Healthcare Reform: What Does it Mean to You and Your Patients?

Angela Maynard RN, MSN, OCN, CBCN

Health care reform is in jeopardy even though the Affordable Care Act (ACA) was signed into law March 23, 2010. The House of Representatives voted to repeal the ACA on January 19, 2011. There are also several law suits on file debating the constitutionality of the act by some of the State’s Attorney Generals. During the budget cuts the House has cut funding that threatens the implementation of the ACA. In addition, the health care reform debate has raised many concerns and it appears that it will continue to be an ongoing discussion.

Nursing has an active leadership role in determinations of health care. As health care providers, we see how access to care affects patient outcomes. One such example of how lack of access can affect care would be a 37 year old mother of two who was diagnosed with late stage cervical cancer. She did not have insurance, despite being employed part time for a local nursing home. She did not seek medical attention until her pain was so severe she could no longer put it off. She not only had to fight for her life but also Medicaid coverage. Access to medications can also affect outcomes of care. Some patients will stop taking oral chemotherapy medications, nausea medications, or have to pick and choose what medications they are going to get filled this month because they are in the “donut hole” and simply can’t afford to pay full price for their medications.

There are problems with our healthcare system that the ACA is trying to improve. One issue that the ACA is attempting to address is cost. Insurance policies are expensive with the average annual premium $14,000. Healthcare costs are the fastest growing part of the federal budget due in part to the aging of our population resulting in many more people with health problems. In addition, our health system emphasizes acute care and treatment and is not oriented to prevention and wellness. Another issue that the ACA is attempting to address is the issue of preexisting conditions. Insurance companies can turn people down for having preexisting health conditions, charge businesses and people more if they are sick, and set lifetime limits on benefits. This means people who need healthcare the most may not be able to afford health care. In fact one in seven people do not have health insurance. Others have small policies that do not cover much, or are underinsured. Significant out of pocket financial burden of $1,200 or more annually for adults with disabilities is common.

The problem with our healthcare system is supported by several reports. According to a report from the U.S. Census Bureau (2009), the number of people covered by private and employment based health insurance declined. Four out of five of the uninsured are in working families and adults age 30 and older comprise more than half (52%) of the uninsured (Kaiser Commission on Medicaid and the Uninsured, 2008). The American Cancer Society (2009) stated patients with cancer and survivors often are unable to find adequate and affordable coverage. Also, according to the 2010 National Healthcare Quality Report disparities based on race and ethnicity, socioeconomic status persist at high levels. The goals of healthcare reform are to contain costs, expand access to care, reform the insurance industry, promote health and prevent disease, and grow the workforce.

How does the ACA help?
Phase one is in effect now, 2010-2014.
• Insurers are limited on how they spend premium dollars, by not using too much in administrative costs.
• Some services will become free for both private insurance and Medicare enrollees like immunizations, annual exams, and screening tests such as, mammograms.
• Medicare enrollees will get more help with drug costs. Seniors get a rebate of $250 to help cover the donut hole. The plan is to slowly close the hole so that enrollees only have to pay 25% of cost.
• Young people can stay on their parents insurance until age 26.
• Small business will get tax breaks to help pay for employees health insurance.
• No lifetime limits on health care coverage allowed.
• Insurers cannot refuse to cover children who have a preexisting health condition.
• High risk pools for adults who are sick and uninsured will receive government subsidies to help pay for the cost of insurance.

Continued on following page
Make new friends but keep the old, one is silver and the other gold. I find myself thinking about this old girl scout song today as I sit down to write my “from the editor.” Maybe it is because I am writing this while waiting for my husband to build a campfire while we are taking a break and spending the weekend camping. Girl scouts and camping seem to go hand in hand in my mind. There are so many of you who read this newsletter who are my gold friends, oncology nurses with me for such a long time that we have golden friendships. We have seen each other grow not only in our careers but as women. We watched as some of us moved in and out through the organization due to family, school, or other career commitments. But, we did not forget our friendships that were forged as we became oncology nurses. Recently I saw two nurses who I worked with long ago in the homecare phase of my career. One is now with Blue Cross and the other had started her own chapter of ONS where she lives north of Detroit. Old, golden friends, still passionate about caring for oncology patients. Excellent nurses, exceptional women.

But what about those silver friends- those who are new to oncology nursing. I keep seeing them on the patient units where I work at Karmanos. I feel some days inadequate to mentor them- too caught up in my own patients, too caught up in my own life. Yet, I need to sit back and remember that I was there once. A novice to the practice of oncology. A novice to nursing. There was even that time when I did not want to be a nurse! Funny that was so long ago, but there were those wonderful oncology nurses who took me under their wing and healed the insult, renewed my spirit, and helped me forge again my passion for oncology nursing. I am grateful to those wonderful nurses who were role models, and spirit lifters. I am grateful to those patients who helped me more fully develop my calling. I am not sure all of those nurses realized the impact that their mentoring and role modeling had on my career. I hope that they know that I value their friendship and their vision that guided my career. More importantly, I hope I too can serve as a role model and mentor to those new nurses I see every day.

So how about you? Can you see the gold friends and the silver friends in your career? How about making more silver friends and inviting a colleague to a membership meeting? Sure, it is hard to get motivated to come to a meeting, but I guarantee that the silver friends you make at the meeting will make up for the few hours once a month that you spend. Who knows, you may end up like me and have a wonderful collection of gold oncology nurse friends that sustain you through your career! Make new friends, but keep the old, one is silver and the other gold!

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Phase two, 2014 and beyond.
- Medicare will be expanded to cover all low income individuals and families in every state.
- Depending on what you earn, you may get a health insurance tax credit.
- Insurance exchange will be available to view insurance options where you can compare insurances and purchase what works best for you.
- No one, no matter what age, will be turned down for insurance or charged more if they are ill.
- People will be required to have health insurance or pay special fees. Employers will have to pay fines if they don’t insure employees.

The outcome is 32 million people who don’t have insurance will have it.

How will it be paid for?
One of the goals of healthcare reform is to drive down the cost. Healthcare costs are projected to increase to $4.1 trillion by 2016. The cost of the ACA is $938 billion according to the Congressional Budget Office, or 2% of the federal budget. Part of the debate is how to pay for the reform and not inflate the federal deficit. One of the solutions is that savings from health care providers will be realized. Have you felt the pinch where you work? Fees paid to hospitals will be decreased from Medicare insurers. Medicare will look at ways to make healthcare systems more efficient and increase quality of care, or get a bigger bang for the buck. There are Federal Advisory Boards that make recommendations on dealing with costs. Also projected are higher Medicare taxes for those with higher income. There will also be taxes on insurers and businesses who offer high end benefit plans, companies that make medical devices, and drugs. The challenge will be developing payment systems that work to improve value and quality.

How Does the ACA Improve Access to Care?
- ACA expands access to care by providing coverage for the uninsured.
- ACA offers incentives for physicians and nurse practitioners to go into primary care, increasing the primary care workforce.

Impact on People with Cancer
- The creation of the high risk pools for those with preexisting conditions who are uninsured.
- Affordable coverage due to elimination of annual and lifetime caps.
- Increased access to early detection, prevention, treatment, and follow-up care. Early detection and preventive services covered by insurance with no co-payments.
- Improved access and coverage of prescription drugs for Medicare enrollees.
- Insurance coverage to cover routine costs for patients participating in clinical trials. In 2014, insurance companies cannot drop an individual for participating in a clinical trial.
- Provisions of the National Pain Care Policy Act of 2009 were included in the act that includes: the Institute of Medicine to hold a conference on pain to support the creation of training efforts to educate healthcare professionals about pain assessment and treatment. Also, empowers the National Institutes of Health to enhance the national pain research agenda.
- The ACA supports research efforts by establishment of Patient Centered Outcomes Research Institute to identify research priorities and conduct research that compares effectiveness of medical treatments.

Impact on Nursing
The U.S. nursing shortage is expected to grow to 260,000 by 2025 due to increased healthcare demands of an aging population and aging workforce. The ACA addresses the projected shortage of nurses through:
- Grants for nurse education, practice, and retention.
- Education loan repayment and scholarship programs.
- Nursing faculty loan program.
- Advanced nursing education grants.
- Workforce diversity grants.
- Grant programs to support nurse-managed primary care clinics.
Challenges to the implementation and continuation of the ACA exist. The outcomes are yet to be measured and many questions will need to be answered. Who will police the healthcare law? Will it reduce incidence and morbidity resulting in lower costs or will it increase costs with new patients seeking prevention and early detection? Will the increased access to care produce higher patient volumes and exacerbate the physician and nursing shortage? Does it really improve access to care when you have no clinics in your neighborhood? Will decreasing Medicare and Medicaid reimbursement discourage healthcare professionals from practicing in primary care? Finally does the ACA really save any money or does it cost us more?

The American Nurses Association (ANA), 2010 identified expansion of healthcare resources, health policy, and planning for health regulation as key areas of health care. “The goals to provide quality healthcare while addressing the costs and quantity of available healthcare services will continue to be social and political priorities for nursing actions” (ANA, p.5). Nurses understand the needs of patients, families, and healthcare professionals so your voice is important in the evolution of healthcare reform. We have a seat at the table in improving the health of the American people. Please tell your stories to your legislators, regulatory commissions and the media.

Most of the information in this article came from web site resources on healthcare reform and for further information you can learn more from the following:

Oncology Nursing Society: http://www.ONS.org
Department of Health and Human Services: http://www.healthcare.gov
Henry J. Kaiser Family Foundation: http://www.healthreform.kff.org
Coalition of Michigan Organization of Nurses: http://www.micomon.org

Meeting Summaries >>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>

February Annual Conference Pancreatic Cancer

Presented by: Anthony F. Shields, M.D., Ph.D.
Summarized by: Theresa Benacquisto RN,BSN,OCN

This year’s conference featured a lecture by Dr. Antony Shield on pancreatic cancer. As the fourth leading cause of cancer death in both men and women, this lecture was a timely presentation. According to US mortality statistics from 2007, cancer deaths from pancreatic cancer rank second behind heart disease with a rate of 23.2%. There are an expected 30,700 cases of pancreatic cancer each year with a resultant 30,000 deaths. In fact only 1-3% of patients diagnosed will survive five years and the number of long term survivors has not changed since the 1960’s. There are no screening tests available for pancreatic cancer. The risk factors for pancreatic cancer include cigarette smoking, a high intake of fat and animal protein, diabetes, pancreatitis, H-pylori, exposure to chemicals, familial syndromes such as familial atypical multiple mole melanoma, HNPCC, BRCA2, Peutz-Jeghers, and ataxia-telangiectasia.

Several pathology types are associated with pancreatic tumors. Ninety-five percent of pancreatic cancers are adenoc ductal. Three to five present are endocrine tumors (islet cell). One percent are acinar tumors, with other pathology types comprising less than one percent. There are many genetic oncogenes identified in pancreatic cancer included K-ras (80% of tumors), AKT2, Cyclin D1, Her-2, and MYB. Tumor suppressor genes are p 16 (95%), p53, DPC4, BRCA2, p300, hMLH1 and hMSH2.

Symptoms occur late with pancreatic cancer. Symptoms associated with pancreatic cancer include abdominal pain with or without backache, obstructive jaundice, unexplained weight loss, fatigue, DVT, depression, and onset of diabetes mellitus. Once pancreatic cancer has been diagnosed, staging studies are multidetector CT scan, endoscopic ultrasound, and laparoscopy in special cases to look for peritoneal implants.

The whipple operation is potential curative therapy. Cancer at the head of the pancreas can be removed with the gallbladder, stomach portion, and duodenum with this major surgery. Contraindications to resection are hepatic, serosal, peritoneal, or omental metastasis; encasement of the perihilar portal vein, celiac axis, hepatic artery, or superior mesenteric artery; and extension outside the pancreas or nodal disease.

Of those patients diagnosed with pancreatic cancer, 10% are diagnosed with localized or resectable disease, 30% have locally advanced disease and 60% are diagnosed with metastatic disease. Treatment for early disease includes adjuvant therapy after radical surgery. There is benefit to this in small studies. Chemotherapy regimens include Gemcitabine +/- 5 FU/XRT. Locally advanced unresectable disease treatment is palliative 5 FU/XRT.

More than 80% of patients present with advanced disease. Radical surgery offers a small chance of cure (15-20%). 20-25% of those undergoing exploration have resectable disease. Perioperative mortality in experienced centers is 1-4%.

The goals of therapy are to palliate disease-related symptoms, improve quality of life, delay disease progression, and prolong survival.

Gemcitabine has shown improved survival in Phase III studies. In advanced disease median survival was six months with a one year survival rate of less than or equal to 20%. No cytotoxic combination is better than gemcitabine in an “average” patient. Subsets of patients may benefit from an added drug such as platinums and fluoropyrimidine. SWOG-0205 is one Phase III study of Gemcitabine vs Gemcitabine + Cetuximab for metastatic or locally advanced pancreatic cancer with unexplained weight loss, fatigue, DVT, depression, and onset of diabetes mellitus. Once pancreatic cancer has been diagnosed, staging studies are completed. Staging
no prior chemo for advanced disease. Patients could be randomized to either Gemcitabine 1g/m² weekly or Gemcitabine 1g/m² weekly with Cetuximab 400/250mg/m². Results showed no survival benefit. Another Phase III study in progress is Gemcitabine +/- Erlotinib a small molecule inhibitor. Also, Gemcitabine vs FOLFIRINOX is a Phase III study from ASCO 2010. Day 1 of FOLFIRINOX includes Oxaliplatin 85mg/m² + Irinotecan 180mg/m² + Leukovorin 400mg/m² + 5FU 400mg/m² bolus followed by 5FU 2400mg/m² over 46 hours every 2 weeks. Response was 27% vs 11% with Gemcitabine alone. Progression free survival was 6.4 vs 3.4 months with better survival of 10.5 vs 6.9 months. These patients need Neulasta post chemotherapy. Younger patients with good performance status tend to tolerate this treatment better.

Symptom management for abdominal pain is with non-narcotics, narcotics, and nerve blocks. Obstructive jaundice is treated with biliary stent placement. Other problems that may need symptom management include depression, venous thromboses, anorexia, malnutrition, and co-morbid conditions such as diabetes.

In conclusion, a one drug or one target approach is unlikely to succeed in treating pancreatic cancer. More tissue-based research involving genetics is necessary for better understanding of the biology of human pancreas cancer. Small well designed trials with strong scientific hypotheses must be aimed at major increments in patient outcome. Routine screening is not useful in the general public.

March

Services of the Leukemia Lymphoma Society

Presented by: Janet Miller, LPC
Summarized by: Theresa Benacquisto RN,BSN,OCN

The March program meeting was a summary of the programs offered by the Leukemia Lymphoma Society. The services provided include: patient services, research, advocacy, community services, volunteers, and professional education. You can access these services through their web site at: www.LLS.org. The Michigan chapter web site is www.LLS.org/MI.

Patient and family support programs include: family support groups, patient financial aid, co-pay assistance program, Patti Robinson Kaufmann first connection program, educational programs, informational resource center, advocacy, back to school, and honored hero program.

Visit www.LLS.org/copay for patient co-pay assistance applications which may be completed and submitted on the web site.

2010-2011 patient financial aid program begins each July 1 and ends each June 30. Patients need to submit a new application every year. However, the funding for 2010-2011 will be depleted by April 15, 2011. Patient aid will resume in the new fiscal year beginning in July 1, 2011.

The Leukemia & Lymphoma Society also provides free materials about leukemia, Hodgkin and non-Hodgkin lymphoma, myeloma, myelodysplastic syndromes and myeloproliferative disorders to patients, caregivers, and healthcare professionals. All materials are reviewed by medical experts. Materials are shipped free of charge and healthcare providers may order up to maximum of 50 copies monthly for redistribution of most booklets and a single copy of each DVD, video, or fact sheet. Fact sheets may be duplicated as needed.

There are also free educational opportunities available on telephone and on-line for health care professionals, with CE’s offered. Sign up for e-mail invitations at www.LLS.org/email.

For more information contact Jan Miller, LPC/ Patient Services Manager/ Michigan Chapter/ 248 581-3885/ 1471 E. 12 Mile Rd./ Madison Heights, MI 48071/ jan.miller@LLS.org.

MDONS available awards:

Applications available through the MDONS website http://metrodetroit.vc.ons.org

Certification Awards for free registration for ONCC certification or renewal, (OCN, AOCN, or CPON). Up to 3 awards available. Application due November 1st

Bachelor’s Degree Scholarship. Awarded to a nurse enrolled in a BSN degree program for the year in which they apply. Amount $500. Application due November1st.

Advanced Practice in Nursing Scholarship. Awarded to a nurse enrolled in a MSN degree or Doctoral degree nursing program for the application year. Amount $500. Application due November 1st

Institutes of Learning Scholarship. Maximum of $1,000 to apply toward registration, travel to & from Fall Institute & lodging, & per diem expenses. Application due September 1st

Nursing Student Educational Scholarship. Awarded to a nursing student in their last year of the nursing curriculum and interested in oncology nursing. Amount $500. Up to two awards available. Must be nominated by a MDONS member. Application due November 1st

Annual MDONS Conference Scholarship Elaine Valdez Scholarship Eligibility for the scholarship includes: Registered Nurse with less than 2 years of oncology experience., nominated by a current MDONS member. Elaine introduced many of her new oncology colleagues to MDONS, and truly valued all that MDONS has to offer its members. She was always at the MDONS conference and we feel that the scholarship is a fitting way to honor her memory. The winner will be chosen at random from all nominations received by January 15.
Meeting Summaries

April
Managing Dysphagia in Neurologic and Head and Neck Disorders
Presented by: Kathy Roeder, MA, CCC-SLP
Summarized by: Sabrina Richer, RN, MSN, OCN

Can you imagine not being able to eat because you can't swallow? No one thinks about developing a swallowing disorder and if it actually happens, it takes you by surprise. It can be very debilitating and difficult when you can't eat or drink because you can't swallow.

The normal physiology of swallowing encompasses three phases. The oral phase involves the mouth. This phase is relatively easy to understand. It is everything you do before you swallow. The pharyngeal phase involves the throat and swallowing is a voluntary mechanism. The third phase is the esophageal phase.

In the oral phase, a normal swallow requires good lip closure as well as good oral mobility and strength. The normal physiology of swallowing is quite complex. There are actually 33 muscles and 5-7 cranial nerves involved. Numerous muscles and nerves function in the oral phase. The temporalis muscle elevates and retracts the mandible (trigeminal nerve involved). The buccinators maintains food between the molars (facial nerve). The masseter elevates the mandible (trigeminal nerve). The orbicularis oris is involved in closing and puckering the lips (facial nerve). The temporalis muscle elevates (trigeminal nerve involved). The buccinators maintains food between the molars (facial nerve). The masseter elevates the mandible (trigeminal nerve). The orbicularis oris is involved in closing and puckering the lips (facial nerve). Next the intrinsic lingual muscles work to shorten the tongue, turn the tip and sides, narrow and elongate, and eventually flatten and widen the tongue to assist with food passing through the oral cavity. Again several nerves are involved.

The pharyngeal phase involves receptors in the back of the mouth and pharynx that relay to the swallowing center in the medulla. The palatopharyngeal folds pull together medially to form a slit in the upper pharynx through which the bolus passes. The soft palate and tongue play their part and the larynx and hyoid bone are pulled upward and forward to enlarge the pharynx and create a vacuum to pull the bolus downward. Eight extrinsic muscles of the larynx work to accomplish this maneuver as well as seven intrinsic muscles. The epiglottis drops down over the top of the larynx to protect the airway and allow the bolus to pass down. Pharyngeal constrictors are involved in the speed and timing of the contractions to help move the food down the pharynx. At the end of the pharyngeal phase, the muscles relax and the bolus enters the esophagus.

Three factors that cause the food to move down the pharynx are the propulsion of the tongue, the stripping action of the pharyngeal constrictors and the presence of negative pressure which originates in the esophagus and is transferred to the pharynx. Many cranial nerves are involved in this entire process including the trigeminal, facial, glossopharyngeal, vagus, spinal, and hypoglossal.

As you can see, if you had surgery or radiation to any part of the head or neck which involves the muscles or had some type of neurological impairment, swallowing could be a problem. An alteration in the anatomy due to a head or neck cancer could do the same. One needs saliva to swallow and if you lack it because of past radiation swallowing is compromised.

A modified barium swallow is used many times to assess a patient’s swallowing but you should actually obtain a CT scan. To treat patients, there are exercises to increase lip closure, improve tongue strength and buccal strength. Forced adduction exercises are used for vocal cords and supraglottic swallow for laryngeal elevation. Pharyngeal constriction and laryngeal elevation can also be accomplished by a patient using a transcutaneous neuromuscular electrical stimulation unit. This is a pulsed intermittent electrical charge. It is done 60 minutes at a time while the patient practices swallowing. It is exercise with a boost. The boost is given for two to three weeks although you need an intact nerve for it to work. Changing food consistencies can help patients and slowly advancing diets to tolerance also helps.

One must also observe for aspiration risk in these patients. Patients who are primarily at risk are acutely ill patients, bedridden patients; neurologically impaired, anterior corpectomy/laminectomy post-op patients, geriatric patients post ORIF, post intubation and patients with non-rebreather masks, high flow oxygen, and advanced COPD patients.

There is also a risk for aspiration pneumonia especially in patients who have had a known aspiration, are acutely ill, have respiratory or cognition problems, NG tubes, oral pathogens, or are on certain medications. Sometimes patients do need an NG tube or a PEG tube and the question must be asked: For Whom? For What Purpose? When? And Why Not?

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Monthley Program Notice

**Date:** Tuesday September 13, 2011  
**Topic:** Non Small Cell Lung Cancer: Mini Symposium  
**Speaker:** TBA  
**Location:** Restaurant TBA  
**Sponsor:** MDONS chapter  
**CNE credit:** 1.5

**Date:** Tuesday October 11, 2011  
**Topic:** Chronic Myelogenous Leukemia  
**Speaker:** TBA  
**Location:** St John, Main, VanElslander Cancer Cente  
**Sponsor:** IMER presentation  
**CNE credit:** 2.0

In 2011, program flyers will no longer be mailed out. Refer to program section in newsletter or check the website for up-to-date information.

http://metrodetroit.vc.ons.org
Ruth Dein, MA, BSN, OCN®, LLPC, NCC has brought many skills and attributes to the MDONS. She received her nursing diploma in 1972 and worked in various hospital settings before taking a 7-year hiatus to have 4 children. When Ruth returned to nursing, she joined the staff on a medical/surgical unit at William Beaumont Hospital. Ruth was frequently asked to work on the oncology unit and found this to be quite challenging. After learning more about chemotherapy and the other cancer treatments, Ruth asked to be permanently assigned to the oncology unit.

In 1990 Ruth was promoted to an Oncology Nurse Clinician and educating the oncology nursing staff was added to her list of duties. In 1993 she earned her bachelors degree in nursing (BSN). She also began working part-time with patients on clinical trials as a Research Staff Nurse with Cancer Care Associates. Later that year she added a second role to her job as Oncology Nurse Educator. She served as an educational resource for staff, patients, families, caregivers and community cancer agencies out of the William Beaumont Cancer Center. In 1998, the Oncology Nurse Educator position became full-time. During subsequent years Ruth attended graduate classes at Oakland University, receiving her Master of Arts in Counseling in 2004. She obtained licensure through the State of Michigan and certification through the National Board of Certified Counselors (NBCC) in 2005.

Since 2001 Ruth has been a Supportive Care Nurse at the Beaumont Cancer Center. Ruth assesses oncology patients identifying those who may be struggling with issues such as depression, anxiety, loss of self-esteem, pain, financial or other family issues. Her interventions include counseling, psychosocial interventions, education and/or referrals to appropriate resources for psychiatric assessment or long-term therapy. It is important to Ruth that all patients receive assistance. Her role also includes presenting cancer prevention programs in the community such as “Consequences of Smoking” to middle school students. Ruth has made multiple presentations a year since 1994, and she is a member of Beaumont's Speakers Bureau.

Ruth's exposure to nurses came early in her life. Her father was transferred to Brazil to work when she was 7 years old. Soon after their arrival, Ruth became ill and was hospitalized with appendicitis. No one on the hospital staff could speak English. Their attempts at communication and concern for her welfare greatly impressed her. In the 8 years in Brazil, Ruth and her family visited her aunt and uncle who were missionaries in the north and later the interior of Brazil. Part of their visitations included a trek to a leper colony and remote other villages for services. The lack of available medical care and support services in these remote areas was profound. These events instilled in her the desire to care for others. Ruth is hoping that when she retires she will be able to participate in short term mission/medical work with her husband, Robert.

Ruth and her husband, Robert have been married for 33 years, and have 4 children: Heather (27), Robert (25), Holly (22) and Emily (21). Holly and Emily are currently in college. She also has 2 grandchildren, who are a source of much joy, and is anticipating a new granddaughter in June.

Ruth’s hobbies are knitting and crocheting. She states she would do them 24/7 if she had the time. Five years ago Ruth developed a blanket program, “Creating Comfort for those Challenged by Cancer” at Beaumont’s Royal Oak Cancer Center. To date 950 blankets have been distributed to patients in Beaumont’s in-patient oncology unit, the Infusion Center and 3 oncology medical offices. Blankets are made from7 X 7 inch knitted or crocheted squares, which are then assembled into a 42 X 56 inch blanket. A card is attached to each blanket indicating that the handiwork was made by volunteers and cancer survivors, so that the recipient may be warmed in body, mind and spirit, and that they are supported and wish well. Many community groups and senior centers donate their time, talent, and materials to this project.

MDONS has provided Ruth with a great opportunity for learning oncology nursing as well as a source of networking that Ruth has found invaluable. The passion for excellence in nursing demonstrated by ONS members has been a continuing source of inspiration and support for Ruth.

Included in the information that Ruth sent me was a “Sharing and Caring Profile” article written for patients. The following excerpt reveals her thoughts and values as an oncology nurse. She tells patients

“Never underestimate the value of your struggle in the eyes if those who can only watch from the window. We can learn how to live from you.”

Joan C. McNally, MSN, RN

Childhood Leukemia

Treatment for childhood acute lymphoblastic leukemia, the most common pediatric malignancy, relies on self- or parent-administered daily oral chemotherapy given over a period of about two years. Therefore, chemotherapy adherence is critical. A new Oncology Nursing Forum article offers an evolutionary analysis of adherence in this population. After reading, be sure to discuss the journal club questions with your colleagues! http://ons.metapress.com/content/e6434r1766454757/
Evidence-based practice is an integral component in providing best practice data to optimize the clinical care for our patients, and thereby, improve treatment outcomes. As oncology nurses, we garner a vast array of knowledge, experience, skill, and talents that are essential for providing quality patient care. Health care is ever evolving and the quest to acquire validated information is a continuous process. We frequently attend conferences and read journals to remain current and maintain our licensure. Many nurses rarely disseminate their knowledge by sharing their own experiences by participating in research projects, submitting publications or giving presentations. In fact, the prospect of participating in any of these activities, particularly public speaking, is a daunting prospect for most individuals. Hence, the invaluable expertise and talent of many nurses remains untapped.

A variety of factors may hinder the oncology nurse's motivation or desire to engage in these activities, such as unfamiliarity with research guidelines or the lack of financial resources. The Oncology Nursing Society (ONS) provides a number of resources that may be used to promote their vision of excellence in providing quality care through the integration of research and evidence-based practice from project inception to publication and/or presentation of research findings (http://www.ons.org/Research).

Have you identified a patient care issue that warrants further investigation, but you are unsure of how to proceed? Whether you are a novice or experienced investigator, the ONS provides a Research and Evidence-Based Practice Consultation Program to its members that provides guidance in conducting your research initiatives. Experienced nurse researchers or other experts are available to answer questions and to facilitate the design, development and implementation of your project. The ONS Foundation demonstrates its commitment to the endorsement of nursing research by offering several grants, awards and fellowships. A comprehensive list of available funding sources as well as tips for completing your grant application is available on the ONS website (http://www.onsfoundation.org/apply).

Does the thought of speaking in public create a panic attack? An interactive Speaker Training Web course is available to assist you in the preparation and delivery of your presentation. Self-paced modules are available for completion (http://www.ons.org/CourseDetail). However, your greatest source of support usually comes from your own peers and colleagues if you elect to accept the challenge to present your findings in the form of an oral presentation. While some individuals have an innate ability for public speaking, first time jitters are common for the majority of us. There are a variety of forums available for you to share your findings on a local or a national level, thus providing another avenue for career advancement.

Finally, consider publishing your work in the form of an abstract or manuscript. The Oncology Nursing Forum is but one of multiple sources available that highlights our contribution to evidence-based practice. It is up to us to recognize the value of our input as we put evidence into practice. While the process may seem cumbersome, the possibility of implementing new strategies and interventions to improve patient care and treatment outcomes is a great incentive.

“Research serves to make building stones out of stumbling blocks” (Arthur D. Little).
The Chapter Capsule

...is a publication of the Metropolitan Detroit Chapter of the Oncology Nursing Society. MDONS is devoted to improving the quality of care given to patients experiencing cancer. This newsletter is published four times a year, in spring, summer, fall and winter. Letters and articles from members are welcomed. All material is subject to editing for space and clarification. Neither the Metro Detroit Chapter nor the ONS National Office assumes responsibility for opinions expressed herein. Acceptance of manuscripts does not indicate or imply endorsement. Materials may be submitted to:

Carole Bauer, BSN, RN, OCN, CWOCN
6116 Smithfield Drive, Troy, MI 48085

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Michelle Wallace, mwallace@beaumonthospitals.com

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Secretary
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Newsletter Editor
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Membership and Correspondence to:
Theresa Benequisto, 1844 Markese, Lincoln Park, MI 48146

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