



IOMSN Update

Multiple Sclerosis Nursing in 2001: A Global Perspective

Update on MS Nurse Credentialing

The implementation process for the credentialing of multiple sclerosis (MS) specialist nurses has been brought closer to its goal. The Multiple Sclerosis Nurses International Certification Board (MSNICB, see Table) has determined the date for the initial certification examination. It will precede the June 4, 2002 joint meeting, in Baltimore, of the Consortium of Multiple Sclerosis Centers (CMSC), the International Organization of MS Nurses (IOMSN), the Latin American Committee for Treatment and Research in MS (LACTRIMS), and the Rehabilitation in MS (RIMS) organization. "We expect all components of MS nurse certification to be in place by March 2002, at which time registration for the first examination will be open to all nurses who qualify and who wish to participate," said Heidi W. Maloni, RN, MSN, CNRN, CRNP, the primary organizer of the MSNICB.

Ms. Maloni has been at the forefront of the lengthy and arduous preparatory activities that include identifying MS nursing domains, developing a core curriculum for nurse education, composing a fair and balanced written examination, determining eligibility requirements, registering a trademark for the credential, and numerous addi-

tional tasks entailing significant time and effort. "As part of the preparation, the MSNICB has also compiled a candidate's handbook outlining the decisions of the certification board and explaining all the steps necessary to obtain certification," she related.

A major objective was reached when the MSNICB engaged an accredited testing company to fulfill the administrative services related to the test itself. The Professional Testing Corporation, which oversees certification testing for nearly 60 medical and professional organizations and which guarantees the validity and reliability of the MS nurse certification test, will be responsible for the following:

- printing and distributing a marketing brochure
- printing and distributing a brochure and test application form for MS nurses
- printing the test
- setting up test sites
- collecting the fees
- providing proctors to monitor test sessions
- grading completed tests using a computerized system

Ms. Maloni noted that the test would be specific to the domains of MS nursing, which were originally defined by the MS Nurse Specialists Consensus Committee in the mono-

graph *Multiple Sclerosis: Best Practices in Nursing Care* and later refined by the MSNICB. "Sixty-five percent of the exam questions will be focused on clinical practice, 13% on advocacy, 15% on education, and 7% on research," she advised. "Also, the exam will consider regional and cultural bias."

The initial exam will be limited to English-speaking MS nurses, but "by the next scheduled offering of the certification test in November 2002, it will have been translated into French, Dutch, Italian, Spanish, and other languages," Ms. Maloni stated. She added that the MSNICB is working on an item analysis—with input from MS nurses from different nations—that will allow inclusion of questions specific to MS care in a given country when nurses from that region are being tested. "This is necessary because parameters of clinical practice, health care insurance, drugs available for treatment, and funding for research may vary from nation to nation," she explained. "Even the number of questions to be included in the exam and the time that must be devoted to completing it were decided by consensus of MS nurses worldwide."

When asked how she felt about the time and effort that has been invested in MS nurse credentialing, the interim results, and the foresee-

able outcome, Ms. Maloni replied, "I've been very heartened by the enthusiasm for this effort expressed by the majority of nurses

I've met. There has been an enormous amount of cooperation, and many MS organizations and nurses have offered suggestions and input

that have been gratefully accepted. The fact that nurses are empowered by this process is wonderful," she emphasized. MSX

Table. Members of the Multiple Sclerosis Nurses International Certification Board

Cira Fraser, RN, CS, PhD

Graduate Faculty, Monmouth University, West Long Branch, NJ; clinical practice in MS care at Maimonides Medical Center MS Care Center, Brooklyn, NY

Jocelyne Frenette, RN, MSN

Faculty of Medicine, Sherbrooke University Nursing Program; MS Clinic Coordinator, CHUS-Hôpital Fleurimont, Fleurimont, Quebec

Marco Heerings, RN, MSN, NP

Nurse Practitioner, Multiple Sclerosis Center, Groningen University Hospital, Groningen, Netherlands

Michelle Keating, RN, OCN

Nurse Educator, St. John's Mercy Medical Center, St. Louis, Mo

Beverly Layton, RN

Clinical Research Nurse Coordinator, University of Alabama, Birmingham

Heidi Maloni, RN, MSN, CNRN, CRNP

Patient Advisory Board, National Multiple Sclerosis Society; Teaching Assistant, Community Public Health Nursing, Catholic University of America, Washington, DC; Coordinator, Multiple Sclerosis Nurses International Certification Board

Amy Perrin-Ross, RN, MSN, CNRN

Neuroscience Program Coordinator and MS Center Coordinator, Loyola University Medical Center, Maywood, Ill; Consultant, National Multiple Sclerosis Society

Suzanne Smeltzer, RN, EdD, FAAN

Associate Professor and Project Director of Health Promotion for Women With Disabilities Project, Villanova University College of Nursing, Villanova, Pa

Nicki Ward, RN

Lecturer-Practitioner in Multiple Sclerosis, University of Central England, United Kingdom

Judy Wollin, RN, PhD

Tenured Lecturer, School of Nursing, Queensland University of Technology, Queensland, Australia

Telephone Care Study Reveals Pattern in Outpatient MS Clinic

A recent study looked into the type, frequency, and duration of telephone patient encounters in an MS clinic. While nurses at the University of Calgary MS Clinic in Alberta handled almost 11,000 patient-related telephone calls between September 1, 1999 and August 31, 2000, the type and frequency of issues, and the duration of the interactions were not known. Since nurses at this clinic process such a high volume of calls and spend close to 50% of their time on

this function, Colleen Harris, RN, MN, Nurse Coordinator at the University of Calgary MS Clinic and colleagues investigated all patient-related telephone encounters that occurred over a four-month period. The researchers used a checklist that included 10 call types and three duration categories to do their monitoring.

Call Categories Provide Insights

The researchers found a consistent pattern in the results over the entire study period. A minimum of 30% of each month's encounters were related to the category of disease modifying therapy; psychosocial issues followed with an average of about

15%; next came symptom management with close to a 14% average. Other categories noted were relapses, employment and disability concerns, calls from a physician or other professional regarding patient care, queries about medications other than disease modifying therapy, complementary therapy inquiries, appointment and test results encounters, and referrals to professionals outside of the MS program.

With regard to call duration, 25% of symptom management calls and 30% of relapse calls lasted between 11 and 20 minutes. Over 80% of the encounters in other categories lasted 10 minutes or less. The remainder of the calls lasted more than 20 minutes.

According to the researchers, the information gathered in this study will help them to focus on developing the health care services and education necessary to serve the needs of the persons with MS in their region.

Poster Wins Labe C. Scheinberg Award

At the annual Consortium of Multiple Sclerosis Centers (CMSC) meeting in Fort Worth, Tex, this past

spring Ms. Harris and colleagues were recipients of the prestigious Labe C. Scheinberg Award for the poster that describes this study. The award, which was given for Best Poster in Neurorehabilitation, is named for Labe C. Scheinberg, MD, a well-known neurologist and one of the CMSC founders. As part of this honor, the researchers have been provided with an expenses-paid trip to a Rehabilitation in Multiple Sclerosis meeting in Europe to present their poster. MSX

How Your MS Nursing Colleagues View the New Criteria

MS Exchange asked MS nurses in the United States (Kathleen Costello, Baltimore; Marie Namey, Cleveland; Amy Perrin-Ross, Maywood, Ill; and Julie Saunders, Portland) and abroad (Lynn McEwan, London, Ontario, and Bernadette Porter, London) for their reactions to the new diagnostic criteria for MS. Most agreed that the biggest change from the 1982 criteria is the importance of the role of magnetic resonance imaging (MRI) in diagnosing MS. As Ms. Namey stated, "These new criteria reflect the emphasis on MRI to demonstrate dissemination of lesions in space and time. [As a result] these new criteria may eliminate the misdiagnosis of MS in some individuals." Ms. Porter added that the criteria "will be particularly helpful for the management of the earliest disease stages." Ms. Perrin-Ross praised the new categories of MS diagnosis—MS, possible MS, and not MS—for doing away with "a lot of gray areas that previously confused clinicians and patients." Ms. McEwan concurred, calling the new categories "more clear and concise" and preferable to the older clinical definite MS (CDMS) and laboratory-supported definite MS. Ms. Namey and Ms. McEwan, however, pointed out that many areas of similarities remain between the two sets of criteria.

Asked about the significance for MS nurses, Ms. Costello answered that the criteria would enable nurses to better help people understand the ramifications of the disease, particularly those who may have spent years attempting to obtain a diagnosis of their symptoms. Ms. Saunders and Ms. Perrin-Ross agreed that the new criteria provide more information to educate clients and offer a clearer definition of an MS "attack." As indicated by Ms. McEwan, these criteria will be easier to explain to people with MS, as well as to other health care professionals.

None of the respondents thought that the new criteria would change the essentials of MS nursing. Ms.

Namey noted that uncertainty about diagnosis is not eliminated, and the period of uncertainty is "a time when MS nurses need to continue to support and educate people with MS and their families. It is very important that a good trust relationship exists between the health care provider and the person with MS."

Ms. McEwan expressed the hope that the new criteria will ensure an accurate diagnosis. As she explained, "Over the past year, I have seen an increase in the number of misdiagnoses: People are given a diagnosis of MS based on a few nonspecific, white matter lesions found on MRI. This poses significant implications for the person and for the MS team. Some people are more devastated to learn that they do not have MS or only possible MS. Eliminating the MS diagnosis puts them back at the stage of diagnostic uncertainty—wait, worry, and wonder." Ms. Saunders and Ms. Porter said that persons with MS may be able to start treatment sooner, thereby lessening complications associated with advanced MS. Ms. Saunders noted that earlier treatment may result in more families in their childbearing years "facing difficult and important family-planning decisions."

Delayed diagnosis presents another concern—delayed treatment—for those people who do have MS. As

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Ms. McEwan observed, the timing of treatment is not standardized and varies according to MS centers and neurologists. "Some initiate treatment based on CHAMPS [Controlled High-Risk Subjects Avonex Multiple Sclerosis Prevention Study], and others start after two attacks," she elaborated. (According to CHAMPS' findings, use of interferon beta-1a is beneficial in people who are at high risk for developing CDMS [that is, they have experienced a single

neurologic event suggestive of demyelination and have multiple brain lesions as seen on MRI scans]). Ms. McEwan also speculated about how HMOs or government drug programs may interpret the new criteria and if this would adversely impact drug coverage. *MS Exchange* editorial board adviser, Carol Saunders (Virginia), expressed a related concern: "Insurance governs our practices and the tests we can order," and wondered

if nonacademic research institutions will be able to follow all the elements of the criteria.

Still, as Ms. Costello said, "MS is an unpredictable disease," even with new criteria. Ms. Perrin-Ross cited the example of the monosymptomatic patient. "Monosymptomatic patients are more difficult to diagnose and because Table 3 [Diagnostic Criteria, see original article] starts with 'two or more attacks,' some clinicians may delay diagnosis." MSX

New Criteria for Diagnosis of MS

The International Panel on MS Diagnosis, under the guidance of the National Multiple Sclerosis Society and the International Federation of MS Societies, convened in London during July 2000 to revise the diagnostic criteria for MS. It has been nearly two decades since the criteria for MS diagnosis were considered for update.

Throughout the past 20 years, knowledge of MS has greatly increased, prompting the need for changes in disease categories, and for integrating magnetic resonance imaging with other diagnostic methods. The

Panel also clarified specific definitions used in the diagnosis of MS (see Table).

The authors of the guidelines emphasize that the diagnosis "is best made by an expert who is familiar with the disease, its differential diagnoses, and the interpretation of paraclinical assessments (imaging, cerebral spinal fluid analysis, and evoked potentials) that can supplement the diagnostic process." The complete article, "Recommended Diagnostic Criteria for Multiple Sclerosis: Guidelines from the International Panel on the Diagnosis of Multiple Sclerosis," appears in the July 2001 issue of the *Annals of Neurology*, Volume 50, pages 121 to 127. MSX

TABLE. DIAGNOSTIC CRITERIA

Clinical Presentation	Additional Data Needed for MS Diagnosis
Two or more attacks; objective clinical evidence of two or more lesions	None ^a
Two or more attacks; objective clinical evidence of one lesion	Dissemination in space, demonstrated by MRI ^b or Two or more MRI-detected lesions consistent with MS plus positive CSF ^c or Await further clinical attack implicating a different site
One attack; objective clinical evidence of two or more lesions	Dissemination in time, demonstrated by MRI ^d or Second clinical attack
One attack; objective clinical evidence of one lesion (monosymptomatic presentation; clinically isolated syndrome)	Dissemination in space, demonstrated by MRI ^b or Two or more MRI-detected lesions consistent with MS plus positive CSF ^c and Dissemination in time, demonstrated by MRI ^d or Second clinical attack
Insidious neurological progression suggestive of MS	Positive CSF and Dissemination in space, demonstrated by: 1) Nine or more T2 lesions in brain or 2) Two or more lesions in spinal cord, or 3) Four to eight brain plus one spinal cord lesion or Abnormal VEP ^e associated with four to eight brain lesions, or with fewer than four brain lesions plus one spinal cord lesion demonstrated by MRI and Dissemination in time, demonstrated by MRI ^d or Continued progression for one year

If criteria indicated are fulfilled, the diagnosis is multiple sclerosis (MS); if the criteria are not completely met, the diagnosis is "possible MS"; if the criteria are fully explored and not met, the diagnosis is "not MS."

^aNo additional tests are required; however, if tests [magnetic resonance imaging (MRI), cerebral spinal fluid (CSF)] are undertaken and are *negative*, extreme caution should be taken before making a diagnosis of MS. Alternative diagnoses must be considered. There must be no better explanation for the clinical picture.

^bMRI demonstration of space dissemination must fulfill the criteria derived from Barkhof et al, 1997, and Tintore et al, 2000. See Table 1 in original article.

^cPositive CSF determined by oligoclonal bands detected by established methods (preferable isoelectric focusing) different from any such bands in serum or by a raised IgG index.

^dMRI demonstration of time dissemination must fulfill the criteria listed in Table 2 in original article.

^eAbnormal visual evoked potential (VEP) of the type seen in MS (delay with a well-preserved wave form).

Source: McDonald WI, Compston A, Edan G, et al. Recommended diagnostic criteria for multiple sclerosis: guidelines from the International Panel on the Diagnosis of Multiple Sclerosis. *Ann Neurol*. 2001;50:121-127. Reprinted with permission of John Wiley & Sons, Inc.