THE MISSOURI NURSE
WRITING A NEW PRESCRIPTION FOR CHANGE IN MISSOURI

SECOND REGULAR SESSION
[TRULY AGREED TO AND FINALLY PASSED]
CONFERENCE COMMITTEE SUBSTITUTE FOR
HOUSE COMMITTEE SUBSTITUTE FOR
SENATE COMMITTEE SUBSTITUTE FOR
SENATE BILL NO. 724
104TH GENERAL ASSEMBLY
2008

AN ACT
amending sections 195.070, 195.100, 195.417, 334.102, 750.470 and 750.475 RSMo, and
in lieu thereof, enacting a new section to be known as section 195.017, enacting five
additional provisions to be known as the "Missouri Nurse Practice Act" and creating a
regulatory framework for the practice of nursing in Missouri, as follows:

Section...
IN THIS ISSUE:

CEO’S CORNER .......................................................................................................................... 3

PRESIDENT’S MESSAGE .......................................................................................................... 4

CHANGES IN MISSOURI COLLABORATIVE PRACTICE LAW (SB 724) ........................................... 5

BATTLE AGAINST CHILDHOOD OBESITY IN MISSOURI ................................................................. 6

HELPING AT RISK MOMS GET STARTED .................................................................................... 8

MISSOURI STUDENT NURSES ASSOCIATION ............................................................................ 9

TITLES AND WHO MAY USE THEM .............................................................................................. 9

NURSES FILL VOID FOR RURAL HEALTH .................................................................................. 10

HELPING THE IMPAIRED NURSE ............................................................................................... 11

ALTERNATIVE TREATMENTS FOR SMOKING CESSION ............................................................... 12

SMOKING BANS AND PSYCHIATRIC FACILITIES ..................................................................... 13

AETNA ACTION ENCOURAGES EARLY CANCER DETECTION .................................................. 15

TDAP EDUCATION DURING POSTPARTUM PERIOD ................................................................ 16

RN DELEGATES TO ANA’S BIENNIAL MEETING ....................................................................... 18

MEMBERSHIP ACCOMPLISHMENTS .......................................................................................... BACK COVER

MONA STAFF

CHIEF EXECUTIVE OFFICER
Jill Kliethermes, APRN, FNP-BC
Email: jill@missourinurses.org
Lisa DeSha
Email: lisa@missourinurses.org
Stella Lindsey
Email: stella@missourinurses.org
Sara Fry
Email: sara@missourinurses.org
Rhonda Beul
Email: rhonda@missourinurses.org
Rachel Carr
Email: rachel@missourinurses.org

DIRECTOR OF ASSOCIATION OPERATIONS
email: stella@missourinurses.org

LABOR RELATIONS REPRESENTATIVE
Stella Lindsey
Email: stella@missourinurses.org

CONTINUING EDUCATION COORDINATOR
Sara Fry
Email: sara@missourinurses.org

OFFICE SERVICES COORDINATOR
Rhonda Beul
Email: rhonda@missourinurses.org

ADMINISTRATIVE ASSISTANT
Rachel Carr
Email: rachel@missourinurses.org

The Missouri Nurse encourages readers to submit articles and information for publication. Contact the Missouri Nurses Association (Mona) office for submission requirements and deadlines. The Missouri Nurse reserves the right to edit manuscripts. Mona reserves the right to utilize published articles in a variety of formats and for the purpose of the organization. Photographs, if included, should be of crisp and clear quality. Materials should be sent to: Editor, The Missouri Nurse, Missouri Nurses Association, P.O. Box 105228, Jefferson City, MO 65110.

The Missouri Nurses Association is accredited as an approver and provider of continuing nursing education by the American Nurses Credentialing Center’s Commission on Accreditation, for the periods of February 2008 – February 2012 (Approver) and February 2008 – February 2014 (Provider).

The Missouri Nurse (ISSN 0026-6655) copyright 2008 - Missouri Nurses Association. The purpose of The Missouri Nurse, the official publication of MONA, is to disseminate information regarding policies, positions, and activities of the Association and to provide a forum for discussion of nursing issues relevant to its members.

The Missouri Nurse is published four times a year by the Missouri Nurses Association, P.O. Box 105228, Jefferson City, Missouri 65110. Subscription price is $12 per year (included in dues) for members, $50 per year for non-members, $55 per year to foreign countries. Periodicals Per the Post Office Postage Paid at Jefferson City, MO 65102. For information and rates on ads, please call MONA at (573) 636-4623.

POSTMASTER: SEND ADDRESS CHANGES TO: THE MISSOURI NURSE, P.O. BOX 105228, JEFFERSON CITY, MO 65110
The General Assembly adjourned at 6 p.m., on Friday, May 16, for the legislative interim. Missouri Nurses Association had a very successful session. In addition to getting the prescriptive authority for controlled substances legislation passed, we were successful in defeating numerous damaging proposals that were introduced. Listed below are some examples of legislation that were discussed this year.

During the start of the session, MONA’s Governmental Affairs Committee worked on safe staffing legislation with MONA member and State Representative Rebecca McClanahan. Language was drafted and shared with key stakeholders. The bill was not filed because the Technical Advisory Committee (TAC), which MONA has three representatives and was appointed by the Governor several years ago, decided to accomplish safe staffing language through the Rules & Regulation process. If all goes according to plan, the Rules & Regulations process should take almost a year to complete.

The whistleblower legislation was another issue that MONA’s Governmental Affairs Committee supported. State Representative Paul LaVota introduced the “Health Care Whistleblower Protection Act”. His bill would prohibit any employer from taking any retaliatory action against an employee for certain reasons listed in HB1816. This language was included in the omnibus health care bill voted out of Special Committee on Healthcare Transformation in April, but never moved forward.

Senator Wes Shoemyer’s SB821 would have put a Registered Nurse on the MO HealthNet Committee. However, SB821 never made final passage.

At the beginning of session, there was much discussion around a statement on the Missouri State Medical Association’s website regarding a new definition of “medicine”. MONA found the language damaging to the nursing profession and opposed it. The State Board of Healing Arts voted to approve the language, however, there was never any legislation filed during the session or amended containing the provision.

Senator Loudon’s legislation to legalize and regulate lay midwifery passed the Senate on an omnibus Professional Registration House bill on the last day. However, the House never approved the amendment and the bill died in the last hour of session (HB2081).

The General Assembly approved $300,000 for planning and design of a new Nursing and Optometry School on the University of Missouri – St. Louis campus. They also approved $300,000 for the planning and design of a new Nursing/Health Professions School on the University of Missouri – Columbia campus (HB2023).

I have only touched on a few of the issues from the 2008 legislative session. Please visit our website at www.missourinurses.org to view the complete end of session report provided by MONA’s lobbyist, Kyna Iman.

Thank you for your continued support of MONA, your professional association–The Voice of Nurses in Missouri.

---

**CEO’S CORNER**

**Legislative Wrap-Up**

Jill Kliethermes, APRN, FNP-BC

---

**Benefits**

Please visit our website at www.missourinurses.org

1. **Prepaid Legal** – Discounted rates for members
2. **CEU4U** – Online Continuing Education
3. **Liability Insurance** – MARSH
4. **Dell Computers** – MONA/ANA members receive 12% discount
5. **Wyndham Hotels** – MONA/ANA members receive 10% discount
6. **Choice Hotels** – MONA/ANA members receive 15% discount
7. **Global Volunteers Program** – MONA/ANA members receive $175 discount
8. **Special Room Rates** – Walt Disney World Swan and Dolphin Resorts
9. **Land’s End** – MONA/ANA members receive 10% discount
10. **AVIS and Budget** – Discounts for MONA/ANA members
11. **Bank of America** – Members receive special rates on credit card services
The 2008 legislative session ended with the usual flinging of papers in the Missouri Senate and House of Representatives on May 16, 2008. Among those papers was one very important piece of legislation, Senate Bill (SB) 724.

For four years, MONA worked to pass legislation that would authorize Missouri’s advanced practice registered nurses (APRNs) to prescribe controlled substances, as practiced in 47 other states. Jill Kliethermes, MONA CEO, Kyna Iman, MONA lobbyist, and I spent many hours at the Missouri Capitol over the last four months facing the non-stop opposition of physician groups as they fought to defeat the bill. Every month, MONA members, who are APRNs, visited the Capitol in their white lab coats wearing a large white button stating “Prescription for Change.” MONA members spent their days off walking the halls to locate their senator or representative to recruit their support for SB724 or offered testimony at hearings scheduled with minimal notice. Members who were not able to come to the Capitol wrote letters, called offices and sent e-mails weekly to keep the issue before their elected officials. Our colleagues in the Missouri Association of Nurse Anesthetists were valid allies in the effort, providing invaluable assistance during the session. Finally, MONA members kept their dues coming so that the activity could be funded.

The three physician groups that opposed SB724 presented many obstacles during the legislative session. Negotiations with the many interested parties took place weekly during the process, changes to the bill did take place. Members and non-members may disagree with the changes, but MONA made the best decisions it could considering the obstacles faced. On May 2, 2008, the bill passed the House (127 Ayes, 17 Nos) and on May 16, 2008, it passed the Senate (33 Ayes, 1 Nos).

The final copy of SB724 can be found at [http://www.senate.mo.gov/08info/pdf-bill/tat/SB724.pdf](http://www.senate.mo.gov/08info/pdf-bill/tat/SB724.pdf), starting at page 25. The bill was amended to include amendments to the controlled substance statutes. Many lessons were learned this year by MONA staff, officers and members. The voice of nursing must become louder at the Capitol to work on behalf of the interests of Missouri’s registered nurses. Physicians elected to office and the lobbyists of the physician groups have the power and money delay any legislation that they oppose. The one registered nurse in the Capitol, MONA member Representative Rebecca McClanahan (D2), needs the support of more nurses in the Capitol. And help is on the way. I refer you to the back cover where info is available on the nurses running for state office in 2008.

I want to extend my sincere appreciation to all the MONA members, MONA staff and our lobbyist who worked and sacrificed to accomplish this major goal. Missouri APRNs are one step closer to being able to prescribe controlled substances. Now the battle of rule writing starts. MONA will participate in the rule making process, and will keep members informed about the progress on the MONA website, [www.missourinurses.org](http://www.missourinurses.org).
Changes in Missouri Collaborative Practice Law

By Richard D. Watters, Lashly & Baer, P.C., St. Louis, Missouri

That part of Senate Bill 724, as truly agreed, finally passed and signed by the Governor affecting advanced practice registered nurses, will become law on August 14, 2008. It is fairly well known that this bill authorizes an advanced practice registered nurse (APRN), but excluding CRNAs, who hold a “certificate of controlled substance prescriptive authority” (Certificate) from the Board of Nursing (BON) and who is delegated the authority in a Collaborative Practice Agreement (CPA) to prescribe any controlled substance in Schedules III, IV and V, except for himself/herself or his/her family. What many are unaware of are the changes that this Bill requires for all CPAs between physicians and APRNs.

Controlled Substance Authority

To prescribe controlled substances, a CRNA must first obtain a Certificate from the BON. To obtain the Certificate, an APN must: 1) submit proof of successful completion of an advanced pharmacology course that includes preceptorial experience in the prescription of drugs, medicines and therapeutic devices; 2) provide documentation of a minimum of 300 clock hours preceptorial experience in the prescription of drugs, medicines and therapeutic devices with an qualified preceptor; 3) provide evidence of a minimum of 1,000 hours of practice as an APN (none of which hours can be obtained in the APN’s education program); and 4) have a CPA delegating controlled substance prescribing authority with a physician who has an unrestricted DEA number and whose practice is comparable in scope, specialty and expertise to that of the APN.

At this time, we do not know what kind of proof of completion, what type courses and experience, what documentation of clock hours, and what evidence of practice and qualifications of a preceptor will be required by the BON. This will have to await further guidance from the BON through position statements or regulations.

The law also requires that, in addition to the BON, the Healing Arts Board, Pharmacy Board and the Department of Health and Senior Services all have to approve any rules and regulations that may be adopted relating to the prescription of controlled substances by APRNs. At this time, we don’t know if the Boards will be trying to adopt rules, but if they do, it could take some time to obtain all the approvals.

We know that APRNs with controlled substance prescriptive authority will only be able to prescribe a 120 hour supply of any Schedule III narcotic controlled substance and that the CPA must contain a list of the controlled substances the APRN is authorized to prescribe.

CPA Requirements

SB 724 also imposes requirements on all CPAs involving APRNs; not just those with controlled substance prescriptive authority. By August 14, 2008, all CPAs involving APRNs should be modified to include the following:

1. Complete names, home and business addresses, zip codes, and telephone numbers of the collaborating physician and the APRN;
2. A list of all other offices or locations besides those listed in where the collaborating physician authorizes the APRN to prescribe;
3. A required posting at every office where the APRN is authorized to prescribe and a prominently displayed disclosure statement informing patients that they may be seen by an APRN and have the right to see the collaborating physician;
4. All specialty or board certifications of the collaborating physician and all certifications of the APRN;
5. The manner of collaboration between the collaborating physician and the APRN, including how they will:
   (a) Engage in collaborative practice consistent with each professional’s skill, training, education, and competence;
   (b) Maintain geographic proximity; and
   (c) Provide coverage during absence, incapacity, infirmity, or emergency by the collaborating physician;
6. A list of all other written practice agreements of the collaborating physician and the APRN;
7. The duration of the written practice agreement between the collaborating physician and the APRN; and
8. A description of the time and manner of the collaborating physician’s review of the APRN’s prescribing practices. The description must include provisions that the APRN shall submit documentation of the APRN’s prescribing practices to the collaborating physician within fourteen days. The documentation must include, but not be limited to, a random sample review by the collaborating physician of at least twenty percent of the charts and medications prescribed by the APRN.

Previously, only if the APRN was involved in the diagnosis and initiation of treatment for acutely or chronically ill or injured patients, was the collaborating physician limited to collaborating with no more than three full time equivalent (FTE) APRNs. Under SB 724, this 3 FTE limitation applies to all collaborative practice agreements involving APRNs (except for APRNs employed by hospitals and treating only inpatients, as well as APRNs employed by population based public health services).

(Continued on page 6)
Health Care Providers Lead the Battle Against Childhood Obesity in Missouri

As childhood obesity increases at a disturbing rate across Missouri and the US a unique, interdisciplinary team of Missouri's health care experts have come together to provide solutions. Their first effort was to develop an Activity and Nutrition Tool Kit to assist health care providers screen, assess and treat youth who are overweight.

It has been well established that obesity is a condition with multi-factorial causes. Therefore, it will take action in many different settings to affect a reduction in pediatric obesity rates. Through the work of the Missouri Council for Activity and Nutrition (MoCAN), a strategic plan identifying priority actions to reduce Missouri's obesity rates has been developed and is now being implemented. The state's plan outlines strategies for multiple settings, including schools, worksites, families and communities, public policy, and health care systems. One priority action identified for health care systems is to increase the support for promoting physical activity and nutritional habits that prevent and control obesity and chronic disease.

To do this, an interdisciplinary work team, comprised of physicians, nurses, dietitians, and insurance industry professionals, created a tool kit to assist health care providers establish consistent procedures for assessing patient nutrition and physical activity habits, determining weight status, prescribing treatment, and managing long-term care.

Missouri has seen the following trends in children and adolescents across the state:

- Our youth, ages 10-17, rank 15th in the nation in percent of overweight.
- In the past five years the prevalence of obese middle school students increased by 75 percent.
- In the past five years the prevalence of obese high school students increased by 64 percent.
- From 1996 to 2006 the prevalence of obese children 2 to 5 years of age participating in the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) increased by 48.8 percent.

The dramatic increase in the prevalence of obese children is associated with significant health and financial burdens, warranting strong and comprehensive prevention efforts. Carrying additional weight can affect nearly every organ system, including the cardiovascular and endocrine systems as well as mental health. In some cases, the mental stress of social stigmatization imposed on obese children may be just as damaging as the medical comorbidities. Additional complications of obesity include asthma, obstructive sleep apnea, and orthopedic and gastro-intestinal disorders. Health problems typically seen in obese adult populations are being more commonly diagnosed in the pediatric population. In addition, children and

Collaborative Practice Agreements and SB 724

As a result of Senate Bill 724, all collaborative practice agreements involving APRNs will have to be modified. This is not limited to CPAs for controlled substances. For additional information, please contact the MONA Office at (573) 636-4623.

Also, under the existing collaborative practice regulations, only those practices where the APRN is engaged in the diagnosis and initiation of treatment for acutely, chronically ill or injured patients is the APRN required to practice at the same location as the collaborating physician for at least one calendar month before the CPA can practice at a location where the physician is not present. Under SB 724, collaborating physicians must determine and document the completion of a period of at least one month during which the APRN practices with the collaborating physician continuously present before the APRN practices at any location where the collaborating physician is not continuously present. This provision applies to all APRNs, regardless of the type of practice, except for APRNs working in population based public health services.

Miscellaneous Provisions

No physician can be required by contract or other agreement to collaborate with an APRN against the physician's will. No APRN can be required by contract or other agreement to collaborate with a physician against the APRN's will. Both have the right to refuse such collaborations without penalty.

SB 724 inserted “registered” into the title of advanced practice registered nurse. It also excludes from qualification as an APRN, those nurses practicing in specialties that do not have a recognized specialty board to certify them, even if the nurse has advanced education, training and experience.

While we will have to wait for the rules and regulations to be adopted before APRNs will be able to prescribe controlled substances, many other provisions of SB 724 do not require the adoption of regulations and will soon become part of the law of collaborative practice. All APRNs should review their existing CPAs and take action to bring them into compliance by August 14, 2008.
adolescent’s hospitalization rates for the conditions exacerbated by excess weight have tripled. The probability of childhood obesity persisting into adulthood is estimated to increase from 20% at age 4 years to approximately 80% by adolescence. It is likely that any comorbidities will also remain in adulthood making potential future health care costs associated with pediatric obesity staggering.

The pediatric community is well positioned to take a leadership role in prevention and early recognition of pediatric obesity. The earlier an effort is made to prevent overweight in children, the more likely they will remain at a healthy weight. Children routinely see a physician throughout childhood for well child check-ups. Thus, the clinic setting serves as an ideal environment for preventive education. In addition, parents are more likely to implement behavior change as a result of information received from their physician, as physicians are highly trusted and influential sources for health information. Health care providers must make the effort to focus on preventive efforts for childhood obesity.

Assessing Weight Status

One purpose of the tool kit is to stress the importance of monitoring weight and weight status in children. When a child first shows an upward weight trend, parent and child can be effectively counseled before a more serious impact on health occurs. Early recognition of excessive weight gain relative to linear growth should become routine in pediatric care. At a minimum, Body Mass Index (BMI) should be calculated and plotted annually, along with assessments of eating and activity patterns for all children and adolescents. Guidelines for evaluating BMI in those younger than 18 years were recently revised in the recommendations released by the Expert Committee on the Assessment, Prevention, and Treatment of Child and Adolescent Overweight and Obesity.

BMI is evaluated using the following percentile cutoffs (2-18 years)

<table>
<thead>
<tr>
<th>Status</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Underweight</td>
<td>BMI-for-age-and-gender is less than the 5th percentile</td>
</tr>
<tr>
<td>Overweight</td>
<td>BMI-for-age-and-gender between the 85th and 94th percentiles</td>
</tr>
<tr>
<td>Obese</td>
<td>BMI-for-age-and-gender is greater or equal to the 95th percentile or BMI exceeding 30 (whichever is smaller)</td>
</tr>
</tbody>
</table>

Once weight status has been identified, providers need the framework and tools for appropriate treatment. The Activity and Nutrition Tool Kit for Healthcare Providers offers the following useful tools for treating youth in their practice:

- **Family Lifestyle Self-Assessment.** This assessment enables providers to quickly identify lifestyle behaviors that would benefit from further assessment and education.
- **Family Pledge & Goal Log.** This patient handout helps keep families on target with nutrition and activity goals.
- **A Pocket Guide: Screening and Treatment of Child and Adolescent Overweight.** This unique tool summarizes the most recent expert committee of pediatric health professionals’ recommendations for screening and treatment guidelines on a guide small enough to carry in a coat pocket.
- **Assessment and Counseling Form for Pediatric Overweight.** Assists providers in documenting comorbidities, weight trends, lab values, and counseling completed in one concise record.
- **Healthy Families: Tips for Parents.** This parent handout offers support and reminds parents of the critical role they play in the treatment of overweight children and adolescents.
- **BMI Wheel to quickly identify body mass index.**
- **BMI-for-Age Percentiles Growth Charts.** After determining BMI, these charts can be used to determine BMI-for-age percentiles in order to assess weight status.
- **Blood Pressure Tables** to assess levels in all pediatric patients.
- **Blood Cholesterol Classification Chart** to assess cholesterol levels.
- **State of Missouri Consensus Screening Guidelines for Pre-diabetes and Diabetes**

To order a tool kit free of charge, visit the Missouri Department of Health and Senior Services web site at [http://www.dhss.mo.gov/Obesity/Publications.html](http://www.dhss.mo.gov/Obesity/Publications.html).

MoCAN is looking for health care providers interested in advocating for improved health for all Missourians. For more information about MoCAN or the tool kit, please contact Patricia Kramer, M.S., R.D., L.D., at pat.kramer@dhss.mo.gov or by phone at (573) 522-2820.

**Resources**


**Data Sources**

- Missouri Nutrition Survey for School Children (NSSC)
- Pediatric Nutrition Surveillance System (PedNSS)
- Youth Risk Behavior Surveillance System (YRBS)
- Youth Tobacco Survey (YTS)
Helping At-Risk Moms Get Started

Sometimes, the simplest solutions can help solve the biggest problems.

Working as a neonatal nurse for 16 years, Sharon Rohrbach saw too many babies leave the hospital health and then return soon after with life-threatening conditions caused by neglect. So she started the Nurses to Newborns Foundation in 1992, an organization that sends nurses into the home of at-risk mothers to provide parenting education and emotional support, as well as diapers, food and clothes for their babies. “When you watch a baby die in its mother’s arms, it is a huge motivation to change what isn’t working,” says Ms. Rohrbach, who lived that terrible experience multiple times in her nursing career. “I just couldn’t sit back and do nothing to help these children, who were dying from preventable problems.”

Ms. Rohrbach, now 65, started her nursing career in 1976. She grew up in St. Louis, got married at 17 and raised four children, working part time as a secretary. When her children were older, she went back to school to get her nursing degree and landed in the neonatal unit at St. Anthony’s Medical Center in St. Louis. She soon realized that babies born to young or low-income mothers were more likely wind up back at the hospital with infections, jaundice and other maladies.

Thinking most of the problem stemmed from the fact that women were discharged after 24 hours, before many of the problems like jaundice could be detected, Ms. Rohrbach started Nurses for Newborns to provide nursing care for mothers and babies after they arrive home.

At first, she ran the organization – part time while still working as a nurse – as a for-profit company, hoping to get insurers to cover the cost of the home visits. But that proved difficult. Then, in 1991, the state of Missouri gave Nurses for Newborns $50,000 to provide its services to poor, uninsured mothers.

Seeing firsthand how poor mothers lived, Ms. Rohrbach felt compelled to change the focus of the organization. “I walked into these women’s homes, and I realized right away the length of time they stayed in the hospital was the least of their problems,” she says. Many of the babies were living in cramped, unheated houses, didn’t have a crib, and had no warm clothes or even diapers. Many of the mothers were addicted to drugs; victims of abuse of had a history of mental illness.

In 1992, Ms. Rohrbach turned Nurses for Newborns into a nonprofit organization. Nurses visit at-risk mothers and babies in their homes, bringing food, clothes, diapers and personal-care items and helping them with basic parenting skills. The results have been highly encouraging: There are far fewer hospitalizations, compared with babies who are not followed by the program; no reported cases of neglect or abuse; few injuries; higher immunization rates; and fewer repeat pregnancies.

“I didn’t know anything about running a nonprofit, I was just trying to save babies’ lives,” says Ms. Rohrbach, who left her nursing job in 1991 to devote herself full time to Nurses for Newborns.

The organization has served more than 50,000 families in Missouri and Tennessee. With 75 employees and a $3.6 million annual budget, Nurses for Newborns is now nationally recognized for its innovative work helping reduce infant mortality. Ms. Rohrbach travels 30 weeks a year; writes 52 grants applications a year; with a goal of raising at least $8,000 a day; and does advocacy work for the uninsured on state and federal levels – a pace she admits is exhausting.

She plans to step down from her post as chief executive of Nurses for Newborns by the end of 2009 to focus on a new company she has founded, Dynamic Change, which will offer consulting to nonprofits to help those better serve vulnerable populations. She’ll continue to work with Nurses for Newborns as a consultant, with the goal of expanding the program nationwide.

“I…plan to take things a bit more slowly,” Ms. Rohrbach says, “choosing how to best use my skills to help the greatest number of people.”
Missouri Nursing Students’ Association

The Missouri Nursing Students’ Association (MONSA) consists of approximately 900 students who are in nursing programs throughout Missouri. The mission of MONSA is to enhance professional nursing students’ education and practice in all environments to assure quality, affordable, and accessible health care for the people of Missouri. Students must be a member of the National Students’ Nursing Association (NSNA) to be a member of MONSA. MONSA is an entity separate and apart from NSNA and its administration of activities, with NSNA exercising no supervision or control over these immediate daily and regular activities.

MONSA’s Board of Directors is made up of nine nursing students who are elected at the organization’s annual convention. One non-voting state consultant and two advisors are appointed by the board to provide guidance and assistance as needed. Desma Reno, MSN, APRN, GCNS-BC, Southeast Missouri State University, is the state consultant. Gail Allen, BSN, RN, Cox College, and Abbie Schmoll, RN are the MONSA advisors.

Over 250 nursing students participate in MONSA’s annual convention, which features leadership and career development activities, opportunities to listen to nursing leaders, hear about job opportunities and the chance to network with hundreds of other students. In addition, the program includes a state board exam mini review.

This past year, the MONSA board has been active in participating in state and national meetings. In March, the board attended the NSNA national convention which was held in Grapevine, Texas. Students participated in the convention activities, attended leadership development meetings and also had booth to sell tee shirts to help fund future MONSA activities. In addition, two students ran for national office. Kenya Haney, a RN-BSN student from University of Missouri-St. Louis, was elected as the Breakthrough to Nursing Director. Jill Phillips, a junior at Southeast Missouri State University, was elected to the Nominations and Elections Committee-Northern Election Area. This was an exciting time for the MONSA board to be able to not only attend a national convention but also be involved in campaigning for Missouri students for office.

Upcoming events include their annual convention to be held on October 31 and November 1, 2008, in Columbia, Missouri. The convention will be held at the Holiday Inn Executive Center. Information about the convention can be found on the MONSA web site: www.monsa.org, or you can email them at monsa@charter.net.

2007-2008 OFFICERS

<table>
<thead>
<tr>
<th>Title</th>
<th>Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>President</td>
<td>Kristen Maxey</td>
</tr>
<tr>
<td>Treasurer</td>
<td>Jill Phillips</td>
</tr>
<tr>
<td>Secretary</td>
<td>Brandy Gregory</td>
</tr>
<tr>
<td>St. Louis Area Director</td>
<td>Judy Sherman</td>
</tr>
<tr>
<td>Northern Area Director</td>
<td>Celeste Molen</td>
</tr>
<tr>
<td>Southern Area Director</td>
<td>Rebecca Robbins</td>
</tr>
<tr>
<td>Public Relations Director</td>
<td>Patsy Schanda</td>
</tr>
<tr>
<td>Convention Director</td>
<td>Alicia Schmidt</td>
</tr>
<tr>
<td>Nominations/Elections Chair</td>
<td>Makenna Wright</td>
</tr>
</tbody>
</table>

Titles, RN, LPN, and APRN, Who May Use

Council on Nursing Practice - Missouri Nurses Association

By: Nancy Barr, Chair

The Council on Nursing Practice is seeking input from members of the Missouri Nurses Association regarding the use of the title “nurse.” The title “nurse” is protected by Missouri Statute 335.076 and may only be used by those persons who are licensed in the state of Missouri as Licensed Practical Nurses, Registered Nurses, or Advanced Practice Registered Nurses. If you are aware of medical assistants or others saying or using the title “nurse” when working with patients please send examples to the Council on Nursing Practice by emailing to info@missourinurses.org.
Two smiling young boys come bounding out of the examination room at Pilot Grove Rural Health Clinic. It was a good day, no shots, just a prescription. Three years ago, the family would have traveled at least 30 miles to get the boys treated for an ear infection. Today, they can walk into the office of Laurie Beach and find quality medical care for the entire family.

Beach is not a doctor. She is part of an increasing trend of nurse practitioners opening up clinics in rural Missouri. A nurse practitioner is an advanced-practice nurse who holds a master’s degree from a nursing school. They are trained to diagnose and treat symptoms. Whereas, registered nurses (RNs) are trained to identify a patient’s response to a treatment only after a diagnosis.

“The number of nurse practitioners is growing,” says Shirley Farrah, nursing administrator for the University of Missouri Sinclair School of Nursing.

In 1996, there were less than 40,000 nurse practitioners nationwide. Nine years later, that number increased to 141,000, according to the U.S. Department of Health and Human Services. With the rising cost of health care and the lack of facilities in rural areas, these professionals are filling a niche by providing an affordable alternative.

“When (nurse practitioners) first started, the rationale was, we have a lack of health care and physicians do not want to go into very rural, remote areas,” Farrah explains. “They typically want to go into areas with more resources.”

The medical field started preparing nurses to provide care for these locations in the 1970s. After 30 years, the idea is catching on in Missouri. With the help of the Missouri Nursing Association, Farrah surveyed nurses in the state to identify how many own or manage their own practice. She found 12 across the state, predominantly in rural areas.

The idea of providing care for her neighbors and friends drew Beach back home. A native of Pilot Grove, she lived on a row-crop and livestock farm. She graduated from the local high school, where she was active in 4-H and FFA, then went off to college. Beach spent 20 years as a nurse in a University of Missouri medical clinic. She opened her clinic in 2005. Since then, she has had more than 12,000 visits.

“I am actually kind of overwhelmed at how fast and how successful it has been,” Beach says.

In a community of only 700 people, Beach draws from a 50-mile radius extending to Boonville, Marshall, Sedalia and Columbia.

She cares for all ages, from infants to the elderly, with anything from sore throats to sprained ankles and even stitches.

“One man called from the field and said he had his finger cut off in a combine and wondered if I could sew it up,” Beach says laughing.

Beach’s office is one of 300 rural health clinics in the state, notes Marti Cowherd, who sits on the board of the Missouri Association of Rural Health Clinics.

“We have the largest number (of rural clinics) in the U.S.,” she says. “We just surpassed Texas a year ago.”

To have the designation “rural health clinic,” state guidelines require the clinic to serve the uninsured or underinsured population in a health professional shortage area (HPSA). More than 80 percent of Missouri’s 114 counties are designated as HPSAs.

Cowherd, a nurse practitioner, opened a clinic to fill the need for rural health care in Richmond.

“I see primarily Medicaid and Medicare populations that most people in the county do not want to see,” Coward says.

The Family Practice of Ray County offers this nurse the flexibility to give quality care beyond medicine.

“I don’t have a company telling me how many patients I have to see in a day,” she says.

It gives her the opportunity to visit for 45 minutes with a stressed new mother who just needs a shoulder to cry on and a few words of wisdom. Or help a diabetic develop a nutrition plan. Since Ray County does not have a dietician, Cowherd jumps in to provide that type of information for her diabetic patients.

“We have a whole room dedicated to diabetes information,” she says.
Helping the Impaired Nurse

MONA's Peer Assistance Committee

Dianna Phares, Ph.D, DNP, RN, FNP, BC, Chair MONA Peer Assistance Committee

The Missouri Nurses Association represents nurses on all fronts – even on those that are difficult to discuss but that are nonetheless all too real. One of these is the addicted or impaired nurse. A nurse who is addicted to any substance is a serious issue to our profession, but through MONA, there is help.

The Impaired Nurse and Addiction

- It is estimated that 1 out of every 7 nurses become addicted to drugs or alcohol.
- Chemical dependency and substance abuse are liabilities to the nursing profession!
- Education promotes early identification, intervention, and treatment.
- There is a high recovery rate for nurses who get treatment.

A quick history and facts of addiction:

- Addictive substances were brought to America by European explorers.
- Marijuana was brought to America by the Spanish in 1545.
- In the early 1800s, opium was the exotic of early drug use but was legal and easily obtained.
- By 1832, opium was first used heavily in medicine as a cure-all – and later for pleasure.
- In 1862, morphine came into use as an extraction of opium and was used during the Civil War for wounded soldiers.
- Post-war, it was called Soldier’s Disease due to its continued use by both North and South soldiers.
- In the 1890s, William Halsted, M.D. founder of Johns Hopkins School of Medicine, discovered the first local anesthetic – cocaine – and became the first known physician addict.
- During the early 1900s, alcohol abuse among the average American rose dramatically.
- At least 1 million Americans are known to be in treatment for drug or alcohol abuse.
- Almost 75% of drug users are employed.
- Addiction can start as young as 12 years of age, sometimes younger.
- Chemical dependency and drug addiction are progressive, chronic diseases.
- Addiction can be relapsing in nature and if untreated, can be fatal.
- Addiction is physiological and using drugs repeatedly over time changes brain structure and function.

The medical profession has many risk factors:

- Stress (life and death decisions)
- Suppression of feelings and emotions
- Emotional and physical exhaustion (odd shifts, double shifts and overtime expected)
- Awareness of the therapeutic effects of drugs
- Easy accessibility to drugs
- A grandiose belief that “it can’t happen to me.”

Estimated incidence of drug addiction:

- General population = 1 in 10 (10%)
- Nurses = 1 in 7 (14%)
- Nurse anesthetists = 1 in 5 (20%)
- Doctors = 1 in 8 (12.5%)

As you can see, addiction in the medical profession is a mirror of society – a reality we must work to change. MONA’s Peer Assistance Committee was established to help impaired nurses.

MONA understands how professionals can become impaired. Call the MONA Peer Assistance voicemail at (573) 636-4623, ext 228, to learn more about the facts of addiction and treatment options that are available to you. Your nursing license is precious – don't jeopardize it! All calls are confidential.
Alternative and New Treatments for Smoking Cessation

Jennifer Schmidt RN, BSN, Graduate Student; Janice Putnam RN, PhD, Associate Professor, University of Central Missouri, Department of Nursing

The death rate attributed to smoking in Missouri is higher in rural areas than urban ones (Miller, Simoes & Chang, 1997). In order to help the many rural clients in Missouri, nurses should be aware of the evidence supporting alternative and new treatments for smoking cessation.

Auricular therapy for smoking cessation is a technique in which a small stimulus is applied to the nerve endings on the exterior of the ear. Auricular therapy was developed in the 1950’s by a neurologist, Dr. Paul Nogier, (Golstein, n.d.). Research at UCLA at the same time is often cited in .com internet sites. It is claimed that after introduction of this stimulus, smokers lost their desire to smoke and reported few to no withdrawal symptoms. While there have been many anecdotal reports of clients having success using auricular therapy for smoking cessation, there is no strong research available to support this.

In a meta-analysis (N=22) by Ter, Reit, Kleijnen and Knipschild (1990), it was concluded that the results did not support the efficacy of acupuncture for smoking cessation. This was supported by a more recent meta-analysis by White, Rampes, and Campbell (2006) who also concluded that, “There is no consistent evidence that acupuncture, acupressure, laser therapy or electrostimulation are effective for smoking cessation, but methodological problems mean that no firm conclusions can be drawn. Further research using frequent or continuous stimulation is justified”.

In 2006, the FDA approved Chantix (varenicline tartrate) as an oral medication that blocks nicotine receptors to support smoking cessation. The FDA reported that Chantix provides, “some nicotine effects to ease the withdrawal symptoms and by blocking the effects of nicotine from cigarettes if they resume smoking” (FDA, 2006). Six clinical trials found Chantix to be more effective than placebo in smoking cessation. Chantix treatment occurs over twelve weeks and may continue an additional twelve weeks if needed. Adverse effects include nausea, headache, vomiting, flatulence, difficulty sleeping, sleep disturbances, and abnormal taste perception.

A nurse with knowledge of the newest evidence supporting smoking cessation provides a valuable service to their clients. Under the nurse practitioner’s management, a rural primary care clinic can also serve to identify, prescribe and treat clients with tobacco addiction.

References


Smoking Bans and Psychiatric Facilities
Submitted by: Laurel B. Homedale BSN, RN, University of Missouri - Columbia

Over the past few years, there has been a large drive to initiate public and national smoking cessation programs, as well as policies to ban smoking from restaurants, hospitals, bars, and other public establishments.

It is another issue to consider if smoking should be banned from psychiatric hospitals. Smoking rates among individuals with mental illness are at least two times that of the general population (Sacco et al., 2004). It is estimated that over 70% of patients with schizophrenia are heavy smokers (Dursun & Kutzer, 1999). When patients with chronic mental illness are admitted into inpatient facilities, they are often stripped of many privileges, including that of smoking. While many hospitals still allow smoking for their psychiatric inpatients, many of them have gone smoke-free, creating multiple adverse effects for the patient. The absence of smoking can cause severe nicotine withdrawal in patients, as well as increase the potential for aggressive behavior. Nurses who practice in psychiatric facilities need to be aware of how the lack of smoking can affect patients with mental illness.

Patients admitted into locked psychiatric facilities should have the right to smoke, just as they would in their own environments. Designated smoking areas in these facilities are often placed away from visitors, staff, and non-smoking patients, therefore not subjecting others to second-hand smoke. Facilities that ban smoking in its entirety often face ethical issues between the rights of smokers and nonsmokers because outdoor second-hand smoke is not seen as a potential threat (el-Guebaly et al., 2002). Allowing smoking in psychiatric facilities can also protect staff and other patients from aggressive acts.

Smoking and the Mentally Ill
It is not uncommon for patients to identify that smoking is one of their primary coping skills in managing symptoms of their illness. Being able to smoke while hospitalized is a top priority for these patients, regardless of the quality of care they might receive or if the facility is appropriate in meeting their needs for stabilization. Patients with mental illness often smoke as a form of self-medication. Nicotine acts on several neurotransmitters, including that of dopamine, serotonin, acetylcholine, glutamate, and norepinephrine (el-Guebaly et al., 2002). Nicotine is thought to particularly act on dopamine and glutamate to reduce the negative symptoms present in schizophrenia (i.e. apathy, poor social interaction, mask-like appearance, etc). Patients with schizophrenia often have difficulty processing auditory information and sensory improvement is often seen after smoking (Lyon, 1999). Nicotine is thought to have a calming effect for those with mental illness, often reducing their social inhibitions, making it easier to interact with others. Isolating and withdrawing from social situations is often common among those with mental illness. Patients with depression often smoke due to the fact that nicotine is thought to elevate their mood state. Finally, patients with drug or alcohol dependence are also much more likely to smoke (el-Guebaly et al., 2002).

Impact on Patients
Smoking is extremely prevalent among patients with severe and persistent mental illness. When patients decompensate and seek inpatient treatment, smoking may not be an option for them depending upon the facility’s regulations. For many, smoking provides a sense of structure in a life that often has little organization (el-Guebaly et al., 2002). Patients with chronic mental illnesses such as schizophrenia often use smoking as a means of social interaction. When smoking is not permissible, these patients often lose the opportunity for social interaction and therefore tend to isolate. A second issue is that of nicotine withdrawal. The sudden absence of nicotine in psychiatric patients can potentiate their current psychiatric symptoms or precipitate a relapse of mood symptoms. Nicotine withdrawal may also change the blood levels of psychotropic medications and could potentially become toxic (el-Guebaly et al., 2002). In facilities where smoking was permitted, patients often identified that they suffered from low self-esteem and feelings of self-degradation when their supply of cigarettes was gone and they were forced to steal, smoke cigarettes from the ground, or beg from other patients (Lawn & Pols, 2003).

Impact on Nursing Staff
Psychiatric nurses have one of the highest rates of smoking when compared to nurses from other fields. Extensive interviews conducted by Lawn & Condon (2006) with psychiatric nurse staff revealed several interesting points. Nurses identified that smoking was seen as a means of interaction with patients. Nurses also felt they were faced with an ethical dilemma considering both autonomy and beneficence. Staff believed patients had the right to smoke, as well as having the ability to make their own decisions considering smoking. Nurses in psychiatric facilities also discussed the difficulty they had in prioritizing harms and concerns, implying that staff felt that allowing the patients to smoke was less harmful than the current issues/symptoms they were currently experiencing (Lawn & Condon, 2006). Inside the hospitals, smoking is used by the staff as a form of reward/motivation for those patients who attend and participate in groups, those who obey the rules and regulations of the unit, and also to deter combative behavior. Smoking is also used as behavioral management when as needed medications are (Continued on page 14)
not sufficient (Lawn & Condon, 2006). Staff has also abused the vulnerability of smokers in inpatient facilities by removing privileges if the patients are not compliant with treatment. This can place nurses at an increased risk for violence.

**Failure of Smoking Cessation Programs**

Smoking cessation programs in psychiatric facilities are often not effective. Public health agendas are often satisfied by smoking bans, but these bans often have little effect on smoking cessation as a whole. In fact, most patients resume smoking almost immediately when they are discharged (el-Guebaly et al., 2002). As stated previously, individuals with mental illness are more likely to smoke and more likely to relapse back into using cigarettes when their illness becomes unstable (Lawn & Condon, 2006). One smoking cessation program referenced in an article by Lyon (1999) took place over 10 weeks with 24 patients diagnosed with schizophrenia. Only three patients were smoke-free at the end of six months. Failure of smoking cessation programs among patients with schizophrenia may be attributed to impaired cognition when admitted into psychiatric facilities. Nurses often fall short of addressing smoking cessation with patients because many found it inappropriate to talk about when patients were in crisis or acutely ill. In interviews conducted by Lawn & Condon (2006), staff often had difficulty discussing smoking cessation with patients because they viewed smoking as a choice and also due to the risk of increased agitation.

**Nicotinic Receptors**

Nicotinic acts on several receptors in the brain and may be beneficial in treating some cognitive deficits that are present in illnesses such as schizophrenia, Alzheimer’s disease, Tourette’s, Parkinson’s disease, and ADHD because of its effect on central nicotinic acetylcholine receptor systems (Sacco, Bannon, & George, 2004). There is new evidence supporting the use of transdermal nicotine patches and nicotine gum to act on receptors in patients with Tourette’s syndrome to reduce the presence of tics. Of course, due to social and ethical concerns, extensive testing of the benefits of nicotine in patients who are non-smokers is not ideal. Further research to develop prescription drugs that act on nicotine receptors without the potential for addiction would be helpful in patients that do have mental illnesses that affect their cognitive states (Dursun & Kutcher, 1999).

**Need for Additional Research**

Before a decision is made regarding this issue, additional information and research is needed. First, further research should be conducted to determine the negative and positive effects that nicotine has on different types of mental disorders, including mood disorders, anxiety disorders, and thought disorders.

Second, smoking cessation programs should be evaluated in each state to determine if the percentage of smokers has actually decreased, and if fewer chronic diseases secondary to smoking have been diagnosed. Also, evaluating those cities that have banned smoking from public places would be valuable in determining if this has in fact reduced the number of smokers in the city or just where they are able to smoke. The results from this research should determine if smoking cessation programs are actually cost-effective for the economy.

Third, different classes of psychiatric medications should be tested with both smokers and non-smokers to determine if smoking affects the way the drug is metabolized in the smoking group, as well as if the tolerability of the medication is altered. Medication classes that would warrant these studies should include benzodiazepines, antipsychotics, anticonvulsants, stimulants, and antidepressants, which include the most common classes of medications being prescribed. These results should be included with the drug studies to be able to evaluate how each patient will respond to the medication considering smoking as a factor.

Lastly, the average census, length of stays, and profits should be compared between different psychiatric hospitals in the area. As previously stated, many patients will only receive care in those facilities who still allow smoking. Does this really create a deficit in profit from the non-smoking facilities? Are the patient populations different from facility to facility?

**Summary and Recommendations**

Nurses and other clinicians working with mentally ill clients should assess each patient carefully to determine if and how much the patient is smoking. This can then direct staff to provide the patient with nicotine replacement if the facility is non-smoking (Lyon, 1999). Lawn & Pols (2003) agree that identifying nicotine withdrawal more effectively in patients may reduce the incidence of violent acts. In facilities that continue to allow smoking, it is recommended that the facility provide cigarettes to patients who do not have their own supply as a means to decrease their involvement in impulsive behaviors such as stealing, prostitution, and violence in the facility (Lyon, 1999). In the future if facilities begin to educate patients regarding smoking cessation, these groups should be specifically geared for patients who are cognitively impaired and acutely ill.

Policymakers and those involved in public health need to recognize that although smoking does have adverse effects, it can have multiple benefits for those with mental illness. Nicotine helps to reduce the symptoms of mental illness, as well as decrease aggressive behaviors in locked facilities. Inducing forced nicotine withdrawal among patients who are admitted into non-smoking facilities is often not addressed by staff and can exacerbate the symptoms of their illness.
America's Nurse Anesthetists Commend Aetna for Restoring Coverage of Anesthesia that Assures Most Effective, Comfortable GI Endoscopies

Action Encourages Early Detection of Colon Cancer to Save Lives

WASHINGTON, D.C. - Today's announcement by Aetna that it will restore coverage for anesthetics services that assure patients the most effective, comfortable and efficient delivery of life-saving colonoscopies was lauded by the 37,000-member American Association of Nurse Anesthetists (AANA), which had requested the health insurance giant to reverse its recent policy change denying such coverage.

"Colon cancer kills, early detection saves lives, and the most reliable method for early detection is colonoscopy," said AANA President Wanda O. Wilson, CRNA, PhD. "Patients and physicians agree that the safest and most comfortable colonoscopy is delivered with monitored anesthesia care (MAC) provided by a Certified Registered Nurse Anesthetist (CRNA) or other anesthesia professional. As nurse anesthetists, our primary interest lies in improving patient safety, comfort, and access to high quality care.

"By restoring coverage for MAC as AANA had requested, Aetna is making colonoscopies safer and more accessible for patients," said Wilson. "When a major insurer like Aetna says it will cover the best colonoscopy method, it hopefully will encourage more adults to undertake this life-saving procedure. It should also lead other health plans in covering or continuing to cover GI endoscopy MAC."

CRNAs provide the lion's share of MAC services in the United States for patients undergoing colonoscopies in hospitals, ambulatory surgical centers, and physician offices, working in most instances directly with the surgeon performing the procedure.

In December 2007, Aetna proposed denying coverage of MAC by anesthesia professionals in routine GI endoscopy cases, effective April 1, 2008. On behalf of nurse anesthetists, Wilson wrote to Aetna Chief Medical Officer Troyen Brennan, MD, MPH, and urged Aetna to withdraw the policy. In her letter, Wilson stated that "(i)t erects new barriers between patients and the safest, most comfortable, most thorough and efficient method for delivering life-saving diagnostic GI endoscopy screenings....The value of having a CRNA provide propofol MAC for GI endoscopy is that it enables a more thorough, higher quality procedure in less time, a distinctly superior outcome relative to other methods of sedation for GI endoscopy."

Wilson also shared her letter with representatives of the American Cancer Society. Some 153,000 Americans were diagnosed with colorectal cancer in 2007. Five-year survivability of early-detected colorectal cancer exceeds 90 percent, but only 39 percent of colorectal cancer is detected early. "Clearly too few people avail themselves of GI endoscopy screening, on account of several factors including discomfort and out-of-pocket cost," Wilson wrote.

In a February meeting, AANA and Aetna representatives carefully examined the evidence Aetna was relying on to make policy. Included were data showing that patients undergoing colonoscopy with propofol rated their procedures as being more comfortable (81% vs. 47%).” FDA labeling requires propofol to be administered by general anesthesia specialists such as CRNAs. The data also showed that patients were more likely to report that they felt no discomfort (84% vs. 66%) and had a shorter recovery time (12 min. vs. 93 min.).***

“We respect that Aetna has expressed concerns about propofol MAC for colonoscopies costing too much,” said Wilson. “Though insurers have reportedly stated that anesthesiologists charge up to $1,000 for this service, such a figure is two to three times what CRNAs report from other private payers, and about eight times Medicare’s fee. We realize Aetna hopes that new technology can further reduce costs. With the Institute of Medicine reporting that today’s anesthesia is 50 times safer than in the early 1980s, America’s CRNAs have long been on the forefront of technological change that improves patient safety.

“Using CRNAs to provide MAC for colonoscopies represents a win-win for patients and health plans alike,” said Wilson. “We enable an uncomfortable procedure to be delivered more comfortably, more effectively, and more efficiently, with greater patient satisfaction than currently available alternatives. With a CRNA at the head of the table, the surgeon can focus full attention on the GI procedure. The peace-of-mind that colonoscopies can be safe, comfortable, and thorough with CRNA care should encourage more people to undertake this life-saving screening.

“Aetna’s business is in its millions of health plan members and its shareholders,” Wilson concluded. “Our business as CRNAs is in patient comfort and safety. Clinicians and insurers should keep open the lines of communication in the interests of the people we serve.”

About the AANA

Founded in 1931 and located in Park Ridge, Ill., the AANA is the professional organization for more than 90 percent of the nation's CRNAs. As advanced practice nurses, CRNAS administer approximately 27 million anesthetics in the United States each year. CRNAs practice in every setting where anesthesia is available and are the sole anesthesia providers in more than two-thirds of all rural hospitals. For more information, please contact the Senior Director of Communication, Christopher Bettin at (847) 655-1143.

Tdap Education and Administration During the Postpartum Period
Shawnna Jackson, RN, BSN

Abstract
Pertussis, or whooping cough, has reemerged in adolescents and adults due to the waning immunity of childhood vaccines, subsequently increasing the risk of transmission to susceptible populations, particularly infants. Pertussis in infants can lead to severe complications, increased hospitalizations, and death. The pertussis booster, Tdap, was licensed in 2005 and recommended for use on adults ages 19-64 to prevent pertussis and extend immunity. Decreasing pertussis incidence would decrease the risk of exposure and illness in susceptible infants and the general population; however, many adults are not receiving education from providers and therefore are not getting the Tdap vaccine.

The use of Tdap vaccine is high priority among public health agencies and is also becoming a high priority in healthcare facilities. A Tdap Education and Administration Program would prevent pertussis among adults and adolescents and thus protect the health and safety of infants and the population at large. One program has been implemented that provides education and ring vaccination of all close family members in contact with infants. Other alternative programs could provide Tdap education to health care providers and patients and support administration of Tdap vaccine to household contacts of infants, specifically women of childbearing age and new mothers in the immediate postpartum period.

Pertussis Epidemiology
Pertussis, or whooping cough, is a highly contagious respiratory illness caused by the bacteria, B. pertussis. Pertussis is transmitted by close contact with an infected person through respiratory droplets, for example coughing and sneezing, with an average incubation period of 7 to 10 days. Symptoms may include flu-like symptoms for the first two weeks followed by severe coughing; these symptoms are often more severe in infants. People with pertussis are most infectious during the first few weeks of illness, sometime before the severe cough begins, and may be contagious greater than 6 weeks (CDC, 2006). Pertussis is one of the most infectious diseases, with one single case potentially leading to 15 secondary infections (Wendelboe, et al, 2007).

Over 50,000 cases of pertussis were reported in 2004 and 2005; this number reflects the greatest number of cases since the 1950s (Texas Children’s Hospital, 2008). Pertussis is preventable through vaccination; however, immunity from pertussis containing childhood vaccines wanes after 5-10 years causing adolescent and adult populations to be susceptible to pertussis (CDC, 2006). Additionally, adolescents and adults with pertussis frequently are misdiagnosed leading to multiple medical visits, prolonged infectious periods, and increased potential of transmission to infants and the population (CDC, 2006). Pertussis cases in adolescents and adults have been increasing since the 1980s, which may reflect a true increase of pertussis and improved reporting and testing (CDC, 2006). In 2004, most cases were identified in the 10-19 age group (38%), followed by those 20 years and older (28%). From 1997-2000, the pertussis rate in adolescents has increased by 62% and outbreaks are occurring in middle schools (Hitchcock, et al, 2006). One study suggested that immunizing adolescents would save up to 1.6 billion dollars and prevent up to 1.8 million cases of pertussis (Hitchcock, et al, 2006).

With the incidence of pertussis growing among adults and adolescents, comes an increased risk of transmission to susceptible populations, including infants. Infants do not have full immunity from pertussis until they have received at least three doses of pertussis containing vaccine, making infants under 6 months the most susceptible (Texas Children’s Hospital, 2008). Infants under 12 months of age make up 19% of cases and 92% of pertussis deaths in the US from 2000-2004. Of those with pertussis, 63% required hospitalization and 13 % had pneumonia (CDC, 2006). Infants that are not fully protected from pertussis account for the majority of hospitalization and deaths (Hitchcock, et al 2006).

How pertussis is transmitted to unimmunized or incompletely immunized infants has been increasingly reviewed. According to the CDC (2006), attack rates among household contacts exposed to pertussis with no immunity can be up to 80-90%. In a study from 1999-2002, 57% of pertussis exposures in infants was unknown; however, 32% of cases were identified as the mother, father, sibling, or grandparent (CDC, 2006). An infected adult is frequently the source of infection for susceptible infants (Clark, et al, 2006). Studies reported by the Texas Children’s Hospital reveal that greater than 75% of infants get pertussis from infected family members. Community contacts, non household, may account for 34% of infant pertussis (Wendelboe, et al, 2007).

Tdap Education and Administration
Tdap (tetanus, diphtheria, and acellular pertussis) vaccine was licensed in 2005 and recommended for use on adults ages 19-64 to prevent pertussis which would decrease exposure to the infant population and decrease healthcare costs (CDC, 2006). In studies
of efficacy, levels of pertussis antibodies were significantly higher in those that received vaccine; 98% had detectable levels after five years, indicating that the vaccine is effective for at least five years (Edelman, et al, 2007). Though a 10 year interval is recommended, the interval from the last Td dose to a dose of Tdap can be as short as 2 years for adults in close contact with infants and for healthcare workers (CDC, 2006). Health care providers who have not received Tdap are at risk of exposure and transmitting pertussis to patients. This risk to health care providers is 1.7 times greater than that of the general population (CDC, 2006).

A Tdap Education and Administration Program would prevent pertussis among adults and adolescents and thus protect the health and safety of infants and the population at large. An ideal program would be utilized by hospitals and would provide Tdap education to health care providers and patients and support administration of Tdap vaccine to household contacts of infants, specifically women of childbearing age and new mothers in the immediate postpartum period. Tdap education and subsequent administration is high priority among public health agencies and is also becoming a high priority in many healthcare facilities. In January 2008, the Center for Vaccine Awareness and Research at Texas Children’s Hospital implemented the county’s first “cocoon strategy” Tdap vaccination program. This program provides Tdap education and vaccination to mothers and adolescent and adult family members that may come in contact with infants, thus protecting infants from pertussis. This model has been recommended by the CDC since 2006, but has not been implemented by any other health care facility (Texas Children’s Hospital, 2008).

Because implementation of a hospital based program may be challenging, another effective measure may be to target women of childbearing age prior to pregnancy. This is similar to recommendations that ensure MMR vaccine has been given; when this is not done, the immediate postpartum period is also an option (CDC, 2006). A nationwide survey revealed that 81% of physicians would recommend Tdap, though only 68% routinely assessed immunization status (CDC, 2006). A survey of obstetricians showed that 78% would recommend Tdap in the immediate postpartum period if supported by ACIP (Clark, et al, 2006). Survey respondents felt that the responsibility of administering Tdap to new mothers or others in close contact with infants was that of adult primary care providers (89%), then obstetricians (62%), public health (61%), and pediatricians (24%) (Clark, et al, 2006).

It is critical that health care providers and hospital policymakers understand that pertussis has reemerged and is a threat to our infant population, but it can be prevented successfully. Providing education to parents and providers could likely lead to Tdap vaccine administration to susceptible populations and reduce infant pertussis cases, hospitalizations, and death.

References

Centers for Disease Control and Prevention. Preventing tetanus, diphtheria, and pertussis among adults: use of tetanus toxoid, reduced diphtheria toxoid and acellular pertussis vaccine. MMWR 2006; 55 (No.RR-17).


RN Delegates To ANA’s Biennial Meeting Take Action To Work Toward Greater Nurse Retention, Address Public Health Issues

Nancy Barr, Mary Chaston, Corrine Fessenden, Marcia Flesner, Glen Jett, Jan Polizzi, Desma Reno, & Dianne Schmidt were among the more than 600 elected registered nurse delegates to the American Nurses Association (ANA) House of Delegates. Several proposals passed designed to improve nurse retention rates while simultaneously advancing the public’s health at its meeting held in Washington, D.C.

With one half of all new graduate nurses leaving their first professional assignment in less than one year, delegates resolved to support the successful integration of new nurses into the work environment, including residency programs, and to support nursing research efforts that demonstrate effective plans for successful integration of new nurses into the work environment.

"Retention of nurses is a vital element in combating the critical nursing shortage. Nurse residency programs that provide a structured, mentored environment will help new nurse graduates progress from beginners to competent nurses. At a time when the nursing shortage threatens to impact the quality of patient care, we owe it to the nursing profession, and the public we serve to work toward the successful integration of newly graduated nurses into the work environment as well as improving the working conditions for experienced nurses,” said ANA President Rebecca M. Patton, MSN, RN, CNOR.

ANA members also resolved to increase awareness and education among nurses about the effects of intimate partner violence on the health, safety and welfare of families, children, and communities, and advocate for the use of evidence-based clinical guidelines in caring and treating victims of violence. ANA endorses the use of routine, universal and culturally sensitive intimate partner violence screening tools and protocols in all nursing specialties and settings.

Additionally, ANA delegates passed the following measures, many of which could have significant impact on public health:

- Delegates approved a resolution that recognizes the impact global climate change has on the health of the world’s population and encourages nurses to advocate for change on both individual and policy levels. The measure calls on ANA to incorporate global climate change into its legislative agenda, and support public policies that endorse sustainable energy sources and reduce greenhouse gases.
- ANA also resolved to advocate for research to identify real or perceived gaps and barriers to health care for veterans and their families.
- Recognizing concerns over the adverse affects linked to food additives and contaminants, ANA has resolved to work collectively with CMAs, affiliates and health care organizations to eliminate purchasing milk and dairy products for use in the health care industry that contain hormones.
- ANA resolved to recognize the impact human trafficking has on the public health and the profession of nursing, and to advocate for and seek opportunities to ensure nurses have the skill sets to properly identify and refer victims of human trafficking. ANA has also resolved to advocate and support legislation that further enhances protection and prosecution in an effort to decrease the incidence of human trafficking.
- ANA, one of the original supporters for the establishment of the nation’s Social Security program, resolved to work with Congress and the President to strengthen Social Security and extend its solvency beyond 2042.
- ANA resolved to advocate for the expansion of Medicare from the traditional “medical model” to include a focus on prevention, wellness and primary care services.
- ANA resolved to advocate and promote legislative and educational activities that support advanced degrees in nursing. Increasing the level of education required for continued registration as a registered nurse by requiring RNs to attain a baccalaureate degree in nursing within ten years after initial licensure, while maintaining the multiple entry points into the profession.
- ANA further resolved to advocate for legislation that increases access to oral health care for older adults and support efforts to raise awareness of the importance of oral health and preventive care for older adults.
- ANA resolved to begin a dialogue with the American Red Cross over the elimination of its Chief Nurse Officer position, and to urge the Red Cross to re-instate a Chief Nurse Officer position at its national headquarters.
Dedicated to Serving Missouri Nurses and Other Health Care Professionals

Our Health Care Attorneys:

Richard D. Watters
Kenneth C. Brostron
Judith C. Brostron, RN, LLM
Wendy J. Wolf, RN
Nancy R. Vidal, RN, CNP
Sarah K. Cahill
Matthew J. Eddy
Stephen G. Reuter
Michael J. Smith
Stuart J. Vogelsmeier
Mark R. Feldhaus
Tricia J. Mueller
Margaret C. Scavotto

The Lashly & Baer team of attorneys routinely represent nurses, hospitals, nursing homes, long-term care facilities, physicians, and other health care providers. Our team has a long history of success through alternative dispute resolution methods and trial.

LASHLY & BAER, P.C.
Attorneys at Law
714 Locust Street St. Louis, Missouri 63101 (314) 621-2939
20 East Main Street Belleville, Illinois 62220 (618) 233-5587
www.lashlybaer.com

The choice of a lawyer is an important decision and should not be based solely upon advertisements.
Congratulations on Achieving Your Doctorate of Nursing Practice  
Carol Matthews, MSN, CFNP, CPNP,  
Lila Pennington, MSN, RN., DNP, CS, FNP, and  
Dianna Phares, RN, MSN, DNP, FNP

Congratulations to Sandra Doolin Aust, who was Honored with a 2008 Kansas City Spirit Award

Sandra Aust’s early interest in helping others led her to a career in nursing. She has worked for many years as a Registered Nurse in clinical settings and has also founded and managed nursing related organizations. Most recently she embraced the challenge to educate Missourians across the state about stem cell research. Many people have benefited from her hundreds of presentations all around the state. Sandra remains active with the Harvest Ball which she co-founded 21 years ago. The Ball has raised millions of dollars for charitable efforts in the Northland. She recently finished serving as President of the Kansas City, Missouri Board of Parks and Recreation Commissioners. Despite enormous budget cuts for the Park Board, Sandra managed to continue to provide great services to the Kansas City Community by forging new partnerships and attracting outside financial support to help make up for lack of City funding. Sandra currently is involved in promoting the Liberty Memorial, serves on the City of Fountains Foundation, and is active in Friends of Line Creek, among a host of other organizations all aimed at making Kansas City a better place.

MONA is very proud of your accomplishments!

MO Nurses Running for State Office in 2008

State Rep. Rebecca McClanahan  
District 2,  
www.rebeccamcclanahan.com/district2/  

Former State Rep. Jan Polizzi  
District 97,  

Jeanie Kirkton, State Representative  
District 91, www.jeanneekirkton.com/

Sandra Aust, Senate  
District 17, sandra4senate.com/  

Former State Representative  
Joan Barry, Senate  
District 1,  
www.electjoanbarry.org/web/main/

Thank you for your contributions to PAC!

8th District  
Anonymous  
Beth Brothers  
Beth Kenney  
Beth Knox  
Beth Schrage  
Beth Sweener  
Bridget Howard  
Cassandra Lutes  
Catherine Schafer  
Christine Kunz  
Cynthia Ann Moran  
David LaFevers  
Desma Reno  
Elaine Doyle  
Frances Pulliam  
Geneva Kilgore  
Georgene Bosaw  
Glen Jett  
Janet Adams  
Janet Samuels  
Janice Jones  
Jeanne Shellabarger  
Jennifer Gwin  
Josetta Wahwassuck  
Judy Wienke  
Karin Rippe  
Katheryn Smith  
Kathy Ayers  
Laura Dulaney  
Laura Seabolt  
Laurie Beach  
Lindy Ford  
Lori Ashstock  
M D Kempf  
Corporation

Margaret White  
Maria Bitzer  
Marietta Graham  
Marsha Burris  
Marsha Kempf  
Mary Freiburghaus  
Matthew Fiori  
Micheal Whipkey  
Patty Summerford  
Nancy Enger  
Ray Erickson  
Rita Tadych  
Ruth Beckmann  
Murray Living Trust  
SE MO Nurses  
Advanced Practice

Thank you for your contributions to the MO Nurses Foundation!

Allison Kellenberger  
Brenda Reid  
Desma Reno  
Diane Spalding  
Jan Polizzi  
Karen Poe  
Marilyn Murphy  
Mary Berhorst  
Myra Aud  
Nancy Zaner  
Theresa Phillips  
Wendy Evans

Calendar

2008

**JULY 25**  
Medical/Surgical Review Course, Inn at Grand Glaze, Osage Beach, MO

**AUG. 7**  
District 18 Meeting, 6 p.m.  
Membership Committee Conference Call, 7 p.m.

**SEPT. 8**  
Continuing Education Conference Call, 10 a.m.

**SEPT. 10**  
Council on Nursing Practice, 10 a.m. - 2 p.m.

**SEPT. 12**  
Governmental Affairs Comm. 10 a.m. - 2 p.m.

**SEPT. 29**  
Continuing Education Provider Training

**OCT. 9-10**  
MONA Board Meeting

**OCT. 15**  
APRN SIG Meeting, Noon - 4 p.m.

**OCT. 16-19**  
National Conference on Professional Nursing Education and Development, InterContinental Hotel, Kansas City, MO

**NOV. 1-2**  
Healing Images™ – Guided Imagery for Health, Guided Imagery Certification Symposium, St. Louis, MO

**DEC. 11-12**  
MONA Board Meeting

**DEC. 12**  
Governmental Affairs committee

2009

**FEB. 25**  
2009 Nurse Advocacy Day, Capitol Plaza Hotel, Jefferson City, MO

**APRIL 16-17**  
19th Annual Advanced Practice Nursing Conference, Holiday Inn Select, Columbia, MO

Thank you for your contributions to PAC!