Nurses Ranked as Most Trusted Professionals for 16th Consecutive Year

For the 16th consecutive year, the American public has ranked nurses as the professionals with the highest honesty and ethical standards, according to a Gallup poll released Dec. 26. The annual poll has ranked nurses as the most honest and ethical out of a wide spectrum of professions, including pharmacists and grade school teachers.

“Nurses provide much more than bedside care. We advocate for patients, deliver primary care, meet the complex needs of patients with chronic conditions, volunteer for disaster relief efforts, and are a trusted voice in boardrooms across the country,” said Pamela F. Cipriano, PhD, RN, NEA-BC, FAAN, president of the American Nurses Association (ANA).

According to the poll, 82 percent of Americans rated nurses’ honesty and ethical standards as “very high” or “high.” The next closest profession, military officers, was rated 11 percentage points behind nursing.

It is a wonderful time to be a nurse. The opportunities are boundless. Age, race, gender, ethnicity, religion, and politics are all invited, encouraged, and all are welcome in our profession of nursing. As I write this message to you, we have stepped into a new year and the most recent Gallup Poll (December 26, 2017) was released. Since 2001, for the sixteenth year in a row, nursing has received the amazing honor of being ranked the sixteenth year in a row, and the most recent Gallup poll (December 26, 2017) was released. The American public has ranked nurses as the professionals ranked as most trusted. As I write this message to you, we have stepped into a new year and the most recent Gallup Poll (December 26, 2017) was released. Since 2001, for the sixteenth year in a row, nursing has received the amazing honor of being ranked the sixteenth year in a row, and the most recent Gallup poll (December 26, 2017) was released. The American public has ranked nurses as the professionals ranked as most trusted.

It is my pleasure to serve each of you. I would love to hear from you and would appreciate input and suggestions you may have. Our responsibility as Board members is to support the mission of ANA-MAINE, our individual autonomous states (ME, NH, NY, RI, VT) whose purpose is to enhance the sustainability and voice of its members is to support the mission of ANA-MAINE. We will continue to refine our strategic plan. As in the larger healthcare community of inter-professional collaboration, ANA-MAINE hopes to create more intra-professional opportunities with our diverse Maine nurses and nursing specialties with their respective boards. As one example, ANA-MAINE developed a cooperative relationship with OMNE (Organization of Maine Nurse Executives) for our respective annual Fall meetings. As a result, the past two annual meetings of each membership organization enjoyed better attendance, shared costs and space, collaborative planning time, input, and energy. The meeting also created greater networking opportunities for the nurses and students in attendance. Successful intra-professional collaboration is doable and cost effective. By working together, we are stronger, more diverse, and can make more of an impact.

Since September, I have attended several conferences, representing ANA-MAINE in my new leadership role as President. I attended the Maine Nurse Workforce Summit in Orono. Lisa Harvey-McPherson, RN, MBA, MPM, and her team are to be applauded for their extraordinary work to synthesize the volumes of research data they studied and presented. President-elect, Bob Abel, MSN, RN, CHPN, CMC, CCM and I attended the Nurse Leadership conference in Washington, DC. ANA’s initiative for this year is Advocacy At the Bedside and Beyond, as they also continue with the Healthy Nurse, Healthy Nation campaign. More recently, I attended a full day of strategic planning in New York as a board member of the NEMSD. Essentially the NEMSD is a collaborative group of individual autonomous states (ME, NH, NY, RI, VT) whose purpose is to enhance the sustainability and voice of its member states through the effective utilization of shared services and resources to champion quality health care and advance the profession of nursing. The vision is building empowered NEMSD SNAs as the collaborative voice of nurses to promote optimal growth and sustainability of the nursing profession.

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Respectfully,

Catherine Snow, RN, PMHNRN-BC
Cultural Affairs Lecture at Saint Joseph’s College

SAINT JOSEPH’S COLLEGE, Standish – A Cultural Affairs lecture was delivered by Sue Henderson and Juliana L’Heureux, co-authors of Maine Nursing: Interviews and Reflections on the role of the nursing profession in Maine. Henderson is a former Saint Joseph’s College faculty member; L’Heureux is a Saint Joseph’s College graduate from the Masters in Healthcare Administration program. Lead author Ann Sossong is retired from the University of Maine, and co-author Valerie Hart teaches at the University of Southern Maine. Sossong and Hart were unable to attend due to their academic schedules. Mary Pelletier, editor was also a guest at the lecture. Professor Edward Reilly introduced the program to the audience of faculty, students, alumni and guests on October 25th.

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The Maine Center for Disease Control and Prevention is looking for nurses statewide who want to be part of Maine’s Public Health Nursing team.

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Psychiatric Nurse Practitioner (Family or Adult)

We are seeking Nurse Practitioners to provide psychiatric evaluations and ongoing psychiatric medication management for a diverse caseload in a recovery focused, integrated care environment.

Maine Family Psychiatric Mental Health NP License & DEA Certificate required.

Positions available in the Belfast, Brunswick, Lewiston, and Sanford regions.

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[RIGHT] Photo credit Juliana L’Heureux

(left to right) Juliana L’Heureux, BS, MHSA, RN, Susan Henderson, RN, MSN, and Professor Edward Reilly at Saint Joseph’s College in Standish, Maine October 25, 2017

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Follow nursing on Facebook on the ANA-Maine and American Nurses Association pages.

ANA-MAINE Executive Director Search

ANA-Maine is seeking a Registered Nurse in the State of Maine to serve as an Executive Director in a consultant role for the organization.

Key qualifications include:

- Baccalaureate degree in nursing, required: Master’s preferred.
- Demonstrated leadership capabilities.
- Prior leadership experience in nursing or related health field.
- Knowledge of current health care and nursing issues: state, national, and international.
- Knowledge of legislative procedure, advocacy, and parliamentary law.
- Public speaking experience.
- Ability to travel, both in and out of state, and attend national meetings.
- Strong financial acumen.

More information and detailed job description is located at www.anamaine.org/ExecutiveDirectorSearch. Those interested in this position should submit a resume and cover letter to info@anamaine by April 1, 2018.

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Maine Medicaid Expansion Implementation Status

Juliana L’Heureux, BS, MHSA, RN

Medicaid.gov
Keeping America Healthy

Maine Question 2 was the first instance in the nation to approve the Medicaid expansion through a citizen initiative.

Maine voters approved the Medicaid expansion “Question 2” initiative by a decisive margin on November 7, 2017, when the referendum question was on the ballot. The fully implemented expansion will provide for 70,000-80,000 qualified beneficiaries to receive health coverage. On January 3, 2018, a timetable for the implementation will proceed through the Maine Department of Health and Human Services (DHHS) and ultimately must be approved by the Centers for Medicare and Medicaid Services (CMS).

In funding the expansion, federal dollars must be matched by a percentage of state allocations in order for the draw of dollars to be accessed in the amount necessary to pay for the benefit. Maine’s Office of Fiscal and Program Review estimated that the state’s portion of the cost would be about $54.5 million and the federal match will be 90 percent of the cost of the expanded coverage. Under the Affordable Care Act, the law allows any citizen with an income up to 138 percent of the poverty level — $16,642 — to qualify for coverage under the expansion.

Maine Question 2 November 7, 2017

<table>
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<tr>
<th>Results</th>
<th>Yes</th>
<th>No</th>
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<tr>
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<td>141,436</td>
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Maine passed Question 2, with 58.95 percent voting to enact the initiative.

Medicaid is a federally funded program that provides health insurance to groups of low-income people and individuals with disabilities. Maine’s Medicaid program is known as MaineCare. The Affordable Care Act, also known as Obamacare, provided for the expansion of Medicaid to cover all individuals earning incomes up to 138 percent of the federal poverty level.

In 2012, the U.S. Supreme Court ruled that the federal government could not withhold funds from states that refused to expand Medicaid. The ruling had the practical effect of making Medicaid expansion optional for states. In 2018, the federal government financed 94 percent of the costs of state Medicaid expansion. For 2020 and subsequent years, the federal government will cover 90 percent of the costs. As of October 2017, Maine was among 19 states that chose not to expand Medicaid because Governor Paul LePage vetoed the legislation five times. Maine was the first state in the nation to approve the Medicaid expansion through a ballot initiative.

Question 2 was designed to require the state government to provide Medicaid through MaineCare for persons under the age of 65 and with incomes equal to or below 138 percent of the official poverty line. In 2017, this amounted to annual income of $16,642 or less for an individual and $33,948 or less for a household of four.

In the expansion, the Medicaid coverage could cover around 70,000 additional qualified people, but others estimated that it would affect about 80,000 residents.

The Maine Department of Health and Human Services (DHHS) was required by the initiative to present a plan to the U.S. Department of Health and Human Services, for approval within 90 days of the measure taking effect.

Maine DHHS was allotted 180 days following the measure’s effective date to adopt rules to ensure that people eligible for Medicaid under the expansion have access to services. In Maine, initiatives normally go into effect 30 days after the official proclamation of election results.

If the initiative requires spending beyond available state funds, however, and does not provide a funding mechanism, the implementation can be delayed until 45 days into the following legislative session. If the expansion continues on an uninterrupted timeline, the enrollments could begin in July 2018 (or the beginning of fiscal year 2019). Nevertheless, the potential for delays is anticipated if CMS or the US DHHS asks for clarifications about the expansion, thereby delaying the timetable, and while the Maine legislature identifies the source for the state’s share of the funding.

Timetable for implementation in the absence of interruptions:

1. Jan. 3, 2018 - Legislature convenes. Thirty days have passed since the governor’s proclamation and the law becomes effective on this day.
2. Feb. 17, 2018 - While the law is effective on January 3rd, it becomes operative 45 days after the Legislature convenes.
3. April 3, 2018 – This is 90 days after the effective date, and DHHS must submit a State Plan Amendment to the federal government by this day.

July 2, 2018 (state fiscal year ‘19) – No later than 180 days after the effective date, people become newly eligible under the law.

Maine’s Office of Fiscal and Program Review (OFPR) estimated that the state’s portion of the Maine Medicaid expansion will cost about $54.5 million. The state’s share is relatively small considering the return on investment of $9 from the federal government for every $1 Maine invests. (Maine Equal Justice Partners Fact Sheet)

Maine Equal Justice Partners in Augusta has been supporting efforts with advocacy groups that are working towards a timely implementation of the expansion as approved by the voters. ANA-Maine has participated in the Mainers for Health Care advocacy coalition in support of the Medicaid expansion.


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Steering a New Course

Anthony McGuire, PhD, new director of the Saint Joseph’s College nursing program, takes the Center for Nursing Innovation in an exciting new direction

Emma Deans

In the summer of 2016, Dr. Anthony McGuire set off on a cross country road trip adventure which ended, as all great journeys do, with a new life chapter. Starting in California, he caravaned with his mother, son, and dog through the misty woods of Washington, among snow-capped mountains in Montana, across expansive grasslands of South Dakota, and beneath towering waterfalls at Niagara, until finally arriving at a small college nestled beside Sebago Lake in his home state of Maine—Saint Joseph’s College.

Upon arriving, and as chair of the nursing department, Dr. McGuire promptly rolled up his sleeves to restructure the College’s nursing programs and elevate the level of workforce preparedness of its nursing graduates. Previously a faculty member at California State University in Long Beach, California, McGuire also serves as the nurse practitioner program director and a nursing professor at Saint Joseph’s College.

Dr. McGuire brings measured insight to this position with 31 years of experience as a registered nurse and 18 years of experience as a board-certified acute care nurse practitioner. Born in Alaska but raised in Gardiner, Maine, McGuire earned an associate’s degree in nursing from Central Maine Medical Center and a bachelor’s degree in business administration at the University of New England. But nursing, rather than business, called to him. “There’s a stigma associated with being a male in the nursing field. It’s something I work to change every day,” he explains. He continued to explore the country as a traveling nurse, working in Boston, New York, Miami, Virginia, and throughout California.

Then, he decided to further his education, earning a bachelor’s degree in nursing from California State University – Long Beach, and master’s and doctoral degrees in nursing from the University of California – Los Angeles. Having lived away from his home state for most of his adult life, McGuire saw the opportunity at Saint Joseph’s College to come home and still serve his profession.

Dr. McGuire is already implementing steps to boost the rigor of the nursing admissions process and the qualifications of faculty, bringing the number of doctorally prepared faculty to five. He created a new position, family nurse practitioner coordinator, filled by Kelly Hudock, CRNP, DNP, which has helped streamline communications. He is supportive of nursing students who want to apply their skills through international service trips and is ironing out details for those students to receive credits. Overall, he’s striving to build a robust, integrated program that increases integration between online and campus departments.

“Ultimately, what differentiates Saint Joseph’s College from other campus and online programs is our faith-based core values and investment in people,” he says. Because Maine has the oldest population in the country, Dr. McGuire believes it’s necessary for educational institutions to collaborate with hospitals to determine the gaps in the nursing profession and how to best address them together. To this end, he has formed a partnership with Maine Medical Center through which a cohort of 18-24 undergraduate unlicensed staff will complete a 2 ½ year program. Maine Med will provide the facilities; Saint Joseph’s College will provide the degree. It’s just one way he envisions the College addressing the statewide demand for licensed nurses. “I want to use my three plus decades of experience and infuse it into this institution to make it the best it can be. I want a personal legacy of strengthening the nursing population in Maine,” he says.

Dr. McGuire is a fellow for the American Heart Association, chair of the program committee at the Western Institute of Nursing, and an ambassador to the American Association of Critical Care Nurses. His research deals with the effects of depression in cardiovascular patients with a specific focus on acute coronary syndrome (ACS) patients, the utilization of bedside nurses in the identification of depression, and outcomes mediated by depression in this population of patients.

Saint Joseph’s College offers an on-campus BSN, an online RN to BSN, RN to MSN Fast Track, as well as online graduate programs for FNP, nursing administration, nursing education, a Certificate of Advanced Graduate Study, and MSN/MBA and MSN/MHA dual degrees. Learn more about nursing at: www.sjcme.edu/sjcnursing.
Domench identified substance addiction as the single biggest cause of America’s preventable deaths. In fact, the death toll from addictions is ravaging the US, and has been climbing by the thousands for years. In 2015, opioid overdose deaths killed more people in the US – 52,000 – than guns, car crashes, and even HIV/AIDS at its peak. Moreover, overdoses since the epidemic began in the late ’90s killed more people than the entire population of Atlanta, GA.

2017 data reports even higher mortalities, as the deadly synthetic opioid fentanyl continues to spread across the US. “Fentanyl is a nasty drug. It’s ten times stronger than morphine,” said Domench. Vox.com reported that public health officials at every level of government have been unable to reverse or even stabilize the rising death toll from the addiction crisis. Many people who have been afflicted by addictions began their use with the misuse of highly addictive prescription painkillers.

Street drug categories in order of their overdose rates are:
- Opioids
- Sedative Hypnotics like Barbiturates, Benzodiazipines and Sedative Hypnotics
- Dissociatives/Hallucinogens like “Angel Dust”
- Stimulants like cocaine and caffeine powder
- Designer Drugs like “Ecstasy” or “Molly”

Heroin has a variety of street names, like sugar, smack, horse, dope, H or Big H, junk, skag, skunk, white horse or China white.

“Nurses should try to become familiar with the names used by those who are describing their street drugs and use, because, being familiar with the different terms can help to assess the best practices needed to care for patients who are addicted,” said Domench.

Street drugs are dangerous because there’s no way to know how strong they are or what substances may be in them. It’s even more unsafe to use them along with other substances, like alcohol and marijuana.

Alarming information was presented about the drug Acryl-fentanyl. In fact, Naloxone may not be effective after a person has ingested or inhaled this dangerous substance. This is a type of Narcan-resistant Fentanyl that has been found in batches of heroin and causing numerous overdoses and deaths. Apparently, it’s hundreds of times more powerful than morphine as reported in Narconan.org.

Unfortunately, Maine ranks as among the nation’s highest in the per capita overdose rate of people who consume street drugs.

Some general information about street drugs is available at WebMD. Additionally, Domench recommended the following literature:
- Info on street drug alerts and trends: www.drugabuse.gov/drugs-abuse/emerging-trends-alerts
- Info on MDMA and Designer Drugs: www.enowid.org and https://holisafe.org
- Info on research use of LSD, MDMA and other currently illegal drugs: www.maps.org

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February, March, April 2018

ANA Maine Journal Page 5

Attending the OMNE meeting on Nov. 6, were ANA-Maine Board members Paula Delahanty, with Dan Domench, Juliana L’Heureux, and Patricia Boston, who is also an OMNE member and the past president of ANA-Maine.

Nurses are caring for patients who experience the devastating impact of the nation’s opioid epidemic, in all practice settings. In fact, addicts may not be the people who we expect to care for, as the prescription opioid abuse in the elderly is also reaching unprecedented levels and is an urgent concern, reported in Narconan.org (Prescription Opioid Use in the Elderly an Urgent Concern).

Illegal opioid use and the addiction crises continue to involve more patients and their families. Nurses must be increasingly aware about the many substances now available, known as “street drugs.”

Ongoing education is offered throughout our health care systems, informing providers and caregivers about the signs and symptoms of opioid abuse and addiction. Understanding the many terms and the kinds of ingredients used in addictive substances will help nurses to understand the depth of the problems and the costly impacts facing patients, families and our communities.

Dan Domench, M.S., Ed. CADC, is a certified addiction counselor with 25 years of experience. He presented an educational program to the Organization of Maine Nurse Executives (OMNE) on Friday, November 17, 2017, at the nurses’ monthly lunch meeting held at the Senator Inn in Augusta. His presentation was accompanied with an informational handout titled, “Street Drugs: Alerts and Trends in Maine and New England.”

Overdoses to street drugs is increasing, says Catherine Lorello-Snow, a nurse who is the president of ANA-Maine and the Director for Spurwink Mental Health Center in Portland. In fact, the use of Narcan as an intervention to save lives among those who overdose, is on the rise. “It’s been reported to me that last year the social workers in a Portland shelter facility were reversing an accidental opioid overdose with Narcan every 18 days, but this year the overdoses at the same place have increased to one every 8 days.”

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Info on opioid epidemic: “The Family That Built an Empire of Pain: The Sackler dynasty’s ruthless marketing of painkillers has generated billions of dollars – and millions of addicts.” by Patrick Radden Keefe

https://www.newyorker.com/magazine/2017/10/30/the-family-that-built-an-empire-of-pain

Contact information for Dan Domench, M.S., Ed. CADC is danidomench@gmail.com

Street Drugs Alerts and Trends – A Review of What Nurses Need to Know

Juliana L’Heureux, BS, MHSA, RN

Domench identified substance addiction as the single biggest cause of America’s preventable deaths. In fact, the death toll from addictions is ravaging the US, and has been climbing by the thousands for years. In 2015, opioid overdose deaths killed more people in the US – 52,000 – than guns, car crashes, and even HIV/AIDS at its peak. Moreover, overdoses since the epidemic began in the late ’90s killed more people than the entire population of Atlanta, GA.

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Info on ayahuasca (see the New Yorker article): “The Drug of Choice for the Age of Kale: How ayahuasca, an ancient Amazonian hallucinogenic brew, became the latest trend” by Ariel Levy.

www.newyorker.com/magazine/2016/09/12/the-ayahuasca-boom-in-the-us

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Info on inhalants: www.inhalants.org/final_medical.htm

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The Endocannabinoid System: What Nurses Need to Know, An Introduction

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Medical cannabis is now legal in 29 states and Washington DC, along with recreational cannabis also being legal in several states. As nurses, we have a lot to learn about cannabis, including how it works in the mind-body-spirit system, and how we can best advocate for and support patients who could or do benefit from this medicine.

The largest receptor system in the body is called the endocannabinoid system (ECS). The ECS was discovered over 20 years ago, with Dr. Ralph Mechoulam (Faulkner, 2015) being a pioneer in this area in the mid-1990s. There are 25,000+ scientific published articles exploring cannabis and its medicinal benefits, yet, most nurses likely know very little, if anything, about the ECS.

A functioning ECS is essential to our health and well being. Endocannabinoids and their receptors are found throughout the body, in the brain, organs (pancreas and liver), connective tissue, bones, adipose tissues, nervous system, and immune system. We share this system in common with all other vertebrate animals, and some invertebrate animals (Sulak, 2015). Cannabinoids support homeostasis within the body’s system; the ECS is a central regulatory system, cannabinoid receptors are found throughout the body, and they are believed to be the largest receptor system in our bodies. Cell membrane cannabinoid receptors send information backwards, from the post-synaptic to the pre-synaptic nerve. CB1 found primarily in the brain) and CB2 receptors (found mostly in the immune system and in the bones) are the main ECS receptors (Faulkner, 2015), though several more are currently being studied. http://www.ncbi.nlm.nih.gov/pubmed/16596770

Endocannabinoids are the chemicals our own bodies make to naturally stimulate the cannabinoid receptors; anandamide and 2-arachidonoylglycerol (2-AG) are two well known endocannabinoids (Sulak, 2015) that are produced by the body as needed, though not stored in the body. The body produces these endocannabinoids in a similar fashion to how it produces endorphins (Pfrommer, 2015), and activities such as exercise, yoga, osteopathic manipulation, and acupuncture support the endogenous production of cannabinoids. Endocannabinoids are also found in breast milk and in our skin. Alcohol interferes with endogenous cannabinoid production.

Phytocannabinoids: In general, we think of the cannabis plant as the generator of exogenous cannabinoids that we can ingest in a variety of ways, namely psychoactive THC (works with the CB1 receptors in the brain and also in the gut) and non-psychoactive CBD (works with the CB2 receptors in the immune system and the gut). Other plants such as Echinacea also produce non-psychoactive cannabinoids and work with the ECS to support health and well being through homeostasis (Sulak, 2015).

The exogenous phytocannabinoid THC, or the psychoactive compound found in cannabis, works primarily on CB1 receptors (hence the “high feeling” in the brain), while the phytocannabinoid CBD works primarily with the immune system and creates homeostasis around the inflammatory response through interactions with CB2 receptors. Though CBD does not have psychoactive effects. Other cannabinoids and their actions are still being studied, such as the non-psychoactive phytocannabinoids CBN and CBG. Our bodies react to both our own production of endogenous cannabinoids and to the ingestion of phyto-cannabinoids found in the cannabis plant, and other non-psychoactive plants such as Echinacea. To read more about the science behind the ECS and endocannabinoid receptors, the following are excellent resources: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2241751/.

Cannabinoid Deficiency Syndrome: It should be clear that everybody makes cannabinoids and everybody needs cannabinoids to function. People who do not make enough cannabinoids need to supplement with exogenous cannabinoids through cannabis ingestion, in much the same way that a diabetic needs insulin supplementation. Dr. Ethan Russell’s (2004) publication on Clinical Endocannabinoid Deficiency explains this particularly well: http://www.net.edu/pdf/75_12_06.pdf.

Homeostasis:
Cancer: “Cannabinoids promote homeostasis at every level of biological life, from the sub-cellular, to the organism, and perhaps to the community and beyond. Here’s one example: autophagy, a process in which a cell sequesters part of its contents to be self-digested and recycled, is mediated by the cannabinoid system. While this process keeps normal cells alive, allowing them to maintain a balance between the synthesis, degradation, and subsequent recycling of cellular products, it has a deadly effect on malignant tumor cells, causing them to consume themselves in a programmed cellular suicide. The death of cancer cells, of course, promotes homeostasis and survival at the level of the entire organism” (Sulak, 2015, paragraph #7). Cannabinoids support apoptosis and suppress cancer tumor angiogenesis (McPartland, 2008).

Heart disease: Additionally, it has been stated that the ECS plays an important function in protecting the heart from myocardial infarction and cannabinoids can have anti-hypertensive effects (Lamontagne et al, 2006). They should be used with caution with cardiovascular patients, as THC can cause tachycardia and there may be an increased risk for cardiovascular related incidents post ingestion.

Inflammation: When inflammation occurs, the ECS helps to stop the process, similar to applying the brakes on a car. This is why cannabis is proving to be good medicine for inflammatory related illness. “Activation of CB2 suppresses proinflammatory cytokines such as IL-1 and TNF-α, while increasing anti-inflammatory cytokines such as IL-4 and IL-10. Although THC has well-known anti-inflammatory properties, cannabidiol also provides clinical improvement in arthritis via a cannabinoid receptor–independent mechanism” (McPartland, 2008).

PTSD: “This review shows that recent studies provided supporting evidence that PTSD patients may be able to cope with their symptoms by using cannabis products. Cannabis may dampen the strength or emotional impact of traumatic memories through synergistic mechanisms that might make it easier for people with PTSD to rest or sleep and to feel less anxious and less involved with flashbacks memories. The presence of endocannabinoids in limbic systems, within stress-sensitive nuclei of the hypothalamus, as well as upstream limbic structures (amygdala), point to the significance of this system for the regulation of neuroendocrine and behavioural responses to stress. Evidence is increasingly accumulating that cannabinoids might play a role in fear extinction and antidepressive effects. It is concluded that further studies are warranted in order to evaluate the therapeutic potential of cannabinoids in PTSD.” (Passie et al, 2012).
Seizures: Cannabis and CBD have been used to support pediatric treatment-resistant epilepsy, and while more research needs to be done in this area, many parents are becoming medical marijuana refugees by moving to states where they can procure cannabis for their children who suffer from seizures.

Co-agonists: Cannabis increases the pain relieving effects of morphine, as discovered by researchers at UCSF. The two medications are synergistic, and this provides great hope for patients suffering intractable pain at end of life, chronic pain sufferers, and opioid addicts. (http://www.mapsgroup.org/research/archive.png?Abrams_2011_Cannabinoid_Opioid.pdf)

For Nurses: So as nurses, what do we need to know to support patients who use cannabis?

Legal issues: If you live or work in a state that has legalized medical or recreational use of cannabis, such as Maine, it is still important to familiarize yourself with the laws in your state, as well as your own workplace policies around supporting patient’s use of medical cannabis. Patients may have questions and as a patient advocate, your responsibility is to support patients with their knowledge and use of this medicine within the confines of your practice setting and state laws.

You should also be aware of constraints around your role as a nurse in supporting patient use of medical cannabis. For instance, Kaiser patients in some states are likely to be removed from chronic pain patient programs if they test positive for cannabis. Nurses with knowledge around the benefits of medical cannabis can also advocate to support shifts in such policies will no longer align with the emerging ECS science.

Safety: While cannabis is known to be extremely safe (far safer than opiates and alcohol) and is impossible to overdose on, medical cannabis patients should be supported in how to manage their cannabis intake, monitor for side effects, and store their medications safely. Cannabis consumers still need to store medication out of reach of children and pets. They should be supported in knowing the safety of driving or operating machinery if they consume THC-based cannabis medicines. They also may need information on cannabis testing for both THC-CBD ratios, pesticides and other hazardous materials. Many patients need assistance with the basics around medical cannabis use, such as dosage, ratios of THC-CBD, strain selection, and ingestion methods. Side effects may include anxiety, short term memory loss, changes in perception, dry mouth, dry eyes, hypotension, and dependence.

Overcoming Stigma: Unfortunately, a stigma was created around cannabis during the process of prohibition in the 1930’s, which was largely financially and racially driven. Contradictory state and federal laws, and the stigma around smoking cannabis (though many cannabis patients can now get relief from vaporizing, tinctures, edibles), along with a clear ignorance around the body’s ECS, serve to further the stigma associated with medical cannabis. Educate yourself on the roots of the prohibition of the medicine: http://orgin.oregonstate.edu/article/legalization-marijuana-brief-history


American Cannabis Nurses Association: There are many nurses actively involved in supporting the use of medical cannabis and defining the nurse’s role in this process. The ACNA has a mission to advance excellence in cannabis nursing practice through advocacy, collaboration, education, research, and policy development. http://americancannabisnursesassociation.org/

In Israel, nurses actively support patients in cannabis consumption from the process to the dosage. http://www.youtube.com/watch?v=Hk1j-Dl43DF

Nurses’ supporting patients healing process through cannabis medications may someday be commonplace in the USA as well.

References:


Primary Changes and Updates to the Recommendations

This report updates the 2016–17 recommendations of the Advisory Committee on Immunization Practices (ACIP) regarding the use of seasonal influenza vaccines (MMWR Recomm Rep 2016;65[No. RR-5]). Routine annual influenza vaccination is recommended for all persons aged ≥6 months who do not have contraindications. A licensed, recommended, and age-appropriate vaccine should be used.

For the 2017–18 season, quadrivalent and trivalent influenza vaccines will be available. Inactivated influenza vaccines (IVs) will be available in trivalent (IV3) and quadrivalent (IV4) formulations. Recombinant influenza vaccine (RIV) will be available in trivalent (RIV3) and quadrivalent (RIV4) formulations. Live attenuated influenza vaccine (LAIV) is not recommended for use during the 2017–18 season due to concerns about its effectiveness against (H1N1)pd09 viruses during the 2013–14 and 2015–16 seasons. Recommendations for different vaccine types and specific populations are discussed. No preferential recommendation is made for one influenza vaccine product over another for persons for whom more than one licensed, recommended product is available.

Updates to the recommendations described in this report reflect discussions during public meetings of ACIP held on October 20, 2016; February 22, 2017; and June 21, 2017. New and updated information in this report includes the following:

- Vaccine viruses included in the 2017–18 U.S. trivalent influenza viruses will be an A/Michigan/45/2015 (H1N1)pdm09–like virus, an A/Hong Kong/4801/2014 (H3N2)-like virus, and a B/Brisbane/60/2008–like virus (Victoria lineage). Quadrivalent influenza viruses will contain these three viruses and an additional influenza B vaccine virus, a B/Phuket/3073/2013–like virus (Yamagata lineage).

This report focuses on the recommendations for use of vaccines for the prevention and control of influenza during the 2017–18 season in the United States. A Background Document containing further information and a summary of these recommendations is available at www.cdc.gov/flu/professionals/acip/index.htm. These recommendations apply to licensed influenza vaccines used within Food and Drug Administration–licensed indications, including those licensed after the publication date of this report. Updates and other information are available at CDC’s influenza website www.cdc.gov/flu. Vaccination and health care providers should check CDC’s influenza website periodically for additional information.

SMHC Oncology Nurse Navigator Peggy Belanger Receives Prestigious National Award from the American Cancer Society

PEGGY BELANGER, R.N., B.S.N., O.C.N. has been named a recipient of the 2018 American Cancer Society Lane W. Adam Quality of Life Award. Belanger is the only Maine recipient of the award in 2018.

“Peggy is a remarkable caregiver,” said SMHC President and CEO Ed McGeachey. “She puts her heart and soul into the care she provides to our cancer patients. At a time that might be the most hopeless of a person’s life, Peggy is there to provide support, strength, guidance, and perhaps most importantly, hope. She is incredibly deserving of this national recognition from the American Cancer Society.”

“An oncology nurse navigator, Peggy guides patients and their families throughout their cancer journey,” added Cancer Care Service Line Director William Perron, R.N. “Her caring, empathetic nature is recognized by patients and colleagues alike. She understands the importance of helping the patient and family process the impact of a cancer diagnosis on all levels. Peggy’s dedication to, and passion for, patient-centered care is astounding, and ultimately has changed hundreds of lives over the 33 years she has been at SMHC.”

According to the American Cancer Society (ACS), this award also represents the concept of the “warm hand of service,” which is an integral part of the American Cancer Society’s commitment to excellence in cancer care and specifically emphasized by Lane W. Adam when he served as executive vice president of the ACS. Lane’s definition of the warm hand of service was to “serve others and enrich the purpose of one’s existence.” Peggy has volunteered with the ACS for more than 30 years, and is an 11-year volunteer with ACS Cancer Action Network. Her dedication to easing the burdens of cancer have been recognized through two prestigious awards including the American Cancer Society’s 2015 Sandra C. Labaree Volunteer Values Award, and the 2014 Southern Maine Health Care Caregiver of the Year Award. Peggy volunteers for a free medical clinic to help the underserved and uninsured patients in her community and she founded a choral group that performs for hospice patients. She embodies warmth, compassion and care that are needed to help someone through their cancer journey.

About Southern Maine Health Care

Southern Maine Health Care (SMHC) is a national award-winning healthcare system with a non-profit mission “to improve the health and health care of the communities we serve.” SMHC includes a full service, acute care medical center in Biddeford, with York County’s only inpatient mental health unit. Emergency care, surgical services, and diagnostic and therapy services are available at SMHC’s Medical Centers in Biddeford and Sanford. SMHC offers primary care and multi-specialty physician services, diagnostic and therapy services, and Walk-In Care centers in various York County communities including Biddeford, Kennebunk, Saco, Sanford and Waterboro. SMHC is Joint Commission accredited and has been recognized for quality excellence by numerous outside organizations. To learn more about SMHC and SMHC providers, visit www.smhc.org, https://www.youtube.com/c/smhcorgme, or https://twitter.com/SMHCHealth.

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SMHC Oncology Nurse Navigator Peggy Belanger, R.N., B.S.N., O.C.N. has been named a recipient of the 2018 American Cancer Society Lane W. Adams Quality of Life Award. Belanger is one of only seven individuals across the country, and the only person in Maine, to receive this high honor in 2018.
We are experiencing a growing opioid addiction epidemic in the United States, and it is well documented that Maine has one of the highest rates of opioid drug misuse and neonatal abstinence syndrome in the country. Despite decades of research and development of practice guidelines, maternal and neonatal outcomes have not improved substantially. I became concerned with these trends as a staff nurse in the pediatric intensive care unit and a pediatric nursing clinical instructor, which led me to the focus of my doctoral dissertation work. I conducted an ethnographic study in northern Maine titled Experiences and Perceptions of Rural Postpartum Women with Substance Use Disorders Inclusive of Opioids Regarding Their Care. The purpose of the study was to better understand the experiences and perceptions of pregnant and early postpartum women with substance use disorders living in rural areas regarding their care for pregnancy, parenting, and recovery, with the aim to add their voices to inform development of effective care models and supportive public policy. I subsequently consented and interviewed 13 women, ranging in age from 22 to 40 years, with diverse demographics in terms of race/ethnicity, relationship status, child custody, and stage of addiction recovery. Six of the state's 16 counties were represented, covering a geographic area of approximately 20,000 square miles, more than half of the state.

During formal interviews, participants described both supportive and challenging care experiences they encountered for their substance use disorder, their pregnancy, and their subsequent delivery and participation in their baby's care. Their experiences and perceptions of care uncovered three domains with underlying themes: challenges of getting treatment and care (i.e., service availability, distance and geographic location, transportation, collaboration and coordination among providers), physical and emotional safety, opportunities to bond (i.e., proximity, information), and relationships (i.e., respect, empathy, familiarity, inclusion, interactions with care providers). Their personal accounts were supported by conversations I had with health care providers; observations of care environments and participant interactions with others in the context of care; and review of artifacts, such as publicly available information.

The women's experiences and interpretations of how they were perceived by both outpatient and inpatient care providers seemed to dominate the interviews; they revealed a willingness to accept inconvenience and logistical challenges to receive care where they felt respected and understood. They indicated that they chose to travel longer distances from their homes to access treatment and care by providers they perceived as more competent. The women expressed feelings of guilt, shame, and embarrassment, particularly when they talked about the effect of their substance use on their babies and the rest of their families. They expressed fear of being judged by health care providers based on their prior experiences or those of their acquaintances.

Such fear and stigma have been shown to be barriers to treatment and care, discouraging women from seeking and engaging in substance use treatment and prenatal care, potentially increasing the risk of harm to the mother and baby. The women spoke of some of the challenges they encountered to be with their babies and their belief that their involvement in their baby's care was important. They felt their presence and active participation in their baby's care alleviated their baby's distress. The women conveyed a need for connection, whether that be with providers and caregivers, other women in similar circumstances, or their babies and other family members. They all expressed gratitude for the opportunity to tell their stories and hope the information they shared would be helpful to others. They wanted people to understand that addiction and recovery were hard; they were doing their best despite the barriers; they took responsibility for their choices, sometimes other responsibilities kept them from being with their babies; and judgment and disrespect were triggers to relapse that also discouraged them from being honest. The women encountered limits in access for both their substance use disorder treatment and pregnancy care, most notably regarding availability and insurance coverage for services, often having to wait to get treatment. In general, they described gaps in information and their understanding of available resources and the impact of their substance use on their babies. Paired with this lack of information were variable degrees of inclusion in decision-making and the care of their newborns. The findings from this study highlight the following:

- the need for more integrated, coordinated, collaborative care models
- non-punitive public policies, expansion of buprenorphine prescribing privileges, and expanded insurance coverage
- provider education on compassionate, women-centered approaches that incorporate a harm reduction philosophy, which are key to successful care of these women

Nurses connect with women in both community-based and inpatient settings and, as such, can positively impact the care of these women and their babies through provision of skilled, nonjudgmental care. Evidence and resources are available to provide compassionate care. It is imperative that nurses become actively involved in development of public policies to support collaborative, integrated models of care, reduce rural and poverty-related health disparities, and discourage punitive treatment of women that only serves to impede their access to treatment and care.

Debra Kramlich, PhD, RN, CNE, CCRN-K

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Keynote Speaker: Karen Daley, PhD, RN, FAAN. Daley served from 2010 to 2014 as the president of the American Nurses Association, the nation’s largest nursing organization representing the interests of the nation’s 3.6 million registered nurses. She has spent more than 25 years in clinical practice. Daley was listed among Modern Healthcare’s “100 Most Influential People in Health Care” and, in 2013, was selected by Modern Healthcare as one of the “Top 25 Women in Healthcare.”

Speaker: Joyce Stamp Lilly, RN, JD. Lilly is a Registered Nurse and lawyer who has been representing nurses in front of the Texas and Rhode Island Boards of Nursing since 2001. Lilly worked as a nurse in acute and community settings including medical-surgical, and psychiatric settings. She is familiar with the culture of Nursing and understands many of the problems facing nurses today. For more information about Lilly, see her website nursingcomplaint.com.

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What is the Northeast Multistate Division (NEMSD)?

The NEMSD is a business entity that the following state nursing associations (SNAs) – ANA-Maine, New Hampshire Nurses Association, ANA-New York, ANA-Rhode Island, and ANA-Vermont have established together. By collaborating together, these five states have developed a shared services business model that allows each state nursing association to improve efficiencies and costs by streamlining resources, tools, and technologies. The establishment of the NEMSD is a tremendous opportunity for all SNAs involved. It allows each state to strengthen both its financial and support systems by sharing services, while retaining each state’s unique identity and governance.

Why Should I Care?

The ways in which the work of membership associations is achieved is changing rapidly. Providing relevant programs and services, leadership and volunteer opportunities, education, and advocating for nurses, the nursing profession and patients are all critical aspects of the work of state nursing associations. To ensure that nursing membership associations continue to grow, respond to the complexities of health care reform and the delivery of health care, and the significant role of the nurse within those environments is recognized and supported, collaboration and innovation are required. Nurses are leaders. Leaders seek opportunities to develop, improve, and succeed. The NEMSD is an excellent example of nursing leadership. Nurses leading innovative partnerships is a way to engage and respond to our ever-changing environments. By committing to building relevance, relationships, and revenue, the NEMSD is working to ensure that the future of SNAs remains vibrant, strong, and successful. Without the significant presence of SNAs, the voice of nursing is diminished. The work of today should include a vision for the future. The NEMSD’s mission is to collaboratively enhance the power, strength, success, sustainability, and voice of the NEMSD member states through the effective utilization of shared services and resources to champion quality health care and advance the profession of nursing. This is the work of the NEMSD.

What is required to participate?

A vision for the future and a willingness to engage are just a few of the ways to participate in the NEMSD. Utilization of the NEMSD Continuing Nursing Education Unit, attending events hosted by the NEMSD member states such as annual conventions, athletic and student events, and a cruise from Boston to Bermuda are examples to engage with the NEMSD. The vision of the NEMSD is to build empowered NEMSD SNAs as the collaborative voice of nurses to promote optimal growth and sustainability of the nursing profession. Recognizing that SNA members and SNAs are deserving of products, services, and opportunities that reflect their interests and needs is reflected in that vision. The establishment of a business entity that provides shared resources specific to education, advocacy, professional development, and enhances membership will certainly guarantee success for the NEMSD SNAs.

Maine’s Public Health Nursing Workforce to Double

The Maine Department of Health and Human Services is more than doubling its public health nursing workforce in rural areas.

The Portland Press Herald reported DHHS will fill 50 positions to comply with a new state law that requires Maine to have at least 50 public health nurses on staff. That staff of front-line nurses who respond to infectious disease outbreaks and perform health prevention duties was slashed by more than half under Gov. Paul LePage’s administration, from 59 in 2011 to about 25 positions in early 2017.

“Public health nurses have always been a high priority for me,” DHHS Commissioner Ricker Hamilton told the newspaper. Seven of the nursing positions have been filled so far, and DHHS received more than 30 applications.

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