

ViewPoint

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COPD and Care Coordination: Promoting Interprofessional Management to Achieve the Triple Aim

Rebecca Engdahl and Beckie Kronebusch

Patients with chronic disease require interprofessional collaboration to coordinate their care and improve outcomes. Chronic obstructive pulmonary disease (COPD) can be a challenging disease for patients and providers to manage. Fortunately, there are standards to guide care coordinators in their practice as they work with the interprofessional team. The Global Initiative for Chronic Obstructive Pulmonary Disease describes COPD as “a common, preventable and treatable disease that is characterized by persistent respiratory symptoms and airflow limitation that is due to airway and/or alveolar abnormalities usually caused by significant exposure to noxious particles or gases” (Global Initiative for Chronic Obstructive Lung Disease [GOLD], 2020, p. 1). The pocket guide (GOLD, 2020) notes the disease is currently the fourth leading cause of death in the world with projection to advance to the third leading cause of death by 2020. Due to continued exposure to COPD risk factors and an aging population, the burden of COPD is projected

to further increase in the decades to come (GOLD, 2020). The Centers for Disease Control and Prevention (2018) projects the cost attributed to having COPD will increase to approximately \$50 billion by 2020.

GOLD (2020) describes COPD as a preventable and treatable chronic medical condition. Nurses working in care coordination and transition management (CCTM™) contribute to effective care transitions and overall patient outcomes for patients with COPD. The CCTM role is being advanced by the American Academy of Ambulatory Care Nurses (AAACN). In its position paper, “The Role of the Registered Nurse in Ambulatory Care,” AAACN (2017) recognizes that “the RN is the team member most qualified to coordinate the elements of care with patients and caregivers, as well as to facilitate the functioning of interprofessional teams across the care continuum” (p. 2). A care coordinator partners with the

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Many settings. Multiple roles. One unifying specialty.



The Evolution of AAACN



Kristene Grayem

Happy New Year! Like all of you, your AAACN Board of Directors is looking to the new year with excitement and anticipation of all that we will accomplish in 2020. At the annual fall board meeting, the AAACN Board conducts a thorough review of the strategic plan. Approximately every 5 years, the Board has worked with a strategic planning consultant for an even deeper review of the plan and the future. In 2010 and 2014, the Board worked with Schiller Consulting to create and refine AAACN's current mission, vision, strategic plan, and tagline. This set a foundation for the work AAACN is currently doing. In fall 2019, we brought in consultant Brian Riggs of The Dialogue Shop to help us assess AAACN's

current state and begin designing our future state. Given the current focus on ambulatory care in health care and shifting payment models, your Board of Directors wants to ensure our high-level priorities and strategies are the ones needed to serve AAACN in the future.

At the September board meeting, we spent time identifying AAACN's most pressing issues as well as identifying what our "ideal state" looks like. We reviewed the current and future state summaries and strategic plan gaps identified by AAACN volunteer leaders at the 2019 Leadership Symposium. We evaluated AAACN's current 2018-2019 strategic plan, our mission, vision, core values, tagline, and goals.

The goals of this discovery session were to understand who we are right now, further clarify and define our future path, identify and set priorities, identify what support is needed to attain the priorities, and lay the proper foundation for AAACN.

In the session, Riggs pushed the Board to be creative, open minded, and to think outside the box. He challenged us to design a future-focused strategic plan. He used a stepwise approach to understand AAACN's history, our previous plans, and define the current state of AAACN culture, leadership structure, membership, and team. We identified seven impact factors affecting AAACN:

- Professionalism and the role of the RN in ambulatory care.
- The return on investment (ROI) of the RN.
- Awareness of ambulatory care.
- Partnerships.
- Infrastructure/governance.
- Member experience and engagement.
- Identity/brand.

Following these intense and informative conversations, we reviewed our current strategic plan structure and had the opportunity to look at other organizations' strategic plan formats. Your Board of Directors was extremely

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Inside and Out: Overview of Common Female Genital Infections in the Ambulatory Care Setting

Stacy Christensen

The presenting symptoms associated with female genital infections can be confusing for providers, nurses, and patients. There are, however, several distinct characteristics that help separate one infection from the other, especially if a good symptom history is obtained. The internet is often a first line source of personal symptom causes due to the privacy it offers. However, like much of the health-related content on the internet, misinformation exists which can result in erroneous self-diagnosis and treatment. Ambulatory care nurses are well positioned to assist women presenting with these complaints because of the comfort many feel when disclosing personal information to nurses. Genital infections can be internal or external, sexually or non-sexually transmitted. Having a general awareness of the unique distinctions between the many types of female genital infections can help the ambulatory care nurse better triage, manage, and educate patients presenting with such symptoms, regardless of the patient encounter setting.

Yeast Infections

One of the most common vaginal infections experienced by women is candida, a fungal infection known to many as a yeast infection. Approximately 70% of women will experience a yeast infection at some point (Bongomin et al., 2017). Yeast is not considered a sexually transmitted infection (STI), as small amounts are typically present as part of the normal vaginal

flora. However, because the vaginal canal is dark and moist, a favorable environment exists for yeast overgrowth. While yeast can flourish without any triggers, there are factors that increase the chances of developing a yeast infection. Antibiotics can alter the balance of the lactobacilli; the bacteria that tends to impede the growth of yeast. With lower concentrations of lactobacilli, the pH of the vagina tends to become less acidic, favoring the growth of yeast (Borges et al., 2014). In addition, pregnant women, poorly controlled diabetics as well as the immunocompromised can develop yeast infections on a frequent basis as the body is less capable of preventing the growth of yeast in these circumstances. Women with yeast infections typically present with an intense vaginal itch, external irritation, and mucosal redness. Intercourse and urination may cause a burning sensation. Yeast infections alone do not usually result in any type of foul odor and, if a foul odor is present, the infection is not likely to be simple yeast. Upon speculum insertion, the vaginal canal will often contain a thick curd-like discharge that may or may not be noticed by the patient. While cultures can be done, yeast is often confirmed by simple microscopic examination of the discharge on a slide that has a drop of potassium hydroxide (KOH) added. The KOH lyses the cell membranes in the sample, making it easier to identify the hyphae and spores that confirm this infection (Hildebrand & Kansagor, 2019).

There are a multitude of over the counter and prescription treatment options for yeast infections. Vaginal antifungals typically ending with 'azole' are effective and often provide quick symptom relief. They come in a multitude of formulations including suppositories, creams, and oral pills, and are generally safe to use with a low side effect profile. While symptoms tend to improve quickly, patients should be advised to complete the recommended length of treatment. Cool compresses can provide relief if the external vaginal area is raw or irritated. Many advocate the use of cotton underwear, loose clothing, acidophilus supplements and/or yogurt consumption to prevent recurrence. Data regarding efficacy of these management options is a bit inconclusive, however, and additional research into the complex reasons why women experience yeast infections and how they can be prevented is warranted (Gonçalves et al., 2016). It is best if sexual activity is abstained until treatment is completed. While a return to the office is not usually necessary, after treatment, women should be encouraged to seek further evaluation should symptoms persist.

Bacterial Vaginosis

Another common, yet frequently self-misdiagnosed infection is bacterial vaginosis (BV). This infection is not classified as sexually transmitted, yet there are many unanswered questions as to how women actually develop it (Muzny & Schwebke, 2016). While the etiology of

BV is poorly understood, it is thought that a disruption in the normal vaginal flora is the cause. When the pH of the vagina is altered, the healthy aerobic lactobacilli have difficulty preventing the unhealthy anaerobic bacteria from invading. Douching, semen, and aggressively washing the vagina can all serve to alter the delicate balance of the vaginal flora, deplete healthy bacteria levels, and result in a favorable environment for BV (Muzny & Schwebke, 2016). While it is possible to have asymptomatic BV, women who present with BV often seek treatment for a classic fishy odor and a vaginal discharge. The odor can be especially noticeable after intercourse due to the combination of the discharge and semen. Upon exam, women may have creamy discharge at the vaginal opening. Unlike yeast, there is no change in the color of the mucosa. Speculum exam will reveal additional creamy vaginal discharge and a fishy odor may be observed by the practitioner, magnified if the discharge is put on a slide and a drop of KOH added, commonly known as a positive ‘whiff’ test. Healthy vaginal epithelial cells tend to have crisp clear borders when seen under the microscope. However, in BV, the abnormal bacteria stick to the clear cells, giving them a dirty or speckled appearance (commonly referred to as clue cells) under the microscope (Centers for Disease Control and Prevention [CDC], 2015).

Patients with BV are commonly treated with the oral antibiotic metronidazole (Flagyl). It is important to educate women about the potential for Flagyl to cause severe abdominal pain if the patient consumes alcohol while being treated. This medicine also comes in a vaginal gel form called Metrogel-Vaginal. Clindamycin is also another treatment option and is offered as a vaginal cream called Cleocin or Clindesse. Partner treatment is not required or recommended in the majority of cases; however, sexual abstinence is advised during the course of treatment and for several days

after. This is especially true if vaginal clindamycin is used, as it can break down the latex in condoms (CDC, 2015). BV can be a frustrating infection that tends to recur often in many women (Machado et al., 2015). Recommending consistent condom use and advising women not to alter the vaginal environment by douching or using scented female hygiene products are important education components that can assist patients presenting with BV.

Gonorrhea and Chlamydia

Gonorrhea and chlamydia are STIs, each having a similar symptom profile in women. Unlike men who usually are alerted to these infections because of dysuria, women with either gonorrhea or chlamydia can have no subjective symptoms, especially in the early stages (American College of Obstetricians and Gynecologists [ACOG], 2019a). If symptomatic, women with gonorrhea and/or chlamydia will often complain of vaginal discharge (usually without odor or itch), spotting and/or mild pelvic cramping. On exam, the external vaginal area will be normal color with or without a mucous-like yellow tinged discharge at the opening. A speculum exam may reveal a totally clear cervix or a cervix that bleeds easily when touched (known as friable) with a mucopurulent discharge at the OS (cervical opening). A greater concern exists if the patient is experiencing pelvic pain, as this indicates the infection may have advanced into the uterus and fallopian tubes. Confirmatory diagnosis is made through swabs sent for culture or nucleic acid amplification tests, but often treatment is initiated proactively based on clinical suspicion (Pugsley & Peterman, 2019), especially if there is a history of new sexual partners, mucous discharge, pelvic discomfort, and/or the presence of numerous white blood cells on microscopy. Because prompt detection and treatment is crucial in preventing pelvic inflammatory disease, which can lead to infertility, routine gonorrhea and chlamydia screening is recommended

for all sexually active women under age 25 and older women if at high risk (new partners, multiple partners, or partners with other partners) (LeFevre, 2014).

Chlamydia is commonly treated with a 1g single dose of azithromycin. Gonorrhea is typically treated in a dual fashion with an intramuscular injection of 250mg ceftriaxone and 1g azithromycin. Nurses need to educate patients on the importance of abstinence through treatment and for a week following treatment. Condom use should be stressed, and it is critical that sexual partners seek treatment so that re-infection does not occur (Workowski & Bolan, 2015). It is recommended women testing positive for either gonorrhea or chlamydia be screened for all STIs, including HIV, syphilis, and hepatitis. Gonorrhea and chlamydia infections require reporting to state and local health departments as well as the CDC. Ambulatory care nursing staff may therefore be asked to assist with this important aspect of public health surveillance and monitoring.

Trichomonas

Trichomonas is a sexually transmitted parasitic protozoan. While it can be asymptomatic, trichomonas often results in unpleasant symptoms which prompt patients to seek evaluation quickly. Women with trichomonas typically develop a thin, yellow discharge that has a foul odor. While itch may or not be an issue with trichomonas, the odor is extremely bothersome to many women. Upon exam, the external vaginal mucosa will appear deep red and a thin discharge may be present at the opening. On speculum exam, the redness and typically frothy discharge are seen in the vaginal canal and the cervix may also contain small red spots commonly referred to as ‘strawberry spots’ (Van Der Pol, 2016). Occasionally, the cervix may exhibit friability when touched with a swab. Trichomonas is diagnosed by lab testing or by visualizing the active protozoan and their flagellum (tails) under the microscope after normal saline is added to the discharge.

Table 1.
Summary of Assessment and Treatment of Female Genital Infections

| | Subjective Data | Objective Data | Common Treatment Options* | Patient Education |
|-------------------------------|---|--|---|--|
| Yeast | Vaginal itch +/- thick white discharge; may have irritation, dysuria, burning | Vaginal mucosa darker red; thick white 'curd-like' discharge on vaginal walls and/or cervix; hyphae and spores seen under microscope after KOH added to sample of discharge | Vaginal preparations: Miconazole (Monistat) Clotrimazole (Gyne-Lotrimin) Butoconazole (Mycelex) Terconazole (Terazol) Oral option: Fluconazole (Diflucan) | <ul style="list-style-type: none"> • Cool compresses • Avoid tight fitting clothes • Encourage cotton underwear • Finish all medication as prescribed • Abstain from sex during treatment |
| Bacterial Vaginosis | Creamy off-white discharge; fishy odor | Creamy white discharge in vaginal canal; presence of 'clue cells' under microscope after normal saline is added to sample | Vaginal preparations: Metronidazole (Metrogel) Clindamycin (Cleocin) Oral option: Metronidazole (Flagyl) Tinidazole (Tindamax) | <ul style="list-style-type: none"> • Avoid douching, washing inside vagina, and feminine hygiene products • Encourage condom use • Avoid alcohol if oral metronidazole prescribed • Encourage additional STI testing |
| Trichomonas | Yellow or white thin discharge with foul odor; may have irritation, spotting, and discomfort with urination and/or intercourse | Erythematous external vaginal mucosa; yellow frothy vaginal discharge; active trichomonas under microscope after normal saline added to sample | Metronidazole (Flagyl) Tinidazole (Tindamax) | <ul style="list-style-type: none"> • Seek treatment for partners regardless of their symptoms • Avoid alcohol and intercourse while being treated • Recommend additional STI screening • Stress condom importance |
| Gonorrhea/Chlamydia | May be asymptomatic in early stages; yellow vaginal discharge, occasionally mixed with mucous; spotting, discomfort on intercourse, and/or pelvic cramping may be present | Normal vagina and cervix may be observed, especially in early stages; clear or yellow muco-purulent discharge at cervical os; cervix may bleed when touched and/or be tender when moved during bimanual exam and fever may be present in case of pelvic inflammatory disease | Chlamydia: Azithromycin (Zithromax) OR Doxycycline Gonorrhea: Ceftriaxone IM (Rocephin) PLUS Azithromycin | <ul style="list-style-type: none"> • Partners to be treated • Avoid intercourse until 7 days after treatment • Recommend further STI screening • Stress condom importance |
| Syphilis | Primary stage: Painless oval lesion on genital area Secondary stage: Non itchy rash, enlarged lymph nodes, and/or lesions on mucous membranes | Single lesion (may be more than one) present in genital area, red, non-draining, non-tender; macular rash on trunk, palms, and/or feet, lymphadenopathy | Benzethine penicillin G IM | <ul style="list-style-type: none"> • Partners and contacts to be treated • Recommend further STI screening, especially HIV testing • Patients should return for further testing 6 and 12 months after treatment • Stress condom importance |
| Genital Herpes | Tender lesions in genital area; may have dysuria, low grade fever, enlarged groin lymph nodes | Vesicular lesions present anywhere in genital area in various stages; may have low grade fever and/or inguinal lymphadenopathy | Famciclovir (Famvir) Acyclovir (Zovirax) Valacyclovir (Valtrex) | <ul style="list-style-type: none"> • Emotional support • Educate about transmission: transmission potential high when active lesions present; transmission also possible immediately before or after lesions arise • Educate about prevention methods: strategies to keep immune system strong, medication to suppress outbreaks • Recommend further STI testing, especially HIV testing • Condom importance: can reduce (but not eliminate) risk of transmission |
| Genital Warts | Growth or 'skin tag'-like bumps; single or multiple present on any area in genital or anal region; may or may not itch | Single or multiple raised lesions in genital or anal region; often take on a cauliflower like appearance | Trichloroacetic acid OR Podophyllin applications by provider External creams: Imiquimod (Aldara) Sinecatechins (Veregen) | <ul style="list-style-type: none"> • May need multiple treatments • Educate on benefits of human papillomavirus vaccination • Recommend further STI testing, especially HIV testing • Condom importance can reduce – but not eliminate – risk of transmission |
| Sebaceous Cyst | Tender raised bump on external genital area | Erythematous, round, raised lesion in external genital area | Warm soaks, possible incision and drainage, antibiotics | <ul style="list-style-type: none"> • Good hygiene practices • Avoid squeezing lesion |
| Bartholin's/Skene's Duct Cyst | Painless or tender raised bump next to vaginal or urinary opening; may have discomfort with walking or intercourse | Erythematous, raised, fluctuant lesion to right or left of vaginal introitus or urinary meatus | Warm soaks, possible incision and drainage, catheter insertion to promote drainage, and/or antibiotics | <ul style="list-style-type: none"> • Good hygiene practices • Avoid squeezing lesion |

Note: *For possible allergy and pregnancy-specific treatment recommendations, please refer to www.cdc.gov/std/tg2015/tg-2015-print.pdf

Once diagnosed, oral Flagyl is the mainstay of treatment and women should be advised to abstain from alcohol during treatment. As with the other infections, women should abstain from sexual activity until treatment is completed. Because trichomonas is sexually transmitted, partners must also be treated to prevent re-infection. Testing and screening male partners for trichomonas is inconclusive, so partners of women testing positive should be treated based on reporting alone (CDC, 2019).

Infections can also occur on the external female genitalia and a woman may present to the outpatient setting with concerns about growths, bumps, or sores on the outer aspect of the vagina. Often a good history can help differentiate between three common conditions- herpes, genital warts, and cysts.

Herpes

Genital herpes is an STI that occurs as a result of exposure to the herpes simplex virus (HSV). Exposure can be via the oral or genital route through contact with an infected individual. Genital herpes lesions are typically very painful, especially if a woman is experiencing her first infection. Often there will be accompanying dysuria as pain intensifies when urine hits an open herpetic ulceration. Exam will reveal single or multiple vesicular (fluid filled, open or healing) shallow erythematous lesions in the external genital area. Herpes is diagnosed by a viral culture and/or bloodwork (ACOG, 2019b).

Because it is viral, there is no cure; however, symptoms and outbreaks can be greatly minimized with antiviral medication. Antivirals which can decrease both transmission likelihood and frequency of outbreaks include acyclovir, valacyclovir, and famciclovir. Patients often feel extremely isolated and distraught by this diagnosis, despite the fact that HSV afflicts approximately one out of five individuals (Bradley et al., 2014). Nurses can play a major role in providing emotional support to the patient and may also offer important education regarding herpes prevention

and transmission in a non-judgmental and compassionate manner.

Genital Warts

Often, patients will seek evaluation of a non-tender growths or skin tags. Occasionally, they will report mild itch and an increase in the numbers of these growths over time. These presenting symptoms are frequently discovered to be genital warts, caused by one of the human papilloma viruses. Genital warts are sexually transmitted and extremely common. On exam, patients will have non-tender single or multiple raised lesions that may be discrete or confluent. The lesions will often appear a bit pinker or paler in color than the underlying skin tone, usually taking on a cauliflower-like appearance. Diagnosis is often based on appearance, although practitioners can biopsy a lesion if uncertainty exists (Workowski & Bolan, 2015). Treatment options include self-application of a prescription cream and/or, trichloroacetic acid application by a clinician. Eradicating the lesions can take weeks. Cryotherapy and laser treatment are also options should patients have extensive lesions. As with HSV, receiving a diagnosis of genital warts is difficult for many patients as warts are sexually transmitted and there is great stigma associated with this (Daley et al., 2015). Women are often as confused to how, when, and where they were infected, and answers to these questions are almost impossible to deliver. Again, education and emotional support are crucial in assisting patients with this diagnosis.

Cysts: Sebaceous, Bartholins, Skenes

Other common lesions often noticed by patients in the external genital area are cysts. Because there are many glands, as well as a concentration of hair follicles present in the external vaginal area, the potential for blockage is high. When the glands get blocked, a cyst develops (Kilpatrick, 2019). Women often present with concerns that these lesions may be herpes or warts. Cysts

are quite different in that they are usually singular, raised, red, and rounded bumps. They can be tender if inflamed and enlarged but usually do not itch. Women should be reassured that these are not sexually transmitted and typically resolve over time on their own. If infected and inflamed, warm compresses, antibiotics and/or incision and drainage may be needed. It is recommended that women who are prone to these cysts practice good hygiene, while avoiding tight fitting clothes and scented feminine hygiene products in order to reduce the risk of recurrence (ACOG, 2019c).

Occasionally women experience a blockage in a larger gland in the vaginal area. Bartholin's glands sit at the lower aspect the vaginal opening – one to the right and one to the left. Their purpose is to lubricate the vagina. If a Bartholin gland becomes blocked, a woman will usually develop a soft, tender cyst to the right or left of the vaginal opening. These cysts can be small and asymptomatic, or they can become quite large and tender, interfering with walking, intercourse, and even sitting (Lee et al., 2015). Warm soaks may be an initial treatment in order to encourage spontaneous drainage. Large and uncomfortable Bartholin's cysts occasionally need insertion of a small catheter to drain and maintain patency of the gland. Surgical drainage, along with a course of antibiotics to facilitate healing, is also a treatment option. Similarly, the small openings that surround the urinary meatus (periurethral glands) called Skene's glands may also become blocked, resulting in a Skene duct cyst. Skene duct cysts can be small and asymptomatic, or large, resulting in urinary symptoms, UTIs, and/or discomfort with intercourse. Treatment options for symptomatic Skene duct cysts include excision and antibiotics (Kilpatrick, 2019b).

Syphilis

One last sexually transmitted lesion not to be overlooked is the syphilis lesion. While syphilis rates had been steadily trending downward from the

1940s to the late 1990s, the 21st Century has seen a reversal in the incidence rates of this highly contagious infection. Alarming, between 2016 and 2017, the United States experienced a 10% increase in syphilis rates, with a 72.7% increase overall between 2013 and 2017 (CDC, 2018). Syphilis is typically a painless single lesion that appears on the genital or rectal area but can also present in the mouth. The lesion often goes unnoticed due to the relative lack of symptoms. Syphilis can have serious complications if not treated early. Should the lesion go untreated in the primary stage and resolve, a serious secondary stage syphilis can result months or years after, indicated by a classic macular rash on the trunk, palms of the hands and/or soles of the feet. Unless secondary syphilis is treated, individuals can progress to the tertiary stage, where severe and fatal health problems impacting the eyes, brain, heart, and other organs can occur. In addition to the risk on the individual, the consequences to a fetus are dire if a pregnant woman has untreated syphilis, as congenital syphilis is associated with a 40% infant death (CDC, 2018). If syphilis is suspected, a blood test will be ordered to confirm. Prompt treatment with intramuscular penicillin and partner notification are recommended; contact investigations are imperative (CDC, 2019). Safe sex education should be provided, and, like gonorrhea and chlamydia, syphilis must be reported to the health departments and the CDC.

Resources

While not exhaustive, Table 1 provides a brief overview of the common findings associated with these infections. It is meant to serve as a quick guide to enhance assessment and care of women presenting to the ambulatory care setting with a genital concern. Regardless of diagnosis, all women should be advised to return for re-evaluation if symptoms persist or increase.

The CDC can serve as an invaluable resource for ambulatory care nurses

encountering both male and female patients with genital infections. The 2015 CDC treatment guidelines provide a comprehensive guide to management of such conditions. Infectious disease personnel at the CDC are also helpful in responding via email or phone to questions and challenges to care that may arise.

Summary

Ambulatory care nurses are often the first line in responding to patient concerns and play an important role in outpatient triage by obtaining a thorough patient history, whether it be in person or via telehealth mode. Critical reasoning and astute clinical judgment are necessary attributes of the ambulatory care nurse in order to expedite appropriate care and treatment (American Academy of Ambulatory Care Nursing, 2020). Knowledge of the clues to diagnosis and the nature of the infection can assist ambulatory care nurses to provide appropriate health education on the management of the condition. Empathy and a caring approach can serve to help women who may feel uncomfortable and or embarrassed by the presenting symptoms and or resulting diagnosis. ●

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A Real Situation: Drug Diversion in Nursing

Leslie Morris



Drug diversion is a serious problem in nursing and it is on the rise. “More than 100,000 doctors, nurses, technicians and health professionals” are abusing or dependent on prescription drugs each year, putting patients at risk (Eisler, 2014, para. 4). Diversion of drugs is defined as the unlawful channeling or misuse of regulated and/or prescribed pharmaceuticals (Tanga, 2011). Drug diversion is a national problem that is growing. Every health care organization is susceptible to drug diversion. Since drug diversion is a secretive act, reliable statistics are not available.

Drug diversion not only affects the individual nurse, but it becomes a societal problem when injectable drugs are tampered with in health care facilities. The Centers for Disease Control and Prevention (CDC), along with state and local health departments, have examined infection outbreaks originating from drug diversion activities involving health care providers. The CDC documented a wide variety of disease outbreaks from 1983-2013 which were a result of drug diversion by health care providers affecting facilities spanning the United States. Further, the CDC reports, “these outbreaks revealed

gaps in prevention, detection, or response to drug diversion in U.S. healthcare facilities” (CDC, 2019, para. 6). Lax institutional controls have led to large fines for some organizations and put licenses in jeopardy. Boston’s Massachusetts General Hospital agreed to pay \$2.3 million to resolve allegations employees were able to divert controlled substances for personal use due to a lack of controls (Relias Media, 2016). In another settlement, the University of Michigan Health System (UMHS) agreed in 2018 to pay the United States \$4.3 million as part of a settlement resolving allegations that UMHS violated certain provisions of the Controlled Substances Act (U.S. Drug Enforcement Administration, 2018). At Emory University Hospital in Atlanta, between October 2008 until July 2013, two employees illegally diverted more than 1 million doses of controlled drugs. Subsequently, the two employees were fired, the hospital had to pay a \$200,000 fine, and the Georgia State Board of Pharmacy placed the hospital’s pharmacy license on probation for 3 years (Ellison, 2016).

There are many ways in which drugs can be diverted by health care providers no matter what the workplace setting.



Nurses need to learn to identify the opportunities for possible drug diversion and comply with established policies and procedures to prevent it.

Some of these are removing medications of discharged patients; taking medications from pumps, drips, or discarded vials in sharps containers; removing larger doses of medication when a smaller dose is available; not documenting administration or wastage of medications; utilizing unnecessary overrides to obtain medications; or stealing medications for personal use from a lock box or cabinet, never intending to administer to a patient. The list continues with theft of home medications, removal under a colleague's sign-in, diluting a dose with water or saline, removal of duplicate doses, and substitution of a dose with other medication, water, or saline (Berge et al., 2012; Kristof, 2018). Diverted drugs are not limited to controlled substances or pain relievers. They also include tranquilizers, stimulants, sedatives, antibiotics, and anti-emetics (Berge et al., 2012).

Ambulatory care nurses should understand the problem and be able to identify the risk factors and signs signifying potential substance abuse which can lead to drug diversion. The demands of nursing can cause a significant amount of stress. Medications are easy to obtain in the course of the nurse's work and nurses tend to focus on caring for others and overlook caring for themselves. As professionals, nurses should know the signs of diversion as related to our colleagues. By knowing the signs, we can establish if it is an incident, pattern, or trend. Some common signs of someone diverting drugs are increasing frequency of coming to work early and staying late, volunteering for overtime, unusually helpful, numerous trips to the bathroom, disappearing from the unit for long periods of time, attendance issues, and involvement in medication discrepancies (Carpenter, 2014).

What is the impact of drug diversion and/or substance abuse? For the patient, it is being cared for by an impaired provider, pain medication not given or in a limited dose, and possible exposure to a blood borne pathogen. For the nurse who is diverting, it is the possibility of criminal prosecution, loss of livelihood and license, overdosing, and death (Berge et al., 2012). For the organization, the impacts are numerous. There are liability concerns – both civil and regulatory, negative publicity that could damage the organization's reputation, and large fines with the possibility of its license being restricted or revoked.

An ambulatory care nurse's responsibility is to be aware of drug diversion as a threat to our patients, ourselves, and the community. Nurses need to learn to identify the opportunities for possible drug diversion and comply with established

policies and procedures to prevent it. In order to deal with this issue, it will require vigilance, policy, a robust enforcement program, and help for those affected. We must protect our patients and the nurses who care for them whose licenses could be on the line if we don't. ●

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- ◆ Follow the *Publication Manual of the American Psychological Association, Seventh Edition (2020)*. *Manuscript Success* by Leslie H. Nicoll (2012) is also a helpful reference.

Items to Note:

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- Descriptive phrases such as “a patient with cancer” rather than “a cancer patient” are encouraged.
- In-text citations are shortened with “et al.” upon first mention for references with three or more authors.
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Chapter in a book:

DeBiase, V.M. (2019). Patient education and counseling. In C.B. Laughlin, & S.G. Witwer (Eds.), *Core curriculum for ambulatory care nursing* (4th ed., pp. 165-183). American Academy of Ambulatory Care Nursing.

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COPD and Care Coordination

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patient and interprofessional roles to develop a plan of care and promote self-efficacy of the patient's management of their lung disease. The following exemplar illustrates the role of the care coordination and transition management registered nurse (CCTM RN®) in patient self-efficacy in managing lung disease.

Jane Doe was hospitalized for COPD exacerbation three times in the past year. Prior to hospitalization, this 75-year-old woman was active – volunteering in her community, attending her grandchildren's activities, and a member of the senior citizens group. Each exacerbation has left her short of breath, progressively decreasing her functional capacity to live independently in her home. After the last hospitalization she was discharged with supplemental oxygen, making it difficult to leave the home, therefore reducing her socialization. She struggles to maintain her home and make her own meals before she runs out of energy for the day. Jane recognizes she has been told to stop smoking but, after 60 years, continues to smoke six cigarettes daily.

Her pulmonologist placed Jane on a long acting bronchodilator and anticholinergic for maintenance management of COPD. She cannot afford to refill these medications as it is now September and she has reached the 'donut hole' in her pharmaceutical coverage. When Jane does take her medications, she doesn't see much difference in her breathing; therefore, she only takes her inhalers in the morning.

As a CCTM RN partnering with Jane, consider the patient's exposures to risk factors for exacerbation. Tobacco smoking is the most commonly encountered risk factor for COPD (GOLD, 2020). Smoking cessation is a key intervention for all COPD patients who continue to smoke. In fact, the GOLD (2020) recommends brief smoking counseling be offered at every contact with a tobacco using patient. CCTM RNs can utilize

Table 1.
Triggers Assessment

| Triggers Assessment | | |
|--|--|--|
| Risk for exposure to: <ul style="list-style-type: none"> • Secondhand smoke • Air Pollution (indoor and outdoor) • Occupational exposures (dust, fumes, gases) | Patient awareness: <ul style="list-style-type: none"> • Air quality alerts • Timing/avoidance of outdoor activity when alerts occur • Home ventilation | Prevention of illness: <ul style="list-style-type: none"> • Pneumococcal vaccination (per CDC guidelines) • Annual influenza vaccination • Decrease risk of illness; avoid crowds in cold and flu season; wear a mask and wash hands to reduce infection |

Sources: Mayo Clinic, 2017; Global Initiative for Chronic Obstructive Lung Disease (GOLD), 2020.

health coaching skills such as motivational interviewing to promote goal setting towards smoking cessation and avoidance of other triggers (see Table 1). Referrals to nicotine dependence centers, quit lines, and collaborating with providers for potential pharmacologic interventions are other interventions a CCTM RN can consider.

Pharmacological treatment of COPD is guided by the severity of symptoms and frequency of exacerbation risks. The Global Initiative for Chronic Obstructive Pulmonary Disease has outlined 2020 recommendations for managing COPD that are a guide for prescribers to treat the disease. Considerations of side effects, comorbidities, drug availability, cost, patient's response, preference, and ability to use the drug delivery device should be made when determining treatment (see Figure 1).

For patients with severe resting hypoxemia, oxygen therapy is indicated for disease management (GOLD, 2020). A simple outing may be taxing for patients on oxygen therapy. Heavy oxygen canisters further weigh down patients with poor endurance. Travel logistics with oxygen adds complexity to

itineraries that become affected by oxygen availability. The nurse should explore safety of oxygen in the home, from fall risk from tubing to flammable exposure. Patients need to work with their oxygen supplier to ensure the equipment meets their needs.

According to GOLD (2020), physical activity is a strong predictor of mortality in the COPD patient. Activity reduces fatigue and dyspnea from the disease. Pulmonary rehabilitation provides a solid foundation to build activity goals in an environment where patients learn techniques such as pursed lipped breathing and energy conservation while beginning physical activity in a monitored environment. Explore with the patient what activities bring joy, what time of day the patient feels the most energy to exercise, and timing of bronchodilators prior to exercise. Exercise does not have to be all or none; short periods of activity throughout the day can bring great benefit. COPD resources are available from the COPD Foundation and the American Lung Association for patient, caregivers, and providers.

COPD exacerbations are major events that impact rates of hospitalizations



Figure 1.
Assessment Considerations for Pharmacological Barriers to Medication Compliance



and admissions, and greatly impact the health status and disease progression of an individual. Acute COPD exacerbations present with baseline changes in dyspnea, cough, or sputum. Goal of treatment is to minimize negative impacts of exacerbations and to prevent subsequent exacerbations. GOLD (2020) recommends case management to provide patient support and education regarding self-management with focus on prevention of exacerbation complications. The CCTM RN partners with the COPD provider and patient in developing an action plan for treatment of COPD exacerbation. This patient centered plan provides a reference for patients to recognize the early symptoms of COPD exacerbation and build self-efficacy for the patient to treat these symptoms quickly. Action plans sometimes include prescribed oral steroids and antibiotics to have at home should symptoms develop

outside of clinic hours. Coaching patients to increase use of short-acting beta 2 agonists and anticholinergics, adjusting body positioning (such as tripod position), pursed lipped breathing, oxygen titration (keeping saturations 88-92%), and use of air movement can build confidence that patients can manage their breathlessness. Finally, the CCTM RN can support patients by reminding them to be patient as their lungs recover from this acute event. Time management and prioritization of activities are important skills during recovery.

Jane partnered with a CCTM RN and her COPD provider after her hospitalization and entered a pulmonary rehabilitation program. She started nicotine dependence counseling and with nicotine replacement, stopped smoking. Jane discovered she could afford her inhaled medications by changing to a formulary substitute. She takes her inhalers on a

regular basis. With healed lungs, Jane no longer needed supplemental oxygen. She had more energy and joined an exercise class at a senior citizens center. Together, Jane and her CCTM RN built an action plan. Jane could recognize signs of exacerbation and quickly take action to reduce the impact on her life. Jane spent the past year with her grandchildren and not in the hospital.

This exemplar demonstrates the powerful impact the CCTM RN partnership with the patient with COPD has on quality of life and utilization of care. As with many chronic conditions, management of COPD is not linear. There are many considerations to reducing symptom impact. Awareness of these considerations and treating COPD with a team approach (patient, provider, and CCTM RN) leads to improved outcomes for all. ●

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In Memoriam: Pat Reichart, AAACN Director of Association Services

Our AAACN community is deeply saddened by the loss of Pat Reichart, former Director of Association Services. Pat was loved and respected for her service to AAACN as she worked to support members, volunteers, and leaders for many years. We consider her dedication instrumental to the success AAACN is experiencing today.

Pat's association management career at Anthony J. Jannetti, Inc. (AJJ), AAACN's management firm, spanned 24 years, with more than 13 of those years managing AAACN's daily



operations. She retired in June 2016, and enjoyed the last few years spending time with her two granddaughters, traveling, quilting, and enjoying time with her husband Marty, who also was employed by AJJ.

When she retired, Pat said that "Working for AAACN and its amazing members has been the most satisfying and enjoyable position. I have always said, 'I should have been a nurse. Working with and helping nurses achieve their goals has been the next best thing.'"

A graphic for the AAACN 45th Annual Conference. At the top is the AAACN logo (American Academy of Ambulatory Care Nursing) and the text "45th Annual Conference" in a stylized font. Below this is the slogan "Register Today!" in large, purple, cursive letters, with musical notes and a staff line behind it. Underneath is a green button with the website "conference.aaacn.org". The bottom half of the graphic features a colorful skyline of Chicago buildings, including the Willis Tower. At the bottom, the word "CHICAGO" is written in large, white, block letters, with "April 15-18, 2020 • Hilton Chicago" written in smaller text across it.

From the President

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engaged and motivated to lay the foundation necessary to develop a 2020-2023 strategic plan. The Board held a two day in-person follow up session with Riggs to complete this work in February 2020. We cannot wait to share the outcomes of that meeting with you!

At the conclusion of our work with Riggs, we plan to have a roadmap that will allow us to focus on the future of the organization, a framework for strategy and goal development, prioritized efforts including how the plan should look, how the Board and staff will interact with the plan, and how the plan will be incorporated across the organization. The Board will also uncover the current environmental concerns and drivers, conduct succession planning to identify the next generation of ambulatory care nursing leaders, and define how we will remain relevant. We will ensure that our management company, AJJ, is aligned with AAACN's culture, expectations, and vision, and that AAACN's internal and external brand is aligned in a way that will take us into the future.

I look forward to sharing an update on our strategic planning with you at the 45th Annual Conference in Chicago, April 15-18, 2020. I hope to see you there! The future looks bright for AAACN and ambulatory care nursing. ●

Kristene Grayem, MSN, CNS, PPCNP-BC, RN-BC, is Vice President, Population Health Management, Akron Children's Hospital, Akron, OH. She may be contacted at president@aaacn.org

Are You Attending the 2020 Annual Conference?

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happy about your day. Ron Culberson is a speaker, author, and humorist whose mission is to change the workplace culture by boosting productivity and staff happiness. His clients include NASA, Johns Hopkins University, and the U.S. Senate. Enjoy this lively presentation as the perfect kick-off to your conference experience.

General Session Speaker:



Shelly Schwedhelm, MSN, RN, NEA-BC

Thursday, April 16

“Ebola, MERS, Measles: Not in My Clinic!”

Shelly Schwedhelm is the Executive Director

of Emergency Management and Biopreparedness at the University of Nebraska Medical Center. In this session, she will discuss the current infectious disease landscape and what clinical nurses and nurse leaders need to know to be prepared. You'll leave her session with a deeper understanding of the services and operations critically needed to prepare for the global threat of infectious diseases.

Town Hall Facilitator:



Debra Cox, MS, RN

Friday, April 17

“Ambulatory Care Is the Future of Nursing”

Debra Cox is the Nurse Administrator for E-Health at Mayo Clinic. She will lead the

year's Town Hall discussion on how the passion, resources, and evidence-based knowledge of ambulatory care nurses will impact the future of nursing. Ms. Cox will present her insights and knowledge on e-health practices for health care teams and encourage attendees to take the mic and share their own experiences with their colleagues.

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