



Kinesis



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Letter from the President

Debbie Heim



What the New Chapter Membership Model Means

for You and CTC-ONS

Effective July 1, 2013 chapter membership is now included in ONS national membership, eliminating the need for members to maintain separate national and local memberships.

Why Is National ONS implementing this new model?

During 2011 and 2012, a Membership Models Task Force of the ONS Board of Directors reviewed various aspects of the ONS membership experience to determine ways to continually improve that experience and to position the Society for future growth and sustainability. Their work took into consideration a significant amount of data, including member feedback de-

rived from a number of sources. Among other key outcomes, this research revealed that members who were engaged in ONS at the local level tended to be much more engaged at the national level as well, demonstrated higher levels of overall satisfaction, and were much more likely to retain their membership for a number of years. However, at the time, only about one-third of all ONS members belonged to their local chapter. These factors contributed to the task force recommending, and the Board approving, a new membership model whereby chapter membership is no longer an optional add-on experience but automatically included as part of ONS membership.

How Will the New Chapter Membership Model Work?

- Members already affiliated with a chapter will remain affiliated with that chapter.
- Members not yet a chapter member will be assigned to the

closest chapter based on the zip code of their preferred mailing address (home or work).

- Members will have the option of changing their default chapter assignment and/or adding additional chapter memberships when they join ONS or renew their membership.
- \$10 will be added to the ONS dues amount to cover the chapter membership, and that amount will be rebated back to each member's chapter.

Why \$10?

The Task Force and the Board collected and analyzed data regarding dues from all ONS chapters and considered the financial implications of various dollar amounts. The dues amount charged by chapters varied greatly, with some chapters charging no dues, some minimal dues, and some up to \$40. The average amount charged by all chapters was about \$21, with the amount depending on what products and services each chapter offers, and whether or not the dues amount covered attendance at the chapter's din-

ner meetings.

The task force and Board wanted to keep the dues amount as reasonable as possible while still providing chapters with enough revenue to maintain their current level of operations. A financial analysis showed that, because of the large influx of new members, virtually all chapters will realize a significant increase in dues revenue, even at the \$10 amount. Keep in mind that the average chapter's membership will now triple.

For previous CTC-ONS members, the cost difference will be minimal: previous National ONS dues were \$103 and CTC-ONS dues were \$25, for a total of \$128. The new National/local dues amount is \$130 (dues increase plus \$10 chapter membership fee), so the increase is actually only \$2.

Please feel free to contact me or any Board Member with questions about this new Membership Model.

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Letter from the Editor

Ruth Gholz RN MS AOCN

As I read many of the postings the key work now is CHANGE. We see changes in membership, education re: chemotherapy and biotherapy and now there are new qualifications from the Commission on Cancer for accreditation.

How does one stay abreast of the administrative and clinical changes? In my experience the best way is to network, ask questions, join newsletter blogs and become a member of linked in.



I have been told that I always ask questions-yet this behavior has strengthened my knowledge base, provided me with new friends and pushed me to greater opportunities.

Will you consider asking, growing and sharing that information? This newsletter needs you to assist in the networking. As a nurse in the VA system I am not around many of the activities in the private sector and my areas of interest may not be yours. Please consider

contributing as an author or just sharing Kudos about each other. Many nurses function under a clinical ladder- sharing your information via media will help move forward on the ladder.

At the present time there is not a co-editor and please send correspondence to gholzcanty@fuse.net. It would be fabulous to win the Chapter nurse letter award in 2014.

Be well and keep on caring.

News from national



Connections: Advancing Care Through Science November 8–10, 2013 Dallas, TX 14.75 contact hours of CNE

Quality and Safety in Oncology Nursing

September 20–21, 2013 Virtual Conference

Care Coordination: Improving Patient-Centered Care October 18–19, 2013 Virtual Conference

ONS Congress May 1–4, 2014 Anaheim, CA



Clinical Practice Welcome to our newly updated Clinical Practice Area!

If you provide care to patients with cancer, you'll find the top resources and information about symptom management, specific diseases and conditions, critical patient education information, prevention and detection, and much more in this newly revised Clinical Practice Area

CNE Central

Advances and Updates in Breast Cancer

NLearn About Hypercalcemia in the Oncology Patient

New CINV Webcourse Now Available

Learn More Regarding Cognitive Impairment

New Online CNE: Sleep-Wake Disturbances

Leadership Development

... YOU MAY BE INTERESTED IN...

Some articles and websites you may be interested in:

1. **Medscape Nurses: Drugs of Abuse: What Clinicians need to know NOW** by Christopher Rosenbaum MD MS

2. www.Oncologynurseadvisor.com

3. www.nccn.org

4. Value Based Cancer care

5. ReachMD

6. cocsource@facs.org

7. Innovations in oncology

8. *The Oncology Nurse*®-APN/PA

9. www.Painedu.com

10. www.Cancercare.com

This is just a start. Have no fear- maybe you can develop a group and have each nurse review 3-4 sites and share the information as deemed important.

Happy learning!



CTC ONS Program Committee News

CTC-ONS will begin our new year of programs with the subject that received the highest rank in the recent Needs Assessment survey, "Medical Futility of Care: Ethical Considerations and Strategies to Respond to Futility Issues," on Tuesday, September 17th. Our presenter will be Jennifer Hester, DNP, APRN, ACHPN, Palliative Care Clinical Nurse Specialist, The Christ Hospital.

This program will be sponsored by VITAS, and the venue will be announced as soon as available.

SAVE THE DATE...9/17/13!

Future programs will be "Updates from ONS Congress," which will be presented on Wednesday, October 16th, and "HPV-Associated Head and Neck Cancer," which will be presented on Thursday, November 14th.



Many thanks to our members who are working hard to make sure that our programs are informative and enjoyable: Debbie Heim, Sue Partusch, Gigi Robison, Ann Fuhrman, Debbie Heidrich, Carol Turner, and we welcome back Kim Blanton to town and to our committee!

Sharon Sanker

CTC-ONS Program Committee Chair

The PSYCH Corner

A funny thing happened on the way to my dissertation!

By: Barb Henry, MSN, APRN-BC

I am working on my Doctorate in Nursing Practice (DNP), which involves a dissertation. A dissertation requires a theoretical framework. Some of us may cringe when we think about the nursing theory class we took as undergrads, though some may be excited when talking about theory and the great nursing leaders who have come along since Florence Nightingale. Recently, I found a new theory developed by nurses in the Phillipines that fits my dissertation project and oncology nursing, a model to help us understand our patients. I hope you will review the theory and let me know if you agree.

The “**Ribbon of Cancer Survivorship**” described the many phases of cancer survivorship and psychological coping (Guzman, Jimenez, Jocsen, et. al, 2013). The theory was developed using a grounded theory approach with 27 Filipino cancer survivors who had been diagnosed at least 6 months prior to the study, were 40 years or older, and could read and write. Though the sample studied to develop the theory was small, the concepts described by subjects seems to fit what American cancer survivors have described during psychotherapeutic encounters in the past 15 years with this author.

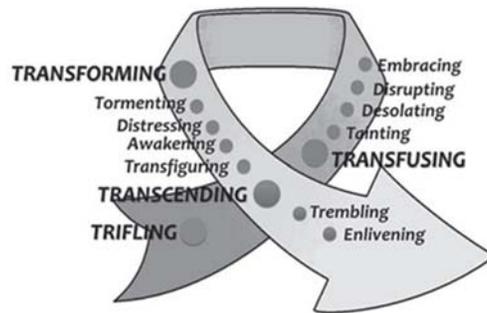
The Trifling Phase: Living Before Cancer was named to describe the moments of indifference and negligence toward health before the cancer diagnosis. Life was easy; survivors were preoccupied mainly with work, perhaps even experiencing a happy-go-lucky time of low stress without excessive concern for health issues.

The Transfusing Phase: Accepting the Reality of Cancer occurred when survivors were diagnosed with cancer. This phase encompassed an overwhelming amount of stress and emotional upset instilled with shock, denial, and negativity, though later slowly movement toward acceptance (Guzman, et. al, 2013). During the transfusing phase, there was a *tainting stage* like a dark cloud blanketing survivors with sorrow and hopelessness followed by a *desolating stage* of depressing disengagement. Survivors feared death, bargained with God, and isolated themselves a bit in sadness before entering the *disrupting stage*. Disruption occurred when survivors experienced bothersome alterations in everyday life, and had to learn how to deal with their insecurities, feeling incomplete inside. The *embracing stage* of transfusion leads to an openness in disclosing to their loved ones and acceptance of having cancer. As survivors embraced their disease, they became more vigilant and aware of the other aspects of their lives, taking more risks and becoming more appreciative of life with spirituality being a major component.

The Transforming Phase: Being Strong in the Midst of Cancer came next with *four substages: tormenting, distressing, awakening, and transfiguring*. *Tormenting* described the emotional torture and unbearably painful burden from drastic changes from the disease affecting survivors, families and friends. There was a state of isolation from society, mostly because of the social stigma of cancer along with external indicators of the disease like mastectomies, colostomies; and difficulty accepting the feeling of being incomplete, disrupting body image, relationship with society, and overall self-esteem. Tormenting was followed by the *distressing stage* of cancer survivorship because of the emotional and psychological struggles (Guzman, et. al, 2013).

Fortunately, most survivors are able to move on to an *awakening stage* in which survivors move on to an increasingly positive view, enlightened in a way that they have risen from their misery and began reconnecting with others. Survivors made amends and developed a more positive outlook in life, rebuilt themselves into a faithfully strong person as they proceed through the *transfiguring stage*; a metamorphosis. The last **Transcending Phase: Living Beyond Cancer** addresses survivors’ ability to gather their experiences about cancer to go beyond themselves to help and inspire other people. Survivors moved in and out of any of the phases and stages many times in their cancer journey and often experienced fear of recurrence *trembling stage*. Survivors reported having a more positive outlook on life, reaching an *enlivening phase* of survivorship. Refer to Figure 1 below for a visual representation of this theory.

Figure 1. Ribbon of Cancer Survivorship



Used with permission and adapted from Guzman, et. al, 2013.

Reference

- Guzman, A., Jimenez, B., Jocsen, K., Junio, A., Junio, D., Jurado, J., & Justiniano, A. (2013). This too shall pass : A grounded theory study of Filipino cancer survivorship. *Journal of Holistic Nursing* 31(1):35-47.



CDC now recommends hepatitis C testing for ALL baby boomers.

About 3% of people born from 1945 to 1965 have hepatitis C. That's 5 times higher than among adults born in other years.

This higher incidence is partly due to exposure before implementation of universal precautions and blood screening for hep C.

The time is right for testing and treating. New drugs are "game changers" with cure rates up to 75% for some patients.

Test all patients born from 1945 to 1965...plus others with known risk factors, such as IV drug abuse, HIV, or dialysis.

For patients who test positive, discuss new treatment options, including the hepatitis C protease inhibitors (Incivek, Victrelis).

Looking for information quickly? Consider signing up for newsletters and alerts from

[Www.NCCN.org](http://www.NCCN.org)



Recipients of the University of Cincinnati Florence Nightingale Awards.

It is an honor to be recognized as a Dean's Award recipient and this year 2013 there were two oncology nurses honored

1. Peggy Brooks OHC
2. Anne Wainio Cincinnati VAMC

As these nominations arise please remember to nominate your peers. Everyone is working very hard to provide quality oncology nursing, it could be many of us in 2014! Oncology nurses provide a service of excellence and should be honored. When ever you receive an alert about award nominees look around- there are candidates everywhere, and remember there is always the opportunity for self nomination.

Historically nurses have been shy about visibility and being in the lime-light. Times have changed and we must be our own advocates and celebrate each other! The next opportunity will be our chapter awards- stand tall and brag about yours or others achievements. (the extra cash is another great incentive

2013 ONS Foundation Pearl Moore Career Development Award

Amy Kimble, RN, BSN, CHPN of TriHealth- Bethesda North Hospital has been awarded the 2013 ONS Foundation Pearl Moore Career Development Award in the amount of \$2,000 to attend the 2014 ONS Congress in Anaheim, California. Amy Kimble was nominated by her Assistant Manager and her peers for this award. She is a charge nurse and the chair of the Work Culture Committee on 5300. Amy is a member of the Bethesda North Ethics committee and strong advocate for the integration of Palliative Care into Oncology.

Please take the time to meet these nurses and thank them for their excellence

Leukemia and Lymphoma Society

Mission Day 2013 Sharon Sanker RN OCN



On June 2nd and 3rd I was among 240 people from around the country who traveled to Washington DC to speak to our state representatives with the Leukemia and Lymphoma Society Mission Day 2013.

The goals of LLS are *Cures and Access*: providing funding for research and development efforts around the world to find *Cures* for blood cancers, and ensuring patient *Access* to quality, affordable, coordinated care.

An important element to provide *Access* for patients to these life-saving drugs is through **advocacy** and **public policy**. Our purpose on Mission Day was to speak to our Congressmen on behalf of two bills that are currently pending in the House of Representatives, **HR 1801** and **HR 460**, that focus on drug affordability for patients.

The **Issue** is this: Traditionally, chemotherapy has been delivered intravenously or subcutaneously in an inpatient or outpatient setting by a medical provider. With this method of administration, the drug was rolled into the cost of the treatment/visit and patients were required to pay a small co-pay, as required by their Medical Plan. With more self-administered, oral pills or self-injectable, cancer therapies on the market, patients receive their therapy at their local pharmacy counter under their Prescription Plan and are subjected to significantly higher cost-sharing requirements. This creates significant **Access** barriers for patients.

HR 1801 is the **Cancer Drug Coverage Parity Act**. It is designed to eliminate this *Access* barrier by requiring insurance carriers to provide the same coverage for cancer treatment, whether it is administered by a medical provider or self-administered as prescribed medication. It would prohibit higher costs (co-payments, co-insurances, deductibles) incurred by those patients who are receiving anti-cancer therapy as prescription medications.

HR 460 is the **Patients Access to Treatments Act**. It would prevent insurance carriers from requiring patients to pay more for medications classified as "specialty-tier" drugs than what they currently charge as a co-payment for non-specialty tier brand drugs. For example, if an insurer is currently charging \$30 for non-specialty tier brand drugs and 50% for specialty drugs, the insurer can charge no more than \$30 for the specialty drug. This will affect *Access* to many drug therapies, as well as anti-cancer therapies.

Patients who are taking Gleevec, an oral anti-cancer therapy for CML, are likely to have a co-pay of 25-50% of the cost of the drug. One month's supply costs \$7,000 a month, so the patient may be responsible for \$1,750 to \$3,500 a month. Even with assistance from the drug manufacturer or other pharmaceutical resources, our patients often face the possibility of "medical bankruptcy" or the dilemma of having to choose between the medication they need to stay alive or taking care of the essential needs of their families.

My friend, Evelyn, from Batavia is currently facing this exact issue. Gleevec has kept her in remission from CML for twelve years. But the rising cost and possible loss of financial assistance has caused her to consider opting out of taking this drug. It is heart-wrenching for Evelyn and her family to face this decision. As Evelyn says: "a patient with cancer does not need that extra worry of how we're going to pay for our drug."

I told Evelyn's story when we visited the offices of our Ohio Congressmen, Senator Rob Portman (R), Representative John Boehner (R), Representative Steve Chabot (R) and Representative Brad Wenstrup (R). We discussed these *Access* and affordability issues that affect our patients lives every day. We urged them to co-sponsor and support these two bills.

We can help. Our patients can help. Their families, care-givers and friends can help. We can all help put these policies in place so these life-saving treatments are accessible for the patients who so urgently need them.

I urge you to do **THREE** things:

Be an advocate for your blood cancer patients and introduce them to the Leukemia and Lymphoma Society literature at your facility and their website, www.LLS.org. Every blood cancer patient deserves this knowledge, assistance and advocacy.

...continues on page 6...

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Sign up for the Advocacy Network on www.LLS.org and encourage your patients to do the same.

Encourage your patients, family, friends and health professionals to call our legislators. Our elected government

www.house.gov and www.senate.gov are very user-friendly websites for information regarding our representatives.

Here are the local offices of our Senators and the Representatives serving our local districts.

CALL AND ASK THEM TO SUPPORT:

HR 1801 Cancer Drug Coverage Parity Act

HR 460 Patients Access to Treatments Act

Senator Rob Portman (R)

312 Walnut St.

Suite 3075

Cincinnati, OH 45202

Phone: (513) 684-3265

Senator Sherrod Brown (D)

425 Walnut St.,

Suite 2310

Cincinnati, OH 45202

Phone: (513) 684-1021

Representative John Boehner (R)

Local District 8 Office:

7969 Cincinnati-Dayton Road

Suite B

West Chester, OH 45069

Phone: (513) 779-5400

Representative Steve Chabot (R)

Local District 1 Office:

441 Vine Street, Rm. 3003

Cincinnati, OH 45202

Phone: (513) 684-2723

Representative Brad Wenstrup (R)

Local District 2 Office:

7954 Beechmont Ave.

Cincinnati, OH 45255

Phone: (513) 474-7777

I never saw myself as a lobbyist, but Mission Day 2013 made me realize that each one of us can make a difference for the people that we care for every day. Our advocacy for our patients does not need to be confined to the office, clinic or the hospital. Take the opportunity to advocate for their rights with your elected representatives, and urge them to do the same.





Survivorship Workshop

On April 16th, TriHealth Inc held their first Survivorship Workshop at Good Samaritan Hospital. The keynote speaker was Jennifer Klemp, PhD, MPH, Founder and CEO of Cancer Survivorship Training, Assistant Professor of Medicine, Division of Clinical Oncology, and Director of Cancer Survivorship at the University of Kansas Cancer

Center. Following an introduction and overview of survivorship, patients and family members could attend 30 minutes sessions on a variety of topics related to effects of cancer treatment. The first series included presentations on cardio-toxicity, pulmonary toxicity, or neurotoxicity, and included risk factors, signs & symptoms, and management of long term effects. During the second series, patients and family members could attend presentations on infertility options, sexuality or chronic pain syndromes. During the lunch break, attendees could gather information from display tables featuring ACS, Cancer Family care, Cancer Support Community, and the leukemia Lymphoma Society. After lunch, patients and family members could attend presentations on genetics and inherited cancers, spiritual needs, or fatigue, depression and exercise. The closing remarks were made by Dr Klemp who then discussed the effect of cancer on the individual and family. Approximately 75 patients, family members and oncology nurses attended the event. This was a first attempt to educate cancer patients about survivorship, and a great deal of information was shared by physicians, nurses, chaplains, and therapists who participated in the event.

Susan Partusch RN MSN OCN