For those of you who know me well, I am sure it will bring a smile to your face for me to admit that while I sit at the keyboard (Remember when we called it typing?), I struggle for something to say or a way to begin this column.

It has been a demanding first quarter of 2008. ISNA has been very busy on behalf of all nurses in Indiana. Thankfully, our wonderful staff keeps the day-to-day operation of our Association running smoothly. Not to mention keeping our headquarters together and safe. (We survived the January tornadoes—have you ever heard of such a thing?) We closed 2007 with positive results: our Association is financially sound, confirmed by our annual audit.

The ISNAP program continues to serve nurses needing assistance with substance abuse. The ISNAP staff meets regularly with the Indiana State Board of Nursing. The Committee on Oversight (Continued on page 2)

President’s Message

Ella Harmeyer
MS, RN

Relapse and Relapse Prevention

October 3, 2008

ISNAs Third Fall Workshop is scheduled for Friday, October 3, 2008, at the Holiday Inn Select Airport in Indianapolis. The theme for 2008 is “Relapse & Relapse Prevention.” Keynote speakers are Michael Wilkerson, MD, and Jackie Fazeli, RN, LCSEW. Dr. Wilkerson is Medical Director of Hartford Health Services in Alabama. He has also worked as the Medical Director of Talbott Recovery Campus in Atlanta, GA, as well as the Medical Director of North Carolina’s Physician’s Health Program. Ms. Fazeli, who is the Healthcare Professional Advocate for Bradford Health Services, has provided several presentations (Continued on page 5)

2008 Legislative Review

by Ernest Klein, RN, CAE
Executive Director and Lobbyist

The second session of the 115th Indiana General Assembly adjourned before the midnight deadline on March 14, 2008. Although this was the “short” session, legislators tackled several significant proposals including property tax reform (passed) and illegal immigrants (didn’t pass).

HB 1172 Various Professions and Occupations

This large bill, authored by ISNA member Rep. Peggy Welch, RN, D-Bloomington, became increasingly larger during the session as it was amended several times. Language added was from SB 154 Select Joint Commission on Medicaid Oversight, SB 155 Study on Domestic Violence Prevention, HB 1720 Uniform Blood and SB 363 Uniform Emergency Health Practitioners Act.

Although the language for the Nurse Licensure Compact remains in the bill, we will have to wait to see if the National Compact Administrators (the unselected group of out-of-state individuals who regulate the Compact) will not permit Indiana to join. An amendment supported by the Attorney General to require investigations to remain confidential until charges are filed with the Board of Nursing (current law) remains in the bill. The Compact Administrators want investigations to be placed in the national data system. If Indiana is permitted to join the Compact, it will not be effective until at least July 1, 2009. ISNA will keep Indiana nurses informed re: Indiana’s participation in the Nurse Licensure Compact.

This bill also contains language that would permit the Indiana Professional Licensing Agency to use a larger percentage of the nurse license renewal fees to fund the Indiana State Nurses Assistance Program.

SB 302 Professional and Occupation Licensing

This Senate bill was another large bill to clean up and make language consistent among the various licenses administered by the Professional Licensing Agency. There are two issues that specifically impact nurses: (1) the provision that prohibits Advance Practice Nurses from entering into collaborative practice agreements with physician assistants and (2) one which adds APNs to the list of practitioners who are subject to sanctions if they repackauge and then sell free samples they received from the drug manufacturers.

HB 1125 Various Government Matters

Last session, the General Assembly adopted a two-year budget with appropriations for the Area Health Education Centers (AHEC). More than halfway through the fiscal year, the State had not released any of the funds. Many legislators were not pleased that the administration decided to withhold the funds. The approved conference committee report requires the Budget Agency to allot and otherwise take the steps necessary to make available the expenditure and distribution to area health education centers before May 2, 2008, at least 75 percent of the amount appropriated by P.L. 234-2007 for (Continued on page 9)
To look over the schedule is exhausting! We have Indiana nurses on a wide variety of committees. On the national level. Take the time to find out who is running in your area and what their positions are year to prepare you for activity for next year's session. Politics never go away!

The 2008 election cycle requires all of us to be vigilant over the next several months. In addition to positions to be filled in the state election, this year Indiana has gained considerable attention at the national level. Take the time to find out who is running in your area and what their positions are on nursing and health care issues. PLEASE VOTE!

ISNA also coordinates the participation of Indiana nurses on a wide variety of committees. To look over the schedule is exhausting! We have roles with the Indiana State Board of Nursing, the Medicaid Advisory Committee, the Indiana Workforce Development Coalition, the Indiana Association of Nursing Students, and more.

My email in-box holds correspondence on workplace violence (especially among nurses), safe staffing issues, guidelines for responding to emergencies or disasters, and the shortage of nursing staff and faculty. These are just a few of the fifty professional emails I receive each day. Occasionally our firewall diverts an email that I really need. If you email me and do not get a response, please email me again or leave a voice mail message. Technology is great when it works, but it can be a nightmare when it does not!

We fight some old battles over and over again. Last week I received a copy of a letter from ANA President Patton to Michael Leavitt, Secretary of Health and Human Services. He has appointed the study committee for the Healthy People Objectives for 2020 and failed to include a nurse (or nurses) on this committee. We are the largest health provider group and education is part of our daily practice regardless of setting or specialty. Yet amazingly, we are not invited to the decision making table.

Some issues are relatively new such as clarifying professional standards during times of national disasters or pandemics. This has become more urgent given the struggles of Hurricane Katrina and the threat of pandemic influenza. Some local communities did not immediately appoint a nurse to community task forces as they were developed. I need to end with a request for your support and your presence as a part of ISNA. We are doing great work on behalf of Indiana nurses, but we could be doing so much more with increased membership. Your skills and talents would strengthen the organization. We miss you. Sometimes we get tired. For each member of ISNA, there are 100 Indiana nurses who do not belong to the Association. Consider becoming a part of a great group. Your help will be greatly appreciated.

PRESIDENT’S MESSAGE (continued from page 1)

legislative sessions are more hectic than usual in short session years.

Mr. Klein also took the Legislative 101 program on the road again this year and provided a number of workshops for nurses across the state on how to monitor legislative issues and interact with legislators. Although it is timely to be able to discuss the bills being introduced during the session, Mr. Klein is more than willing to bring this workshop to your area nurses any time of the year to prepare you for activity for next year’s session. Politics never go away!

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APPLICATION FOR RN MEMBERSHIP

Or complete online at www.NursingWorld.org

Last Name, First Name, Middle Initial

Street or P.O. Box

County of Residence

City, State, Zip+4

1. SELECT PAY CATEGORY
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     Employed full or part time.
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     Monthly (EDPP)-$22.92.
   - Reduced Dues -- 50%
     Not employed; full-time student, or 62 years or older.
     Annual-$135.50,
     Monthly (EDPP)-$11.71.
   - Special Dues -- 25%
     62 years or older and not employed or permanently disabled.
     Annual $67.25.

2. SELECT PAYMENT TYPE
   - FULL PAY - CHECK
   - FULL PAY - BANKCARD

Card Number

VISA/Master Card Exp. Date

Signature for Bankcard Payment

3. SEND COMPLETED FORM AND PAYMENT TO:
   Customer and Member Billing
   American Nurses Association
   P.O. Box 17026
   Baltimore, MD 21207-0405

The Midwest Nursing Research Society (MNRS) held its 2008 conference in Indianapolis March 28-31. Three ISNA members were among the presenters:

- Janet Carpenter presented “Modeling the Hot Flash Experience in Breast Cancer Survivors.”
- “Serious Games as a Strategy for Health Promotion in Youth” was addressed by Anna McDaniel. Both are Indiana University School of Nursing researchers.
- IU School of Nursing Dean Marion E. Brosme, who is also editor of Nursing Outlook, the official journal of the American Academy of Nursing, presented in a special session entitled “Strategies for Becoming Effective Manuscript Peer Reviewers.” She was joined by three other editors of leading nursing journals.

Ruth Davidhizar, Dean of the School of Nursing at Bethel College in Mishawaka, Indiana, and Co-author, Dr. Joyce Newman Giger, Professor and Lulu Wolff Hassenpluf Endowed Chair at UCLA, have written a chapter entitled “Promoting Culturally-Appropriate Interventions Among Vulnerable Populations” in the 2007 Annual Review of Nursing Research. In addition, Dr. Davidhizar has authored a chapter entitled “Active Listening” in Evidence-Based Nursing Care Guidelines Medical-Surgical Interventions (2008) published by Mosby/Elsevier. She also authored “The Successful Nurse Scholar as Interdisciplinary Collaborator and Leader” in Nurse Author and Editor (Dec. 2007).
Two Nursing Students from Indiana Elected to National Office

Jenna Sanders and Grant Tyler, both students at the University of Saint Francis, Fort Wayne, Indiana, were elected to serve on the Board of Directors of the National Student Nurses’ Association (NSNA) for the 2008-09 term. The election occurred during NSNA’s 56th Annual Convention in Grapevine, TX, March 26-30.

Jenna Sanders is the new President of the National Student Nurses’ Association, having served as NSNA’s Vice-President for 2007-08. Grant Tyler was elected as a Director, and will chair the Membership Committee as well as serve on the Breakthrough to Nursing, Disaster Preparedness, and Image of Nursing Committees.

Indiana Student Nurses Hold Annual Meeting

More than 125 of Indiana’s most promising nursing students used the 2008 annual convention of the Indiana Association of Nursing Students (IANS) to continue to “chart their careers in nursing.” Held at the University Place Conference Center and Hotel on the IUPUI campus February 8-10, 2008, the IANS convention featured nationally known speakers who gave students new perspectives on their future nursing careers. The keynote address by Dr. Angela Barron McBride, former Dean of the Indiana University School of Nursing, encouraged students to intentionally plan their careers to allow for stages of growth and personal development. Students also heard from academic leaders, nursing professionals, and patient families about topics ranging from medication errors to charting to Alzheimer’s disease to graduate degrees in nursing. IANS members elected next year’s board at the convention. The officers are: President Christen Alexander, Vincennes University; Vice President Rauf Khalid, University of Indianapolis; Secretary Joy Faulkner, Ivy Tech Community College-Madison; and Treasurer Stacie Koole, Purdue University.

Social Networking Terminology

Not familiar with all the terminology around social networking? Here are just a few terms that will help you get started:

Online social network—An online web space that allows participants to connect with others within a community. For ANA this will be an ANANurseSpace, an online, password protected community for ANA members and nursing students, housed in ANA’s Members Only Section of www.NursingWorld.org.

Community—a group of participants, focused around specific interest or commonality. An example would be a Staff Nurse Community, Educator Community, Advanced Practice RN Community, Student Nurses Community.

Blog—A web log that is a series of entries by one or more authors, written in chronological order and displayed in reverse chronological order so that the most recent entry is at the top. Blogs can be formal, presenting resources, expert content, or informal, presenting stream of thought ideas, or anywhere in between.

Online ‘Discussions’—Read other people’s ideas, documents, invitations or blogs and comment on them by posting your own entries of any length, connected directly with the item that you are responding to. When reading discussions, you are able to see the initial idea and the responses from others, as well as comment yourself. This process allows multiple ideas to be presented.

Rate postings—This is a feature on the site that allows participants to rate the different content (blogs, documents, videos, discussions) posted on ANANurseSpace, from one star (you did not like it) to 5 stars (it is great material). The average of all ratings is visible to other participants.

Professional Profile—This is where you record information about you, where you work, your education, and what your interests are. This helps you find other nurses like yourself—by location, work experience, interests—that you can reach out to and connect with. It can also allow you to find friends from the past.

Content” on the left side menu in the Member Center. Log in and look for the ANANurseSpace button.

What if I know Nothing About Participating in Online Communities?

Do not worry! ANANurseSpace will have a tutorial for first time users and help information throughout the site. Look “First Time Users” or “tutorial for first time users” and help information for first time users and help information.

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The best way to learn is to get in and try it. There are no mistakes—you can get as much out of it as you wish and you choose if and when you participate.

How Will I know if Something Happens that I want to Participate in?

The site brings the info you want to your e-mail box, but only IF you want it. ANANurseSpace is set up so you can choose what you want to be notified about and when. Choose if you want notification sent to your e-mail about entries into discussions or communities you are participating in, and notification of messages from other participants. Choose to have notices sent to your e-mail immediately, daily or weekly.

This tool is for you—ANA hopes you find it a new asset in your complex personal and professional life as a nurses. Please come and join in!

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CONTROVERSIES & INNOVATIONS IN PERINATAL HEALTH: AN INDIANA PERINATAL NETWORK FORUM. March 19-20, 2008, Sheraton Indianapolis City Centre Hotel. Provider: Indiana Perinatal Network, 1991 East 56th Street, Indianapolis, IN 46220. Contact: Sarah Hundgen, 317/924-0825, Ext. 4222 or shundgen@indianaperinatal.org. Contact Hours: 9.5.


SAFE TRAVEL FOR ALL CHILDREN: TRANSPORTING CHILDREN WITH SPECIAL HEALTHCARE NEEDS. April 11-12, 2008, Legacy Emanuel Hospital, Portland, Oregon. Provider: Transporting and Emergency Services, Oregon Health & Science University, Children's Hospital for Children, 575 West Drive, Room 004, Indianapolis, IN 46202. Contact: Judith Talty, 317/274-2977 or jtalty@iuupui.edu. Contact Hours: 13.7.

ISCVPR 21ST ANNUAL MEETING AND CONFERENCE. April 9 & 10, 2008, Valleymont Resort, 1361 S McCracken Road, Greenwood, Indiana. Provider: Indiana Society of Cardiovascular & Pulmonary Rehabilitation, Porter Hospital, 814 LaPorte Avenue, Valparaiso, IN 46383. Contact: Susan Bauman, 219/263-4629 or susan.bauman@porterhealth.com. Contact hours: 8.5 [(2/preconference; 6.5/conference)]
Approved Providers

The ISNA Committee on Approval approves continuing nursing education providers to award nursing contact hours to the individual activities they develop and present. Any individual, institution, organization, or agency in Indiana responsible for the overall development, implementation, evaluation, and quality assurance of continuing nursing education is eligible to seek approval as a provider. Information must be submitted describing three different educational activities planned, presented, and approved by the ISNA Committee on Approval.

Indiana State Nurses Association in the two years preceding the application and should be representative of the types of educational activities usually provided. Applications are reviewed by the Committee on Approval at their biannual meetings in May and November. For information contact the ISNA office, e-mail cead@IndianaNurses.org, or visit the ISNA web site www.indiananurses.org/education. The following are continuing education providers approved by the ISNA Committee on Approval.

<table>
<thead>
<tr>
<th>Provider</th>
<th>Contact</th>
<th>Approved to</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bloomington Hosp &amp; Healthcare System P.O. Box 449 Bloomington, IN 47402-1149</td>
<td>Ronda Hendricks 812-353-5212 <a href="mailto:hendricks@bloomingtonhospital.org">hendricks@bloomingtonhospital.org</a></td>
<td>June ’10</td>
</tr>
<tr>
<td>Clarion Health Partners, Inc. P.O. Box 3367 Indianapolis, IN 46206</td>
<td>Sandra Pierry 317-962-4728 <a href="mailto:spierry@clarian.org">spierry@clarian.org</a></td>
<td>June ’10</td>
</tr>
<tr>
<td>Clarion North Medical Center 11700 N Meridian Street Carmel, IN 46032</td>
<td>Deborah A. Green 317-688-2470 <a href="mailto:dagreen@clarian.org">dagreen@clarian.org</a></td>
<td>Dec. ’09</td>
</tr>
<tr>
<td>Columbus Regional Hospital 2400 E 17th Street Columbus, IN 47201</td>
<td>Helen Carter 812-376-5651 <a href="mailto:hrcarter@cvh.org">hrcarter@cvh.org</a></td>
<td>June ’09</td>
</tr>
<tr>
<td>Community Health Network 1500 N Ritter Avenue Indianapolis, IN 46219</td>
<td>Romma Woodward 317-355-5059 <a href="mailto:tweedward@community.com">tweedward@community.com</a></td>
<td>June ’09</td>
</tr>
<tr>
<td>The Community Hospital 901 MacArthur Boulevard Munster, IN 46321</td>
<td>Colette Lewandowski 219-436-4504 <a href="mailto:clewandowski@comhs.org">clewandowski@comhs.org</a></td>
<td>Dec. ’09</td>
</tr>
<tr>
<td>Deaconess Hospital 600 Mary Street Evansville, IN 47747</td>
<td>Ellen Wathen 812-450-7249 <a href="mailto:Ellen_wathen@deaconess.com">Ellen_wathen@deaconess.com</a></td>
<td>Dec. ’10</td>
</tr>
<tr>
<td>EIHOB, Inc. 250 N Belmont Street Indianapolis, IN 46222</td>
<td>Christie Sprinkle 317-972-4600, Ext. 123 <a href="mailto:christie.sprinkle@ehob.com">christie.sprinkle@ehob.com</a></td>
<td>Dec. ’09</td>
</tr>
<tr>
<td>Good Samaritan Hospital 520 S 5th Street Vincennes, IN 47591</td>
<td>Judith A. Morgan 812-885-3333 <a href="mailto:jmorgan@ysvin.org">jmorgan@ysvin.org</a></td>
<td>June ’09</td>
</tr>
<tr>
<td>Health Care Education &amp; Training, Inc. 9640 N Augusta Drive #421 Carmel, IN 46032</td>
<td>Joyce Alley 817-247-9008 <a href="mailto:jballey@hcet.com">jballey@hcet.com</a></td>
<td>June ’09</td>
</tr>
<tr>
<td>Health Care Excel, Inc. 2902 Ohio Boulevard, Suite 112 P.O. Box 373 Terra Haute, IN 47803-0713</td>
<td>Terri Neaderhiser 812-234-1499, Ext. 302 <a href="mailto:tneaderhiser@inpqg.edps.org">tneaderhiser@inpqg.edps.org</a></td>
<td>June ’09</td>
</tr>
<tr>
<td>King’s Daughters’ Hosp &amp; Health Services One King’s Daughters’ Drive Madison, IN 47250</td>
<td>Kathleen Trader 812-205-0495 <a href="mailto:Traderk@kdhhs.org">Traderk@kdhhs.org</a></td>
<td>June ’10</td>
</tr>
<tr>
<td>LaPorte Regional Health System PO Box 250 LaPorte, IN 46352-0250</td>
<td>Janene R. Arnett 219-326-1234, Ext. 3130 <a href="mailto:larnett@laporte.org">larnett@laporte.org</a></td>
<td>Dec. ’09</td>
</tr>
<tr>
<td>Lutheran Health Network 7900 West Jefferson Boulevard Fort Wayne, IN 46804-4160</td>
<td>Jan Colone 260-435-7452 <a href="mailto:jcolone@lutheran-hosp.com">jcolone@lutheran-hosp.com</a></td>
<td>June ’10</td>
</tr>
<tr>
<td>Major Hospital 150 W Washington Street Shelbyville, IN 46176</td>
<td>Lisa Reboulet 317-308-5281 <a href="mailto:lrebo@majorhospital.com">lrebo@majorhospital.com</a></td>
<td>June ’10</td>
</tr>
<tr>
<td>MCV &amp; Associates Healthcare Inc. P.O. Box 68194 Indianapolis, IN 46268</td>
<td>Cora Vizcarra 317-872-7786 <a href="mailto:Consultmcv@mcvassociates.com">Consultmcv@mcvassociates.com</a></td>
<td>Dec. ’09</td>
</tr>
<tr>
<td>Memorial Hospital &amp; Health Care Center 805 W 9th Street Jasper, IN 47546</td>
<td>Kelly Hartwick 812-481-8502 <a href="mailto:khartwick@mhbc.org">khartwick@mhbc.org</a></td>
<td>Dec. ’10</td>
</tr>
<tr>
<td>Memorial Hospital of South Bend 615 N Michigan Street South Bend, IN 46601</td>
<td>Diane Parmelee 574-284-7179 <a href="mailto:dparmelee@memorialab.org">dparmelee@memorialab.org</a></td>
<td>Dec. ’09</td>
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National HealthCare Innovations 333 East First Street Warren, IN 46792 | Carol White 260-375-4253 carol.white@nationalhi.com | June ’08 |
| Parkview Health System 2200 Randallia Drive Fort Wayne, IN 46805 | Debra Stam 260-373-7051 deb.stam@parkview.com | June ’09 |
| Porter 814 LaPorte Avenue Valparaiso, IN 46383 | Carol Walker 219-203-4714 carol.walker@porterhealth.org | June ’09 |
| Purdue University Continuing Nursing Education 562 N University Street West Lafayette, IN 47907-2069 | Patricia Coyle-Rogers 765-494-4030 percg@purdue.edu | Dec. ’10 |
| Reid Hospital & Health Care Services 1401 Chester Boulevard Richmond, IN 47374 | Karen Everett 765-983-3094 keverett@reidhealth.com | June ’08 |
| R.L. Roudebush VA Medical Center 1481 W 10th Street Indianapolis, IN 46202 | Janet Lutz 317-988-4243 janet.lutz@med.va.gov | Dec. ’10 |
| St. Francis Hospital & Health Centers 1600 Albany Street Beech Grove, IN 46107 | Kathy Fox 765-544-8312 Kathy fox@sfsa.org | June ’08 |
| St. Joseph Regional Medical Center 801 E LaSalle Street South Bend, IN 46617 | Joanne Weaver 574-237-7643 weaverj@srmc.com | Dec. ’09 |
| St. Margaret Mercy 5454 Hoffman Avenue Hammond, IN 46320 | Mary Ann Adamson 219-932-2300, Ext. 34549 Mary ann.Adamson@stfrhs.org | June ’09 |
| St. Mary’s Medical Center 3700 Washington Avenue Evansville, IN 47750 | Sue Miller 812-481-4852 smiller@stmarys.org | June ’09 |
| St. Vincent Hospital & Health Care 2001 W 86th Street Indianapolis, IN 46240 | Wianda K. Powell 317-338-6820 wpowellstvincent.org | Dec. ’10 |
| Schneider Medical Center 411 West Tipton Street Seymour, IN 47274 | Karen Weskey 812-524-3342 kweskey@schnecksmed.org | June ’09 |
| Scott Memorial Hospital 1451 N Gardner Street Scottsburg, IN 47150 | Shannon Carroll 812-752-8572 Shannon carroll@bsmh.org | June ’09 |
| University of Southern Indiana College of Nursing & Health Professions 8600 University Boulevard Evansville, IN 47712 | Margaret A. (Peggy) Graul 812-465-1161 pgraul@usi.edu | Dec. ’10 |
| Valparaiso University College of Nursing LaBien Hall Valparaiso, IN 46383 | Julie A. Koch 219-464-5281 jkoch@valpo.edu | Dec. ’09 |
| VA Northern Indiana Health Care System 1700 E 38th Street Marion, IN 46953 | Laura A. Johnson 765-674-3321, Ext. 3513 laura.johnson@med.va.gov | Dec. ’09 |
| Wishard Health Services 1001 W 10th Street Indianapolis, IN 46202 | Norma Wallman 317-630-7536 norma.wallman@wishard.edu | Dec. ’09

(Continued on page 7)
## Indiana Nurses Calendar

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<thead>
<tr>
<th>Date/Time</th>
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<th>Contact Information</th>
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<tbody>
<tr>
<td><strong>Open Enrollment</strong></td>
<td><strong>RN Refresher Course</strong></td>
<td>Ariane Smith 317/921-4988 1/800/712-1470, prox 2 for staff, ext 4988 <a href="mailto:gsmith608@ivytech.edu">gsmith608@ivytech.edu</a></td>
</tr>
<tr>
<td><strong>Open Enrollment</strong></td>
<td><strong>“Being a Preceptor in a Healthcare Facility”</strong></td>
<td>Website: <a href="http://nursing.iupui.edu/LifelongLearning">http://nursing.iupui.edu/LifelongLearning</a>. Contact information: Office of Lifelong Learning, Indiana University School of Nursing, 1111 Middle Drive—NU 345, Indianapolis, IN 46202, by phone: (317) 274.7779, by fax: (317) 274.0012 or by email: <a href="mailto:censg@iupui.edu">censg@iupui.edu</a></td>
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<tr>
<td><strong>Open Enrollment</strong></td>
<td><strong>“Being a Preceptor in a School of Nursing”</strong></td>
<td>Website: <a href="http://nursing.iupui.edu/LifelongLearning">http://nursing.iupui.edu/LifelongLearning</a>. Contact information: Office of Lifelong Learning, Indiana University School of Nursing, 1111 Middle Drive NU 345, Indianapolis, IN 46202, by phone: (317) 274.7779, by fax: (317) 274.0012 or by email: <a href="mailto:censg@iupui.edu">censg@iupui.edu</a></td>
</tr>
<tr>
<td><strong>May 6-12, 2008</strong></td>
<td><strong>Nurses Week</strong></td>
<td><a href="http://www.NursingWorld.org">www.NursingWorld.org</a></td>
</tr>
<tr>
<td><strong>May 7, 2008</strong></td>
<td><strong>Qualified Medication Aide (QMA) Instructor Education</strong></td>
<td>Website: <a href="http://nursing.iupui.edu/LifelongLearning">http://nursing.iupui.edu/LifelongLearning</a>. Contact information: Office of Lifelong Learning, Indiana University School of Nursing, 1111 Middle Drive—NU 345, Indianapolis, IN 46202, by phone: (317) 274.7779, by fax: (317) 274.0012 or by email: <a href="mailto:censg@iupui.edu">censg@iupui.edu</a></td>
</tr>
<tr>
<td><strong>May 7-July 11, 2008</strong></td>
<td><strong>“Adult Critical Care” Critical Care Nursing</strong></td>
<td>Website: <a href="http://nursing.iupui.edu/LifelongLearning">http://nursing.iupui.edu/LifelongLearning</a>. Contact information: Office of Lifelong Learning, Indiana University School of Nursing, 1111 Middle Drive—NU 345, Indianapolis, IN 46202, by phone: (317) 274.7779, by fax: (317) 274.0012 or by email: <a href="mailto:censg@iupui.edu">censg@iupui.edu</a></td>
</tr>
<tr>
<td><strong>May 7-July 11, 2008</strong></td>
<td><strong>“Neonatal Intensive Care” Critical Care Nursing</strong></td>
<td>Website: <a href="http://nursing.iupui.edu/LifelongLearning">http://nursing.iupui.edu/LifelongLearning</a>. Contact information: Office of Lifelong Learning, Indiana University School of Nursing, 1111 Middle Drive—NU 345, Indianapolis, IN 46202, by phone: (317) 274.7779, by fax: (317) 274.0012 or by email: <a href="mailto:censg@iupui.edu">censg@iupui.edu</a></td>
</tr>
<tr>
<td><strong>May 7-July 11, 2008</strong></td>
<td><strong>“Pediatric Intensive Care” Critical Care Nursing</strong></td>
<td>Website: <a href="http://nursing.iupui.edu/LifelongLearning">http://nursing.iupui.edu/LifelongLearning</a>. Contact information: Office of Lifelong Learning, Indiana University School of Nursing, 1111 Middle Drive—NU 345, Indianapolis, IN 46202, by phone: (317) 274.7779, by fax: (317) 274.0012 or by email: <a href="mailto:censg@iupui.edu">censg@iupui.edu</a></td>
</tr>
<tr>
<td><strong>May 9, 2008</strong></td>
<td><strong>ISNA Committee on Approval of Continuing Nursing Education</strong></td>
<td>317/299-4575 or email <a href="mailto:ce@IndianaNurses.org">ce@IndianaNurses.org</a></td>
</tr>
<tr>
<td><strong>May 15, 2008</strong></td>
<td><strong>Indiana State Board of Nursing</strong></td>
<td>317/234-2043 or <a href="http://www.pla.in.gov">www.pla.in.gov</a></td>
</tr>
<tr>
<td><strong>May 16, 2008</strong></td>
<td><strong>Nursing 2000 Eighteenth Annual Scholarship Benefit</strong></td>
<td>Reservations: $75/person or $110/patron; $40/first degree students; Call: 317/574-1325 or email <a href="mailto:info@nursing2000inc.org">info@nursing2000inc.org</a></td>
</tr>
<tr>
<td><strong>June 2-8, 2008</strong></td>
<td><strong>“Getting Started: an Introduction to Choosing and Using Web Course Management Software” Teaching and Learning in Web-based Courses: A Web-base Professional Certificate Program</strong></td>
<td>Website: <a href="http://nursing.iupui.edu/LifelongLearning">http://nursing.iupui.edu/LifelongLearning</a>. Contact information: Office of Lifelong Learning, Indiana University School of Nursing, 1111 Middle Drive—NU 345, Indianapolis, IN 46002, by phone: (317) 274.7779, by fax: (317) 274.0012 or by email: <a href="mailto:censg@iupui.edu">censg@iupui.edu</a></td>
</tr>
<tr>
<td><strong>June 6, 2008</strong></td>
<td><strong>ISNA Board of Directors/ISNA Delegates to ANA</strong></td>
<td>317/299-4575 or email <a href="mailto:info@IndianaNurses.org">info@IndianaNurses.org</a></td>
</tr>
<tr>
<td><strong>June 16-23, 2008</strong></td>
<td><strong>“Designing Web Pages for Web Course” Teaching and Learning in Web-based Courses: A Web-base Professional Certificate Program</strong></td>
<td>Website: <a href="http://nursing.iupui.edu/LifelongLearning">http://nursing.iupui.edu/LifelongLearning</a>. Contact information: Office of Lifelong Learning, Indiana University School of Nursing, 1111 Middle Drive—NU 345, Indianapolis, IN 46202, by phone: (317) 274.7779, by fax: (317) 274.0012 or by email: <a href="mailto:censg@iupui.edu">censg@iupui.edu</a></td>
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</tbody>
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(Continued on page 8)
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<thead>
<tr>
<th>Date/Time</th>
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<th>Contact Information</th>
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<tbody>
<tr>
<td>June 19, 2008</td>
<td>Indiana State Board of Nursing</td>
<td>317/234-2043 or <a href="http://www.pla.in.gov">www.pla.in.gov</a></td>
</tr>
<tr>
<td>8:30 am</td>
<td>Conference Center Auditorium</td>
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<td></td>
<td>Conference Center Auditorium</td>
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<tr>
<td></td>
<td>302 West Washington Street, Indianapolis</td>
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<tr>
<td>June 22-23, 2008</td>
<td>Center for American Nurses Membership Council</td>
<td><a href="http://www.centerforamericanurses.org">www.centerforamericanurses.org</a></td>
</tr>
<tr>
<td></td>
<td>Washington Hilton, Washington DC</td>
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<tr>
<td>June 23-24, 2008</td>
<td>Center for American Nurses LEAD Summit</td>
<td><a href="http://www.nursingworld.org">www.nursingworld.org</a>; 317/299-4575</td>
</tr>
<tr>
<td></td>
<td>Washington Hilton, Washington, DC</td>
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<td></td>
<td>Washington, DC</td>
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<tr>
<td>June 27, 2008</td>
<td>Igniting Our Strengths: An Affirmative Approach to</td>
<td>Julie Sears, 317-745-3505 or <a href="mailto:jksears@hendricks.org">jksears@hendricks.org</a></td>
</tr>
<tr>
<td></td>
<td>Creating Environments of Excellence</td>
<td>Nursing 2000, 317-574-1325 or <a href="mailto:info@Nursing2000inc.org">info@Nursing2000inc.org</a></td>
</tr>
<tr>
<td>8 am-3:30 pm</td>
<td>The Martin Hotel &amp; Lilly Conference Center, 1901 W</td>
<td></td>
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<tr>
<td></td>
<td>8th Street, Indianapolis</td>
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<tr>
<td></td>
<td>Application has been submitted to ISNA for approval of</td>
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<tr>
<td></td>
<td>5.0 contact hours</td>
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<tr>
<td>July 7-13, 2008</td>
<td>“Teaching and Evaluation in Web-based Courses”</td>
<td>Website: <a href="http://nursing.iupui.edu/Lifelong">http://nursing.iupui.edu/Lifelong</a> Learning</td>
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<tr>
<td></td>
<td>A Web-based Professional Certificate Program</td>
<td>Contact information: Office of Lifelong Learning, Indiana</td>
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<tr>
<td></td>
<td></td>
<td>University School of Nursing, 1111 Middle Drive—NU 345,</td>
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<tr>
<td></td>
<td></td>
<td>Indianapolis, IN 46202, by phone: (317) 274.7779, by</td>
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<td></td>
<td></td>
<td>fax: (317) 274.0012 or by email: <a href="mailto:censg@iupui.edu">censg@iupui.edu</a></td>
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<tr>
<td>July 17, 2008</td>
<td>Indiana State Board of Nursing</td>
<td>317/234-2043 or <a href="http://www.pla.in.gov">www.pla.in.gov</a></td>
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<tr>
<td>8:30 am</td>
<td>Conference Center Auditorium</td>
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<td>Conference Center Auditorium</td>
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<tr>
<td></td>
<td>302 West Washington Street, Indianapolis</td>
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<tr>
<td>August 11-19, 2008</td>
<td>“Clinical Faculty: A New Practice Role”</td>
<td>Website: <a href="http://nursing.iupui.edu/Lifelong">http://nursing.iupui.edu/Lifelong</a> Learning</td>
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<tr>
<td></td>
<td>— IUPUI Web Based Course</td>
<td>Contact information: Office of Lifelong Learning, Indiana</td>
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<tr>
<td></td>
<td></td>
<td>University School of Nursing, 1111 Middle Drive—NU 345,</td>
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<td>Indianapolis, IN 46202, by phone: (317) 274.7779, by</td>
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<td></td>
<td></td>
<td>fax: (317) 274.0012 or by email: <a href="mailto:censg@iupui.edu">censg@iupui.edu</a></td>
</tr>
<tr>
<td>August 15-16, 2008</td>
<td>Med-Surg Nursing Systems Review</td>
<td>Contact: <a href="mailto:Karen.gregg@sfhs.org">Karen.gregg@sfhs.org</a></td>
</tr>
<tr>
<td></td>
<td>Review for nurses taking the Med-Surg Certification</td>
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<tr>
<td></td>
<td>Exam</td>
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<td></td>
<td>St. Francis Hospital, Beech Grove, Indiana</td>
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<td></td>
<td>Sponsored by Central Indiana Chapter, Academy of</td>
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<tr>
<td></td>
<td>Medical-Surgical Nurses</td>
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<tr>
<td>August 20-21, 2008</td>
<td>“Adult Critical Care”</td>
<td>Website: <a href="http://nursing.iupui.edu/Lifelong">http://nursing.iupui.edu/Lifelong</a> Learning</td>
</tr>
<tr>
<td></td>
<td>Critical Care Nursing: IUPUI Web-Based Course</td>
<td>Contact information: Office of Lifelong Learning, Indiana</td>
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<tr>
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<td></td>
<td>University School of Nursing, 1111 Middle Drive—NU 345,</td>
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<td></td>
<td>Indianapolis, IN 46202, by phone: (317) 274.7779, by</td>
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<td></td>
<td></td>
<td>fax: (317) 274.0012 or by email: <a href="mailto:censg@iupui.edu">censg@iupui.edu</a></td>
</tr>
<tr>
<td>August 28-29, 2008</td>
<td>“Pediatric Intensive Care”</td>
<td>Website: <a href="http://nursing.iupui.edu/Lifelong">http://nursing.iupui.edu/Lifelong</a> Learning</td>
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<tr>
<td></td>
<td>Critical Care Nursing: IUPUI Web-Based Course</td>
<td>Contact information: Office of Lifelong Learning, Indiana</td>
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<td></td>
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<td>University School of Nursing, 1111 Middle Drive—NU 345,</td>
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<td>Indianapolis, IN 46202, by phone: (317) 274.7779, by</td>
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<td></td>
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<td>fax: (317) 274.0012 or by email: <a href="mailto:censg@iupui.edu">censg@iupui.edu</a></td>
</tr>
<tr>
<td>August 20-21, 2008</td>
<td>“Clinical Information Systems”</td>
<td>Website: <a href="http://nursing.iupui.edu/Lifelong">http://nursing.iupui.edu/Lifelong</a> Learning</td>
</tr>
<tr>
<td></td>
<td>Nursing Informatics: A Web-based Professional</td>
<td>Contact information: Office of Lifelong Learning, Indiana</td>
</tr>
<tr>
<td></td>
<td>Certificate Program</td>
<td>University School of Nursing, 1111 Middle Drive—NU 345,</td>
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<tr>
<td></td>
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<td>Indianapolis, IN 46202, by phone: (317) 274.7779, by</td>
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<td>fax: (317) 274.0012 or by email: <a href="mailto:censg@iupui.edu">censg@iupui.edu</a></td>
</tr>
<tr>
<td>August 22-23, 2008</td>
<td>“Clinical Information Systems”</td>
<td>Website: <a href="http://nursing.iupui.edu/Lifelong">http://nursing.iupui.edu/Lifelong</a> Learning</td>
</tr>
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<td></td>
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<td>Certificate Program</td>
<td>University School of Nursing, 1111 Middle Drive—NU 345,</td>
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<td>Indianapolis, IN 46202, by phone: (317) 274.7779, by</td>
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<td>fax: (317) 274.0012 or by email: <a href="mailto:censg@iupui.edu">censg@iupui.edu</a></td>
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<tr>
<td>August 21, 2008</td>
<td>Indiana State Board of Nursing</td>
<td>317/234-2043 or <a href="http://www.pla.in.gov">www.pla.in.gov</a></td>
</tr>
<tr>
<td>8:30 am</td>
<td>Conference Center Auditorium</td>
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<td>Conference Center Auditorium</td>
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<tr>
<td></td>
<td>302 West Washington Street, Indianapolis</td>
<td></td>
</tr>
<tr>
<td>August 22, 2008</td>
<td>ISNA Board of Directors</td>
<td>317/299-4575 or email <a href="mailto:info@IndianaNurses.org">info@IndianaNurses.org</a></td>
</tr>
</tbody>
</table>
**INDIANA NURSES CALENDAR**  
(continued from page 8)

<table>
<thead>
<tr>
<th>Date/Time</th>
<th>Event/Location</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>September 8-14, 2008</td>
<td>“Getting Started: an Introduction to Choosing and Using Web Course Management Software” Teaching and Learning in Web-based Courses: A Web-based Professional Certificate Program</td>
<td>Website: <a href="http://nursing.iupui.edu/LifelongLearning">http://nursing.iupui.edu/LifelongLearning</a> Contact Information: Office of Lifelong Learning, Indiana University School of Nursing, 1111 Middle Drive—NU 345, Indianapolis, IN 46202, by phone: (317) 274-7779, by fax: (317) 274-0012 or by email: <a href="mailto:cenug@iupui.edu">cenug@iupui.edu</a></td>
</tr>
<tr>
<td>September 18, 2008</td>
<td>Indiana State Board of Nursing</td>
<td>317/234-2043 or <a href="http://www.pla.in.gov">www.pla.in.gov</a></td>
</tr>
<tr>
<td>September 22-29, 2008</td>
<td>“Designing Web Pages for Web Course” Teaching and Learning in Web-based Courses: A Web-based Professional Certificate Program</td>
<td>Website: <a href="http://nursing.iupui.edu/LifelongLearning">http://nursing.iupui.edu/LifelongLearning</a> Contact Information: Office of Lifelong Learning, Indiana University School of Nursing, 1111 Middle Drive—NU 345, Indianapolis, IN 46202, by phone: (317) 274-7779, by fax: (317) 274-0012 or by email: <a href="mailto:cenug@iupui.edu">cenug@iupui.edu</a></td>
</tr>
<tr>
<td>September 29-30, 2008</td>
<td>Fall Conference, Indiana Association of School Nurses Adams Mark Hotel, Indianapolis</td>
<td>Contact: <a href="mailto:benwyler842@shglobal.net">benwyler842@shglobal.net</a></td>
</tr>
<tr>
<td>October 3, 2008</td>
<td>ISNA/ISNP Fall Workshop Holiday Inn Select at the Indianapolis Airport</td>
<td><a href="http://www.indiananurses.org">www.indiananurses.org</a> 317/299-4575</td>
</tr>
<tr>
<td>October 3, 2008</td>
<td>ISNA Board of Directors Holiday Inn Select at the Indianapolis Airport</td>
<td>317/299-4575 or email <a href="mailto:info@indiananurses.org">info@indiananurses.org</a></td>
</tr>
<tr>
<td>October 4, 2008</td>
<td>ISNA 2008 Meeting of the Members Holiday Inn Select at the Indianapolis Airport</td>
<td><a href="http://www.indiananurses.org">www.indiananurses.org</a> 317/299-4575</td>
</tr>
<tr>
<td>October 6-12, 2008</td>
<td>“Teaching and Evaluation in Web-based Courses” A Web-based Professional Certificate Program</td>
<td>Website: <a href="http://nursing.iupui.edu/LifelongLearning">http://nursing.iupui.edu/LifelongLearning</a> Contact Information: Office of Lifelong Learning, Indiana University School of Nursing, 1111 Middle Drive—NU 345, Indianapolis, IN 46202, by phone: (317) 274-7779, by fax: (317) 274-0012 or by email: <a href="mailto:cenug@iupui.edu">cenug@iupui.edu</a></td>
</tr>
<tr>
<td>October 13-21, 2008</td>
<td>“Clinical Faculty: A New Practice Role” IUPUI Web Based Course</td>
<td>Website: <a href="http://nursing.iupui.edu/LifelongLearning">http://nursing.iupui.edu/LifelongLearning</a> Contact Information: Office of Lifelong Learning, Indiana University School of Nursing, 1111 Middle Drive—NU 345, Indianapolis, IN 46202, by phone: (317) 274-7779, by fax: (317) 274-0012 or by email: <a href="mailto:cenug@iupui.edu">cenug@iupui.edu</a></td>
</tr>
<tr>
<td>October 22, 2008</td>
<td>3rd Annual Critical Link Nursing Symposium University of Notre Dame, South Bend, Indiana</td>
<td>Registration includes continental breakfast and full lunch Contact Carol Whiteman at 574/647-3479 or <a href="mailto:cwhiteman@memorialhs.org">cwhiteman@memorialhs.org</a></td>
</tr>
</tbody>
</table>

Raise your organization’s visibility by having its nursing events posted to the Indiana Nurses Calendar and provide for nurses, this calendar appears in the quarterly ISNA Bulletin and is updated regularly on ISNA’s web site at www.indiananurses.org/events/calendar.htm. The ISNA Bulletin reaches over 100,000 RNs, LPNs and nursing students in Indiana. The web site receives more than 6,000 unique visitors each month.

For $15 per event your information will be posted on the ISNA web site and in the ISNA Bulletin. Your organization’s events will appear in each edition of the Bulletin prior to the activity and are immediately posted to the web calendar. Contact ISNA for information by calling 317/299-4575 or via E-mail ce@indiananurses.org to have your events listed or for more information. The next copy deadline is June 15 for the August/September/October issue of the ISNA Bulletin.

(Continued from page 10)

area health education centers for the state fiscal year beginning July 1, 2007, and ending June 30, 2008.

**2008 Elections**

Finally, if you hadn’t noticed, 2008 is an election year. You may know about the Presidential candidates, but don’t all 100 legislators in House seats and 25 of the 50 Senate seats are up for election. Even before the primary in May, we know that it will be a different General Assembly as more than 10 percent of the current legislators have indicated they will not be returning.

They include:

**Senate**

District 2 Samuel Smith, Jr., D-East Chicago
District 12 Marvin Riegshecker, R-Goshen
District 18 Thomas Weatherwax, R-Logansport
District 19 vacant due to the death of David Ford, Hartford City
District 21 Jeff Drozd, Westfield, will be moving to South Carolina this summer
District 33 Glenn Howard, D-Indianapolis
District 44 Robert Jackman, R-Milroy

**House of Representatives**

District 16 Eric Gutwein, R-Rensselaer
District 26 Joe Micon, D-Lafayette
District 63 Dave Crooks, D-Washington
District 77 G. Philip Hoy, D-Evansville
District 79 Michael Ripley, R-Monroe
District 86 David Orentlicher, D-Indianapolis
District 89 Lawrence Buell, R-Indianapolis
District 94 Carolene Mays, D-Indianapolis
District 97 Jon Elrod, R-Indianapolis

Note that Representatives Orentlicher and Mays are both Democratic candidates in the May Primary for the Congressional House District 7 seat currently held by Rep. Andre Carson. Rep. Elrod will likely be the Republican challenger for that seat in the November election.

So what does this all mean for nurses and nursing?

■ It means that you must register to vote.
■ You must find out who the candidates are and what they believe in.
■ When you find a candidate that you can support — do it!
■ Write their campaign a check, stuff envelopes, make phone calls, or walk door-to-door with them. Get to know them.
■ Let them know what matters to you as a citizen, a parent, a property owner and, yes, as a nurse.
■ And last, but certainly not least—not vote!

Thanks to ISNA’s year-round government affairs team which helps us watch out for the interests of nurses and nursing: SDS Group, Doug Simmons, President; Glenna Shelby, Vice President; and Ron Breymer for their daily presence and assistance at the State House.

**2008 Selected House Bills**

NOTE: The changes made in conference committee are indicated in bold type.

HB1140 Coverage for orthotic and prosthetic devices. (Murphy, Dilullo)
Requires certain coverage for medically necessary orthotic and prosthetic devices under a state employee health plan, a policy of accident and sickness insurance, and a health maintenance organization contract. (The conference committee report: (1) amends the definition of “orthotic device” to provide that required coverage for orthotic and prosthetic devices applies when certain persons provide the device or perform repair or replacement; (2) removes the same coverage and reimbursement for orthotic and prosthetic devices as the coverage and reimbursement under Medicare, but specifies that the applicable deductibles are not required to be equal to Medicare deductibles; (4) specifies that a prosthetic device and orthotic device lifetime maximum coverage limitation must not be included in and must be equal to the lifetime maximum coverage limitation that applies to other items and services generally under the

(Continued on page 10)
null
SB0164 Medicaid claim payments. (Miller)
Specifies that the office of Medicaid policy and planning (office), a managed care organization that contracts with the managed care organization must meet certain requirements concerning part of a person's executed sentence, that the person refrain from contact with a particular individual. Makes it a Class A misdemeanor to fail to provide or cause to be provided a copy of the commission that, except in case of willful misconduct, gross negligence, or other cold storage space, or allow the employee to express the employee's breast milk in privacy; and (3) must provide for reasonable paid breaks for an employee or other cold storage for keeping breast milk that has been expressed. Provides that other employers that, except in willful misconduct, gross negligence, or bad faith, an employer is not liable for any harm caused or arising from: (1) the encryption of an employee's milk; or (2) the storage of breast milk; on the employer's premises.
02/27/2008 Signed by the Governor
SB0219 Lactation support in the workplace. (Simpson)
Requires employers to provide a place for an employee to express breast milk for the employee's infant child; (2) must make reasonable efforts to provide a room or other location in close proximity to the workplace that, except in case of willful misconduct, gross negligence, or other cold storage space, or allow the employee to provide the employee's own portable storage device, for keeping the expressed milk until the end of the employee's work day. Provides that, except in willful misconduct, gross negligence, or bad faith, an employer is not liable for any harm caused or arising from: (1) the encryption of an employee's breast milk; or (2) the storage of expressed milk; on the employer's premises.
02/27/2008 Signed by the Governor
SB0227 Domestic violence issues and invasion of privacy. (Becker)
Removes the "sexual assault standards and certification board" as the "sexual assault victims advocate standards and certification board" and moves control of the board to the criminal justice institute from the department of workforce development. Moves the sexual assault victims assistance account and all balances and encumbrances to the criminal justice institute from the department of workforce development. Removes the executive director of the commission for appointment from membership on the commission and adds representatives of the office of family and social services and state department of health as ex-officio members. Provides that victim advocates and victim service providers may not give testimony, produce records, or disclose certain confidential communications and confidential information without the victim's consent. Provides that a victim may not be forced to consent to the disclosure of confidential information in order to receive services. Requires a victim to be notified if confidential information is disclosed. Makes certain information obtained as part of an application for certain gaming licenses confidential. Allows a court: (1) to prohibit a defendant who has not been released from lawful detention from contacting a particular individual; and (2) to require, as a part of a person's executed sentence, that the person refrain from contact with a particular individual. Makes it a Class A misdemeanor to fail to provide or cause to be provided a copy of the commission that, except in case of willful misconduct, gross negligence, or other cold storage space, or allow the employee to provide the employee's own portable storage device, for keeping the expressed milk until the end of the employee's work day. Provides that, except in willful misconduct, gross negligence, or bad faith, an employer is not liable for any harm caused or arising from: (1) the encryption of an employee's breast milk; or (2) the storage of expressed milk; on the employer's premises.
03/24/2008 Signed by the Governor
SB0249 Emergency medical services commission. (Wyss, Broden)
Requires the emergency medical services commission to establish: (1) a screening and counseling program for the transportation of trauma patients.
03/03/2008 Signed by the Governor
SB302 Professional and occupational licensing. (Mishler)
Allows members of certain licensing boards to participate in emergency meetings to suspend the licenses of practitioners who represent a danger to public health and safety, if a means of communication is used that allows all board members and the public to simultaneously communicate with each other. Allows the state boxing commission members who participate in meetings to consider final approval of a permit for a particular boxing or sparring match or exhibition, if a means of communication is used that allows all commission members and the public to simultaneously communicate with each other. Makes changes in the procedures for renewal of expired certificates and licenses, and provides that the professional licensing agency is to set the times for license renewals for: (1) acupuncturists; (2) architects; (3) landscape architects; (4) athletic trainers; (5) auctioneers; (6) auction houses; (7) auctioneers; (8) animal breeders; (9) animal dealers; (10) home inspectors; (11) nurses; (12) home health facility administrators; (13) home health practitioners; (14) chiropractors; (15) dental hygienists; (16) dietitians; (17) embalmers, funeral directors, and funeral homes; (18) health facility administrators; (19) home inspectors; (20) hypnotists; (21) land surveyors; (22) physicians; (23) nurses; (24) manufactured home installers; (25) optometrists; (26) pharmacists, pharmacies, drug stores, and home medical equipment service providers; (27) plumbers; (28) private investigators; (29) physicians; (30) professional engineers; (31) environmental health specialists; (32) psychologists; (33) real estate brokers and sales persons; and (34) speech and language pathologists and audiologists. Makes changes to the qualifications for licensing of out-of-state architects, accountants; (27) pharmacists; (28) private investigators; (29) physicians; (30) professional engineers; (31) environmental health specialists; (32) psychologists; (33) real estate brokers and sales persons; and (34) speech and language pathologists and audiologists. Makes changes to the qualifications for approval for a particular individual. Makes it a Class A misdemeanor to fail to provide or cause to be provided a copy of the commission that, except in case of willful misconduct, gross negligence, or other cold storage space, or allow the employee to provide the employee's own portable storage device, for keeping the expressed milk until the end of the employee's work day. Provides that, except in willful misconduct, gross negligence, or bad faith, an employer is not liable for any harm caused or arising from: (1) the encryption of an employee's breast milk; or (2) the storage of expressed milk; on the employer's premises.
03/24/2008 Signed by the Governor
SB305 Controlling substances. (Steele)
Provides that a person who has made certain asset transfers is not eligible for residential care assistance. Requires the adoption of rules to implement: (1) a screening and counseling program for individuals seeking long term care services; (2) a process of prior approval for certain individuals seeking admission to a nursing facility; and (3) the annual review of Medicaid rates. Prohibits the state department of health from approving the certification of new or converted comprehensive care beds for participation in the Medicaid program until July 1, 2011, unless the state comprehensive care bed occupancy rate is more than 95% in health facilities. Allows for an exception for replacement beds and continuing care retirement communities under development if specified requirements are met. Makes conforming and technical changes. (The conference committee report does: (1) removes language that transferred the adult guardianship of the individual.
Chemical dependency is a primary, chronic, and progressive disease. If left untreated, addiction can be fatal. Successful rehabilitation is possible, however, with appropriate treatment and support. It is a nurse’s ethical and legal responsibility to help identify impaired colleagues. Detection and treatment protect the rights of the patient, the impaired nurse, and the employer, creating a safer work environment for the patients and the staff.

The Indiana State Nurses Assistance Program (ISNAP) supports nurses in a confidential and non-punitive rehabilitation program. A nurse who meets criteria for ISNAP enters into a recovery monitoring agreement. This individualized plan may include worksite monitoring, limitations on the individual’s nursing practice, substance abuse treatment, AA/NA involvement, and random drug screens. The success rate for people completing treatment as effective as treatments for other chronic health conditions such as diabetes, hypertension, and asthma.

For more information, visit the ISNAP link at www.indiananurse.org, or call 1-800-638-6623 (317-295-9862) to speak to a representative. ISNAP representatives are also available for on-site continuing education seminars.

The Indiana Organization of Nurse Executives (IONE) recently renewed as an Organizational Affiliate of the Indiana State Nurses Association. The Indiana Association of School Nurses is also an ISNAP affiliate organization. ISNAP Organizational Affiliates have voice but no vote at the ISNA annual Meeting of the Members. They are entitled to other ISNA member benefits such as reduced registration fees for ISNA sponsored events and they may make reports and/or recommendations to the ISNA Board of Directors and the annual Meeting of the Members. Affiliate Organizations are also entitled to space in the quarterly ISNA Bulletin.

An ISNA Organizational Affiliate may not be a labor organization but must be an organization comprised of a majority of registered nurses with a governing body composed of a majority of registered nurses. The organization must also have an agreed-upon mission and purpose consistent with the purposes and functions of the Indiana State Nurses Association. ISNA Organizational Affiliates pay a yearly fee based on the number of members of the organization. The current IONE President is Linda Webb, Chief Nurse Executive, Pulaski Memorial Hospital, Winamac.

ISNA ANNOUNCES UPCOMING EVENTS

The Indiana Association of School Nurses (IASN) is busy in preparation for the New School Nurse Orientation that will be held from 8:30 am to 4 pm on July 22-24, 2008, at the Fatima Retreat House in Indianapolis. Overnight rooms will be available at Fatima Retreat House.

IASN is also preparing for the Indiana School Nurse Fall Conference on September 29 and 30, 2008, at the Adams Mark Hotel near the Indianapolis airport.

For further information about the above events and/or about joining the Indiana Association of School Nurses, please contact Carolyn Snyder at 765/362-7493, via email bcsnyder3842@scglobal.net or by visiting the website www.inasn.org.

School nurses will meet for the National Association of School Nurses’ Conference June 27-30, 2008, in Albuquerque, New Mexico. For more information about the national conference go to the website www.nasn.org.

program from the division of aging to the division of disability and rehabilitative services; and (2) a language that exempts, for certain continuing care retirement communities under development from the limitation on Medicaid comprehensive care beds.)

03/24/2008 Signed by the Governor

SB0350 Funding for community mental health centers. (Lawson, Crawford)

Requires a county (other than Marion County) to transfer money to the division of mental health and addiction (division) to satisfy the non-federal share of medical assistance payments to community mental health centers for: (1) certain administrative services; and (2) community mental health rehabilitation services in a specified time frame. Permits the health and hospital corporation of Marion County to make payments to the division for the operation of a community mental health center. Requires the division to ensure that the non-federal share of funding received from a county is applied only for a county’s designated community mental health center. Specifies the manner in which the division may distribute certain excess state funds. Provides that the county levy for community mental health services is allocated to: (1) the division of mental health and addiction; and (2) the community mental health centers. Provides that the provisions of the bill are applicable only to the extent that: (1) the congressional moratorium on the implementation of certain rules by the U.S. Secretary of Health and Human Services is not extended; and (2) the restricted rules are implemented. Makes conforming changes. (The conference committee report removes language authorizing a one-time transfer of funds to ensure that community mental health centers are allocated funding provided in the 2006-2007 state fiscal year and provide notice of available funding; and (2) specifies the manner in which funds are to be allocated for the 2008-2009 state fiscal year appropriation from the tobacco master settlement fund and the state general fund to community mental health centers.)

03/24/2008 Signed by the Governor

For more information on these and other bills passed by the General Assembly this session, go to: http://www.in.gov/apps/lia/session/hillwatch/hillinfo

2008 LEGISLATIVE REVIEW
Asthma is a common chronic disease affecting more than half a million Hoosiers. The Indiana State Department of Health’s Asthma Program recently released a report on asthma in Indiana and found certain populations had a greater burden of asthma.

The Asthma Program report found blacks, children, females, and persons with an annual household income less than $15,000 per year carried a disproportionate amount of the asthma burden with higher prevalence rates, hospitalizations, emergency department visits, and deaths. Several factors that may contribute to these disparities include genetic differences, poverty, environmental exposures, and lack of patient education.

The Asthma Program report, which analyzed data primarily from 2005, found adult men had an asthma prevalence of 6.0 percent, while adult women had an asthma prevalence of 10.3 percent. Adult women had higher asthma hospitalization and emergency department (ED) visit rates than men; however, hospitalization and ED rates were higher for males 14 years of age or younger when compared to females of the same age. Females also had higher asthma mortality rates than males.

Though the prevalence of current asthma was not significantly different between blacks and whites, the asthma ED and hospitalization rates for Blacks were approximately three times higher than Whites. Additionally, the asthma mortality rate for blacks was nearly five times higher.

Children had the highest asthma ED rates and third highest asthma hospitalization rates when compared to all other age groups. Additionally, asthma prevalence was highest among those with an annual household income of less than $15,000 per year.

Individuals in the above mentioned demographic groups should receive special care to help them better understand asthma control since they tend to use the health care system for asthma treatment more often. This may include extra time to evaluate environmental triggers, assessing proper inhaler use during each visit, monitoring use of controller and quick-relief medications, and determining barriers to asthma control (i.e. cost, low health literacy, absence of an Asthma Action Plan, etc.).

Most adults and children with asthma should receive an influenza shot every year. Those adults, who also smoke should be referred to the Indiana Tobacco Quitline at 1-800-QUIT-NOW. While these steps are important for all people with asthma, they are critical for populations disproportionately affected.

In August of 2007, the National Heart, Lung, and Blood Institute updated their Guidelines on the Diagnosis and Management of Asthma, which more clearly defined how to assess asthma severity and control.

Asthma severity measures disease intensity when the patient is not on long-term control therapy, and asthma control measures the extent to which symptoms of disease are minimized and guides decisions on maintaining or adjusting therapy. Severity and control also each involve two domains: current impairment and future risk.

Additionally, the guidelines have tailored disease assessment and treatment plans to three age groups: 4 years of age and younger; 5 to 11 years of age, and 12 years of age and older. These help direct treatment, however, asthma varies widely among patients and does require individualized therapy.

Despite advances in treatment, the guidelines conclude even long-term control medications do not improve the underlying severity of the disease. A copy of the guidelines and a summary can be found at: http://www.nhlbi.nih.gov/guidelines/asthma/index.htm.

By following the National Heart, Lung, and Blood Institute guidelines, Hoosiers can help reduce asthma disparities and the overall burden of asthma in Indiana. Until more research is completed to determine which factors are contributing to these disparities in Indiana, it is important for individuals with asthma to know the disease can be controlled. All people with asthma deserve to lead active, healthy lives.

For more information on asthma or to access the full report on the Burden of Asthma in Indiana contact the Indiana State Department of Health Asthma Program at (317) 233-1325 or www.statehealth.IN.gov/programs/asthma.

### Asthma Disparities in Indiana

<table>
<thead>
<tr>
<th>Adult Asthma Prevalence</th>
<th>Hospitalization* per 10,000</th>
<th>ED visits* per 10,000</th>
<th>Mortality* per 10,000</th>
<th>per 1,000,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Females</td>
<td>10.3%</td>
<td>16.4</td>
<td>43.9</td>
<td>16.4</td>
</tr>
<tr>
<td>Males</td>
<td>6.0%</td>
<td>9.4</td>
<td>34.3</td>
<td>8.1</td>
</tr>
<tr>
<td>Blacks</td>
<td>9.2%</td>
<td>27.6</td>
<td>94.7</td>
<td>55</td>
</tr>
<tr>
<td>Whites</td>
<td>8.2%</td>
<td>10.6</td>
<td>28.3</td>
<td>9.8</td>
</tr>
</tbody>
</table>


* Hospitalization, ED visit, and mortality rates include adults and children.
The American Nurses Association (ANA) is pleased to announce the passage of the Paul Wellstone Mental Health & Addiction Equity Act (H.R. 1424). By a vote of 268 to 149 the House of Representatives passed the measure, which would end longstanding insurance discrimination and removes barriers to care for those facing mental illness.

“We at the American Nurses Association believe the enactment of mental health parity legislation is fundamental to the delivery of comprehensive healthcare,” said President Rebecca M. Patton, MSN, RN, CNOR. “ANA remains committed to ensuring access to quality health care that meets the needs of all Americans.”

The Senate passed a version of the Mental Health Parity Act (S. 558) by unanimous consent in September. Now, Senate and House leaders must work together to reconcile differences between the two versions and produce a bill that can pass in both chambers. ANA calls on the House and Senate to enact meaningful mental health parity legislation before the end of this Congress.

**Key Recommendations:**

- **Registered nurses and other health professionals must prepare themselves and their families for potential emergencies, including the potential for the health profession to be away for extended periods during an emergency.**
- **Registered nurses and other health professionals must use their professional competence to provide the best care possible given the resources and physical conditions under which they are working.**
- **Health facilities and other practice sites must provide opportunities for professional decision-making about adapting standards in drills and exercises on a regular basis.**
- **Health facilities and other practice sites must conduct psychosocial needs assessment for those responding, and arrange for assistance if needed.**
- **Emergency response planners should ensure that the health institutions and professionals are included in all planning for legal declarations of emergencies to assure that concerns about patient care guidelines and relevant regulations are considered.**
- **Emergency response plans should assist in developing plans to return to pre-

**ANA WEBSITE REDESIGNED—Members Only Section**

We are excited about the launch of ANA’s newly redesigned Web site, www.nursingworld.org. We hope you have had a chance to login and visit this exciting new space. The new site features completely new information architecture and a robust search engine which improves site navigation and usability. It has an updated and modern look that makes it easier to find what you and your members seek.

The new site is built with our members in mind. Members who login to the special Members Only section will be able to access the exclusive ANA publications archive, access the free CE section and the CINAHIL password, view daily headlines from the ANA SmartBrief (as well as a link to subscribe to this new daily e-newsletter), view a new section that features individual members and coming soon—access to the latest topic of OJIN: The Online Journal of Issues in Nursing.

We hope that your members have not encountered any difficulties in logging into the Members Only section. If the member had already created a user name and password, this information has been transferred to the new site. If members had not created their own, a user name and password was created for them. If we had one in our database, the member’s e-mail address was set as their user name and their password was set to their last name. If we had no e-mail address for a member, we used their ANA ID as their user name and their password remained their last name. If any members have difficulty logging in, please refer them to us at 1-800-923-7709 or membership@ana.org. We will be happy to assist them. Also, if you have specific members of your staff that need access to the Members Only section, please provide the e-mail addresses and names. Logins specifically assigned to these staff members will be established.

The new site brings some really exciting features for membership. As members submit their application online, a login and password are established for the Members Only section. Although their membership has not officially been established, their login and password are established for the Members Only section. They will be able to view the real-time, online renewal process shortly and hope to have real-time processing of new member applications up and running in the next few months. Beyond that, real-time viewing of the membership database and basic update capabilities are also in the plans. The final step will be setting up reports that can be accessed online when the CMAs need the information rather than only receiving this data once a month on your membership CDs.

**New Titles from Nursesbooks.org**

**Home Health Nursing: Scope and Standards of Practice, 116 pages**

- List price $16.95/Member price $13.45

**Nursing Informatics: Scope and Standards of Practice, 212 pages**

- List price $16.95/Member price $13.45

To order by mail, send to Nursesbooks.org Publications Distribution Center, PO Box 931905, Atlanta, GA 31193-1905.

Orders may also be placed by phone 1/866/937-0323 or online at www.nursesbooks.org. To receive the 20 percent discount, Constituent Members must give their membership number. Postage and handling is $4 for orders up to $25, $6 for up to $50, $8 for $100 orders, etc. Payment may be made by check, Visa and MasterCard. Purchase orders over $500 are accepted.

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**News From the American Nurses Association**

**Congress Passes Mental Health Parity Legislation:**

**ANA Applauds Crucial Bill that Removes Barriers to Mental Health Care**

The American Nurses Association (ANA) is pleased to announce the passage of the Paul Wellstone Mental Health & Addiction Equity Act (H.R. 1424). By a vote of 268 to 149 the House of Representatives passed the measure, which would end longstanding insurance discrimination and removes barriers to care for those facing mental illness.

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As a result of the American Nurses Association’s (ANA) effort to significantly engage registered nurses and the nursing profession in the association’s policy development process, today ANA released a timely policy paper “Adapting Changes the Basic Standards of Practice, Code of Ethics, Competence or Values of the Professional”...
New Trends in Foreign Nurse Recruitment

by Dianne E. Scott, RN, MSN

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Last year, the Health Resources and Services Administration, an agency of the U.S. Department of Health and Human Services, released the 2004 National Sample Survey of Registered Nurses, which collected data on the actively licensed Registered Nurse population as of March 2004. This most recent edition of the survey revealed that over 100,791 (3.3 percent) of the Registered Nurses (RNs) practicing in the United States received their basic nursing education outside of the U.S. While this percentage reflected only a slight increase since 2000, foreign-educated nurses are now licensed in all 50 States and the District of Columbia.

According to the American Hospital Association, 17% of hospitals recruit from abroad to fill nursing vacancies. While the percentage of hospitals looking toward employing foreign-educated nurses (FENs) as part of the solution for the nursing shortage is increasing, questions still arise over the best means to recruit and orient this unique nursing population.

To address some of these issues, the Center for American Nurses interviewed Wanano “Winnie” Fritz, RN, MS, the Chief Nursing Officer and Director of International Operations of HCCA International, a company which specializes in international nurse recruitment and hospital management.

Ms. Fritz’s experiences, both domestic and international, have given her a wealth of cultural and clinical expertise in nursing and management roles in the United States, Thailand, Germany, Russia, and Vietnam. Notably, she was employed for nearly 17 years by King Hussein of Jordan as both the Dean of a School of Nursing and a Health Systems Planner before joining HCCA in 2005.

The Center: Are there ethical issues involved with recruiting foreign educated nurses?

Ms. Fritz: The answer is yes, there can be ethical concerns for both the nurse and the nursing profession. Professional nursing organizations appropriately caution us to not deplete resources in specific countries where there are already serious shortages. For example, in the U.S., we have 8-10 RNs per 1000 population. In South African nations, there are only 1 to 1000. But as a general position, the International Council for Nursing states: “Nurses have a right to migrate and denotes unethical recruitment.” In addition many of the foreign-educated nurses genuinely want to work in the United States.

The Center: What are the reasons that foreign educated nurses want to come work in the United States?

Ms. Fritz: With the increased accessibility to the internet and other media from the United States, foreign-educated nurses are much more exposed to the potential personal and financial benefits and mechanisms to become a nurse in the United States. Many of the foreign-educated nurses obtain a U.S. nursing license to fulfill multiple professional and personal goals. Numerous foreign-educated nurses desire the opportunity to work in clean, safe high-tech hospitals. The economic advantage for nurses working in the United States usually goes beyond their personal financial gain; it carries through to their extended families back in their home country. It has been my experience that most foreign educated nurses will send up to 33% of their salary back to their home country to support their parents, siblings, and other family members. The governments of the foreign countries welcome the influx of financial assistance and are often very accommodating in assisting the nurses who are seeking to enhance their careers in the United States.

The Center: Where do most of the foreign-educated nurses come from?

Ms. Fritz: According to the U.S. Department of Health and Human Services, 58% come from the Philippines, 20% from Canada and 8% from the United Kingdom. 22% come from all other sources. In addition, over half of the foreign-educated nurses were estimated to have baccalaureate or higher degrees.

The Center: What are the advantages of hiring a foreign-educated nurse?

Ms. Fritz: Many (FENs) are highly motivated to be a nurse in the U.S. and usually have dedicated from 2 to 4 years of their lives to reach this goal. In addition, the nurse usually has already demonstrated persistence and adaptability in navigating the immigration and licensure processes.

As U.S. hospitals care for an increasingly diverse patient population, the foreign-educated nurse is also an asset as we work to be culturally competent and provide culturally appropriate care. Finally, the foreign-educated nurse can be a more permanent solution than temporary staffing options since many want to integrate permanently into a hospital and community, resulting in retention rates as high as 85%.

The Center: How would a prospective employer approach the recruitment of foreign-educated nurses?

Ms. Fritz: When choosing a recruitment partner, choose carefully. In the past, there were

(Continued on page 16)
The Center: What are the types of FEN recruiters?

Ms. Fritz: With either model, the commitment period for the nurse typically ranges from 2 to 3 years. When choosing a recruiter, there are two general models:

1. Direct Placement: 55-60% of recruiters pay upfront costs to the recruiting agency; instead, they pay an hourly rate for nurses’ shifts worked. Some large health care systems recruit directly; but most use third-party recruiters because of the complexity of the credentialing, education, licensure, and immigration processes.

2. Lease to Hire: 40-45% of recruiters pay no upfront costs to the recruiting agency; instead, they pay an hourly rate for nurses’ shifts worked for the contract period. The hospital then hires the nurse after having experienced the quality of their work in the hospital for several months.

The Center: What can a FEN be best oriented after she arrives to the United States?

Ms. Fritz: The greatest challenge for a foreign-educated nurse is clarity of speech. While all are required to pass an English exam, accent reduction is also sometimes needed. Recruiters and hospitals assist the foreign-educated nurse by coaching her to listen to talk radio and audio books. Preceptors and colleagues can also help by monitoring phone calls or having the foreign-educated nurse take formal accent reduction courses.

The Center: What are keys to success in working with these nurses?

Ms. Fritz: One of the most important components of a successful long-term placement of a foreign-educated nurse is the extent to which the recruiting company chooses and prepares the candidates. A simple phone interview and skills check list is not enough to ensure success and recruiters should meet potential candidates face-to-face in their country of origin.

The interviewing and preparation phase of the placement should be done with extreme caution and by using various tools to determine the level of critical thinking and decision making. Each nurse that I place in the United States completes a survey tool to determine how she makes decisions. I want to find out how she will accommodate unconventional and unique patient situations, physician interactions, and peer relations, and having a well designed tool can help predict how they may react when encountering real patient situations in this culture.

While all foreign-educated nurses must also take the NCLEX exam for licensure, simply passing the test does not always determine critical thinking skills. My team uses patient vignettes in our verbal interviews with the nurses to get a much deeper assessment of their ability to critically think through situations. The face-to-face interviews are also very helpful in determining the extent of her English speaking skills as well.

The Center: What about orientation to the community?

Ms. Fritz: The orientation to the community is important and should include, at minimum, securing and settling in a safe, appropriate, and furnished apartment; organizing transportation; teaching shopping, taxes, and banking; and processing payroll and benefits documents. An experienced recruitment company will provide this as well teaching U.S. culture, laws, and manners.

The recruitment and integration of the foreign-educated nurse can truly be a win-win situation for all concerned if the above elements are considered. Foreign-educated nurses benefit from their professional “dreams being fulfilled” and their families receiving funds to improve their lives in the home countries. Our diverse patient populations benefit by the culturally diverse nurse population. And healthcare organizations gain permanent staff members who remain as flexible, confident, and competent nurses.

NeW tReNDS IN FOReIGN NuRSe ReCRuItMeNt

(continued from page 15)

only about 30 or 40 companies recruiting nurses from overseas, now there are over 200. The Joint Commission has implemented a certification process which is helping to address some of the quality issues in selecting a reliable recruiting partner, so I highly recommend making sure the recruitment company is certified.

It behooves a healthcare organization to know how long the agency has recruited internationally and learn how many nurses they have brought to work in the U.S. It is just as important to learn the satisfaction rate of their client hospitals as well as their ethics in their practices. I also believe it is important for a recruiting organization to “give back” to the countries of origin.

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The interviewing and preparation phase of the placement should be done with extreme caution and by using various tools to determine the level of critical thinking and decision making. Each nurse that I place in the United States completes a survey tool to determine how she makes decisions. I want to find out how she will accommodate unconventional and unique patient situations, physician interactions, and peer relations, and having a well designed tool can help predict how they may react when encountering real patient situations in this culture.

While all foreign-educated nurses must also take the NCLEX exam for licensure, simply passing the test does not always determine critical thinking skills. My team uses patient vignettes in our verbal interviews with the nurses to get a much deeper assessment of their ability to critically think through situations. The face-to-face interviews are also very helpful in determining the extent of her English speaking skills as well.

The Center: What can a FEN be best oriented after she arrives to the United States?

Ms. Fritz: The greatest challenge for a foreign-educated nurse is clarity of speech. While all are required to pass an English exam, accent reduction is also sometimes needed. Recruiters and hospitals assist the foreign-educated nurse by coaching her to listen to talk radio and audio books. Preceptors and colleagues can also help by monitoring phone calls or having the foreign-educated nurse take formal accent reduction courses.

The Center: What about orientation to the community?

Ms. Fritz: The orientation to the community is important and should include, at minimum, securing and settling in a safe, appropriate, and furnished apartment; organizing transportation; teaching shopping, taxes, and banking; and processing payroll and benefits documents. An experienced recruitment company will provide this as well teaching U.S. culture, laws, and manners.

The recruitment and integration of the foreign-educated nurse can truly be a win-win situation for all concerned if the above elements are considered. Foreign-educated nurses benefit from their professional “dreams being fulfilled” and their families receiving funds to improve their lives in the home countries. Our diverse patient populations benefit by the culturally diverse nurse population. And healthcare organizations gain permanent staff members who remain as flexible, confident, and competent nurses.

*The Center for American Nurses is committed to helping nurses develop both professionally and personally. The Center offers solid evidence-based solutions-powerful tools to navigate workplace challenges, optimize patient outcomes, and maximize career benefits. Whether it’s learning how to handle conflict, gaining continuing education credits, knowing your legal rights, or skillfully managing your money, The Center’s resources add traction, moving you toward the best life a career in nursing can offer.*
Age, gender, and location are keys to predicting patient fall injuries in hospitals

Studies have suggested that serious injuries after a fall in a hospital can increase patient charges by about $4,000. A new study by Washington University School of Medicine researchers suggests hospitals keep close watch on older and female patients in bathrooms and patient care areas if they hope to quell the injuries that occur when patients fall.

The researchers studied 7,082 patient falls that occurred in 9 Midwestern hospitals of varying sizes, missions, and populations from 2001 to 2003. They found that patients were not harmed after more than half of the falls. However, 26.4 percent of patient falls resulted in some sort of injury, ranging from minor to major.

Most of the falls reported for the nine hospitals were unassisted, that is, no staff member was present to help break the fall. Unassisted falls tended to lead to injury. Injuries also ensued when falls occurred in bathrooms or in areas such as nurses' stations, hallways, and examination and treatment rooms.

Women who fell were not likely to be injured; however, if they were injured, their injuries were serious. Though all nine of the hospitals used the same fall reporting system, the researchers found variation in fall definitions. The team recommends standardizing definitions in systems that report patient falls, so research efforts can zero in on risk factors. They also suggest that if hospitals want to know how to prevent falls, their fall reporting systems should collect more descriptive information, including the patient's name, the hospital unit, location, a description of the fall, and the outcome.

This study was funded in part by the Agency for Healthcare Research and Quality (HS11898).


Competing priorities, burnout, and collegial support all play a role in nursing career decisions

Significant staff shortages of registered nurses (RNs) have plagued hospitals for the past 10 years. The nurse shortage will worsen in the next 5 to 10 years, when a large part of the nursing workforce is expected to retire. Comments from 472 RNs who responded to a 2006 survey hint at factors that may impede nurse recruitment and retention.

Nurses recounted several factors that played a large role in their nursing career decisions. These included competing family and work priorities and the struggle to balance them, practice deterrents such as inadequate staffing and work overload, and collegial support.

Many nurses loved nursing as a career and took great pride in it, notes Carol S. Brewer, Ph.D., of the University of Buffalo School of Nursing. However, at certain family stages, family needs took precedent over professional needs. When nurses had young children, they either stopped nursing for a while or worked part-time. Many pursued advanced education in the hope of a better schedule, less shift work on holidays and weekends, increased opportunities for promotion, and salary increases. However, many felt that the advanced degrees did not pay off as they expected.

As nurses aged, some chose retirement in response to intolerable working conditions.

Nurses cited practice deterrents such as pay inequity (for degree of responsibility and skills), lack of respect for hospital nurses, and safety concerns for themselves and patients. They also voiced concerns about exhaustion, stress, excessive work demands and work-related injuries, increasingly ill patients, mandatory overtime, and nurse shortages. These problems gave them more negative attitudes toward nursing. On the other hand, Suzanne S. Dickerson, D.N.S., reported that collegial support encouraged nurses to stay in practice. Most nurses generally enjoyed their fellow nurses and were encouraged to remain in the profession because of them. Employers of RNs must find creative ways to respond to RNs’ concerns in order to retain this skilled group.

The study was supported by the Agency for Healthcare Research and Quality (HS11320). See “Giving voice to registered nurses’ decisions to work,” by Suzanne S. Dickerson, D.N.S., R.N., Dr. Brewer, Christine Kovner, Ph.D., and Mary Way, M.S.N., in Studies examine the impact of nurse staffing on complications, mortality, and length of hospital stay

Two new studies supported by the Agency for Healthcare Research and Quality (HS10153) add to the growing body of research linking nurse staffing to quality of care. The first study found that more hours of care provided by registered nurses (RNs) were related to fewer postoperative complications, mortality, and length of hospital stay

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More RN care reduces complications

More hours of care provided by RNs are related to significantly fewer postoperative pulmonary complications and lower rates of infection among hospitalized children, according to this study. The researchers used administrative data from 1996-2001 to examine discharges of 3.65 million children, ages 1 to 17, treated in 1,943 hospitals in all 50 states. (The majority of the sample were from California. In this group of children, septicemia occurred most often, followed by postoperative cardiac complications, deaths, postoperative pneumonia, and postoperative urin tract infections.

Increasing hours of RN staffing had no effect on these outcomes. However, for three of the four complications (cardiopulmonary complications, postoperative pneumonia, and postoperative sepsis), there was a significant effect of RN staffing. The RN staffing levels were significant at the 25th, 50th, and 75th percentiles of nurse staffing. The increase in RN hours had the largest impact at the lowest level of RN staffing. For example, the researchers estimated that 425 to 596 fewer postoperative cardio-pulmonary complications (75th vs. 25th percentile) would have occurred during the 6-year study period with a 1-hour increase in RN hours per patient day. Similarly, from 95 to 124 fewer cases of postoperative pneumonia complications and from 719 to 787 postoperative sepsis and other infections might have been averted. These results are consistent with studies on the impact of nurse staffing on adverse outcomes for hospitalized adults.


Facility expenditure influences care

This study found that RN staffing (adjusted for case mix) was significantly lower in for-profit than in not-for-profit hospitals. The number and length of hospital stay were similar between the two types of hospitals, after controlling for postoperative patient and market characteristics. Both of these variables also became more similar over time in terms of distribution of RN staffing and length of stay.

The lack of differences in patient outcomes among the two types of hospitals found during the study period, despite RN staffing differences, may reflect the dramatic changes in the operating environment for both types of hospitals due to the growing dominance of managed care in the early to mid-1990s.

Not-for-profit hospitals may have responded to increased competitive pressures by behaving more like their for-profit counterparts. For example, they may have increased the efficiency of their internal operations, such as changing the volume and mix of services, and reducing the length of hospital stay. The study also found that among the two-thirds of cases for whom surgeons did recommend therapy, most often because they perceived the risks exceeded the benefits, the surgical care decision was more likely to occur most commonly among minority women than white women (73 vs. 54 percent), and more commonly in women who were insured by Medicaid or were uninsured than those with Medicare or commercial insurance (54 vs. 49 percent). Women treated by a surgeon who worked closely with oncologists were less likely to experience a system failure (84 vs. 68 percent) than those treated by other surgeons.

Some women with breast cancer do not receive adjuvant treatments recommended by guidelines

Women with breast cancer do not consistently receive adjuvant treatments that have been shown to increase survival rates. Although adjuvant chemotherapy for estrogen receptor-positive cancers is a widely recognized treatment for these tumors, only 62 percent of women with estrogen receptor-positive tumors larger than 1 cm received this therapy.

A survey of surgeons at 6 New York hospitals treated 119 women with breast cancer. Whether a woman received guideline-recommended adjuvant therapy, points out some contributing factors contributing to this. In one-third (22 percent) of cases, surgeons did not recommend adjuvant treatment, most often because they perceived the risks exceeded the benefits. In another third (32 percent) of cases, surgeons recommended a different treatment, most often due to patient frailty or age.

The study was supported by the Agency for Healthcare Research and Quality (HS16299).

More staff and turnover may lead to higher administrative expenses (implying more management capacity) can reduce both staff turnover and staffing levels.

Staff training and benefit expenses did not affect staff turnover and benefit expenses were associated with higher levels of professional staff, that is, registered nurses (RNs) and licensed practical/nurse aides (LPNs). Operating margins were associated with reduced staffing levels. However, when the financial ratios were factored in, the relationship between for-profit or not-for-profit status and operating margins was weakened. Depending on the particular staffing indicator, administrative expenses, operating profit margins, or both, the effects of higher staffing levels and turnover in for-profit and not-for-profit ownership and staffing indicators were consistent with studies on the impact of nurse staffing on adverse outcomes for hospitalized adults.

Bita A. Kash, Ph.D., M.B.A., of Texas A & M University, and colleagues examined the relationship between 10 financial ratios (6 activity expense ratios, 2 growth and risk ratios, and 2 profitability ratios) and staffing levels and turnover in 1,018 Texas nursing homes. The researchers measured expenditures by the ratio of a given type of expenditure to net resident revenues. They found that higher administrative

Multiple Sclerosis: A Multi-Faceted Disease

ONF-06-374

This independent study has been developed to help nurses understand multiple sclerosis. It takes approximately 60 minutes to complete this independent study. A contact hour will be awarded for successful completion of this independent study. The Ohio Nurses Foundation (OBN-001-91) is accredited as a provider of continuing education in nursing by the American Nurses Credentialing Center’s Commission on Accreditation. Expires August, 2008.

DIRECTIONS
A. Please read carefully the enclosed article “Multiple Sclerosis: A Multi-Faceted Disease.”
B. Then complete the post-test.
C. The next step is to complete the evaluation form and the registration form.
D. When you have completed all of the information, mail the following to the Indiana State Nurses Association, 2915 North High School Road, Indianapolis, IN 46224:
   1. The post-test;
   2. The completed registration form;
   3. The evaluation form; and
   4. The fee: $15 for ISNA members; $20 non-ISNA members.

The post-test will be reviewed. If a score of 70 percent or better is achieved, a certificate will be sent to you. If a score of 70 percent is not achieved, a letter of notification of the final score and second post-test will be sent to you. We recommend that this independent study be reviewed prior to taking the second post-test. If a score of 70 percent is achieved on the second post-test, a certificate will be issued.

If you have any questions, please feel free to call Zandra Ohri, MA, MS, RN, Director, Nursing Education, ext. 1087, or Sandy Dale, ext. 1090, Ohio Nurses Association at (614) 237-5414.

OBJECTIVES
Upon completion of this independent study, the learner will be able to:
1. Describe the pathophysiology of MS.
2. Identify medication used to treat MS and related nursing implications.
3. Recognize nursing interventions to deal with symptoms of MS.

This independent study was developed by: Barbara Walton, MS, RN, NurseNotes, Inc., Milan, Michigan. The author has no vested interest.

There is no commercial support for this independent study.

Multiple Sclerosis: A Multi-Faceted Disease

Pathophysiology of Multiple Sclerosis

It is estimated that 400,000 Americans are affected by multiple sclerosis (MS). It typically strikes between the ages of 20 and 50. Some patients experience a limited number of “attacks” and remain healthy for decades, while other patients deteriorate rapidly from the time of diagnosis.

MS is characterized by the formation of multiple lesions or plaques along the nerve fibers in the brain and spinal cord. MS is thought to be an autoimmune process, but what triggers this process is still unknown. Cells that identify antigens are somehow triggered to interpret one of the components of myelin as foreign. When antigen-presenting cells introduce the myelin antigen to T cells, the T cells pass the blood brain barrier and launch an attack on the myelin sheath of the neurons. The attack on myelin activates more T cells and other inflammatory factors such as cytokines are released and more damage is sustained to the myelin. With demyelination, transmission of information via axons becomes more difficult. Besides myelin damage and loss, damage to the axon of the neuron may also result. This is called axonal injury and can yield permanent loss of neural function. There may also be damage and loss of oligodendrocytes. Oligodendrocytes are the cells that produce myelin. If these cells become disabled, there may be a cessation of remyelination. MS is a waxing and waning disease made up of periods of demyelination (exacerbations, attacks or relapses) and remyelination (remissions).

What triggers MS? Factors that trigger MS remain largely unknown, however a number of hypotheses exist. One popular belief is that viruses trigger MS. Blood antibody titers to viruses are elevated in many MS patients. Viruses include varicella zoster, vaccinia, rubella, Epstein-Barr, human herpes virus 6 (HHV-6). The HHV-6 virus antibody is also detected in the cerebrospinal fluid of some MS patients. Being able to identify these viruses may give us insight into the diagnosis and treatment of MS in the future.

Another trigger may be environmental factors. MS occurs more often in countries with a moderate cool climate. The greater distances from the equator, the higher the incidence of MS. There is a hypothesis regarding vitamin D deficiencies or greater need for vitamin D in cooler climates. Because inclimate weather, rain and snow keep people indoors, there is a lack of exposure to sunlight, thus a vitamin D deficiency or greater need for vitamin D results. Lack of vitamin D may result in formation of free radicals that in turn leads to myelin damage. Vitamin D also plays a role in stimulating transforming growth factor (TGF beta-1) and interleukin-4 production, which in turn may suppress inflammatory T cell activity. There is evidence vitamin D may actually provide a preventative effect for patients at risk of developing MS.

Genetic risks for MS exist too. MS is seen in greater number in northern European Caucasians and has the lowest incidence in Asians. While no specific genes have been identified, MS is 10 to 50 times higher for persons with an affected relative than a person with no family history. It is suspected that multiple genes, along with environmental factors or a viral trigger are involved.

Types of MS

There are four main types of MS as follows:
1. Relapsing-remitting: episodes of acute worsening with some amount of recovery and no progression in between. This is the most common form of MS, diagnosed in 85 % of all MS patients.
2. Primary progressive: continuing worsening of symptoms and loss of function, without any distinct relapses.
3. Secondary progressive: Starts as relapsing-remitting MS, and converts to a progressive form with gradual loss of function.
4. Progressive relapsing: progressive disease from the onset, with acute relapses and continuing disease progression.

Another term being used to describe MS in some patients is “benign MS.” Benign MS occurs when a patient experiences only one symptom, remains fully functional, and there are no MRI changes. The one symptom may be optic neuritis by itself. Malignant MS is a term used to refer to very rapidly progressing disease that leads to severe disability and death within a very short period after onset.

(Continued on page 21)
Clinical Signs and Symptoms of MS

This module is titled MS: A multi-faceted disease, because signs, symptoms and deficits vary greatly from patient to patient with MS. Below is a table describing the more common signs and symptoms of MS.

Signs and Symptoms of MS

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Discussion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fatigue</td>
<td>90% of all MS patients report fatigue. Fatigue does not correlate to disease severity or progression.</td>
</tr>
<tr>
<td>Depression</td>
<td>The second most common symptom reported by 70% of all MS patients. Like fatigue, depression does not correlate to disease severity. Suicide is 7.5 times greater in the MS population than general population.</td>
</tr>
<tr>
<td>Motor Involvement</td>
<td>May occur early in the disease, especially in patients who present with multiple symptoms. Weakness in an affected limb, progressing to spasticity, hyper-reflexia, clonus, extended plantar responses and muscle contractions may be present.</td>
</tr>
<tr>
<td>Visual Involvement</td>
<td>Blurring or haziness that can evolve to vision loss. Periorbital pain may occur and optic neuritis (inflammation of the optic nerve) is a common presenting symptom.</td>
</tr>
<tr>
<td>Sensory symptoms</td>
<td>Can be very vague and difficult for the patient to characterize. May be described as a squeezing, burning, numbness or tingling type sensation. Sensory symptoms may be transient but may progress to loss of dexterity.</td>
</tr>
<tr>
<td>Tonic spasms</td>
<td>Brief increases in flexor muscle tone in one or more limbs. Pain is often associated with tonic spasms.</td>
</tr>
<tr>
<td>Brainstem symptoms</td>
<td>Symptoms arise from cranial nerve involvement. Cranial nerves originate along the brainstem. Ophthalmoplegia (optic nerve pain) and nystagmus (rapid eye movements side to side), facial numbness, weakness or pain (trigeminal neuralgia) may occur.</td>
</tr>
<tr>
<td>Cerebellar Involvement</td>
<td>Intention tremors, which can become disabling are frequently seen. Ataxic gait and truncal ataxia, dysarthria (difficulty in forming words) and scanning speech may be seen. Ataxia is the inability to coordinate muscles to complete a voluntary activity.</td>
</tr>
<tr>
<td>Genitourinary symptoms</td>
<td>Urinary urgency, frequency, incontinence, hesitancy and retention and urinary tract infections may be seen at any time during the course of the disease. Constipation is also a common problem.</td>
</tr>
<tr>
<td>Cognitive deficits</td>
<td>40 to 60% of patients with MS will elicit some degree of cognitive impairment. Short-term memory loss, being easily distracted, inability to concentrate, difficulty managing complex tasks and confusion may be seen.</td>
</tr>
</tbody>
</table>

Diagnosis of MS

MS is usually suspected based on the patient’s symptoms. Symptoms highly suggestive of MS include gait disturbances, optic neuritis, persistent double vision, and/or numbness. These symptoms may occur periodically, then resolve and be absent for months or years. It is important to take a comprehensive history of the patient to include not only symptoms, but also family history, exposure to viruses and environmental exposure. Once MS is suspected, further diagnostic tests should be ordered to confirm or rule out the diagnosis. Other tests include:

- **Magnetic Resonance Imaging (MRI)**: scans will reveal lesions that plaques in the white matter that depicts demyelination. MRI’s are also helpful in tracking the progression of the disease. Gadolinium is often used to enhance the view of MRI’s. Gadolinium will highlight new or active lesions that may come and go. Lesions detected without gadolinium represent more severe and permanent tissue damage.

- **Lumbar Puncture**: may reveal the presence of specific antibodies as well as an excess of inflammatory proteins. Serum Testing: may be helpful to many patients. Be sure to include emotional assessments when evaluating an MS patient; changes in mood and behavior may require anti-depressant medications.

Disease Modification

In 1993, with the introduction of interferon therapy, treatment for MS changed dramatically. Interferon stimulation (beta-1a) was approved for use in 1993 for treatment of ambulatory patients with relapsing-remitting MS. In 2003 Betaseron® was approved for use with patients experiencing their first clinical episode and exhibited progression to secondary progressive MS. In 1996 Interferon beta-1a (Avonex®) was approved for use with patients experiencing their first clinical episode and exhibited progression to secondary progressive MS. In 2002, another interferon-beta 1a (Rebif®) was approved for relapsing forms of MS.

How interferons work

In MS it is thought that inflammatory T cells migrate to the central nervous system and are reactivated. Upon reactivation, cytokines are released that begin to damage myelin and axons. Interferons are thought to interfere with the inflammation process and help maintain the integrity of the blood brain barrier, thus preventing the migration of the T cells into the central nervous system. Hence the name interferon, as they “interfere” with this process. Below is a table describing the use of each of the interferons.

<table>
<thead>
<tr>
<th>Drug</th>
<th>% Reduction in Relapse</th>
<th>Dose, Route &amp; Frequency Administered</th>
<th>Special Considerations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interferon-beta 1b</td>
<td>31%</td>
<td>250 mcg, Subcutaneous, Every other day</td>
<td>May be used with an auto injector. Requires reconstitution prior to injection</td>
</tr>
<tr>
<td>Betaseron®</td>
<td></td>
<td>30 mcg, Intramuscular, 1 time per week</td>
<td>Requires refrigeration. Available in a pre-filled, pre-mixed syringe.</td>
</tr>
<tr>
<td>Interferon-beta 1a</td>
<td>32%</td>
<td>22 to 44 mcg, Subcutaneous, 3 times per week</td>
<td>May be used in a pre-filled, pre-mixed syringe. Requires refrigeration.</td>
</tr>
</tbody>
</table>

Side effects of interferons are similar. Many patients experience injection site reactions may appear as redness, pain, lumps and itching. Intramuscular interferon may produce bruising and discomfort. Rarely does skin breakdown or tissue necrosis occur. Be sure to re-evaluate the patient’s injection technique, as that may be the cause of the injection site reaction. Applying ice to the injection site may sometimes help to reduce any discomfort. Some patients finding using a new needle just prior to injecting the medication helps. Patients who experience itching at the site may find over the counter hydrocortisone ointments of benefit. Allowing refrigerated medications to come to room temperature just prior to injection may also help to minimize discomfort. Severe liver damage may occur with interferon usage. It is imperative the patient have a baseline CBC and liver profile done prior to beginning interferon therapy. Other medications have been and may continue to be the medication of choice for one month, and continue re-leafing every three months thereafter. Other side effects may include menstrual irregularities and possible depression. It is unclear if interferons cause depression or whether it is just another symptom of the disease process. Depression is common in individuals with MS. Be sure to include emotional assessments when evaluating an MS patient; changes in mood and behavior may require anti-depressant medications.

Another medication used to modulate MS is glatiramer acetate (Copaxone®). Copaxone® is not an interferon, but a synthetic compound of four amino acids that are the building blocks for proteins that are found in myelin. Patients taking Copaxone® have 33% reduction in relapses. The
medication is administered via daily subcutaneous injection, must be refrigerated, is available in pre-mixed, pre-filled syringes and can be given via auto injector. Patients taking Copaxone® may experience lipoatrophy with repeated injections. This is often seen at the injection site reactions and post injection reactions. As with any medication regimen, compliance is always an issue. It is important for patients and families to understand the interferons and Copaxone® are not “miracle cures.” These medications will still experience relapses, so they need realistic education about what these drugs can and cannot do. Assisting the patient to minimize symptoms and prevent new symptom injection site reactions and post injection reactions as well as building a trusting relationship with the power to develop a strong and ongoing relationship and compliance. Making appropriate referrals for emotional and spiritual support should also be instituted.

Symptom Management

The diagnosis of MS is upsetting, to say the least, for most patients and their families. Patients face the unknown: unpredictable course of this disease where neurological symptoms can fluctuate and progress, and can worsen with something as simple as elevated body temperature or fatigue. Even with the disease manifestations, patients still experience symptoms that accompany MS. Depression, helplessness and hopelessness are common among the MS population and requires a high level of empathy and unconditional regard from healthcare professionals. Some of the aspects to be assessed by nurses and interventions we can use to assist the MS patient and their families.

Psychosocial Issues and MS

Believes he/she is competent and capable of completing tasks, such as self-care. Assessing these areas will give the nurse insight into the patient’s experience of the illness. Believes he/she is confident levels of self-efficacy can be directly correlated to a patient’s willingness and ability to adhere to medical regimens. By assessing the items listed in the “mood” section, inquires about exercise regimens, stress management techniques, dietary supplements and complementary therapies a patient has used. It is important to assess the patient’s ability to assist the MS patient. This can easily be done by asking the patient to undertake activities of daily living in a specific manner. Also assist in the MS assessment by observing patient mobility, balance, and coordination. Watch them as they transfer to the examination table, rise from a chair, or sit in a chair. They may be experiencing. If falls do occur, under what circumstances, and how do they manage the fall? What seems to trigger and alleviate mobility problems? While on a long walk do they notice a foot starts to drag, and with rest, it resolves? Do they report less of an ability to ambulate when feeling hot or fatigued? Do they use canes, walkers, handrails, grab bars, or other assistive devices? Just because you don’t see them using such devices, does not mean they don’t. They may just use them as needed.

Sedentary lifestyle increases morbidity and mortality.

Strengthening exercises such as progressive resistive exercises ranging from isometrics to resistive tubing to weight training. This will help to maintain muscle strength and reduce the risk of falls. As with the interferons, local injection site reactions and post injection reactions are often reported as “stiffness.” Be alert to patient assessment of the positive, a happy memory, or a beautiful day.

Social support has been well documented as a predictor of coping and improved quality of life. Factors that affect social support may include employment status, 1-800-FIGHT MS (1-800-344-4867); www.nmss.org

Mobility and MS

Mobility limitations can affect a person’s vocational and recreational activities, one’s self-esteem and quality of life. Factors that affect a person’s mobility may include; impairment, sensory and visual disturbances, fatigue, cognitive deficits, and depression. Most people have mobility limitations. Lifestyle choices can improve mobility. Changing lifestyle choices can improve mobility and promote safety. Referal to physical and occupational therapies is helpful for patients who use specific devices that would most benefit the patient.

Balance problems can be addressed with vision techniques that include looking ahead, focusing on a target. Another technique called vestibular stimulation uses rocking motion from therapeutic balls or tilt boards, hammocks or swings to improve balance and mobility. This can easily be done as you observe mobility problems are due to a combination of mobility and MS.
Other invisible symptoms include paresthesias, body temperature returns to normal, the fatigue increase in body temperature can greatly increase problems, or because we cannot "see" these cognitive dysfunction, depression, and mood Other invisible symptoms include paresthesias, or limited mobility, and control over the illness. Fatigue happens to everyone at some point in time or another for a variety of reasons. However, research has identified these characteristics to be associated with MS induced fatigue. These characteristics are: comes on suddenly interferes with responsibilities interferes with physical functioning causes frequent problems causes fatigue to markedly increase during relapses and improve with remission. An increased daily energy output is associated with increasing fatigue, particularly when the weather is warm or the patient takes a hot shower, has a fever or has problems with mobility. When the body temperature returns to normal, the fatigue generally lessens. Evaluating fatigue should include assessing for Fatigue due to heat or cold. Exercise, deconditioning due to sedentary lifestyle. Mobility impairment: Patients with MS gradually lose the ability to perform daily activities. Exercise programs can improve fitness, arm and leg strength, bladder and bowel control, and reduce fatigue, depression, and anger. Use appropriate rehabilitation strategies such as mobility aids, assistive devices and energy conservation. Early consultation with occupational therapists to develop exercise programs may be helpful. Medication adjustments in dosing and/or scheduling may help reduce sleepiness and increased fatigue. Cognitive conditions: Patients with MS are not immune to heart or lung disease, diabetes or other diseases that can contribute to fatigue. Management strategies for fatigue may include: Personal exercise programs to improve strength and endurance. Exercise programs can improve fitness, arm and leg strength, bladder and bowel control, and reduce fatigue, depression, and anger. Use appropriate rehabilitation strategies such as mobility aids, assistive devices and energy conservation. Early consultation with occupational therapists to develop exercise programs may be helpful. Medication adjustments in dosing and/or scheduling may help reduce sleepiness and increased fatigue. Fatigue due to depression may respond to Prozac or other anti-depressant drugs. Primary MS fatigue may respond to these medications: Amanatidine (100 mg bid) is an antiviral agent and a dopamine agonist that has been shown to reduce fatigue in MS patients. Modafinil (Provigil®) (100 to 200 mg qd) is a wakefulness-promoting agent and may help reduce feelings of fatigue. Pemoline (Cylert®) (75 mg qd) is a central nervous system stimulant that may be helpful for short-term treatment of MS related fatigue. Aerobic exercise: has been shown to improve cardiovascular fitness, leg strength, and health status and reduce fatigue. Cooling therapy: such as air conditioning or cooling vests can reduce fatigue in heat sensitive MS patients. Energy conservation techniques such as time management, use of mobility aids, and healthy eating can help curb fatigue. Pain Pain was first identified by Charcot in 1872, we know pain is present in 45 to 65 % of MS patients. As much as 32% of these patient report unrelieving pain for at least one month. Types of pain experienced by MS patients include: Acute Pain Syndromes: Trigeminal neuralgia: 400 times more common in MS patients than the general population. Causes severe pain that is described as shooting, stabbing or burning. May occur unilaterally, that can be precipitated by chewing, shaving or tooth brushing. This usually responds to anticonvulsant medications, but may require surgical treatment. Painful tonic spasms: Simple flexor spasms, brought on by movement or noxious stimuli such as brushing the teeth, spasm of upper and lower extremities sometimes called tonic spinal cord seizures, may occur several times per day and usually respond to anticonvulsant medication such as Dilantin®. Lightening-like pain: Intense shooting pain traveling through any part of the body, often precipitated by noxious stimuli such as brushing the teeth or Dilantin® or gabapentin (Neurontin®). Hermitte’s sign: Occurs in any disorder that causes damage to the posterior columns of the cervical spinal cord. Sensation of electric shock that travels down the neck, typically in response to movement therapy has an effect in the treatment of these extremities. Typically responds to carbamazepine (Tegretol®). Optic neuritis: Occurs like a knife like pain, or a dull deep ache or sense of pressure above or behind the eye. Results from inflammation and demyelination around the optic nerve and will subside with steroid treatment. Chronic Pain Syndromes include: Dysesthesia: most common syndrome, described as a burning or aching pain, occurring most often in the legs. Thought to be due to demyelination of the posterior columns of the spinal cord. Pain is usually worse towards the end of the day. Responds better to phenytoin (Dilantin®) and gabapentin (Neurontin®) than carbamazepine (Tegretol®). Band-like pain in torso or extremities: caused by a lesion in the spinal cord, characterized by a persistent burning, often with a rhythmic pattern. May respond to gabapentin (Neurontin®) and phenytoin, (Dilantin®), benzodiazepines may be helpful in resistant cases. Back pain and radiculopathy: may occur due to orthopedic problems, muscle-skeletal changes due to impaired mobility or demyelination. Physical therapy and non-steroidal anti-inflammatory drugs may be used. Tizanidine (Zanaflex®), baclofen (Lioresel®), clonazepam (Klonopin®) or tramadol, (Ultram®) may also be used. Elimination Dysfunction and MS: Patients with MS can experience bladder and/or bowel dysfunction due to and including incontinence. Symptoms may include urgency, frequency, hesitancy, or the inability to empty the bladder completely or incomplete emptying or urinary tract infections. Bladder dysfunction: For urination to occur, the bladder detrusor muscle contracts to expel the stored urine and the sphincter muscle relaxes and opens, permitting the free flow of urine. In patients with MS, the neural connections controlling these processes may be affected resulting in failure to store urine, failure to empty urine or a combination of these problems. Failure to store urine results due to hypercontractility of the detrusor bladder muscle. Patients experience urgency, frequency, nocturia, small post void residual volumes, and leakage or urge incontinence. Bladder training may be helpful, ready to empty 1 to 3 hours after drinking a liquid. Patients may benefit from anticholinergic/ antimuscarinic drugs such as desmopressin nasal spray, or tablets, oxybutynin (Ditropan®), oxybutynin hydrochloride (Oxycontin®), or imipramine (Tofranil®). Failure to empty occurs when the bladder attempts to empty but is unsuccessful due to the inability of the sphincter to relax, thereby obstructing flow and/or a weakened detrusor muscle. Symptoms include urgency, frequency, hesitancy, a sense of incomplete emptying, large post void residual volumes, and frequent urinary tract infections. Intermittent catheterization is generally performed every four to six hours, using a clean technique. Patients wash the catheter with soap and water and store the catheter in an air-permeable container. Be sure the patient understands the procedure and ability to perform this procedure, as they may require assistance. In some instances a patient may need an indwelling urethral or supra pubic catheter. Routine bladder catheterization is typically performed on a monthly basis. Patients may experience spasms of the detrusor muscle, which in turn can prevent voiding. Not only can catheter leakage occur, it is not an indication the patient needs a larger catheter but that changing the catheter more frequently and adding medication to the catheter irrigation solution. Routine catheterization may increase the risk of urinary tract infection. However, if the patient is symptomatic, appropriate antibiotic therapy should be initiated. Combined bladder dysfunction: results in the detrusor muscle working in opposition to the external sphincter muscle. This is sometimes known as a "bladder dyssynergia." There are many interventions for constipation, with prevention being key. Encouraging the patient to take in 1 to 2 quarts of fluid each day, a high fiber diet (20 to 30 gms per day) establishing regular meal times may all help. Fiber can be added easily to diet by consuming fruits, vegetables, cereals and grains. However if adding fiber results in gas, bloating and/or diarrhea, try adding these foods gradually. Peristalsis is dependent on fluids and will slow to one cup of liquid beverage. Timing defecation after meals may be helpful, with correct positioning on the toilet. Have the patient sit on the commode; bend the legs at the knees and place them on the hips. Bulk forming agents, (Metamucil® or stool softeners may be added. Rectal stimulants or suppositories may also be helpful. Lubrication to promote elimination of stool. Incontinence of stool may result due to overflow from constipation, diminished rectal sensation or a decreased rectal sensitivity to stool. Many of the interventions described in the constipation section will prove helpful in dealing with both bowel and bladder problems. When selecting foods, fatty foods or other dietary triggers may decrease the number of incontinent episodes. A daily glycerin suppository may help empty the bowel and avoid accidents.

Sexuality and MS Many MS patients may feel comfortable discussing intimate details, it is important for nurses to include this in their assessments of their patients. MS patients report increased sexuality to the patient either verbally or via written pamphlets, it may provide an invitation for the patient to approach the topic, once a trusting relationship has been established. Be sure to include significant others in giving this information. It is important for both the patient and significant other to realize the changes in sexuality they are experiencing may be due to the progression of the disease or effects of medications, versus thinking it is a reflection of problems in the relationship. While MS is often does bring about changes in sexual behavior.
function, it usually does not affect fertility. Patients and significant others may also benefit from information regarding family planning and contraception. Sexual problems in MS are divided into primary, secondary and tertiary types.

Primary Sexual Dysfunction occurs due to neurological damage caused by MS that directly impairs sexual feelings and/or response. This may present itself as decreased or absent libido, altered genital sensations such as numbness, painful intercourse, or aversion to touch due to heightened sensitivity, decreased frequency or intensity of orgasms, erectile dysfunction, decreased vaginal lubrication, decreased clitoral engorgement and decreased vaginal muscle tone. Interventions that may prove helpful include the following.

Decreased or absent libido is a common complaint among women. When lesions of the central nervous system impair libido, there are numerous sensory, perceptual and emotional pathways that may remain intact. Experiencing pleasure is possible in the absence of libido, thus pleasure may be relearned. Kegel exercises are helpful in maintain muscle tone. Using sexual aids such as vibrators may be of benefit. Some medical supply companies supply these aids. The National Multiple Sclerosis Society references two web sites that sell these products and discretely package their products for shipment. These sites are www.tootimid.com and www.intimacyinstitute.com. Using adequate water-soluble lubrication with K-Y jelly, Replens® or Astroglide® packets may make sexual stimulation and/or intercourse more comfortable. Scheduling time for intimacy, when energy levels are the highest for the patient may be helpful.

Medications used to treat MS may interfere with sexual function. Postponing a dose of medication or timing it to minimize the effect on lovemaking may be all that is needed. Patients should discuss medication scheduling and any changes with their healthcare provider before doing so.

Erectile dysfunction is the primary complaint among men. Medical management includes the use of sildenafil citrate, (Viagra®), vardenafil HCl, (Levitra®) and tadafil. (Cialis®). These medications are taken 30 to 60 minutes prior to intercourse and many men find they work well for them. Crushing the medications can make them work faster. Levitra® and Cialis® are not to be taken more than one per day. Patients with cardiac histories taking nitrate medications should not use these drugs. A significant drop in blood pressure may occur leading to myocardial or cerebral infarct. Other interventions may include the use of Yohimba bark and ginseng. These herbs have been reported to increase erectile functions, but patients should consult with their physicians before using these substances as they may interfere with other medications. Testosterone injections may be given in conjunction with herbal supplements. When first line therapy fails, the patient may use intracavernous injections of alprostadil (Caverject® or Prostin VR®). Prolonged erection (priapism) is a serious concern that requires prompt treatment. MUSE®, which stands for Medication Urethral System for Erections, is a malleable semi-rigid rod with inflatable cylinders that is another permanent option for patients in whom a malleable semi-rigid rod with inflatable cylinders is surgically implanted.

Secondary Sexual Dysfunction occurs as a result of MS related physical changes or side effects of medications that indirectly affect sexual feelings and/or response. This may include bladder or bowel dysfunction, fatigue, non-genital sensory paresthesias that reduce comfort, spasticity, decreased non-genital muscle tone, weakness that interferes with sexual activity, cognitive impairments, tremor or pain. Once identified, many of these symptoms can be eased or alleviated. Interventions that may prove helpful include the following.

Bowel and bladder dysfunctions are often concurrent with sexual dysfunction since there are many shared nerve pathways. Patients become focused on the fear of "having an accident" than on the enjoyment of lovemaking, or may avoid intimacy all together. How to cope with an indwelling catheter during lovemaking becomes a commonly asked question. Women can tape the drainage tube to the abdomen to prevent pulling or pressure. Side lying positions using pillows for support may be helpful. Emptying the drainage bag, using a longer drainage tube, and taping connections will help prevent any leakage. Disconnecting the drainage bag and temporarily clamping the catheter may also be done after first consulting with a healthcare professional. Men can then fold the catheter over the penis and place a condom over both the penis and the catheter. Restricting fluids for a few hours before anticipated sexual activity may help prevent leakage of urine. Men can use condoms to collect and cope with small amounts of urine leakage. Adding padding to the bed can make the worry of an accident manageable. Bowel scheduling techniques previously discussed and emptying the bladder before sexual activity can also ease concerns regarding accidents.

Cognitive changes may be perceived as a loss of love or interest in a partner. Cognitive impairment can have a negative impact on the patient’s ability to concentrate and attention. One suggestion for minimizing this problem would be to create an environment with minimal distractions. Should a distraction occur, develop some strategies to refocus and resume sexual activity.

Pain, fatigue, spasticity and tremors can certainly impact pleasure and performance. Using energy conservation techniques, positioning and previous comfort measures discussed should prove beneficial.

Tertiary Sexual Dysfunction refers to psychological, social and cultural issues that interfere with sexual feelings and/or response. Depression, grief, demoralization, changes in body image and self-esteem, performance anxiety, family and social role changes may all be manifestations of tertiary sexual dysfunction. There may be guilt felt by the patient as they are no longer able to provide financially or "carry their weight" in the traditional family role they had. Caregivers may feel overwhelmed with all their added responsibilities and may resent having to switch roles from caregiver to lover. Treating emotional distress with the methods discussed in the psychosocial section of this module may lead to significant improvement in sexual satisfaction.

Caring for MS patients is challenging, but by educating oneself, the patient can in some be educated and prepared to deal with the multiple facets of this disease.

References
ONF 06-37-1
Multiple Sclerosis: A Multi-Faceted Disease
ONF-06-37-I

Independent Study Registration Form

Name: __________________________________________________________________ (Please print clearly)

Address: ______________________________________________________________
Street City/State/Zip

Daytime phone number: (___) ___________________ ______RN ______LPN

Fee: _______ISNA Member ($15) ______________Non-ISNA Member ($20)

ISNA OFFICE USE ONLY

Date Received: _____________ Amount:________ Check No _________________

MAKE CHECK PAYABLE TO THE INDIANA STATE NURSES ASSOCIATION. Enclose this form with the post-test, your check, and the evaluation and send to: Indiana State Nurses Association, 2915 North High School Road, Indianapolis, IN 46224.

Multiple Sclerosis: A Multi-Faceted Disease
ONF-06-37-I

Evaluation

1. Were the following objectives met? Yes No
   a. Describe the pathophysiology of MS. ❑ ❑
   b. Identify medication used to treat MS and related nursing implications. ❑ ❑
   c. Recognize nursing interventions to deal with symptoms of MS. ❑ ❑

2. Was this independent study an effective method of learning? Yes No
   If no, please comment:

3. How long did it take you to complete the study, the post-test, and the evaluation form?

4. Were the directions clearly written? Yes No
   If no, please comment:

5. Were the post-test questions clear? Yes No
   If no, please comment:

6. What other topics would you like to see addressed in an independent study?

Thank you for your assistance.

Multiple Sclerosis: A Multi-Faceted Disease
ONF-06-37-I

Post Test

Please circle the correct answer. There is only one correct answer.

1. MS strikes more Asian between the ages of 20 to 50.
   A. TRUE
   B. FALSE

2. Cytokines are released and cause more damage to myelin in the autoimmune process of MS.
   A. TRUE
   B. FALSE

3. Myelin is the only tissue damaged in MS.
   A. TRUE
   B. FALSE

4. Viruses are not considered to be a trigger in MS.
   A. TRUE
   B. FALSE

5. Vitamin D may provide a preventative effect for patients at risk of developing MS.
   A. TRUE
   B. FALSE

6. Primary progressive MS is the most commonly diagnosed form, occurring in 85% of the patients with MS.
   A. TRUE
   B. FALSE

7. Relapsing-remitting MS may develop into the secondary progressive form of MS.
   A. TRUE
   B. FALSE

8. Tonic spasm are the most common symptom of MS.
   A. TRUE
   B. FALSE

9. Depression occurs at no greater incidence in the MS population than the general population.
   A. TRUE
   B. FALSE

10. It is very easy for patients to characterize sensory symptoms of MS.
    A. TRUE
    B. FALSE

11. Ataxia is the ability to coordinate muscles to complete voluntary activities.
    A. TRUE
    B. FALSE

12. MRI's lumbar punctures and visual evoked potentials are helpful tools to diagnose MS.
    A. TRUE
    B. FALSE

    A. TRUE
    B. FALSE

14. A pseudorelapse is treated with the same measures as a relapse.
    A. TRUE
    B. FALSE

15. Side effects of steroid use may include weight gain, restlessness, mood swings, and stomach upset.
    A. TRUE
    B. FALSE

16. Interferon therapy did not really change the treatment for MS.
    A. TRUE
    B. FALSE

17. Interferons interfere with T cells crossing the blood brain barrier.
    A. TRUE
    B. FALSE

18. Betaseron® is administered subcutaneously, once a week and must be refrigerated.
    A. TRUE
    B. FALSE

(Continued on page 26)
19. Rebif® and Avonex® require refrigeration.
   A. TRUE
   B. FALSE

20. Side effects of interferons include flu-like symptoms that will subside over time.
   A. TRUE
   B. FALSE

21. Applying ice to the injection site and allowing the medication to come to room temperature may help reduce injection site reactions caused by interferons.
   A. TRUE
   B. FALSE

22. Liver damage is not an issue with interferon therapy.
   A. TRUE
   B. FALSE

23. Copaxone® is another interferon that provides amino acids and reduces relapses.
   A. TRUE
   B. FALSE

24. Post injection reactions related to Copaxone® that present as tachycardia, sweating, anxiety, dyspnea, faint feeling, flushing and/or nausea, should subside in 15 to 20 minutes.
   A. TRUE
   B. FALSE

25. Compliance is not an issue with disease modulating drugs because they cure MS.
   A. TRUE
   B. FALSE

26. Patients who perceive themselves as being in control and who regularly assume leadership roles will have an easier time coping with MS.
   A. TRUE
   B. FALSE

27. Lifestyle assessment should include means of transportation, hobbies, pass-times, financial and insurance concerns and the disclosure of MS to friends, family and co-workers.
   A. TRUE
   B. FALSE

28. Hopeful attitudes may contribute to creating a synergistic effect with treatment.
   A. TRUE
   B. FALSE

29. Encouraging the MS patient to maintain optimal health with a healthy lifestyle can help preserve conditioning and promote well being.
   A. TRUE
   B. FALSE

30. Depression may present as expressions of anger and hostility.
   A. TRUE
   B. FALSE

31. Nurses cannot advocate for the MS patient.
   A. TRUE
   B. FALSE

32. By maintaining solid professional relationships with other health care professionals, nurses are no better equipped to make good referrals for patients.
   A. TRUE
   B. FALSE

33. Most mobility problems are due to a combination of factors.
   A. TRUE
   B. FALSE

34. Patients will not be hesitant to reveal driving problems, so there is no need to involve family members.
   A. TRUE
   B. FALSE

35. There are six characteristics that have been identified that are unique to MS induced fatigue.
   A. TRUE
   B. FALSE

36. Patients with MS are immune from other conditions such as heart or lung disease or diabetes.
   A. TRUE
   B. FALSE

37. In some patients with MS, heat or increase in body temperature can greatly increase fatigue.
   A. TRUE
   B. FALSE

38. Pain is present in 45 to 65% of MS patients and may present as an acute or chronic syndrome.
   A. TRUE
   B. FALSE

39. Bladder dysfunction is categorized as failure to store urine, failure to empty and combined dysfunction.
   A. TRUE
   B. FALSE

40. Intermittent catheterization is taught as a sterile procedure.
   A. TRUE
   B. FALSE

41. Giving patients written materials may provide an invitation to discuss sexuality issues.
   A. TRUE
   B. FALSE

42. By educating ourselves, we can in turn educate patients and help prepare them to deal with the multi-facets of MS.
   A. TRUE
   B. FALSE