

ViewPoint

The Official Publication of the
American Academy of Ambulatory Care Nursing

Education and Engagement of Patients and Families:

Patient education has long been identified as an essential role of the registered nurse (RN). The American Nurses Association's (ANA) *Nursing: Scope and Standards of Practice* (2015) identifies health teaching and health promotion as a standard of practice that all RNs are expected to perform competently. In its *Care Coordination and Transition Management Core Curriculum*, the American Academy of Ambulatory Care Nurses (AACN) links the concepts of patient education and engagement and identifies them as one of the core domains of the Care Coordination and Transition Manager (CCTM) RN (Haas, Swan, & Haynes, 2014).

Although nurses and other health professions have a strong tradition of providing education to patients and families, this education was often provided through one-way communication in which patients were simply expected to comply. This has resulted in less than optimal outcomes and contributed to hospital readmissions (Lovlien, 2014). Patient engagement, on the other hand, describes an active partnership between health professionals, patient, and family, and the importance of "actions that individuals must take to obtain the greatest benefit from the health care

The Essential Role of the Care Coordinator and Transition Manager RN

Stephanie G. Witwer and Deanne W. Wallenstein



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Past, Present, and Future

Kathy Mertens

As an ambulatory care nurse, stop and ask yourself, *what am I part of?* The answer lies in our individual and collaborative efforts. Ambulatory care nurses are vital clinicians and leaders on the front lines of care. As we embark on a new year, we must recognize and honor our tremendous contributions to better health across diverse care settings and individuals' life spans. We are witnessing the rapid evolution of ambulatory care nurses' roles produced by technologic advances, cross continuum practice, interprofessional teams, and care innovations. We continue to partner with others toward health care's triple aim: enhance the patient experience, reduce the costs of care, and improve population health (Berwick, Nolan, & Whittington, 2008). There is tremendous work to do. The intentional action of AAACN, its members, and its volunteers, provides the resources, vision, and expertise to guide future nursing practice and demonstrate outcomes.

Recent activities include revisions to our Core Curricula:

- The *Core Curriculum for Ambulatory Care Nursing, 4th Edition*, is now available via our online store. It represents a fundamental, up-to-date, and evidence-based ambulatory care resource to prepare future nurses, inform lifelong learning, and catalyze positive change across diverse ambulatory care settings.
- The *Care Coordination and Transition Management Core Curriculum, 2nd Edition*, is nearing completion. It incorporates the surge in learnings, evidence, and innovation across the care continuum since the first edition was published in 2014. Look for it later this year.

Two key AAACN task forces are launching:

- The *Telehealth Nursing Practice Education Resources Task Force* will explore available education resources to support telehealth practice, collate these into a toolkit on the AAACN website, and make recommendations for resource development. Telehealth is integral to ambulatory care practice and competencies in this rapidly changing arena are essential.
- The *Academic-Practice Partnerships Guidelines Task Force* will develop guidelines to foster crucial academic-clinical partnerships that are vital in expediting an ambulatory care registered nurse workforce pipeline.

AAACN also continues to actively embrace collaboration with other organizations. At the fall 2018 American Nurses Association (ANA) Organizational Affiliates and Nursing Organizations Alliance meetings, AAACN leaders (CEO, president, and president-elect) joined other leaders in the field to discuss opportunities to advance nursing practice and visibility within our country and globally. It was exciting to learn about upcoming opportunities for collective action.

- An updated *Future of Nursing* report is planned. As part of this work, regional meetings will be conducted to solicit

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Telephone Triage Protocols: Training, Sustaining, and Overcoming Barriers to Use

Laurie Kirkley

Introduction

Telephone triage (TT) is a large component of today's patient care delivery model in ambulatory care. TT, defined by Rutenberg and Greenberg (2012), is "an interactive process between the nurse and client that occurs over the telephone and involves identifying the nature and urgency of client health care needs and determining the appropriate disposition" (p. 5). The focus of TT is to provide patient direction to the appropriate level of care in conjunction with recommended self-care interventions (Blank et al., 2012).

An important function within TT practice is the use of decision support tools (DSTs), or protocols, by the end-user. DSTs are a set of prescriptive algorithms intended to support the nurse's critical thinking and judgment during assessment and triage. Benefits to using DSTs are vast: fostering safe and high-quality care, improving consistency and standardization of care, enhancing efficiency of practice by providing medical delegation to expedite care and interventions following a thorough but focused assessment, and reducing potential errors (Rutenberg & Greenberg, 2012).

New care delivery models are sweeping the nation, transforming and challenging the status quo. Redesigns are incorporating a team-based approach to improve efficiency, cost-effectiveness, and sustainability (Smolowitz et al., 2015). As national health care reform continues, there is a need to improve care delivery especially

in ambulatory care. Telephonic consultation/triage remains on the forefront of interventions improving efficiency of care.

For patients and clinicians, TT can be a bridge to accessing care for patients. Ansell, Crispo, Simard, and Bjerre (2017) performed a systematic review of 11 studies on which interventions were successful in reducing wait times to access provider appointments for primary care patients. Two of the 11 studies used nurse triage interventions in an attempt to reduce wait times for primary care physician appointments. They found wait times were successfully reduced when nurse triage was used as one of several interventions. In addition, the authors state other benefits of telephone consultation included increased patient access to medical guidance and advice, thereby decreasing gaps in health maintenance care of patients with complex conditions and co-morbidities. TT interventions have been pivotal in reducing costs by preventing hospital readmissions and unnecessary emergency room visits. There was also improved quality and satisfaction for patients, payers, and care delivery organizations (Smolowitz et al., 2015).

Nurses are at the forefront of TT and are pivotal within health care delivery models. According to the Institute of Medicine's seminal work (2011), the nursing profession is equipped with in-depth knowledge to oversee patients across the continuum of care while partnering with the remainder of the health care team to lead and impact the evolution of health care delivery models. TT

requires a unique skill set to manage patient-related concerns over the telephone. Registered nurses are highly skilled and can address care and communication gaps (Bodenheimer, Bauer, Syer, & Olayiwola, 2015). The purpose of this article is to describe the implementation successes and challenges of a standardized TT training program to improve the use of protocols at a large intermountain academic health care institution in Aurora, CO.

Protocol Overview and Purchase

The academic health care institution, comprised of 60 ambulatory care clinics, purchased the Thompson and Schmitt protocols in 2011 for TT nursing practice. These protocols are evidence-based DST promoting autonomous nursing triage and assessment of patient complaints over the telephone. The initial startup cost was \$500,000 for activating this functionality in the electronic health record (EHR) with an annual maintenance cost of \$125,000. Within the EHR software, there are embedded, actionable interventions that can be immediately offered to patients during the nurse's assessment, such as over the counter and legend medication recommendations, lifestyle modifications, and nursing care plan interventions. The protocols were purchased without a clear education plan either at roll out or on a continuing basis. In addition, a maintenance plan for protocol content reviews and modifications and how to incorporate feedback from nurses was not formulated or implemented.

During the fall of 2016, a centralized call center was created and the need for standardized expectations and training for all nurses in primary care, whether in the office or in the call center, was identified. The low usage of existing protocols was identified during this process and acknowledged to be a problem to overcome with improved training and oversight.

Standardized Training Program and Outcomes

Training for clinical nurses on the Thompson and Schmitt protocols began in January 2017. There was a total of 163 registered nurse participants: 26 (16%) were from primary care clinics, and 137 (84%) were from specialty care clinics. Any ambulatory care nurse could sign up to attend the course regardless of his/her clinic patient care specialty or location. The 2-hour course curriculum was developed by a masters-prepared, experienced, ambulatory care clinical nurse educator. The curriculum included a blended training methodology of both didactic and hands-on scenario-based components. During the curriculum development phase, embedding current evidence-based practice was integral to ensuring a high-quality product. The objectives of the didactic portion of the course covered topics regarding the broad focus of TT, interstate practice and nursing standards, application of the nursing process to TT, assessment techniques over the telephone, DST usage, and documentation practices. Periodic review questions were embedded throughout the lecture for increased engagement and retention of key elements.

In order to individualize the education, the course's triage call scenarios were tailored from nurse survey data which identified the most common symptom-based calls. The nurses were given the opportunity to participate (as the 'patient' or 'nurse') or observe and navigate the EHR for each triage call scenario. The educators simulated the majority of the scenarios so the nurses could maximize their documentation and

Table 1.
Training Objectives and Didactic Review Question Examples

Objective	Review Questions
Define and describe the broad focus for telephone triage nursing.	Telephone triage is a critical component to accurately and appropriately decide on the patient's _____. Which statement about telephone triage is false? Telephone triage is the management of time-sensitive _____ calls to provide safe, appropriate and timely patient assessment, diagnosis, care planning, implementing, & evaluation via the phone. (Rutenberg & Greenberg, 2012).
Articulate nursing regulations, interstate practice, and standards upholding telephone triage nursing practice.	Telenursing practice occurs where? Three central regulatory issues when examining telephone triage include RN/LPN/LVN scope of practice, interstate practice, and _____. How many states participate in the Nurse Licensure Compact?
Describe the importance of the nursing process in telephone triage nursing practice.	What phase of the nursing process is identified as the cornerstone? What nursing process phase determines urgency of the patient health care needs? What question below falls under the Evaluation phase of the nursing process?
Examine techniques to assess the patient over the telephone.	Generally speaking, how are emergent presentations identified? Which patient presentations may seem deceptively low acuity?
Articulate the purpose, value, components, and proper use of decision support tools.	What statement below is false regarding decision support tools? Decision support tools are best utilized as a(n) _____ to clinical judgment and critical thinking. What should you do when you have multiple protocols available?
Describe best practices for documenting the telephone triage encounter.	Where does the bulk of your documentation lie in SBAR? Where does the advice and plan of care fall in your documentation? True or False: Your documentation should include both pertinent positives and negatives.

navigation skills with the protocols. For example, if a class makeup was mostly family practice and primary care nurses, the triage call scenarios could be, but were not limited to, those diagnoses typically encountered in their practices such as shortness of breath, cough, sinus pressure/pain, fever, and urination pain. Likewise, if the class makeup was a mixture of primary care and specialty care nurses from orthopedics, dermatology, and obstetrics-gynecology, the scenarios could include generalized or local pain, fever and/or nausea and vomiting from a post-operative perspective,

painful urination, and shortness of breath. Important key scenario protocol training elements for specialty nurses included how the protocol could be used to provide appropriate care given their unique patient population.

Formative evaluations were conducted throughout the didactic portion of training focusing on knowledge attainment of essential elements of TT nursing practice. See Table 1 for questions that address the components of each training objective. Post-training highlights regarding the didactic content were:

Table 2.
Nurse Barriers for Use: Quantitative Data
n=23

Question	Not at all	Some of the time	Most of the time	All of the time	Unsure/Don't know
1) Do you currently utilize nurse advice telephone protocols?	8.7% (<i>n</i> =2)	39.1% (<i>n</i> =9)	34.8% (<i>n</i> =8)	17.4% (<i>n</i> =4)	0% (<i>n</i> =0)
2) Do you feel protocols improve patient outcomes?	17.4% (<i>n</i> =4)	52.2% (<i>n</i> =12)	26.1% (<i>n</i> =6)	4.3% (<i>n</i> =1)	0% (<i>n</i> =0)
3) Do you feel Providers value nurse protocol usage?	30.4% (<i>n</i> =7)	39.1% (<i>n</i> =9)	13.1% (<i>n</i> =3)	4.3% (<i>n</i> =1)	13.1% (<i>n</i> =3)
4) Do you feel protocol usage improves your communication with Providers?	30.4% (<i>n</i> =7)	47.8% (<i>n</i> =11)	17.4% (<i>n</i> =4)	4.3% (<i>n</i> =1)	0% (<i>n</i> =0)

- 75% (*n*=122) of nurses correctly identified telenursing practice occurring at the location of the patient rather than at the location of the registered nurse, calling attention to the importance of understanding interstate practice.
- 79% (*n*=128) of nurses correctly identified the purpose of DSTs standardizing the professional nursing practice being provided.
- 91% (*n*=148) of nurses correctly identified choosing the protocol positioning the patient to the highest level of care in the quickest manner when multiple protocols are available for a specific clinical presentation.

Following the training course, the nurses were asked to describe at least one action item needing to be integrated into their TT professional practice. The 107 action items identified by the nurses were grouped into these categories:

- 47% (*n*=50) of the action items identified incorporating the protocols into the nurses' TT practice.
- 36% (*n*=39) of the action items identified the nurse incorporating the standardized communication and documentation method of Situation, Background, Assessment, Recommendation (SBAR) into the triage note.
- 17% (*n*=18) of the actions items were grouped into an 'other' category such as:

- 'Organize my tabs (in the EHR) for more efficient triage workflow.'
- 'Change how I answer the telephone.'
- 'Editing dispositions and care advice.'

All new ambulatory care nurse employees are introduced to this course during new employee orientation. Attendance at the training course is required within the first 90 days of hire or transfer into the ambulatory care setting. The classes are taught via rotation by all seven ambulatory care clinical nurse educators in the professional development department and average attendance at the monthly course offerings for 2017 was about 10 attendees per class.

Measurement and Barriers of Protocol Usage

Training outcomes and effectiveness were evaluated by protocol usage rates. Primary care services were initially targeted since they had a call center that opened in fall of 2016. They also had standardized workflows and expectations for care and the patient experience. Monthly protocol utilization rates were tracked pre-training as baseline data from October to December 2016. Average collective usage rates across all seven organizational primary care practices was 25.1% for the pre-training period. After initiation of TT training in

January 2017, DST usage rates for primary care in 2017 rose to 28.9% in January, 30.1% in February, and 40.4% in April; however, the rates remained below the institutional goal of 80%. A root cause analysis was performed to evaluate the continued specific barriers and gaps in protocol usage.

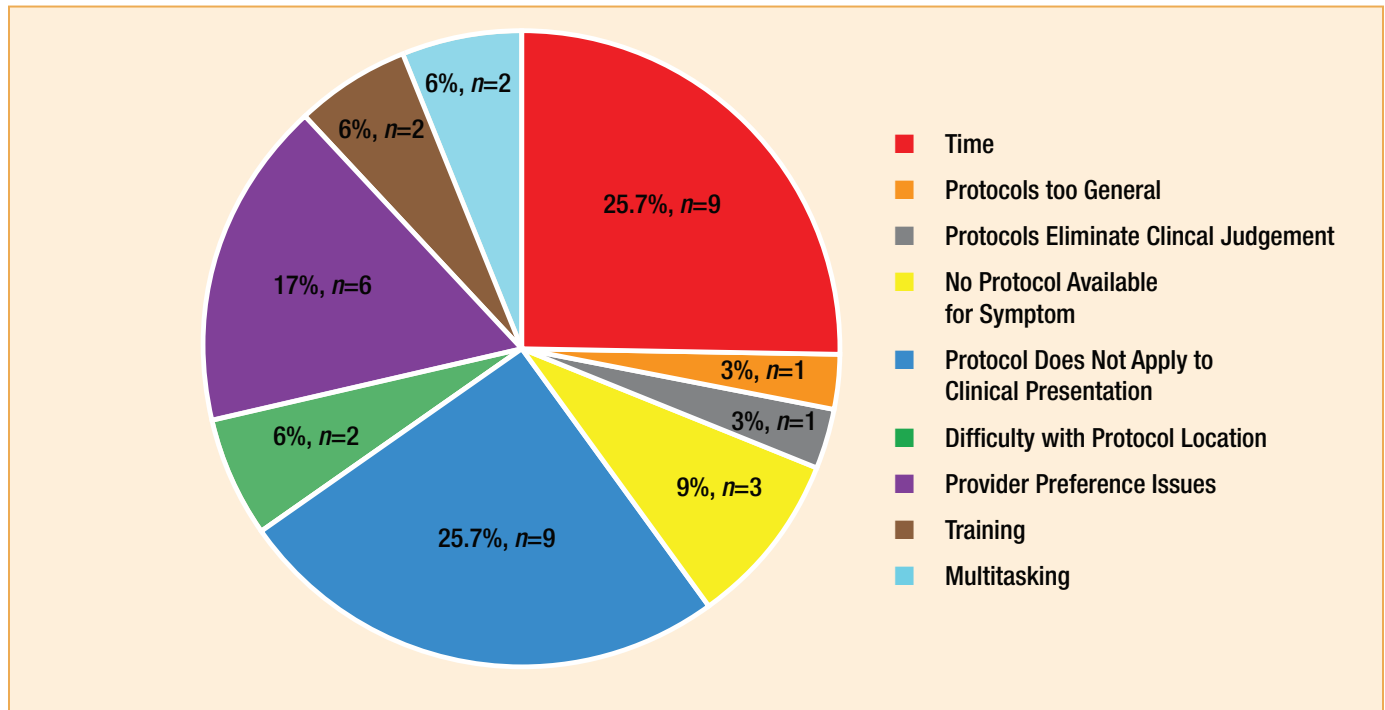
Following the implementation of the training program, the primary care nurses were surveyed to assess for reasons which caused the continued poor protocol usage. A survey eliciting a mixture of quantitative and qualitative feedback was sent to all 30 primary care nurses. The response rate was 77% (*n*=23).

Survey questions included:

- 1) Do you currently utilize nurse advice telephone protocols?
- 2) Do you feel protocols improve patient outcomes?
- 3) Do you feel providers value nurse protocol usage?
- 4) Do you feel protocol usage improves your communication with providers?
- 5) What are your biggest barriers with using telephone advice protocols?

The quantitative questions (numbers 1-4) were assessed using a five-point Likert scale: *not at all*, *some of the time*, *most of the time*, *all of the time*, and *unsure/don't know* (see Table 2). Of the 23 primary care nurses who responded, only two (8.7%) nurses answered *not at all* to using DSTs in their routine practice

Figure 1.
Nurse Barriers to Telephone Protocol Use



(question 1). Most nurses responded *some of the time* to all of the quantitative survey questions. Only one nurse (4.3%) felt providers value nurse protocol usage *all the time*, and three (13.1%) nurses were *unsure/don't know* if providers value nursing practice.

Nine main themes emerged: *Time*, *Protocols too General*, *Protocols Eliminate Clinical Judgment*, *No Protocol Available for Symptom*, *Protocol Does Not Apply to Clinical Presentation*, *Difficulty With Protocol Location*, *Provider Preference Issues*, *Training*, and *Multitasking*. Figure 1 outlines the percentages of barriers reported for each of the nine categories. Three barriers represent almost 70% of the nurse responses. These were *Time*, *Protocol Does Not Apply to Clinical Presentation*, and *Provider Preference Issues*.

Barrier 1: Time

Time included nurse responses depicting time constraints with not only searching, but also using a protocol while triaging a patient. The main concern related to finding the protocol: it

takes a very long time to go through several protocols and it is challenging to search protocols in a timely manner. Others reported it is a cumbersome process that takes time, doing both SBAR and protocol communication and lots of incoming calls=less time to document were additional feedback examples from the nurses on protocol usage.

Barrier 2: Protocol Does Not Apply to Clinical Presentation

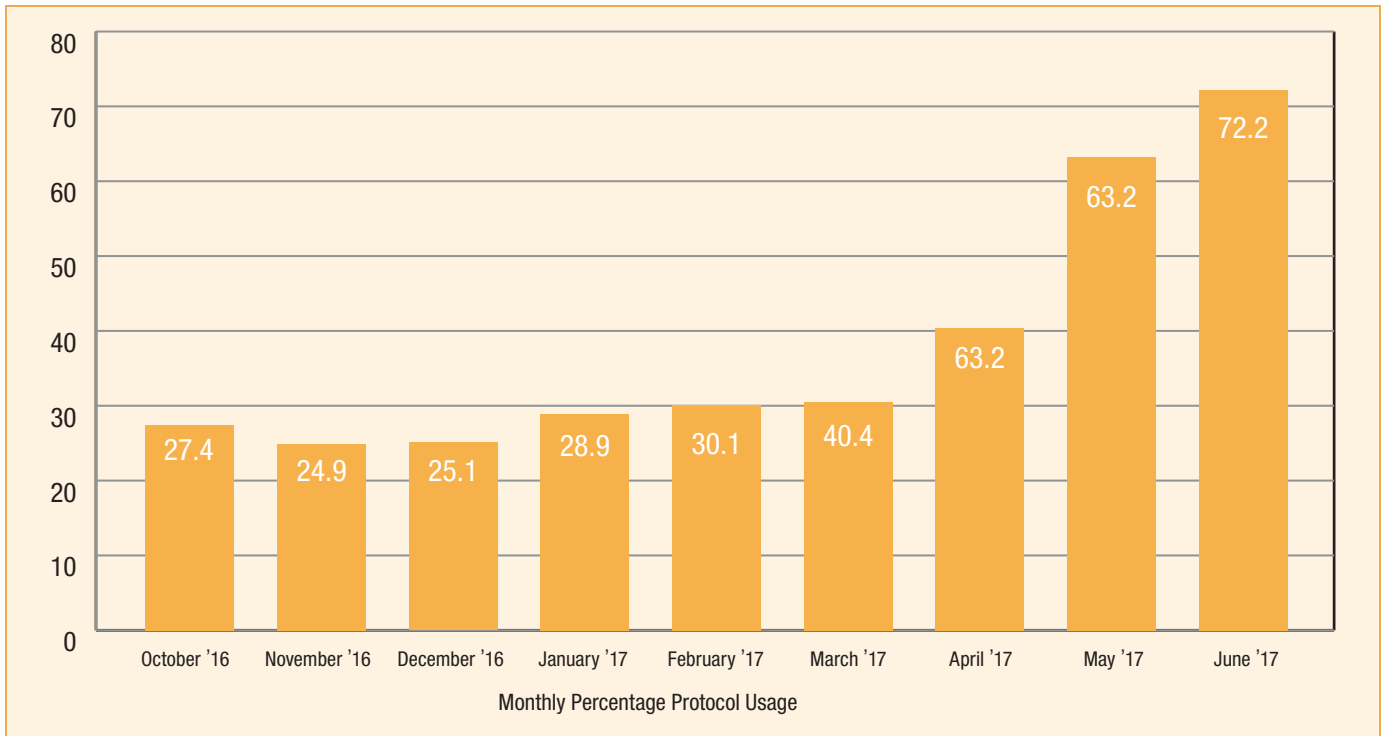
This barrier encompasses those incidences where a complex and often chronic patient situation does not always fit the protocol's suggested or recommended dispositions and home care advice. One nurse shared: *The protocols are very much geared toward acute complaints, when it seems that over half our calls are about more chronic or sub-acute symptoms.* In addition, this category included those cases when patient care necessitates deviation from the protocol. Instead of referring the patient to the emergency department, the patient is redirected to the clinic for symptom management and supportive therapy.

Barrier 3: Provider Preference Issues

Provider Preference Issues, as a barrier to telephone protocol usage, encompassed nurse perception of provider dissatisfaction with the protocol's content and disposition criteria. This barrier also included nurses being unsure of provider awareness of the protocols. For example, one nurse shared: *I don't think providers are aware at all about nurses using protocols. I think they expect us to have the knowledge base without a protocol. But I do think the protocols are useful, in that it guides me to ask things I wouldn't normally have asked, especially in a less familiar scenario.*

Another nurse commented on the provider dissatisfaction with the protocols stating: *Doctors think the protocol uses up too much space that makes the encounter harder to follow.* Interestingly, a remedy for this concern was shared: *If only positive findings showed up in the documentation page, I believe the providers would appreciate the protocol*

Figure 2.
Primary Care Nurse Advice Protocol Usage Rates



usage more – having all the negatives makes the documentation very busy and less likely that a provider will read them. As a consequence of the user feedback, changes to the nurse triage SBAR note have been ongoing. In this case, the SBAR note was relocated to the top of the note screen so it will be the first thing the provider reads. A key lesson learned is the importance of clear and on-going provider communication regarding the protocols and their continued involvement in the content reviews.

Other Qualitative Barrier Responses

No protocol available. In receiving these comments from nurses, the organization has begun to identify opportunities for development of additional protocols.

Difficulty with location identifies challenges in locating the specific protocol within the EHR by the end user. One nurse shared having, *occasional difficulty finding the correct/appropriate [protocol] based on reason for call options. Sometimes I have to try multiple options*

in reason for call to populate the correct protocol. This feedback was essential to begin to identify necessary EHR software changes to improve the linking functionality between ‘reason for call’ and suggested appropriate protocols for triage.

Sustaining the Gain: Results and Implications for Practice

Survey results and protocol utilization rates were shared with nurses during roundtable discussions. These discussions also included clinic leadership, nursing leadership (nursing director), and the identified clinic nurse educator. After sharing the survey results with the nurses, the remainder of time was spent in an open question and answer forum to optimally support and answer the nurse’s questions on protocol content, TT nursing practice, and protocol use. The benefits of using DSTs were again shared with the nurses to assist with instilling protocol usage into the culture of their practice. The common theme throughout the roundtable discussions was the explanation of ‘why’ using evi-

dence-based practice protocols is best nursing practice.

A substantial increase in protocol usage rates was seen in 8 months’ time (see Figure 2). By June 2017, protocol utilization rates averaged 72.2% among all primary care practices – a substantial increase from the baseline of 27.4%. During this time period, the organization provided additional training to the nurses and a supportive environment to succeed. Supporting nurses using DSTs is essential for their success in overcoming obstacles and challenges with not only protocol content familiarity, but also navigation of the EHR.

After investigation of barriers and subsequent discussions with end-users, several organizational opportunities surfaced to improve overall TT practice. These opportunities and lessons learned include, but are not limited to:

- Develop an EHR functionality for end-user feedback submission.
- Develop and sustain a interprofessional telephone protocol committee

to review end-user feedback and to perform annual protocol review.

- Implement EHR functionality for nurses to access, view, and study the protocol content.
- Connect additional key words and reasons for calls to improve locating protocols within the EHR.
- Identify documentation improvements for increased provider satisfaction.
- Provide ongoing utilization reports, real-time data, education, and consultation to assist understanding of current usage state and protocol content.

The opportunities to increase efficiency for end-user nurses have continued to enhance this new organizational TT program, providing guidance for leadership to optimally understand, and address the everyday challenges nurses encounter while using electronically embedded DSTs.

Conclusion

Adequate support with ongoing education and discussion for nurses performing TT in the ambulatory care setting is crucial for optimal success and cultural integration of DSTs. Implementing a sustainable TT training program is the first step to initiating the usage of embedded DST technology and

accompanying practice standards. Opportunities for nurse feedback and making improvements to protocols, workflows, and with DST usage in the EHR, have proven to be effective in sustaining the gain of this new TT program and DSTs and protocol utilization rates. ●

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References

- Ansell, D., Crispo, J.A.G., Simard, B., & Bjerre, L.M. (2017). Interventions to reduce wait times for primary care appointments: A systematic review. *BMC Health Services Research*, 17, 1-9. doi:10.1186/s12913-017-2219-y
- Blank, L., Coster, J., O' Cathain, A., Knowles, E., Tosh, J., Turner, J., & Nicholl, J. (2012). The appropriateness of, and compliance with, telephone triage decisions: A systematic review and narrative synthesis. *Journal of Advanced Nursing*, 68(12), 2,610-2,621. doi:10.1111/j.1365-2648.2012.06052.x
- Bodenheimer, T., Bauer, L., Syer, S., & Olayiwola, J.N. (2015). *RN role reimagined: How empowering registered nurses can improve primary care*. San Francisco, CA: California HealthCare Foundation. Retrieved from <https://www.chcf.org/wp-content/uploads/2017/12/PDF-RNRoleReimagined.pdf>
- Institute of Medicine. (2011). *The future of nursing: Leading change, advancing health*. Washington, DC: National Academic Press.
- Rutenberg, C., & Greenberg, M.E. (2012). *The art & science of telephone triage: How to practice nursing over the phone*. Pitman, NJ: Jannetti Publications, Inc.
- Smolowitz, J., Speakman, E., Wojnar, D., Whelan, E.M., Ulrich, S., Hayes, C., & Wood, L. (2015). Role of the registered nurse in primary health care: Meeting health care needs in the 21st century. *Nursing Outlook*, 63(2), 130-136. doi:10.1016/j.outlook.2014.08.004

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Evidence Supports Longer Injection Needles

Sarah Muegge

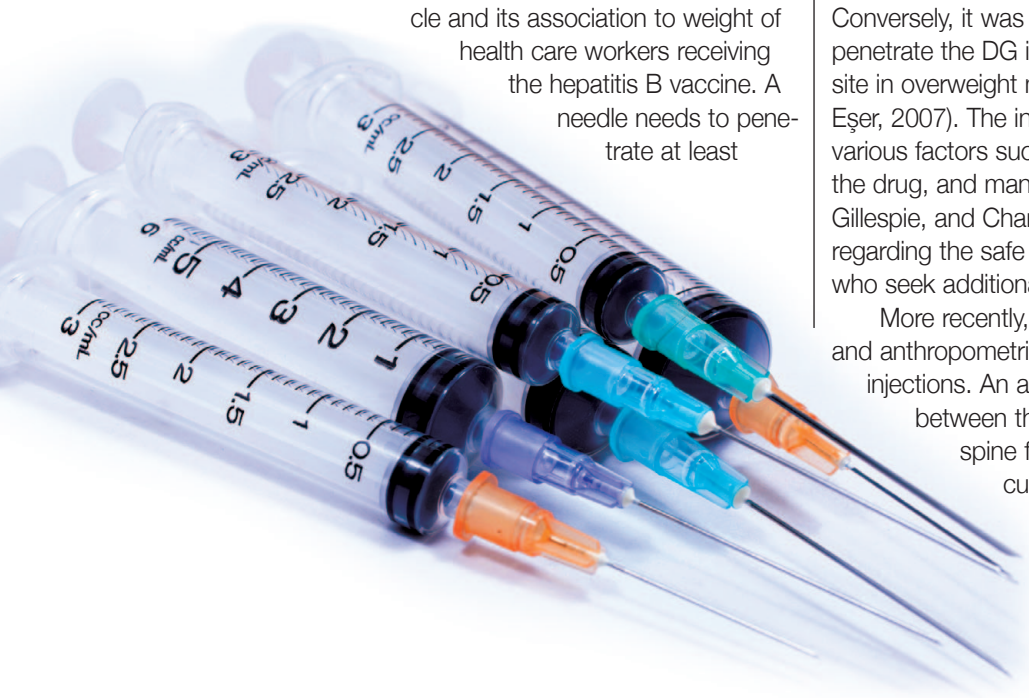
Several years ago, I received a call from a clinic manager requesting assistance. She was receiving monthly injections of octreotide, a long-acting suspension to treat carcinoid syndrome at a local clinic. She reported at her last visit to the treating cancer center there was concern the medication was not reaching the muscle, resulting in poor drug absorption. The cancer center gave her 2-inch-long needles to replace 1 ½-inch needles supplied in the manufacturer drug kit. The manager asked me to speak with the local nurses about using longer needles. This article addresses appropriate needle lengths for intramuscular injections (IM). The topic is important in caring for anyone and especially those with higher body mass index (BMI).

Problems associated with improper needle length for IM injections are underappreciated. After the hepatitis B vaccine was introduced in the United States, there were reports of suboptimal response to the vaccine if it was administered in the gluteal compared to the deltoid muscle. Reports indicated injections administered in the gluteus with 1- or 1 ½-inch needles were not reaching the muscle and instead were deposited in subcutaneous fat where absorption was delayed or compromised (Centers for Disease Control and Prevention, 1985). Poland and colleagues (1997) conducted a study utilizing high-resolution ultrasound to determine subcutaneous tissue thickness (SQTT) in the deltoid muscle and its association to weight of health care workers receiving the hepatitis B vaccine. A needle needs to penetrate at least

5mm into a muscle for proper absorption. The Immunization Action Coalition (IAC) pamphlet (IAC, 2018) recommending appropriate needle length for vaccine administration is based on patient weight from the work of Poland and his colleagues. This is an essential guide for those who administer any deltoid muscle injections, not just the hepatitis B vaccine. Despite the increased obesity seen in our country, I have heard hesitancy among nurses to utilize longer needles. They verbalize concerns that longer needles will be more painful for the patient. Poland and colleagues (1997) reported shorter needles resulted in more pain than longer needles because subcutaneous tissue has more nerve fibers compared to muscle. In addition, the poor vascularity of the subcutaneous tissue means that medications that don't reach the muscle can result in drug failure, local tissue damage, and granulomas.

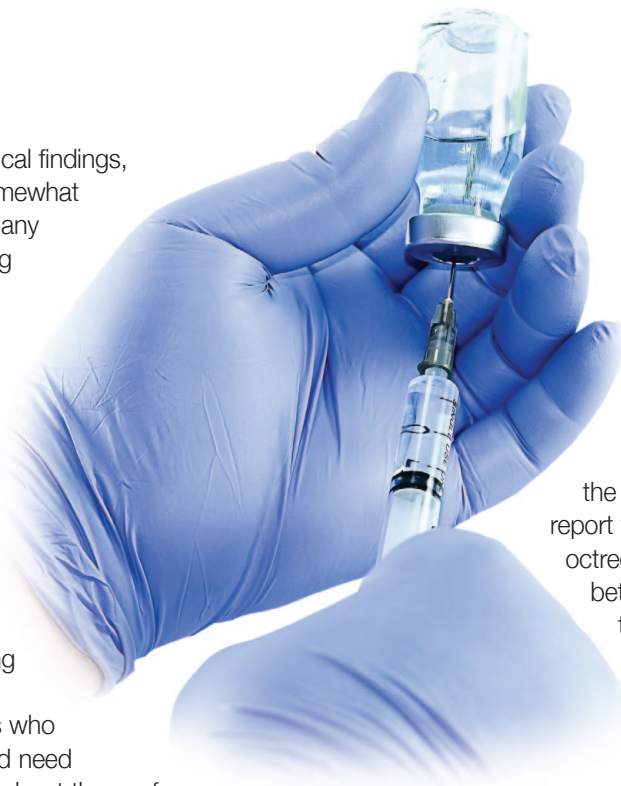
Studies using ultrasound and BMI, as opposed to only patient weight, have evaluated the SQTT at the ventral gluteal (VG) and dorsal gluteal (DG) sites. More than a decade ago, a study was published indicating that there are gender differences in SQTT. The BMI categories included in the study were overweight (25-29.9), obese (30-34.9) and extremely obese (≥ 35). Females typically have more SQTT than males at both the DG and VG site. It is reported that the standard 1 ½-inch needle (38mm) will not deliver effective injections to most females in the overweight or higher BMI category at the DG or VG site. Conversely, it was reported the 1 ½-inch needle would likely penetrate the DG in overweight and obese males and the VG site in overweight males (Zaybak, Güneş, Tamsel, Khorshid & Eşer, 2007). The injection site should be selected based on various factors such as patient preference, characteristics of the drug, and manufacturers recommendation. Brown, Gillespie, and Chard (2015), share their views on the debate regarding the safe utilization of the DG and the VG for those who seek additional information.

More recently, a study compared the use of ultrasound and anthropometric data to predict the likelihood of successful injections. An algorithm describes that weight and distance between the iliac tubercle and interior superior iliac spine for males – and weight, BMI, and waist circumference in females – could predict appropriate needle length for 5mm penetration into muscle. Although this study provid-



ed some interesting theoretical findings, utilizing these findings is somewhat impractical to implement. Many staff have difficulty identifying boney landmarks at the VG site and it is not efficient to measure waist circumference prior to female IM injections. Perhaps findings from this study may spark additional research resulting in easier application in the future (Larkin, Ashcroft, Elgellaie, & Hickey, 2017).

Evidence supports using a 2-inch needle (51mm) in selected males and females who are overweight or obese and need deep IM injection, but what about those of either sex who have a BMI of greater than or equal to 35? One nurse shared a story of administering IM penicillin G benzathine to a man for a chronic infection but she noted his condition was not improving. The man was wheelchair-bound due to his extreme obesity with a BMI of 55. The only deep muscle the nurse could access was the vastus lateralis of his thigh and was using a standard 1 ½-inch needle. The prescribing physician authorized and supported use of a



longer injection needle. The patient's condition improved when the nurse began using a 3 ½-inch spinal needle for the injection. This may seem like an extreme step to take, but this nurse applied knowledge regarding SQTT and her nursing judgment to deliver an effective injection for this patient (Strohfus, Paugh, Tindell, Molina-Shaver, 2018).

Returning to the scenario presented at the beginning of this article, I'm happy to report that the clinic manager receiving octreotide IM, had fewer flushing episodes, and better symptom control when staff switched to administration with a 2-inch needle. This episode brought light to our need to use longer needles for patients who need medications administered deep IM such as antibiotics, hormones, psychiatric agents, etc. Of note, it was difficult for our materials management department to obtain

any 2-inch safety needles for purchase. Eventually, we settled on a 21 gauge, 2-inch, non-safety needle. We recognize this could increase the risk of needle stick injuries but it is what's available. It is puzzling that needle manufacturers are not offering longer safety needles with the prominent rates of obesity seen in the U.S.

To summarize, take time to consider the weight, BMI, and gender of your patient when administering IM injections. Embrace and utilize EBP to ensure the injections you administer are safe and effective. ●

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References

- Brown, J., Gillespie, M., & Chard, S. (2015). The dorso-ventro debate: In search of empirical evidence. *British Journal of Nursing*, 24(22), 1,132-1,139. doi:10.12968/bjon.2015.24.22.1132
- Immunization Action Coalition (IAC). (2018). *Administering vaccines: Dose, route, site, and needle size*. Retrieved from <http://immunize.org/catg.d/p3085.pdf>
- Centers for Disease Control and Prevention. (1985). Suboptimal response to hepatitis B vaccine given by injection into the buttock. *Morbidity and Mortality Weekly Report*, 34(8), 105-108, 113.
- Larkin, T.A., Ashcroft, E., Elgellaie, A., & Hickey, B.A. (2017). Ventrogluteal versus dorsogluteal site selection: A cross-sectional study of muscle and subcutaneous fat thickness and an algorithm incorporating demographics and anthropometric data to predict injection outcome. *International Journal of Nursing Studies*, 71, 1-7. doi:10.1016/j.ijnurstu.2017.02.017
- Poland, G.A., Borrud, A., Jacobson, R.M., McDermott, K., Wollan, P.C., Brakke, D., & Charboneau, J.W. (1997). Determination of deltoid fat pad thickness. Implication for needle length in adult immunization. *Journal of the American Medical Association*, 277(21), 1,709-1,711.
- Strohfus, P.K., Paugh, O., Tindell, C., & Molina-Shaver, P. (2018). Evidence calls for practice change in intramuscular injection techniques. *Journal of Nursing Education and Practice*, 8(2), 83-91. doi:10.5430/jnep.v8n2p83
- Zaybak, A., Güneş, U.Y., Tamsel, S., Khorshid, L., & Eşer, I. (2007). Does obesity prevent the needle from reaching muscle in intramuscular injections? *Journal of Advanced Nursing*, 58(6), 552-556.

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Meaningful Measurement in Ambulatory Care Nursing

Cynthia R. Niesen and Kasey Frost

Welcome to the first column of ambulatory care Nurse-Sensitive Indicator News. This column is written by members of the American Academy of Ambulatory Care Nursing (AAACN) Nurse-Sensitive Indicator (NSI) Team and will be a forum to update ambulatory care nurses on the activity and progress made toward NSI development, standardization, and recommendations for implementation. The NSI Team will also utilize this NSI News column to highlight the future steps AAACN and the Collaborative Alliance for Nursing Outcomes (CALNOC) are taking toward the expansion of NSIs.

Over the last several years, there has been an increasing focus on nursing and quality measurements in the ambulatory care setting. NSIs are measures that specifically involve the contributions from nursing. The American Nurses Association (ANA) and CALNOC (ANA, 1996; CALNOC, 2015) define NSIs as markers of care, or the measured outcomes, that are the result of nursing care. Three elements comprise nurse-sensitive indicators. These include structure (staffing, demographics, etc.), process (nursing interventions, practice, etc.), and outcomes (patient safety, perceptions, functional status, etc.) (Heslop & Lu, 2014).

Beginning in the 1990s through early 2000s, professional organizations such as the ANA, CALNOC, and the National Database of Nursing Quality Indicators™ began developing NSIs within the acute care setting. These indicators have since become widely accepted as valid and reliable measurements in determining nursing care quality and overall performance measurement for health care units, organizations, and systems across the country. In addition to helping with internal measurement, significant work has been done to create databases by which NSI data can be compared across settings (Start, Matlock, & Mastal, 2016).

As the approach to health care delivery has shifted from a reactive mindset to a preventative one, we are seeing dramatic increases in ambulatory care activity (Battaglia, Start, & Morin, 2016). Likewise, as we move toward a health care environment where the focus is increasingly on quality of care and not quantity of care, the role of the ambulatory

care nurse is, and will continue to be, an integral component toward improving the health and wellness of our communities.

Historically, there has not been a mechanism by which to objectively and quantitatively measure the contribution and value of nursing activities in the ambulatory care setting. As such, in 2013 the AAACN Board of Directors commissioned a task force to identify and define NSIs for the ambulatory care setting. In 2015, AAACN and CALNOC entered into a collaborative partnership to define, develop, evaluate, measure, and monitor NSIs for the ambulatory care setting. In 2016, AAACN published the *Ambulatory Care Nurse-Sensitive Indicator Industry Report: Meaningful Measurement of Nursing in the Ambulatory Patient Care Environment* (Start et al, 2016). The report identifies, defines, and proposes nurse-sensitive measures that highlight the value of registered nurses in ambulatory care settings and is available for free at aaacn.org/NSIReport.

When the AAACN *Industry Report* was published in 2016, there were 10 endorsed ambulatory care NSIs which were able to be utilized by organizations wishing to monitor their performance. These NSIs included medication reconciliation, pending diagnostic test results, ambulatory care site demographics, volume measures, staffing, skill mix, and patient hours. For the ambulatory surgical setting, the NSIs focused on adverse outcomes of care, patient burns, patient falls and falls with injury, and hospital transfers/admissions.

There is much work to be done toward the development, dissemination of knowledge, and subsequent utilization and measurement of nursing-sensitive indicators in the ambulatory care setting. In partnership with CALNOC, there will be continued evidence-based development of NSIs for measurement standardization. There are currently five NSIs that have been

identified for further development including hypertension, pain assessment, nurse demographics, body mass index, and fall risk screening (Battaglia et al, 2016). With this work underway, a technical expert panel of nurses with specific in-depth subject or practice setting knowledge will be utilized to provide input for development of one or more NSIs. As CALNOC and AAACN continue





“As we move toward a health care environment where the focus is increasingly on quality of care and not quantity of care, the role of the ambulatory care nurse is, and will continue to be, an integral component toward improving the health and wellness of our communities.”

to look forward, another group of NSIs has also been labeled for future in-depth development and includes all-cause readmissions, admissions, comprehensive diabetes care, advanced care planning, chronic disease, telehealth, and screening for opioids.

As mentioned, the overall objective of the AAACN NSI Team is to facilitate widespread adoption and dissemination of standardized measures to help quantify the role and value of nurses and improve quality of care in ambulatory care health care settings. To begin this work, the AAACN NSI Team recently completed a survey of AAACN nurse members to assess current knowledge of NSIs. The survey data will be used as a starting point for evaluating progress made by the NSI Team. The survey results from AAACN respondents ($n=421$ and 10% rate of return) have been reviewed and summarized. This AAACN member input is extremely beneficial toward identifying perceptions and needs for further NSI education, resources, and factors for development across the ambulatory care nursing community.

Of the respondents, 83% achieved either a Bachelor's degree in nursing (50%) or Master's degree in nursing (33%) as their highest nursing degree. The respondents worked in a variety of nursing roles; staff nurse (21%), manager (16%), and care coordination and transition management (14%), were the highest individual roles replying to the survey. Responses from those in leadership roles; supervisors (7%), managers (16%), directors (11%), and senior nurse leaders (7%), totaled 41% overall. The nurses responding are mainly working in the ambulatory care clinics (76%) and hospital outpatient setting (15%). The survey utilized a 5-point Likert scale (5 being *strongly agree*); here are some of the key findings:

- Regarding the overall general knowledge about NSIs among AAACN members, the weighted average score is 2.9 with 33.5% disagreeing that there is general knowledge and 32% neutral to the question.
- 52% of respondents strongly agree advancement of NSIs is important for ambulatory care nursing with a weighted average of 4.3.
- 32% of the nurses agree they can name five ambulatory care NSIs with 9% in strong agreement, 33% disagreeing, and 12% strongly disagreeing. The weighted average is 2.9.
- 20% of nurses agree their organization uses NSIs and 4.5% strongly agree; the rest disagree (33%), strongly disagree (16%), or were neutral (26%).

- 42% of the nurses were neutral to whether or not obtaining information about ambulatory care NSIs was easy for them; while 34% agree it was and 7% strongly agreed; the rest either disagree (13%) or strongly disagree (4%).
- From a list of five NSIs, respondents were able to choose one or more NSIs they would like to receive more information about. The results demonstrated AAACN members have interest across all five NSIs listed; Hypertension (71%) was the highest, followed by Pain Assessment (68%), Nurse Demographics (67%), Body Mass Index (60%), and Fall Risk Screening (58%).
- The survey found that nurses prefer to receive future communications

regarding NSIs through email (70%); other options were newsletters (47.5%), webinars (44%), the website (42%), or social media (5%).

In conclusion, there is a high level of importance placed on the development of NSIs and the availability of resources; yet, a lack of general knowledge. This demonstrates an opportunity to increase the awareness of ambulatory care NSIs among nurses and organizations. With these factors in mind, and the results of the general interest in the five listed NSIs, it is easy to conclude AAACN's vision for NSI dissemination is set on the right path. In addition, the NSI Team plans to connect with other professional nursing organizations to share NSI development progress. The NSI Team looks forward to providing future NSI updates in this column, new resources on the AAACN website, and at AAACN's 44th Annual Conference in Palm Springs, CA, in May 2019. We look forward to seeing you there! ●

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References

- American Nurses Association (ANA). (1996). *Nursing quality indicators: Definitions and implications*. Washington, DC: American Nurses Publishing.
- Battaglia, R., Start, R., & Morin, M.J.A. (2016). Ambulatory care nurse-sensitive indicators series: Starting with low-hanging fruit: Proposing the adaptation of health care measures to the role of the nurse in ambulatory care. *Nursing Economics*, 34(4), 199-205.
- Collaborative Alliance for Nursing Outcomes (CALNOC). (2015). *Measures codebook supplement*. San Ramon, CA: Author
- Heslop, L., & Lu, S. (2014). Nursing-sensitive indicators: A concept analysis. *Journal of Advanced Nursing*, 70(11), 2469-2482. doi:10.1111/jan.12503
- Start, R., Matlock, A.M., & Mastal, P. (2016). *Ambulatory care nurse-sensitive indicator industry report: Meaningful measurement of nursing in the ambulatory patient care environment*. Pitman, NJ: American Academy of Ambulatory Care Nursing.

CCTM Connections

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services available to them” (Gruman et. al., 2010, p. 351). In order for patients to be engaged, they must have the knowledge, skills, and capacity for meaningful partnerships with health professionals and a strong understanding of their own health status and actions needed to maintain or improve it.

In today’s rapidly evolving health care system, patient education and engagement takes on even more significance. Health care is beginning to be viewed by patients, payers, and providers as an expensive resource to be used to its fullest, rather than as an entitlement to be accessed primarily when ill (Gruman et al, 2010). This change is being fueled by medical breakthroughs, payment reform, high cost increasingly borne by patients, and a rapidly expanding knowledge base emphasizing the importance of patient engagement. It is now well known that the best outcomes are achieved when patients and providers work together as a team with shared decision making and a well understood plan of care with the patient at the center (Carman et al, 2013).

Health care systems becoming accountable for care outcomes and cost are incentivized to seek ways to engage patients to be better managers of their own health and, when needed, to provide resources for patients who need additional support. Patients with multiple or severe chronic conditions often need the support of a CCTM RN. The CCTM RN can identify educational needs and assess barriers to learning. Together, the CCTM RN, patient, family, and health care team work together to provide education and engage the patient in decisions and self-care activities to the best of their ability. The following exemplar describes the important role of the CCTM RN in education and engagement:

Jane Smith was hospitalized three times in one month due to heart failure and atrial fibrillation. Prior to these hospitalizations, this 86-year-old woman was active in the community, driving herself and her friends to lunch and polka parties, and living independently at home.

Following these hospitalizations, Jane is tired and finding it difficult to manage her heart failure symptoms. The most distressing of all is her shortness of breath which has made it hard for her to dance. Jane is enrolled in a care transitions program in which she receives home visits from a nurse practitioner and telephonic support from a CCTM RN at least weekly.

The team is focused on an accurate medication list, home safety, early recognition and management of acute issues, self-management of her heart failure, and linkages to community resources. Jane is focused on being able to dance again!

Through initial assessment, it has been identified that Jane has a knowledge gap regarding the relationship between diet and heart failure. Jane loves to eat out with

friends and her favorite places have beer on tap, popcorn in the corner, and fries served with her hamburger. After her third hospitalization, her nurse practitioner and CCTM RN worked with Jane to help her better understand the relationship between her heart failure exacerbations and diet. Jane’s daughter is actively involved in her care and finds it difficult to discuss diet with her mother. Although she wants to help, she worries that ‘nagging’ Jane about sodium would reduce her quality of life and impact their relationship. The CCTM RN worked with Jane and her daughter to help them understand the connection between Jane’s diet and control of her symptoms, and – more importantly – understand the connection between reducing her shortness of breath and accomplishing her primary objective to be able to dance again.

Now, 2 ½ months later, Jane’s health is improving. Jane and the health care team have a mutually agreed upon plan of care. She is taking – and adjusting – her medications according to the plan, limiting her fluid intake, maintaining her sodium intake goals, and even educating her friends in the apartment complex about the sodium in their foods. Instead of the burger and fries, she’s eating fish tacos and passing on the popcorn. Although she continues to struggle with her chronic disease, her shortness of breath has improved, she is regaining some of her energy, and, most importantly, she is very close to achieving her goal of twirling around the dance floor.

This exemplar describes the power of finding a way to connect the medical plan of care to what is most important to the patient and family. Including her daughter in the education provided a pathway for her to be positively engaged, supporting her mother’s health rather than ‘nagging’ her about what she shouldn’t be doing. Jane has a deeper understanding about the connection between diet and symptoms and sees how her daily decisions affect her chronic condition and her ability to do the things she really enjoys. ●

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References

- American Nurses Association (ANA). (2015). *Nursing: Scope and standards of practice (3rd ed.)*. Silver Springs, MD: Nursebooks.org.
- Carman, K.L., Dardess, P., Maurer, M., Sofaer, S., Adams, K., Bechtel, C., & Sweeney, J. (2013). Patient and family engagement: A framework for understanding the elements and developing interventions and policies. *Health Affairs*, 32(2), 223-231. doi:10.1377/hlthaff.2012.1133
- Gruman, J., Rovner, M.H., French, M.E., Jeffress, D., Sofaer, S., Shaller, D., & Prager, D.J. (2010). From patient education to patient engagement: Implications for the field of patient education. *Patient Education and Counseling*, 78(3), 350-356. doi:10.1016/j.pec.2010.02.002
- Haas, S.A., Swan, B.A., & Haynes, T.S. (Eds.). (2014). *Care coordination and transition management core curriculum*. Pitman, NJ: American Academy of Ambulatory Care Nursing.
- Lovien, C. (2014). Education and engagement of patients and families. In S.A. Haas, B.A. Swan, & T.S. Haynes (Eds.), *Care coordination and transition management core curriculum*. Pitman, NJ: American Academy of Ambulatory Care Nursing.

From the President

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nursing feedback. AAACN will keep you apprised of opportunities, and your participation will inform the report content and recommendations.

Action is underway to raise the status and profile of nursing on a global scale. The year 2020 represents the 200th anniversary of Florence Nightingale's birthday. In honor of this anniversary, ANA and its Organizational Affiliates (including AAACN) will participate in the Nursing Now campaign launched by the World Health Organization and International Council of Nurses (<https://www.nursing-now.org>). Now through 2020, campaign efforts will empower nurses via education, training, and advocacy to work to their full capacity to address 21st century health care challenges. Opportunities for U.S. nurse participation will be forthcoming.

As AAACN advances into 2019, former first lady Michelle Obama sums up our charge, "We've got a responsibility to live up to the legacy of those who



“We are witnessing the rapid evolution of ambulatory care nurses’ roles produced by technologic advances, cross continuum practice, interprofessional teams, and care innovations.”

came before us by doing all that we can to help those who come after us.”

Exciting individual and collective opportunities are available to ambulatory care nurses. What's your next step? Take stock of your goals for the year. Explore new core curriculum content, become certified, mentor a nurse who is new to ambulatory care, participate in one of our Special Interest Groups or task forces, and plan to attend the AAACN Annual Conference in Palm Springs, CA. These actions may boost your career and help you achieve beyond what you have imagined. I hope many of you will join me and your AAACN Board of Directors as we accelerate our influence and impact through activities this year and into the future. Together, let's make Florence proud. ●

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Reference

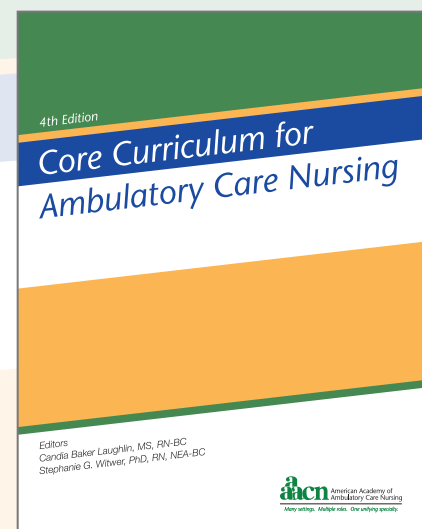
Berwick, D.M., Nolan, T.W., & Whittington, J. (2008). The triple aim: Care, health, and cost. *Health Affairs*, 27(3), 759-762. doi:10.1377/hlthaff.27.3.759

The Core Curriculum for Ambulatory Care Nursing, 4th Edition, 2019, is Now Available!

The book includes new and reconfigured chapters that address ambulatory care nursing professional communication, procedures and technical skills, leadership, nurse-sensitive indicators, and care coordination and transition management. There is expanded content on telehealth technologies, and interventions for health promotion and disease prevention, as well as the needs of special populations at end-of-life and in sedated and surgical procedures.

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Don't Miss the Opening Reception and Silent Auction at This Year's Annual Conference

Join us Wednesday, May 8, 2019, at the Opening Reception. Meet and make plans with first-time attendees, enjoy hors d'oeuvres while reconnecting with colleagues, and take a minute to meet the AAACN Board of Directors.

After a bite to eat and socializing, be sure to check out this year's Hollywood-themed silent auction. Proceeds support the AAACN Scholarship and Education Fund. Take advantage of your local Presidents Day sales and pick up an item to donate! Ideas include jewelry, themed gift baskets, gift cards, or personal devices such as tablets, laptop computers, and headphones. Bring your item to the registration area in Palm Springs.

Attend the Pre-Conference Workshop: Magnet® Recognition in Ambulatory Care: A Recipe for Nursing Excellence (separate fee required). Join Rachel Start and Curlissa Mapp as they address the impact the increased focus will have on ambulatory care, the overall journey to Magnet recognition, and how Magnet aligns with overall organizational goals for health care institutions.

Participate in the Town Hall: Population Health: Social Determinants of Health, Behavioral Health, and the Opioid Crisis. Nancy May will facilitate this open forum to share your "best practice" solutions for this problem facing our nation.

Sit back and enjoy the humor of our Keynote Speaker: Terri Foster will talk about *Surviving and Thriving in the Crazy World of Nursing*. Terry is a nurse humorist that'll make you laugh and restore your pride as a professional nurse as he talks about the crazy and funny things only nurses know!



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AAACN is a welcoming, unifying community for registered nurses in all ambulatory care settings. Our mission is to advance the art and science of ambulatory care nursing.

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New AAACN Leaders

Congratulations to AAACN's newly elected leaders who will take office at the close of the 2019 Annual Conference in Palm Springs, CA!



AAACN's Board of Directors has selected **Anne T. Jessie, DNP, RN**, as President-Elect for 2019-2020. Anne is Senior Director, Clinical Operations at Evolent Health.

As a AAACN member, Anne has served on the Board of Directors since 2016 as a Director and Treasurer. She has also served on the RN Position Paper Task Force, participated in multiple Care Coordination and Transition Management (CCTM) expert panels, authored chapters in the CCTM Core Curriculum, the Core Curriculum for Ambulatory Care Nursing, 3rd Edition, and the Orientation & Competency Assessment Guide, 2nd Edition. We wish her great success as our next President-Elect.

This marks the first year using an updated process for selecting President-Elect, wherein the Board of Directors selects the President-Elect. The change ensures that the most qualified member to serve is selected as the President-Elect to lead AAACN by those members most knowledgeable to make the selection. AAACN members approved this and other changes to the bylaws in the 2018 election.



Deena Gilland, DNP, RN, NEA-BC; Christine M. Ruygrok, RN-BC, MBA, and Assanatu (Sana) Savage, PhD, DNP, FNP-BC, RN-C, CDR, NC, USN, were elected to the Board of Directors. Deena is Vice President of Patient Services and CNO, Ambulatory Care at Emory Healthcare in Atlanta, GA; Christine is Associate Quality Administrator at Kaiser Permanente in Pasadena, CA; and Sana is Phase II Director for DNP Students, USUHS with the United States Navy in Bremerton, WA.



Julie Alban, DNP, MPH, RN-BC, CCCTM, and Katherine Andersen, MSN, RN-BC, CCM, were elected to serve as members of the Nominating Committee. Julie is Nurse Manager - Primary Care VA in The Villages, FL, and Katherine is Virtual RN Care Coordinator for Boise VA in Boise, ID.

Our President-Elect and new Directors will take office at the close of the 2019 Annual Conference. We look forward to a productive year as we welcome our new leaders!