# The Alaska Nurse

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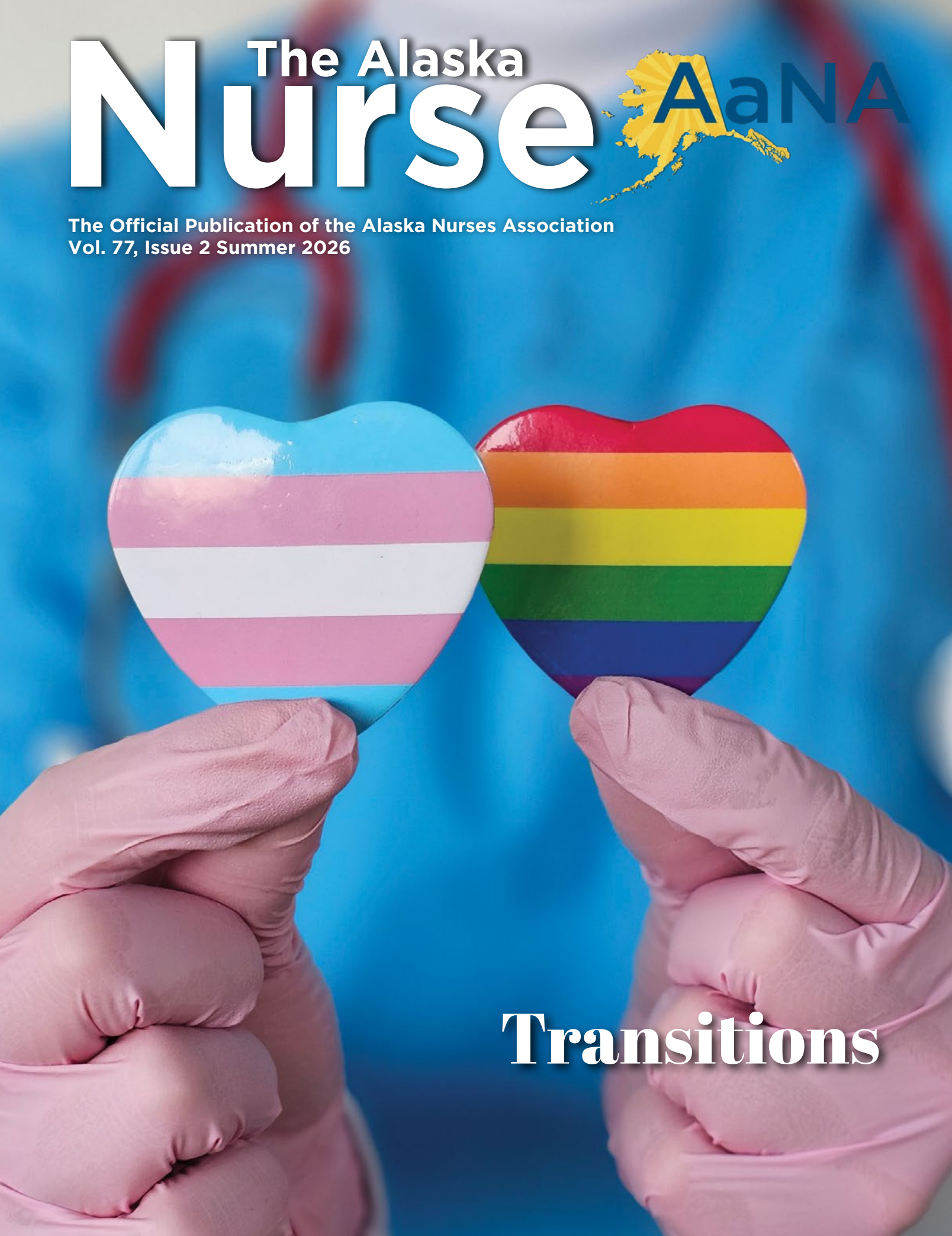

# Transitions

# In This Issue




*AUTHOR GUIDELINES FOR THE ALASKA NURSE: The Editorial Committee welcomes original articles for publication. Preference is given to nursing and health-related topics in Alaska. Authors are not required to be members of the AaNA. There is no limit on article length. Include names and applicable credentials of all authors. Articles should be Microsoft Word documents. Photos are encouraged and should be high resolution. Please include captions and photo credits at time of submission. All content submitted to The Alaska Nurse becomes property of the Alaska Nurses Association. Submit all content by email to Geri@aknurse.org.*


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# From our President

The word transition is defined as a change or shift from one state to another. Today's healthcare landscape embodies this definition. We are living through a period of rapid transformation—one that brings both innovation and uncertainty for those who provide care. From the rise of artificial intelligence and ongoing Medicaid cuts, some aspects of healthcare evolution appear increasingly driven by profit rather than people, challenging the very foundation of nursing.

This issue of The AK Nurse explores transitions at the bedside and within the communities we serve. As nurses, we care for patients from their first moments of life to their final breaths. We walk alongside them through these journeys, offering guidance, compassion, and support during life's most vulnerable and transformative stages. In this issue, we examine the vital role nurses play during these moments of metamorphosis and the broader impact we have across the healthcare system. I am always open to meeting for a cup of coffee and a chat, so please contact me at any time.

*Shannon J. Davenport*

**Shannon J. Davenport, BSN, MSN, RN**
**President, Alaska Nurses Association**

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A Union of Professionals

# AFT Nurses and Health Professionals News Roundup

## ABOUT AFT

AFT is a union of 1.7 million professionals that champions fairness, democracy, economic opportunity, and high-quality public education, healthcare and public services for our students, our families and our communities. AFT is the national affiliate of the Alaska Nurses Association.

## AANA LEADERS ATTEND AFT PROFESSIONAL ISSUES CONFERENCE

AFT nurses and healthcare professionals from across the country, including several AaNA nurse leaders, gathered in Detroit on April 13-15 for the 2026 AFT Professional Issues Conference. Members came carrying the weight of understaffing, growing patient demand and a healthcare system under attack, but they left with something stronger: a shared sense of purpose and concrete plans to act.

***See the conference highlights: aft.org/news/together-we-care-now-its-time-act***

## WASHINGTON NURSES WIN PAY EQUITY FOR FOREIGN-TRAINED NURSES

Pay inequity for nurses trained outside the U.S. is a long-standing issue, but it can be hard to address because many don't realize they're underpaid. When the Washington State Nurses Association learned hospitals were undercounting experience for nurses trained outside the U.S. in order to pay them less, they fought back at the bargaining table—and they won. Hear more about bargaining for pay equity from WSNA nurse representative Jared Richardson in the new issue of AFT Health Care.

***Check out their win: aft.org/hc/spring2026/richardson***

## AFT DEVELOPS RESOURCES TO HELP MEMBERS TACKLE RISING COSTS, DEBT

From housing to healthcare, childcare to college, even the cost of keeping up with credit cards or medical bills, working Americans are struggling under the burden of rising costs and debt. The Fight for Affordability campaign has resources to help AFT members navigate these challenges, including how-to videos and resources, an interactive debt navigator tool, debt clinics and more.

***Explore AFT's affordability resources: aft.org/FightForAffordability***

## NEW WEBINAR SHARES SOLUTIONS YOU CAN USE ON MEDICAL DEBT AND HEALTHCARE AFFORDABILITY

This spring, AFT President Randi Weingarten, public health expert Dr. Vin Gupta, and Covered California Chief Medical Officer Dr. Monica Soni participated in a Vital Lessons webinar to discuss the connection between medical debt and health outcomes, share key findings from the AFT's latest survey on affordability issues, and examine what can be done to improve access to


affordable, high-quality care. They also highlighted tools available through the AFT's Fight for Affordability campaign and Share My Lesson's affordability collection. These tools can help members navigate affordability challenges and support their families.

***Watch the webinar: bit.ly/4wbWBkZ***

## THE SPRING 2026 ISSUE OF AFT HEALTHCARE IS OUT NOW

In the Spring 2026 AFT Health Care, learn how we're standing up for the care our communities need. In this issue: AFT members describe how ICE raids are affecting patient care and how they're fighting back, a public health leader shares why he resigned from the Centers for Disease Control and Prevention, AFT members share how they won $1.1 billion to save SUNY Downstate Medical Center, and a senior policy adviser for Protect Borrowers discusses how to fight the predatory contracts that trap healthcare professionals in unsafe work environments.

***Browse the latest issue: aft.org/hc/spring2026***

## LABOR MOVEMENT LAUNCHES UNION NOW, A NEW CENTRALIZED STRIKE FUND

AFT President Randi Weingarten spoke at a rally in support of the launch of Union Now, a new nonprofit with the mission of serving as a centralized, national strike fund to get money into the hands of American workers looking to organize. She celebrated the new fund as a way to grow union density across the country and fight for the rights of working families.

***Learn about the strike fund: bit.ly/4w7CcNQ***

## LABCORP WORKERS IN OREGON RATIFY A FIRST CONTRACT

Nearly 500 Labcorp laboratory professionals across eight bargaining units represented by the Oregon Federation of Nurses and Health Professionals ratified their first collective bargaining agreement after more than a year of negotiations. These skilled workers organized to win better wages, stronger job protections, and standards that support high-quality patient care. "This contract is more than a win for workers seeking to have their voices respected," says Allister Brister-Smith, a bargaining team leader and Labcorp employee. "It creates a strong foundation for safe staffing and workplace stability, helping us raise the standard of care for our community."

***Read about their contract: bit.ly/4utLjqE***

## IDPROTECTION PLUS MEMBER BENEFIT

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# MENOPAUSE BEGINS EARLIER THAN WE THINK

## Reframing Perimenopause and Hormone Therapy in Modern Clinical Practice


### ABSTRACT

Menopause has traditionally been defined as a condition affecting women in their late 40s to early 50s; however, emerging evidence suggests that hormonal changes begin much earlier, often during a woman's early 30s. Despite evolving research supporting the safety and benefits of hormone therapy (HT), clinical practice continues to be influenced by early 2000s studies such as the Women's Health Initiative (WHI), which raised concerns about cardiovascular and oncologic risks. This paper examines the early onset of perimenopause, critiques historical hormone research, and compares older studies utilizing synthetic hormones with newer evidence supporting bioidentical hormone therapy (BHRT). Additionally, this article highlights the consequences of outdated clinical paradigms and the need for proactive, individualized hormonal management beginning in early adulthood. The goal is to reframe menopause as a continuum and encourage earlier intervention to improve long-term health outcomes.


### INTRODUCTION

Menopause is often approached as an acute transition occurring in midlife; however, it is more accurately understood as a prolonged physiological process. Perimenopause, the transitional phase preceding menopause, may begin as early as the third decade of life. During this time, subtle hormonal shifts, particularly declines in progesterone and fluctuations in estrogen, can produce symptoms that are frequently misattributed to stress or aging.

Despite advances in research, clinical management of menopausal symptoms remains heavily influenced by early studies such as the Women's Health Initiative (WHI), which significantly altered prescribing practices. This reliance on outdated data has contributed to persistent misconceptions regarding hormone therapy (HT), often limiting appropriate treatment options for women.

### EARLY HORMONAL CHANGES IN PERIMENOPAUSE

Hormonal decline does not begin at menopause but rather develops gradually over time. Progesterone is typically the first hormone to decline due to an increase in anovulatory cycles, followed by fluctuating estrogen levels and a gradual decrease in androgens such as testosterone. These changes can manifest clinically as mood disturbances, sleep disruption, decreased libido, and metabolic alterations.

Recognition of these early changes is critical. Failure to identify perimenopause in its early stages often results in fragmented care, with symptoms treated in isolation rather than as part of an underlying endocrine transition.

### HISTORICAL INFLUENCE OF THE WOMEN'S HEALTH INITIATIVE

The WHI trial, initiated in the 1990s and halted early in 2002, profoundly influenced perceptions of hormone therapy. The study reported increased risks of breast cancer, cardiovascular disease, stroke, and thromboembolic events among women receiving combined estrogen and progestin therapy.

- However, several limitations of the WHI must be considered.
- The average participant age was approximately 63 years, well beyond the typical onset of menopause
- Many participants had preexisting risk factors, including obesity and cardiovascular disease
- The study utilized synthetic hormone formulations rather than bioidentical hormones
- The trial was terminated prematurely, limiting long-term interpretation
- Subsequent analyses suggest that these factors significantly impacted the outcomes and generalizability of the findings.

### SYNTHETIC HORMONES AND EARLY RESEARCH

Earlier studies, such as Adamson et al. (2001), examined the effects of esterified estrogens combined with methyltestosterone in postmenopausal women. The findings demonstrated improvements in emotional well-being and symptom relief, particularly in women experiencing chest pain with normal coronary angiograms.

While these results highlighted the importance of hormonal balance, the use of synthetic hormones limits the applicability of these findings to modern practice. Synthetic formulations differ structurally from endogenous human hormones and may produce different physiological effects.

### CONTEMPORARY EVIDENCE AND THE TIMING HYPOTHESIS

Recent research has shifted the understanding of hormone therapy, particularly regarding the timing of initiation. Newer evidence suggests that women under the age of 60 or within 10 years

CONTINUES ON PAGE 8

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Continued from page 6

of menopause onset may experience significant benefits from hormone therapy, with reduced associated risks (Aubrey, 2025).

This concept, known as the timing hypothesis, proposes that early initiation of hormone therapy may confer cardioprotective and neuroprotective effects, whereas delayed initiation may increase risk.

This evolving evidence represents a departure from earlier interpretations of the WHI data and supports a more nuanced approach to hormone therapy.

## BIOIDENTICAL HORMONE THERAPY AND PATIENT DEMAND

Bioidentical hormone therapy (BHRT) has gained popularity as an alternative to synthetic hormones. BHRT utilizes hormones that are structurally identical to those produced by the human body, including estradiol, progesterone, and testosterone.

Fishman et al. (2015) explored the growing interest in bioidentical hormones, noting that patients are increasingly drawn to therapies perceived as "natural." This trend reflects both a dissatisfaction with conventional medical approaches and a desire for individualized care.

While BHRT is often marketed as safer, it is important to distinguish between evidence-based use of bioidentical hormones and unregulated or non-standardized formulations. Nonetheless, when appropriately prescribed, BHRT aligns more closely with physiological hormone replacement.

## IMPACT OF OUTDATED CLINICAL PRACTICE

Despite advancements in research, many clinicians continue to rely on outdated interpretations of hormone therapy risks. This has resulted in:

- Underutilization of hormone therapy
- Mismanagement of perimenopausal symptoms
- Overprescription of antidepressants and sleep medications
- Lack of preventative hormonal care

The persistence of these practices underscores the need for updated education and integration of current evidence into clinical guidelines.

## IMPLICATIONS OF REDUCED RESEARCH FUNDING

The discontinuation of funding for ongoing components of the Women's Health Initiative represents a significant loss for women's health research. Longitudinal data from this study has provided valuable insights into aging, cardiovascular disease, and hormone therapy.

The reduction in funding may hinder future advancements and contribute to continued gaps in knowledge regarding optimal management of menopause and perimenopause

## CLINICAL IMPLICATIONS: EARLY INTERVENTION IN THE 30S

A proactive approach to hormonal health should begin well before menopause. Women in their 30s may benefit from:

- Baseline hormonal evaluation (estradiol, progesterone, testosterone, thyroid function)
- Symptom tracking and early recognition of hormonal changes
- Lifestyle interventions, including nutrition, resistance training, and stress management
- Individualized treatment plans when clinically indicated

Early identification and intervention may mitigate long-term health risks and improve quality of life.

## CONCLUSION

Menopause should not be viewed as an isolated event but as a continuum that begins years earlier than traditionally recognized. The historical reliance on outdated studies has contributed to widespread misconceptions about hormone therapy, limiting effective treatment for many women.

Current evidence supports a more individualized and proactive approach, particularly when hormone therapy is initiated earlier and tailored to the patient. Reframing menopause as a long-term physiological transition allows for earlier intervention, improved symptom management, and better overall health outcomes. Bottom line, educate yourself and stand by your knowledge and convictions. Do not let your physician tell you that hormones are harmful.

*Julie Cottrell, RN, BSN, CPAN, is a registered nurse with over 25 years of experience, including 18 years specializing in post-anesthesia care. She has practiced in diverse clinical settings, with a strong focus on patient safety, perioperative care, and recovery management. Julie earned her Bachelor of Science in Nursing from Southern New Hampshire University and is currently pursuing her Master of Science in Nursing as a Family Nurse Practitioner at Hawai'i Pacific University.*

*In addition to her clinical work, Julie is passionate about education, advocacy, and integrative health. She has authored multiple articles for nursing publications, addressing topics such as GLP-1 therapies, stress in nursing, ADHD in healthcare professionals, and workforce challenges. Her writing reflects her commitment to evidence-based practice and improving both patient outcomes and nurse well-being.*

*Julie is also an entrepreneur with a growing interest in wellness, preventive care, and innovative healthcare delivery models. She is dedicated to bridging traditional and integrative approaches to support whole-person healing.*

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# NM Gender Affirming Care ECHO

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UNM HEALTH SCIENCES

Project ECHO

# FROM RN TO APRN

## Reclaiming Purpose, Autonomy, and the Heart of Nursing


### ABSTRACT

Many experienced registered nurses (RNs) reach a point in their careers where they question whether their emotional exhaustion is due to burnout or a deeper desire for professional growth. This reflective article explores the transition from RN to Advanced Practice Registered Nurse (APRN) through the lens of lived experience. It highlights the role of autonomy, dissatisfaction with systemic healthcare priorities, and the pursuit of meaningful patient-centered care as driving forces behind advancing practice. The APRN role is presented not only as a career progression, but as a reclamation of purpose, professional identity, and clinical influence.


### INTRODUCTION

For many nurses, the decision to pursue advanced practice does not begin with ambition, but with reflection. After years at the bedside, a persistent question may arise at the end of long shifts: Is this burnout, or am I meant for more?

After decades as a registered nurse, I found myself going home not only physically exhausted, but emotionally depleted. This was not the fatigue that resolves with rest, it was a deeper sense of emptiness. It led me to question whether I could continue working within a system that felt increasingly disconnected from the foundational values of nursing.

### BURNOUT OR A CALL FOR MORE?

Initially, I attributed these feelings to burnout. Nursing is inherently demanding, characterized by long hours, emotional intensity, and high patient acuity. However, upon deeper reflection, I realized that my desire was not to leave nursing, but to expand my role within it.

The core issue was not disengagement, it was limitation.

As an RN, I had developed strong clinical judgment, critical thinking skills, and a deep understanding of patient care. Yet, I remained in a role that often required implementation of care plans rather than development of them. While advocacy was a central component of my practice, my ability to independently act on that advocacy was limited.

This realization reframed my perspective: I was not experiencing burnout alone, I was experiencing a lack of autonomy.

### THE NEED FOR AUTONOMY IN NURSING PRACTICE

Autonomy is a critical component of professional satisfaction in healthcare. Experienced nurses possess a wealth of knowledge and clinical insight, yet many find themselves constrained by hierarchical systems that limit independent decision-making.

I sought the ability to:

- Independently assess, diagnose, and treat patients
- Develop and manage comprehensive plans of care
- Build meaningful, longitudinal relationships with patients
- Integrate holistic and patient-centered approaches into practice

The APRN role offered a pathway to achieve these goals.

### SYSTEMIC CHALLENGES IN HEALTHCARE

Another significant factor influencing my transition was the structure of modern healthcare systems. Over time, I observed a growing disconnect between frontline clinicians and administrative priorities.

Concerns included:

- Inadequate staffing ratios impacting patient safety
- Increased workload demands without proportional support
- Emphasis on productivity and revenue generation
- Limited attention to staff well-being and safety

These challenges are not unique to nursing; they affect interdisciplinary teams across healthcare settings. However, nurses often bear the brunt of these systemic pressures, leading to moral distress and decreased job satisfaction.

The perception that financial performance may take precedence over patient-centered care creates an environment where clinicians struggle to practice in alignment with their professional values.

### THE APRN ROLE: EXPANDING SCOPE AND IMPACT

Becoming an Advanced Practice Registered Nurse represents a significant shift in both responsibility and professional identity. It allows nurses to move beyond task-oriented roles into positions of clinical leadership and decision-making.

The APRN role provides:

- Clinical autonomy: Authority to diagnose, treat, and prescribe
- Professional flexibility: Opportunities to work independently, collaboratively, or entrepreneurially
- Enhanced impact: Ability to influence patient outcomes at a higher level
- Alignment with values: Greater control over how care is delivered

For many experienced nurses, this transition is not simply a career advancement—it is a means of practicing in a way that fully utilizes their knowledge, skills, and values.

### THE TRANSITION: AN IDENTITY SHIFT

The transition from RN to APRN is both academically rigorous and personally transformative. It requires a shift in mindset from implementing care to directing it.

This evolution includes:

- Moving from task-based care to diagnostic reasoning

- Transitioning from following orders to creating them
- Assuming accountability for comprehensive patient management

While challenging, experienced nurses bring a strong clinical foundation that enhances their success in advanced practice roles. Years of bedside experience provide insight, intuition, and patient-centered perspective that are invaluable in provider-level care.

## IMPLICATIONS FOR THE NURSING PROFESSION

As healthcare continues to evolve, the role of the APRN is increasingly vital. Advanced practice nurses are uniquely positioned to address gaps in care, improve access to services, and advocate for patient-centered approaches within complex healthcare systems.

Encouraging experienced nurses to pursue advanced roles may help:

- Improve patient outcomes through expanded provider availability
- Reduce burnout by increasing professional autonomy
- Strengthening healthcare systems with clinically experienced leaders
- Promote innovation in care delivery models

## CONCLUSION

For experienced nurses questioning their path, it is important to distinguish between burnout and the desire for growth. While some may choose to leave the profession, others may find fulfillment in expanding their scope of practice.

For me, the decision to become an APRN was not about leaving nursing—it was about reclaiming it.

This journey began with exhaustion, but it led to clarity. I recognized that I did not want to step away from patient care; I wanted to engage in it more fully, more independently, and more meaningfully.

The APRN role provided that opportunity.

However, for nurses considering this path, one critical piece of advice cannot be overlooked: choose your school carefully. Many graduate nursing programs require students to independently secure their own clinical placements, which can become one of the most stressful and limiting aspects of the educational process.

In my own journey, I encountered significant challenges finding clinical sites. Ultimately, I secured my rotations through a placement agency that guaranteed my clinical hours and ensured I could meet graduation requirements. This experience underscored the importance of understanding a program's clinical support structure before enrolling.

Advancing your education should open doors—not create additional barriers. Careful planning, research, and support systems are essential to successfully navigating the transition from RN to APRN.

*Julie A. Cottrell, BSN, RN, CPAN, is a graduate nursing student pursuing her Family Nurse Practitioner degree. She has brought over three decades of nursing experience across multiple clinical settings and is committed to advancing patient-centered, integrative care.*

# LABOR & DELIVERY

# BEST PRACTICES FOR TRANS CARE

By J. E. Piper

*J. E. Piper is an Anchorage-based birth worker and sometime Labor and Delivery Nurse.*
*Note: I am not a member of the trans community and don't claim to speak on its behalf. Trans experiences of pregnancy and birth are as unique and varied as trans people themselves. I have had the privilege of caring for trans patients as a Labor and Delivery nurse and have worked to help create more trans inclusive systems in some of the facilities where I've worked, and that is the background I bring to this subject. (Names have been changed for privacy.)*

Tanner was the first transgender man I ever cared for as a patient during my career as an L&D nurse, and the first trans man who birthed at the hospital where I was working when I met him. I was there for his admission, the start of his induction of labor, and ultimately the birth of his child and discharge from the hospital as an incredibly proud new papa, so we got to spend a lot of time together during his stay. One of the first things I noticed about him even before he got to the unit was how confusing his chart was. The chart was still under his dead name, while the name Tanner was listed in quotes under nickname. The pronouns section of the demographics was blank. There weren't any messages from Tanner's prenatal care providers about any special considerations for his induction. He did have double mastectomy listed in his medical history. That's not common in reproductive age people, but I've certainly taken care of breast cancer survivors who undergone mastectomies and people with BRCA1/BRCA2 mutations who had preventative mastectomies before then. It was enough outside of the norm to make me dig deeper into his chart. I discovered, deep in one of his prenatal care notes, that he was a trans man who'd undergone a gender affirming mastectomy, and had been on testosterone for a number of years prior to deciding to become a parent. While most of us on that particular unit would have called ourselves allies, none of us had ever taken care of a trans man during birth and the postpartum period. Because we had not gotten any kind of a heads up from his prenatal care providers we were left scrambling to try to find way to make what may be the single most gendered space in the whole hospital into a place where Tanner could feel safe, supported, and seen.

Tanner while incredibly excited to meet his baby and become a father, but his experience of being on L&D was one of the most difficult I've ever witnessed. The amount of dysphoria he experienced during things like pelvic exams was palpable. Having nurses visually assessing his genitals for bleeding after birth was extremely hard for him. All of that was made worse by the fact that other than his nurses and very rarely a provider he was completely alone. The experience of childbirth clashed so strongly with his gender identity as a man that the thought of having any friends or family around to witness it felt impossible to him.

Here are some of the things I wish we'd had time to think about ahead of time, some of the things we

worked to change afterwards, and some recommendations for birth preparation when caring for patients like Tanner.

## Changing Our Language

I doubt that any other specialty gets away with half as much gender-based language and assumptions as we do on Labor and Delivery and Postpartum Units. Our whole area of medicine is gendered. We work in "women's health," "maternity care services," "women's service units," and "mother-baby units." Our entire specialty falls under Obstetrics (the root there is "midwife" a word which means "with the woman" in Old English) and gynecology (gyn- comes from the word for "woman" in Greek).

Many people will come to a hospital to give birth and never once during their multi-day stay have a staff member call them anything other than "mama" (or "mom", "honey/hon", "sugar," which is popular with nurses from the south, and I've even heard a few deeply cringe-inducing "mommy's" in the course of my career). "She/her" is so much the default that hardly anyone ever bothers to ask. Everything in sight is either pastel pink or powder blue.

Words like "woman" and "mother" are deeply meaningful to many people, and I'm not arguing that we shouldn't use them. The words we use should reflect the preferences and experiences of the people we're speaking to, and that means we should acknowledge that not everyone who gives birth is a woman, or a mother, or wants us to call them "mama," but some very well might. Rather than making assumptions about what words to use, we need to do a better job of asking people. Every time we assume care of a new patient, we should ask what they want us to call them. Not everyone goes by the birth name listed in the EHR, and not everyone has access to the resources to be able to change their legal name, which is often required to update their demographics in the chart. I've never had anyone get frustrated with me for asking "What do you like to be called?"

Asking questions about pronouns and gender identity can be awkward when you're not used to it, and many staff on L&D units aren't used to it. It does get easier with practice, and the more comfortable a person is asking the question the more comfortable people will be answering it. One helpful way to start is by shifting the language we use in our heads and in how we document. Breast-feeding mothers can become body feeding or lactating patients. Laboring mom can become birthing person. Baby girls and boys can be infant females and males. When referring to any patient, we can try to use "they". Making the switch in our heads, makes it feel much more natural when we start to make the switch in our spoken works. The language can feel awkward at first, and it takes work to make those changes, but we can make people feel safer in our care who otherwise can feel very unsafe during birth and postpartum.

We should also work to adopt policies on using gender inclusive language in our written guidelines and educational materials. AWHONN, ACOG and ACNM (the professional bodies governing perinatal nurses, OBGYN's and Nurse-Midwives respectively) have all adopted such policies.

## Practicing Trauma-Informed Care

Trauma-Informed Care should be universal, but we should be especially diligent with the LGBTQIA+ individuals we serve, and even more diligent with our transgender patients. Trans people in the United States (particularly trans people of color) are significantly more likely to experience physical and sexual violence than our cisgender patients. That should be especially striking to healthcare workers in our specialty because we know just how common that kind of violence is in the people we serve. With the emotional burden of current anti-trans rhetoric and policies, and we can anticipate that many of our trans patients may be carrying some trauma.

Perinatal healthcare can be deeply retraumatizing to any patient, regardless of their identity. There is a loss of control, often a loss of autonomy, frequent invasive pelvic exams, expectations of nudity around strangers often without warning or time to prepare, restriction to a bed and other limitations on movement, strangers coming into a patient's room at all hours of the day and night to name just a few. All of those things can be both traumatizing in themselves (and are frequently cited in research looking at obstetric violence and trauma) and also re-triggering of past trauma. As healthcare professionals working in birth we need to do a much better job than has historically been done in our field, and I think that the increased load of trauma in our LGBTQIA+ warrants extra diligence.

## Recognizing the Differences

Not everyone who is trans has had gender affirming surgeries, takes gender affirming hormones, or practices chest binding. While we should be careful making any of those assumptions, we should also be aware that some aspects of gender affirming care and expression which may affect our patients. For example, it's important for anyone actively trying to carry a pregnancy, or who becomes pregnant and plans to continue the pregnancy, to stop taking testosterone.

This can be a really hard thing for many people as it can feel like going backwards or as a loss of identity. There are some unique challenges

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# TUESDAY TALKS

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**JUNE 16, 2026**
Menopause
Barbara Norton, APRN, CNM

**JULY 21, 2026**
Cancer Rehabilitation
Sarah Kowalczk, DPT, CLT

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Have an idea for a Tuesday Talk? Send it to emlynne@aknurse.org

AaNA

# LICENSE RENEWAL time IS THIS YEAR

LPN, RN and APRN license renewals are approaching. LPNs must renew their license by September 30th. RNs and APRNs must renew their license by November 30th. According to nursing regulations a renewal reminder document will be mailed to each currently licensed nurse at least 60 days before the renewal date. Regulation 12 AAC 44.930 requires nurses to notify the Alaska state board of nursing of a change in mailing address or name change not later than 30 days after the change. Login to the MY LICENSE self-service portal to ensure your contact information is up to date. Failure to receive a renewal notice does not relieve a licensee from the responsibility of renewing a license on time.

**The $200 LPN and RN renewal licensing fee will be the same as in 2024. APRN renewal requires the RN fee and $100.**

According to the Alaska Board of Nursing website:

"Before a license can be renewed, registered and practical nurse licensees must complete two of the following methods for maintaining continuing competency (Article 6 of 12 AAC).

- **30 contact hours of continuing education prescribed under 12 AAC 44.610 (certified by ANCC, ANA, AMA, a nurse practitioner or nurse anesthetist certifying body or approved by another Board of Nursing)**
- **30 hours of participation in uncompensated professional activities prescribed under 12 AAC 44.620**
- **320 hours of employment as an RN or LPN prescribed under 12 AAC 44.630**

In lieu of meeting the above requirements, licensees may qualify for alternative methods of continuing competency pursuant 12 AAC 44.640.

Licensed Practical Nurses who receive their original license on or after October 1 of odd-numbered years or Registered Nurses who receive their original license on or after December 1 of odd-numbered years are not required to provide proof of continuing competency for their first renewal."

Should you choose to renew by using the option of continuing education and/or professional activities it is highly recommended to have more than the minimum 30 hours of continuing education and/or 30 hours of professional activities. Review the criteria for what is acceptable for professional activities in regulation 12 AAC 44.620. It is best practice to contact the Board for clarification of the professional activity and the required documentation prior to submitting your renewal.

Ensure you complete your renewal well in advance of the deadline. It is your responsibility to account for potential delays caused by natural disasters, internet issues, credit card declines, or other unforeseen circumstances. All required documentation must be in your possession by the date you choose to renew. Please ensure that all requirements are completed prior to submitting your renewal. Early submission without completing all requirements will result in disciplinary action by the Alaska State Board of Nursing.

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to supporting patients with body feeding after a mastectomy, and not all mastectomies are compatible with lactation. The person carrying the pregnancy might not want to body feed while a partner or spouse might want to. If so, that needs to be offered prenatally because it takes time to medically induce lactation. Breast binding is not compatible with body feeding and can be dangerous in the immediate postpartum period while someone's body is producing colostrum or milk. The timing of restarting gender affirming postpartum hormones isn't well studied, regardless of feeding plans. Nurses who support pregnant and lactating patients with feeding should be familiar with some of these differences so that they can effectively support body feeding among those who choose to do so.

## Planning Prenatally and Knowing Your Resources

There isn't always a good line of communication between prenatal care providers and in-patient staff. Providers should have conversations about identity, trauma, the potential dysphoria of birth, and preferences for the birth experience starting early in someone's pregnancy. The outcomes of those conversations then need to be effectively communicated between care settings. One frequently missed aspect of Trauma-Informed Care is avoiding the re-traumatization of forcing someone to tell the same stories to each new provider and nurse. It should be on the outpatient team to help start these conversations, but then it needs to be on the inpatient team to make sure they are followed up on and communicated between shifts. There's nothing worse than someone being vulnerable enough to communicate these things to one nurse only to have to start all over when they next nurse takes over.

We also need to vet our resources. Not every doula is knowledgeable and experienced in the care of LGBTQIA+ families. Not every church that runs a diaper pantry is willing to serve LGBTQIA+ parents. Not every pediatrician is going to be embracing of all the different ways a family can be configured. It's our responsibility to know which resources are available to the people we care for, and which might not be.

## Creating More Inclusive Systems and Spaces

The gendered nature of childbirth isn't confined to the words we use or how our policies are written, it's also riddled throughout our clinical spaces in the form of the art that is hanging on the wall, the pictures we use in our handouts, even the colors of the baby blankets and hats we stock. As individual healthcare workers it's important to try to make all of our patients feel safe and welcome, but if the backdrop of where we practice our care remains unchanged it can still feel alienating to some of the communities we serve. In many cities and states, there are either trans specific or more general LGBTQIA+ organizations which are more than happy to help facilitate trainings for staff, complete site audits to provide feedback on making more inclusive spaces, and otherwise help us serve people better.

I'll never forget Tanner, even though I've taken care of other trans and gender expansive patients and families since. There are some many things we could and should have done better for him. Even so, he was so incredibly grateful for our care. After his stay we brought in a local transgender resource center to train our whole unit on best practices. That went so well that the hospital brought them back to train the entire facility. Word got out in the community that we were a hospital that was trying really hard to be a safe and welcoming place and we quickly became a place that LGBTQIA+ families would travel to from around the state for their births. I can think of no greater honor than that.


### References

Moss the Doula - Trans Affirming Perinatal Resources mossthedoula.com/resources

Elizabeth Kukura - Recounceiving Reproductive Health Systems: Caring for Trans, Nonbinary, and Gender-Expansive People During Pregnancy and Childbirth - pmc.ncbi.nlm.nih.gov/articles/PMC9679586.

# NAVIGATING Transitions with DR. AMANDA BEERY


**1. GENDER-AFFIRMING CARE ISN'T ONLY FOR TRANS PEOPLE. CAN YOU TALK ABOUT YOUR ROLE, AND HOW A DOCTOR CAN SUPPORT PEOPLE'S RELATIONSHIPS WITH THEIR BODIES? HOW ARE THE WAYS YOU CARE FOR TRANS PEOPLE DIFFERENT FROM, OR SIMILAR TO, CIS PEOPLE? WHAT KINDS OF GENDER-AFFIRMING CARE DO YOU PROVIDE FOR CIS AND TRANS PEOPLE ALIKE?**

In some ways, helping people navigate transitions is the best way to describe the work that I do. Every visit involves a human in transition!

Before I see a patient for the first time, I usually have a note from another provider that gives some insight into their clinical history. I also pay close attention to the history my MA takes before I go into the room. That might provide me with a framework of past care, or an idea of what a person wants to gain from our interaction. But most importantly, I try hard not to make assumptions, and simply ask questions. It is important for me to meet every patient I see with an openness and curiosity. When they are coming to see me, it is for their reasons - not for mine. So I try hard not to waste time with my own agenda before I go into the room. By the end of the visit, I might have an idea as to the cause of the problems presented, and perhaps a plan for further evaluation or management. But what is most important to me is some level of connection, and some level of trust. Engaging in medical care takes courage - and courage is rooted in vulnerability. People want to be seen, but so often life experiences cause us to build up defenses. If those defenses are in place during our visits, it can be very challenging for me to understand the root of the problem, and offer insight that can help. The biggest complement I receive is when a patient can express that vulnerability with me.

Every time a patient seeks my care, I feel they are trusting me to share my training and expertise - not force it upon them. Shared and informed decision-making is at the heart of what I do. When a patient is faced with options for care or treatment, my job is to offer options, and then support my patient's decisions. I try very hard to make all of my care person-centered. Person-centered care is at the root of gender-affirming care.

I very rarely care for cisgendered men. There are many times when cisgendered women come to me with some level of crisis involving their

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gender expression or identity. I have cared for people struggling with fertility, and questioning what it means to be a woman. During the menopausal transition, some of my patients are in the process of redefining what it means to be feminine, and I try to hold space for that as well.

### 2. WHEN IT COMES TO GENDER-AFFIRMING CARE, WHO DID YOU LEARN FROM? HOW DID YOU GAIN THE KNOWLEDGE YOU HAVE TO PROVIDE CARE FOR TRANS PEOPLE? WHAT WAS TAUGHT TO YOU DURING TRAINING AND WHAT HAVE YOU LEARNED SINCE?

My formal education contained no training on providing gender affirming care (GAC), and there are still very few OBGYN residency programs with a formal curriculum. There is, however, a new focus on bias awareness that is helping students and faculty. Most of medical care relies upon ongoing education – and GAC is no different. My most used reference for care is from the UCSF Gender Affirming Health Program: https://transcare.ucsf.edu/guidelines

### 3. DO YOU FIND ANY RESISTANCE TO THE WAY YOU PRACTICE FROM OTHER PROVIDERS? AND/OR DO YOU FIND THAT IT BUTTS UP AGAINST PROFESSIONAL NORMS?

I've never sensed any resistance to the way I practice from other providers. Perhaps it is there and I am blissfully unaware?

### 4. ANY ADVICE FOR PROVIDERS, SPECIFICALLY IN ALASKA, IN PROVIDING CARE FOR TRANS PEOPLE?

I'll share the advice I give my students when caring for patients: Be kind. Ask questions. Try to understand the patient's goals. Don't force your own agenda. Meet your patient as a human, rather than as a physician. If you know the patient has experienced trauma - acknowledge it! Make sure the patient knows they remain in control of their own care and their own bodies. Be honest - let your patient know when you need to do more research to help them. Be kind.

*Dr. Amanda Beery is a board-certified generalist OBGYN who focuses on gynecology. She cares for people of all ages, and has a special interest in menstrual management, family planning, fertility care, sexual health and the transitions of perimenopause and menopause. In addition, Dr. Beery is an accomplished surgeon and manages complex gynecologic problems. She has an uncommon ability to connect with her patients, and quickly engenders trust and vulnerability. She knows there is great power in education, and wants her patients to leave their visits feeling empowered, worthy and having learned something about themselves.*

*Dr. Beery grew up in Anchorage, living above her family's furniture store in Mountain View. She attended Mountain View Elementary, Clark Junior High and East High School. The first in her family to attend college, her undergraduate time started at the University of Hawaii at Manoa and the University of Washington. She earned a Bachelor of Science degree in molecular and cell biology from the University of Washington. In the years between college and medical school, she worked in Anchorage in fine dining and in Maternal-Child Health Epidemiology for the State of Alaska.*

*Dr. Beery earned her medical degree from the University of Washington School of Medicine, a proud graduate of the Alaska WWAMI program. During her medical school training, her OBGYN rotation was with the providers at Alaska Women's Health. After completing her residency in Obstetrics and Gynecology at Dartmouth, she was delighted to move back home and join her mentors in practice in 2015.*

*Dr. Beery is our managing partner and leads our clinic with the same authenticity and empathy she shows when caring for her patients. She is the gynecologist for the Alaska Bleeding Disorder Clinic, and often sees bleeding disorders in a joint visit with their hematologist. She is also the Clerkship Director for University of Washington School of Medicine students completing their required OBGYN clinical clerkship in Anchorage. She has long been happily married to Dennis, a musician, artist and audio engineer. They have a very well-loved red miniature poodle Jolyon who is the center of their world. When not at work, Dr. Beery enjoys beadwork, reading and writing.*

*Professional Organizations:*

*Fellow, American College of Obstetricians and Gynecologists*

*Diplomate, American Board of Obstetrics and Gynecology*

*Assistant Clinical Professor, University of Washington School of Medicine*

*Member, Alaska State Medical Association*

*Member, Foundation for Women & Girls with Blood Disorders*

*Member, The Menopause Society*

*Member, Obesity Medicine Association*

*Member at Large, Providence Alaska Medical Center Medical Executive Committee.*

# Editor's Note

On June 28, 1969, the NYPD raided the Stonewall Inn, a gay bar in Manhattan. At the time, it was commonplace for police to barge into bars, assault queer people, and strip them to enforce laws requiring that people wear three or more articles of clothing consistent with their assigned sex. That night in June, queer people fought back, and for six days, queer people protested. The Stonewall Riots were the origin of the modern Pride celebrations that take place every June across the world.

For this issue, I wanted to highlight what nurses and providers can do to care for people in transition: whether that's the kind of gender transition that has come under attack, despite gender affirming surgeries having some of the highest satisfaction and lowest regret rates of any procedures; people enduring other kinds of transitions, such as menopause; or nurses transitioning careers.

In Alaska, Pride is celebrated through parades, block parties, and among friends, loved ones, and accomplices. As we all go through transitions in life, I hope we can resist the villaization of trans people, fight against the medical restrictions of trans care, and support the particularities of care that queer and trans people need.

With care,
Mat

# SAVE THE DATES

**SEPT 30 – OCT 2**
**ANCHORAGE**

## Join AaNA at the only conference dedicated to exploring the trending topics that matter to Alaskan nurses!

Come for affordable contact hours relevant to your practice. Stay for unique & engaging presentations by Alaskan experts. Leave with the new friends you made from across the state.

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*The unified voice of nurses in the Last Frontier*

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# 2026 TRENDING TOPICS IN NURSING CONFERENCE

www.aanaconference.org

# SAFE NURSE STAFFING LEGISLATION INTRODUCED IN JUNEAU

By Andrea Nutty, AaNA Programs Director


On April 15, a historic moment in our fight for safe staffing took place as Senate Bill 283 was introduced in the Alaska Legislature. This landmark bill would establish minimum safe nurse staffing standards in hospitals across Alaska. The legislation comes in direct response to the worsening nurse staffing crisis that puts Alaskan patients at risk and pushes dedicated nurses out of the profession.

The Alaska Nurses Association is building a statewide movement to pass this legislation because unsafe staffing is a public health crisis that Alaskans can no longer afford to ignore. While many facilities strive for safety, nurses are seeing a growing trend of increased patient loads that compromise care. SB 283 ensures safety by mandating enforceable nurse-to-patient staffing ratios for specific hospital units (such as 1:4 in medical-surgical units and 1:2 in intensive care units) and creating nurse-led staffing committees to oversee staffing plans at every hospital.

"Nurses have been sounding the alarm on the staffing crisis for years, and today, we finally have a legislative path forward that prioritizes patient safety," said Shannon Davenport, RN, President of the AaNA Board of Directors. " We are grateful

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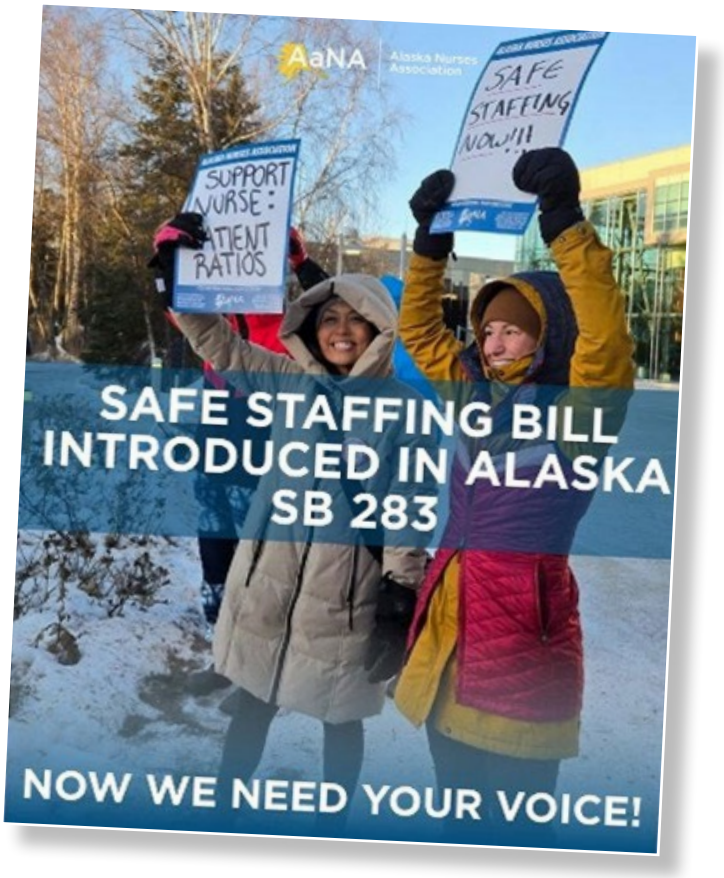

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to the Senate Labor & Commerce Committee for their leadership in sponsoring SB 283. By establishing enforceable, statewide nurse staffing standards, this bill will ensure that when Alaskans go to the hospital, their nurse has the time and resources to provide the high-quality care they deserve."

"We've seen what happens when staffing levels are allowed to deviate from safe standards: medical errors increase and nurses experience moral injury and burnout," said Donna Phillips, RN, Chair of the AaNA Labor Council. "SB 283 is the solution we need to improve working conditions and ensure a sustainable future for nurses at the bedside. It is time for a statewide standard that puts patients and healthcare workers first."

"Across Alaska, unsafe staffing is putting patients at risk and driving nurses out of the profession," says Madison Eckhart, RN, AaNA Legislative Committee Chair. "That's why AaNA is building a statewide movement to pass this bill. We need your help to fight for the quality care that Alaskans deserve. I am asking every nurse and supporter to join our campaign for safe staffing as we work to pass this crucial legislation."



Join our statewide movement for safe staffing to receive updates and be the first to hear about opportunities to take action as we work to pass SB 283!

https://actionnetwork.org/forms/join-the-campaign-for-safe-staffing


By Andy Kratochvil

Every June, Pride Month invites us to reflect on the achievements and resilience of the LGBTQIA+ community—but it's also a powerful opportunity to recognize how queer leaders have shaped other pivotal movements in U.S. history, including the labor movement.

When I was young—even into early adulthood—it was difficult to come out, partly because I rarely saw openly queer people in public life. That lack of visibility made it hard to imagine a future where I could be fully myself. While acceptance has grown in many places, it's still not guaranteed. A recent New York Times article even explored how many people—especially those in public roles—still feel pressure to hide their identities today. That's why learning about queer leaders is so important.

When young people see queer adults thriving—leading, organizing and making history—it reinforces the belief that they too can live openly and purposefully. Representation like this isn't just inspiring; it's life-affirming, contributing to stronger mental health and a deeper sense of belonging for LGBTQ youth.

In many ways, the bravery and advocacy of these leaders not only transformed the workplace, but also helped pave the way for a more inclusive, equitable society—one where younger generations can see themselves represented and empowered to lead. Research from the Trevor Project shows that LGBTQ youth who have visible adult role models experience significantly lower rates of suicide and a greater sense of belonging. Additional findings from the National Institutes of Health reinforce that affirming, inclusive environments improve mental health and identity development outcomes for LGBTQ individuals. These leaders' visibility is more than symbolic—it's a lifeline.

Rooted in a shared commitment to justice, these individuals represent the best of the labor movement—often expanding its scope to include marginalized workers who had long been left out of traditional union narratives. These individuals stood at the intersection of identity and activism, fighting not just for workers' rights, but for dignity, representation and justice for all. Their stories belong in our classrooms, our civic education and our collective memory.

## Andy Kratochvil bio:

*Andy Kratochvil is a proud member of the AFT Share My Lesson team, where he's passionate about discovering and sharing top-tier content with educators across the country. He earned his bachelor's degree in political science and French from California State University, Fullerton, and later completed a master's in international affairs at American University in Washington, DC.*

*A self-proclaimed current events geek, Andy has a particular passion for foreign policy, climate education, and labor advocacy. He brings a global perspective and sharp editorial instincts to his work, curating timely, instructionally relevant resources that support educators and students alike.*

*Outside of work, Andy enjoys hiking, playing video games, reading scary books, and Mexican food. Originally from California, he still loves heading back home to enjoy the Pacific Ocean—especially a good body surfing session under the sun.*

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# CHANGE-MAKING LGBTQ LABOR LEADERS

## NANCY WOHLFORTH

A trailblazer in union leadership, Wohlforth became the first openly LGBTQIA+ officer of a major U.S. labor union. She co-founded Pride at Work, an organization dedicated to advancing workplace protections within the labor movement.

## BAYARD RUSTIN

A brilliant strategist behind the 1963 March on Washington for Jobs and Freedom, Rustin was a Black gay man whose work in the civil rights and labor movements often went unrecognized due to homophobia. He advised labor leader A. Philip Randolph and fought for economic justice alongside civil rights.

## CLEVE JONES

An organizer with UNITE HERE and the creator of the AIDS Memorial Quilt, Jones has long been a voice for LGBTQIA+ rights and labor solidarity. His work continues to bridge the fight for healthcare, dignity and fair labor practices.

## LORENA BORJAS

A trans Latina immigrant and fierce advocate for sex workers and undocumented laborers in New York City. Borjas' grassroots activism provided life-saving support to marginalized workers who were often ignored by traditional labor systems.

## JASMYNE CANNICK

A journalist, media strategist and advocate, Cannick shines a spotlight on workplace inequities faced by Black queer workers. Her work calls out systemic injustice and pushes for real accountability in hiring and labor practices.

## KAY ULANDAY BARRETT

A poet and performer whose advocacy spans disability justice, racial equity and labor rights. Barrett's voice brings intersectional awareness to labor organizing, emphasizing the lived experiences of queer and disabled workers.

## HARVEY MILK

One of the first openly gay elected officials in the U.S., Milk was a passionate advocate for workers' rights, forming alliances with unions like the Teamsters to support inclusive hiring and economic justice. His political activism linked LGBTQIA+ liberation with labor power, setting a powerful precedent for intersectional advocacy.

The labor movement is stronger when it reflects the full diversity of its members. Queer leaders in labor have pushed unions to be more inclusive, shaping workplace policies that uplift all workers, regardless of gender identity or sexual orientation. From healthcare equity to anti-discrimination protections, their efforts have left lasting impacts.

For educators, these narratives are essential teaching tools. They illuminate connections between social justice, labor history and civic action. They encourage students to think critically about equity, to see themselves as future change-makers, and to honor the courage it takes to lead authentically.

Seeing the courage and impact of leaders like Bayard Rustin, Nancy Wohlforth and Kay Ulanday Barrett reminds me that visibility matters—and that living openly can be a powerful act of leadership in itself. Their stories help me, and others, feel seen and validated in a world that hasn't always welcomed us. Their legacy reminds us that the work of building an inclusive labor movement is ongoing. It calls each of us to action—whether that's sharing these stories, advocating for just policies, or making space for every worker to thrive.

Not all of these leaders held a union card—but all of them led. Through advocacy, organizing and coalition-building, they advanced the cause of worker justice in ways that continue to shape the labor movement today. Their work reminds us that labor leadership takes many forms—and every voice matters.

When we lift up the stories of queer labor leaders, we carry forward a legacy of courage, solidarity and justice. Let's continue to lift up their voices—in our classrooms, union halls and communities—so the legacy of inclusive labor leadership lives on.

# WRITE FOR THE ALASKA NURSE MAGAZINE!


## Article Submissions

Submit by sending a pitch or completed piece to mat@aknurse.org by July 17.

## Submission Guidelines:

- Articles should be your own original work.
- Submit all articles in Microsoft Word or Google Doc format.
- Include the full names and credentials of all authors. Author photos are appreciated when possible.
- Photos are encouraged! Please submit high-resolution images along with photo credits and captions.
- If applicable, include a list of references or sources used in your article.

Feel free to share our call for articles with interested friends and colleagues. **We look forward to featuring your article in an upcoming issue!**

Do you have a perspective to share or knowledge that could benefit your fellow nurses? **The Alaska Nurse magazine is looking for contributors for our upcoming issue!** Whether you're a seasoned writer or just passionate about a topic, this is a great opportunity to highlight your work, share your experience, and connect with nurses across Alaska.

**Each issue of our magazine features a different focus related to nursing and healthcare.** Articles do not have to fit the theme and can be personal, educational, or just plain interesting. In 2026, we're particularly interested in book reviews, visual art, poetry, and personal stories – see below for details.

We welcome a wide range of formats, including well-researched articles, profiles, personal essays, and more. If you have something to say related to one of these topics, or a fresh idea we haven't thought of yet, we want to hear from you!

## SUBMISSION OPPORTUNITIES

- **BOOK REVIEWS:** We're interested in reviews of books related to nursing, care work, disability, healthcare, and more. There is no minimum / maximum word count. Please send a pitch in to mat@aknurse.org if you'd like to write a book review.
- **VISUAL ART AND POETRY:** We'd love to highlight the work of nurse artists. Poetry can be submitted by email. Art can be scanned, or you can send a photo of your art for us to print. A wide variety of visual art will be accepted, including but not limited to: collage, paintings, earrings, sketches.
- **RECIPROCITY:** Tell a short story in your own words! This column will center personal narratives by nurses, those we've cared for, and people who inhabit the intersection of both nurse and patient. The goal of this column is to encourage reciprocal understanding between those of us who give and receive care. Word count limit: 500 words.

## FALL 2026 WORKPLACE CONDITIONS

**Submission Deadline: July 17**

This Labor Day, our magazine's theme will be our labor conditions. While submissions don't have to adhere to the theme, we're interested in articles featuring the following:

- Best and worst labor conditions
- How we can advocate for ourselves on personal and political levels
- What do you value in your workplace?
- What makes you want to leave nursing? What makes you want to stay?
- How union organizing impacts nurses in Alaska

Please email mat@aknurse.org if you'd like to pitch or submit an article, or if you have any questions. Check our website for more details: https://aknurse.org/write-for-the-alaska-nurse-magazine/

*We look forward to featuring your article in an upcoming issue!*

# AaNA Calendar of EVENTS

## Upcoming Events

### Modern Nurse Fest
- June 24-26, 2026
- BP Energy Center, Anchorage
- modernnursefest.com

### AFT Convention
- Thursday, July 16, 2026 to Sunday July 19, 2026 - All day
- Walter E. Washington Convention Center, Washington, DC (USA)

### Biennial Nurse Anesthesiology Conference
- August 28-30, 2026
- The Wildbirch Hotel, Anchorage
- nafa.vcu.edu/ce/alaska2026

### Narcan Kit Assembly *(in-person)*
- Hosted by AaNA
- September 4-5, 2026
- Email geri@aknurse.org to participate

### Improving Lives Conference
- Alaska Mental Health Trust Authority
- September 17-18, 2026
- BP Energy Center, Anchorage
- improvinglivesalaska.org

### Nursing Narratives *(in-person)*
- Hosted by AaNA
- September 30, 2026
- Tickets go on sale in late August!
- Bear Tooth Theatrepub, Anchorage
- aknurse.org

### 2026 Trending Topics in Nursing Conference
*(in-person)*
- Hosted by AaNA
- Sept. 30 - October 2, 2026
- BP Energy Center, Anchorage
- aknurse.org
- aanaconference.org

### AaNA General Assembly
*(hybrid)*
- Hosted by AaNA
- October 2, 2026
- BP Energy Center, Anchorage
- aknurse.org

## Recurring Events

### All Alaska Pediatric Symposium
- November 13-16, 2026
- Marriott Anchorage Downtown, Anchorage
- a2p2.org

### Book Club *(virtual)*
- Hosted by AaNA
- Meets every other month
- Contact hours available
- Email krista@aknurse.org to participate
- aknurse.org

### Tuesday Talks *(virtual)*
- Hosted by AaNA
- June 16, 2026 at 6 PM
- July 21, 2026 at 6 PM
- August 18, 2026 at 6 PM
- Free contact hours available
- aknurse.org

## AnNA Meetings

### Board of Directors *(virtual)*
- Held on 4th Wednesday of each month at 4:30 PM
- Email geri@aknurse.org if interested in attending

### Labor Council *(virtual)*
- Held on 4th Thursday of each month at 4:30 PM
- Email geri@aknurse.org if interested in attending

### Providence Registered Nurses Bargaining Unit Meeting *(virtual)*
- Held on 3rd Thursday of each month at 4 PM
- Email invites sent to members each month

### Ketchikan Registered Nurses Bargaining Unit Meeting
- Held on 1st Thursday of each month at 5:30 PM
- Text invites sent to members each month

### RNs United (Central Peninsula Hospital) Bargaining Unit meeting
- Email jenipher.ak.rn@gmail.com for meeting dates

Visit www.aknurse.org/events for frequent updates and information on AaNA events and local continuing education opportunities.

Want to list your event in The Alaska Nurse Calendar of Events and at www.aknurse.org.

Send information to editor@aknurse.org

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