP, FNAP
Secretary – Mary Anne Dumas, PhD, FNP-BC, GNP-BC, FAANP, FAAN, FNAP
Treasurer – Jamille Nagtalon Ramos, EdD, MSN, WHNP-BC, IBCLC, FAANP
Member-at-Large – Laurie Anne Ferguson, DNP, APRN, ANP-BC, FNP-C, CPNP, FNAP, FAANP
Member-at-Large – Denise Link, PhD, WHNP-BC, CNE, FAAN, FAANP
BOD Liaison – Frank Manole, DNP, MBA, ACNP-BC, FAANP

Selection Committee

Chair – Donna Hallas, PhD, PNP-BC, CPNP, PMHS, FAANP
Terri Lynn Allison, DNP, ACNP-BC, FAANP
Michelle A. Beauchesne, DNSc, RN, CPNP, FAAN, FNAP, FAANP
Kathleen S. Burkhart, MSN, APN-c, FAANP
Kahlil Demonbreun, DNP, RNC-OB, WHNP-BC, ANP-BC, FAANP
Valerie Fuller, PhD, DNP, AGACNP-BC, FNP-BC, FAANP
Alison Mitchell, APRN MSN ACNP-BC FAANP
Vanessa Pomarico, Ed.D, APRN, FNP-BC, FAANP
Alicia Gill Rossiter, DNP, FNP, PPCNP-BC, FAANP, FAAN

Nomination Committee

Theresa M. Campo, DNP, FNP-C, ENP-C, FAANP, FAAN
Mary B. Neiheisel, MSN, EDD, FAANP, BC-FNP
Veronica Wilbur, PhD, APRN-FNP, CNE, FAANP

History Committee

Chair: Barbara Sheer, PhD, PNP, FNP, FAANP
# Newsletter Team and Contact Information

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<tr>
<th>Team Member</th>
<th>Column Assignment</th>
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<tr>
<td>Kathy Wheeler</td>
<td>Policy</td>
<td><a href="mailto:kjwheeler623@gmail.com">kjwheeler623@gmail.com</a></td>
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We welcome contributions from our members for the Forum. Please, send your topics to
Mary B. Neiheisel at C00254687@louisiana.edu

Do you have an achievement you would like to share with us?
We highlight self-reported accomplishments of our fellows in our newsletter published quarterly. If you would like to share newsworthy accomplishments please go to URL: https://www.surveymonkey.com/r/FAANPAchievements
Your accomplishments will appear in the Forum, our fellow’s newsletter. (Note: we reserve the right to edit your entry to conform to allotted space).