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aaacn ViewPoint

The Voice of Ambulatory Care Nursing

Patient-Centered Medical Home in the U.S. Air Force

Carol A. B. Andrews
Suzy Harrington

The literature is replete with assessments of the U.S. health care system as expensive, fragmented, and challenged in dealing with the growing list of health care problems among a burgeoning, aging population. While there is broad agreement that the health care system is "broken" and needs to be reformed, there is little consensus on exactly how that reform should take place. One method that has met with some success in the civilian community is called the Patient-Centered Medical Home (PCMH) model. Numerous studies have evaluated the success of various aspects of the model when implemented in civilian health care practice, but little has been written about PCMH in the military community. This article will review the activities involved in PCMH program redesign by the United States Air Force (USAF), as well as the processes and strategies used to address the challenges encountered.

The American Academy of Pediatrics (AAP) introduced the Patient-Centered Medical Home (PCMH) model in 1967, initially referring to a central location for archiving a child's medical record (Improving Chronic Illness Care, 2011). The AAP expanded the concept in 2002, and it was adopted by the American Academy of Family Physicians later in 2002. It was then endorsed by major primary care governing bodies, and in February 2007, the Joint Principles of the Patient Centered Medical Home were published as part of the Patient-Centered Primary Care Collaborative (2007).

The Joint Principles of PCMH include a personal physician/provider, a physician-led medical practice, whole person orientation, coordinated/integrated care, an expectation of quality and safe care, enhanced access to care, and payment reform. This primary care model was designed to improve access, strengthen the relationships between providers

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Ambulatory Care Nursing
Review Questions
Fourth Edition
Candia Baker Laughlin, MS, RN-BC
Editor

"Why Courage?"

American Academy of Ambulatory Care Nursing
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Susan M. Paschke

Our 38th Annual AAACN Conference in Las Vegas was a terrific success! The speakers, the topics, the posters, and the camaraderie of seeing old friends and making new ones made for a great experience for the 700 attendees this year. The energy throughout was palpable – to borrow a phrase from a friend and colleague – it was CPR for our nursing souls!

One of the highlights from the conference was our keynote speaker, Virginia (Ginny) Beeson, who discussed courage in nursing – as individuals, as leaders, as members of a profession dedicated to doing what is right. The title of Ginny's presentation was "Why Courage?" As nurses, we are faced with opportunities to display courage every day – as we advocate for patients and advocate for our profession.

Merriam-Webster's dictionary (2013) defines *courage* as "mental or moral strength to venture, persevere, and withstand danger, fear, or difficulty." Florence Nightingale provided us with some great examples of courage. She rebelled against the wishes of her family and pursued her nursing career. She traveled to the Crimea during wartime and risked her life and her health to improve the conditions for her patients. She was not afraid to take a stand for the well-being of those in her care.

Courage and AAACN

How does this discussion of courage apply to us? The Affordable Care Act's focus on Patient-Centered Medical Homes (PCMHs) and Accountable Care Organizations (ACOs) as a means to enhance access and quality of care necessitates the coordination of patient care between multiple sites and the management of transitions between those sites. Many health care organizations created care coordination educational offerings in response to the need for training for this newly identified role. AAACN, in a courageous and exciting move, took a stand for the well-being of patients and ambulatory nurses who have been serving in the role of coordinators of care and used a unique approach to this concept. During the past year, the work of three expert panels – facilitated by Dr. Sheila Haas, Dr. Beth Ann Swan, and Traci Haynes – resulted in the development of a care coordination and transition management model that includes evidence-based dimensions, activities, and competencies for nurses across the spectrum of care. These expert panels worked diligently to complete the identification and development of the competencies in approximately nine months.

At the conference, a bold new initiative was presented to the Board of Directors with unanimous approval. AAACN is about to embark on the next phase of our Care Coordination and Transitions Management action plan – the development and publication of a core curriculum and corresponding education modules. Together, these modules will become an educational product that will be available to anyone interested in pursuing the care coordinator/transition management role. The plan is to have both of these completed by the end of this year – a very ambitious goal! We are grateful that the same great team will be leading this effort and have confidence in their ability to deliver a terrific product!

The final phase of this project is still in discussion – creation of a method to acknowledge an individual's completion

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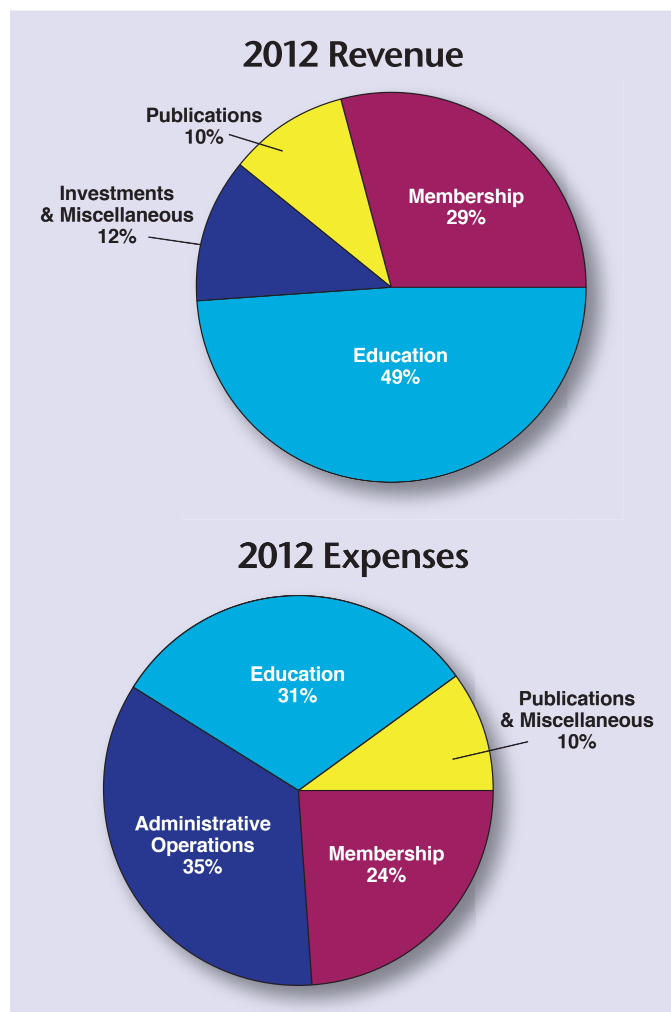
Current AAACN Initiatives

1. Development of care coordination/transition management core curriculum and educational modules
2. Expansion of the certification review course options
3. Participation in Nursing Alliance for Quality Care (NAQC)
4. Nominations for Nurse At Large position on Joint Commission Board of Commissioners
5. Preparation of an RN Residency White Paper
6. Development of Nurse Sensitive Indicators for ambulatory care

2012 AAACN Financial Report

The AAACN Strategic Plan has a foundation of core values to guide the mission and vision of the organization. The core values include responsible health care delivery, visionary and accountable leadership, productive partnerships, appreciation of diversity, and continual advancement of professional ambulatory care nursing practice. Those core values are dependent on a solid financial foundation. The financial foundation of AAACN, in turn, includes several checks and balances.

- AAACN is a volunteer organization, with a Board of Directors elected by the membership. A treasurer, appointed from within the Board of Directors, presents financial reports to the Board for their review and approval. The treasurer is actively engaged in the budget process, reviewing revenue, expense, and investment reports regularly, questioning any variances.
- Anthony J. Jannetti, Inc., the AAACN management company, is responsible for the routine management of AAACN operations and finances. The executive director of AAACN, who works directly for AJJ, oversees AAACN finances in conjunction with AJJ accounting staff.
- Additionally, AAACN utilizes external companies to help manage its financial resources:
  - RBC Wealth Management manages the AAACN investment portfolio and makes recommendations for changes to the Board.
  - Haefele, Flanagan & Co. is an accounting firm that AAACN contracts with to provide an annual review of the financial status of the organization. The Board reviews this report annually, and a summary is presented annually to members.



The annual report for 2012 shows an increase in total assets. The year started with net assets of $478,913, and finished at the end of the year at $556,644. For the first time in AAACN history, total revenue exceeded $1 million! Net revenue for 2012 were $77,731, which reflected a notable improvement from the deficit of $40,047 in 2011. Refer to the pie charts for the breakdown of revenue and expenses.

Along with the increase in revenue, there were also some increased expenses. The most notable expense for 2012 was the cost of publishing the third edition of the *Core Curriculum for Ambulatory Care Nursing.* Revenue from sales of this publication are expected to be realized in future years. Education expenses for the annual conference remained consistent with previous years' requirements.

All of the efforts associated with the mission, vision, core values, and strategic plan exist to benefit the members of the organization. Membership dues and services account for both expenses and revenue. Like many other nursing organizations, AAACN experienced a decrease of 12% in membership in 2009, which was less than the average decrease of 18.5% reported by the Nursing Organizations Alliance. Thankfully, that decrease bounced back by 2012, with the number of members in AAACN being the highest it's ever been – with 2,628 members at the end of 2012! A total of 1,724 individuals renewed their membership in 2012, a retention rate of 74%, which is an improvement of 6% over 2011 and one of the highest in AAACN history.

AAACN ended 2012 fiscally sound. One benchmark of financial stability for nonprofit organizations is having at least 50% of their operating expenses in reserves. AAACN finished 2012 ahead of the benchmark at 55%.

The system of checks and balances used by AAACN to help us weather financial storms in the past has helped solidify our ability to carry out our strategic plan and continue our mission of advancing the art and science of ambulatory care nursing. We remain committed to providing our members with opportunities to advance their practice and leadership skills, as well as connect with others in similar roles to enhance the quality of care for patients in the ambulatory care setting.

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Shingles (Herpes Zoster): Vaccine for a Healthy Future

Barbara Susan McCall
Donna M. Parker

Instructions for Continuing Nursing Education Contact Hours

Shingles (Herpes Zoster): Vaccine for a Healthy Future

Deadline for Submission: August 31, 2015

To Obtain CNE Contact Hours

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Objectives

The purpose of this continuing nursing education article is to inform ambulatory care nurses and other health care professionals about the shingles (herpes zoster) disease process, treatment, prevention, and impact on health care costs. After reading and studying the information in this article, the participant will be able to:

1. Discuss the three most common symptoms seen in the early stage of the shingles process.
2. Identify the single most common long-term complication related to shingles disease.
3. Describe one Medicare guideline related to cost coverage of shingles vaccine.
4. Explain importance of shingles vaccine storage and administration techniques.

The author(s), editor, and education director reported no actual or potential conflict of interest in relation to this continuing nursing education article.

This educational activity has been co-provided by AAACN and Anthony J. Jannetti, Inc.

AAACN is provider approved by the California Board of Registered Nursing, provider number CEP 5366. Licensees in the state of California must retain this certificate for four years after the CNE activity is completed.

Anthony J. Jannetti, Inc. is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

According to the National Foundation for Infectious Diseases (NFID), approximately 50,000 adults die annually in the United States from vaccine-preventable diseases (NFID, 2009). *Preventable* is the key term, as vaccines are among the most cost-effective preventive services available for adults. Despite the fact that vaccines are readily available, the number of American adults who receive needed vaccines remains low. Explanations as to why vaccination rates are low in eligible adults include costs, lack of knowledge about vaccine-preventable diseases, fear of complications, or thinking vaccines will cause the disease or that vaccinations after childhood are not necessary. Vaccines are recommended throughout life. The Centers for Disease Control and Prevention (CDC) published a list of recommended vaccines considered vital for adults over 65 years of age (CDC, 2012d). These vaccines include diphtheria, shingles, influenza, pneumococcal, and tetanus. Of specific note is the vaccine to prevent shingles (herpes zoster), considering its incidence increases with age.

Shingles (Herpes Zoster) Etiology and Progression

Approximately one million cases of shingles are diagnosed in the United States every year (CDC, 2012a). Most cases are seen in adults over 60 years of age. The process begins with chickenpox, the varicella zoster virus, which is mostly seen during childhood. After the person contracts chickenpox, the varicella zoster virus remains dormant (inactive) in the dorsal root ganglia. The virus may remain in this dormant state for years or even a lifetime; however, the virus may reactivate late in life, causing shingles (herpes zoster). According to the CDC (2012a), the reasons for reactivation are not completely understood, but may be due to decreased cell mediated immunity seen with the aging process or immunosuppressive medical conditions. Shingles can occur in an individual more than once, and has been seen up to three times, although this would be rare.

Symptoms during reactivation include pain, tingling, or burning and are typically followed by a red rash that develops into clusters of clear blisters that can continue to form for approximately 3-5 days. The blisters will begin to dry and form crusts, which will fall off in 2-3 weeks (see Figures 1 and 2). Shingles is usually unilateral (affecting one side of the body) and confined to one (or sometimes an adjacent) dermatome nerve pattern whereby the neuralgia pain spreads along the distribution of the affected nerve (Dorland's Illustrated Medical Dictionary, 2011).

According to the CDC (2012a), the shingles virus can spread varicella zoster to persons at risk during direct contact with the blisters until they dry and crust over. Those at risk include persons never having had chickenpox or the varicella vaccine, premature or low birth weight infants, and immunocompromised persons. Unlike chickenpox, shingles is not transmitted through airborne particles.

Treatment and Complications

At this time, there is no known cure for shingles. Antivirals (e.g., acyclovir, valacyclovir, famciclovir) are used to reduce the severity of a shingles event, but to be effective, must be started as soon as possible after the rash appears. Early treatment, within 72 hours of symptoms, may lessen the duration of the event and avoid com-

Figure 1.

Shingles, T5 Dermatome Posterior (Back) View

Patient is exhibiting crusting lesions after nine days of acyclovir treatment.

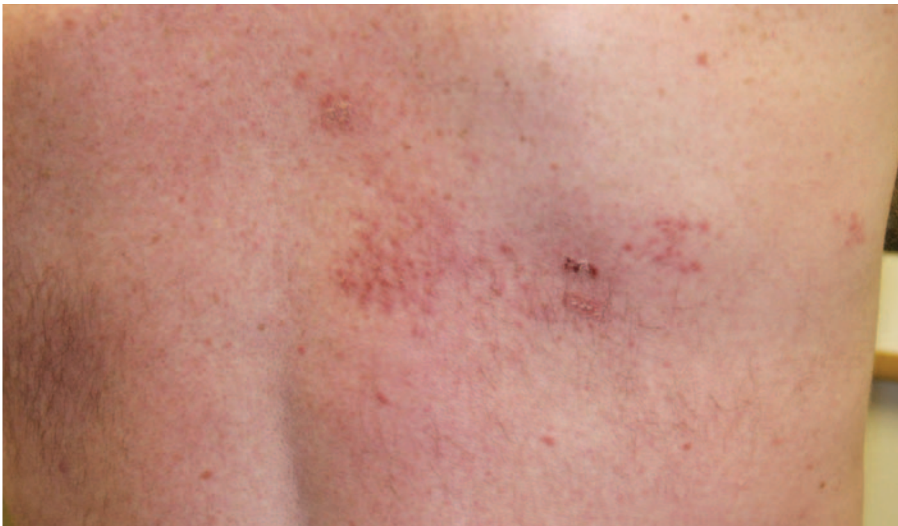
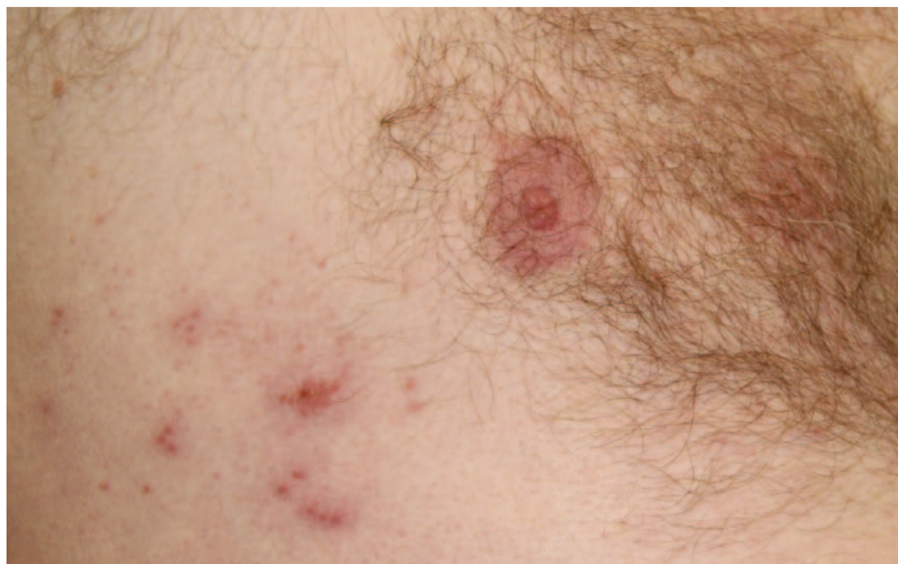


Figure 2.

Shingles, T5 Dermatome Anterior (Front/Chest) View

This is the same patient and treatment time frame as shown in Figure 1.



plications. It is essential the person taking antivirals knows not to miss or stop a dose. Steroids may be used if the shingles event involves the eyes or facial nerves. The need for additional medications such as analgesics, antidepressants, and/or antibiotics will depend upon any complications that occur. Non-medication treatments include relaxation therapy, as stress can worsen pain, and psychological visits if depression occurs.

Approximately 1-4% of people with herpes zoster are hospitalized for complications (CDC, 2012a). Secondary skin infections, from scratching the rash or skin openings, may develop and require antibiotic treatment. Shingles involving the facial area may result in herpes zoster ophthalmicus, or imminent acute retinal necrosis (severe infection in the retina) risking vision loss. Other complications of herpes zoster include cranial and peripheral nerve palsies and visceral involvement (e.g., meningoencephalitis, pneumonitis). Complications occur more frequently and with increased severity in persons with immunosuppressive medical conditions and/or those taking immunosuppressive medications. Immunocompromised persons are at increased risk of developing disseminated herpes zoster (appearance of lesions outside the primary or adjacent dermatomes), which can affect other organs such as the liver or brain causing life-threatening conditions.

Post herpetic neuralgia (PHN) is the most common complication of shingles and is more likely to occur in persons over 60 years of age. PHN causes severe pain in areas where the shingles rash occurred and sometimes beyond the area of the original rash. The pain can be continuous or intermittent, and described as burning, throbbing, tingling, shooting, and sharp. Subsequently, intense itching may occur. PHN may progress to other complications such as depression and insomnia, leading to a person's inability to complete activities of daily living, thereby decreasing quality of life. Because complications can vary, there is no single treatment that relieves PHN. Medical costs to manage PHN can be prohibitively expensive or very costly over time, due to additional necessary treatments. Medications generally prescribed are analgesics, opioids, tricyclic antidepressants, and anticonvulsants such as gabapentin and pregablin, which are sometimes used to help control burning and pain. Lidocaine skin patches are sometimes prescribed to block signals from nerve endings, resulting in numbness.

The Shingles Vaccine: Benefits & Contraindications

Vaccination is the most effective way to reduce the chance of developing shingles and all the potential complications and costs related to the disease. The vaccine was first developed by Merck (Zostavax®) and licensed by the Food and Drug Administration (FDA) in May 2006. , Anyone 60 years of age or older should get the shingles vaccine, regardless of whether they recall having had varicella zoster or not (CDC, 2012c). The Advisory Committee on Immunization Practices (ACIP) also recommends a single dose of shingles vaccine for adults 60 years of age and older to prevent the varicella

zoster virus from becoming active, regardless of whether or not they have had shingles. There is no upper age limit restriction and it is currently a one-time vaccination. The vaccine is a live attenuated vaccine, meaning it is a weakened varicella zoster virus, which stimulates the immune system to fight the virus. Studies show approximately 14% of adults 60 years and older have been vaccinated against shingles (Zimmerman, Gray, Middleton, & Wilson, 2012).

The potential to prevent shingles and/or PHN is one benefit of the vaccine. In a CDC report for health care professionals, it was stated that the vaccine was linked to reducing the risk of developing shingles by about 51% and the incidence of PHN by 67% (CDC, 2012c). Another benefit is the vaccine may assist in preventing illnesses in older adults that can occur as a result of the long-term chronic pain from PHN. As of March 2011, the FDA expanded the age indication for Zostavax to include adults ages 50-59 based on a study showing the vaccine reduced the risk of herpes zoster by approximately 70% (CDC, 2012b). However, in persons in this lower age range, the risk of getting shingles with prolonged pain is much lower than for people 60 years and older. Based on this lowered risk along with shortages and delays of obtaining the vaccine Zostavax in recent years, the ACIP is not issuing its recommendation at this time for routine use of zoster vaccine in adults 50-59 years of age.

Contraindications to the vaccine do exist, particularly in persons who are immunocompromised. Zostavax should not be administered to the following: those with a history of anaphylactic reaction to gelatin, neomycin, or any other component of the vaccine; anyone receiving immunosuppressive therapy, radiation, or chemotherapy treatment; those taking high-dose corticosteroids; patients in primary or acquired immunodeficiency state; those with leukemia, lymphoma, or other malignant neoplasm affecting the bone marrow or lymphatic system; anyone with active, untreated tuberculosis; or women who are pregnant or trying to become pregnant (Merck Pharmaceuticals, 2011).

Concurrent Vaccination Administration

Many times when adults seek preventive care through vaccinations, they are eligible for more than one. Nurses should be knowledgeable of the current recommendations regarding whether the Zostavax vaccine can be given concurrently with others, such as those for pneumonia and influenza.

Merck packaging information recommends Zostavax and pneumonia vaccines be received four weeks apart (Merck Pharmaceuticals, 2011). This is based on a Merck study that showed antibody titers against herpes zoster virus to be lower in persons who received Zostavax and the pneumonia vaccine at the same time, compared to persons who receive these vaccines four weeks apart.

However, other studies conducted by Tseng, Smith, Sy, and Jacobsen (2011) concluded Zostavax was equally effective at preventing the disease, whether it was administered simultaneously with the pneumonia vaccine or four weeks apart. These later studies were based on cell-mediated immunity against the herpes zoster virus, not with the antibody levels, as in the Merck study.

In order to avoid barriers to persons and providers who have the opportunity to receive and administer these two vaccines at the same time, the CDC continues to recommend that Zostavax and pneumonia vaccines be administered at the same visit if the person is eligible for both. It can be administered concurrently with all other live and inactivated vaccines, including those routinely recommended for persons age 60 and older, such as influenza and pneumococcal vaccines. Also, according to the Immunization Action Coalition (IAC, 2011), an inactivated vaccine can be administered the same day as another inactivated or live vaccine. Both the injectable trivalent influenza vaccine and the pneumococcal polysaccharide vaccine are inactivated. Zostavax is live attenuated; therefore, all three can be given on the same day, always in separate syringes.

Patient Identification and Education Opportunities

A patient alert system to identify those who are eligible for vaccines should be established in any primary care practice, whether paper charts or electronic medical record systems are used. Many offices now employ electronic medical records that present an opportunity for identifying patients needing vaccinations through the use of information technology (IT). IT programs exist for automatic notifications that alert health care professionals of age-appropriate vaccinations. With some of these programs, when a patient checks in for a clinic visit, computer generated alerts appear in conjunction with patient intake recording. If approved nursing protocols are in place or a provider order is given, vaccinations can then be administered during that visit.

As patient advocates, nurses should make every effort to educate patients about all aspects of vaccinations. Patients or their legal representatives should be informed with objective information about any vaccine before they receive it, thus involving them in making their health care decisions. As health care professionals, we understand the risks of receiving vaccinations and that most reactions are mild. However, there is always the potential for serious complications, which can have a devastating effect on the recipients and caregivers. Vaccine Information Statements (VISs) are information sheets produced by the CDC that explain to vaccine recipients and their parents or legal representatives, both the benefits and risks of a vaccine. The shingles vaccine VIS was last updated October 6, 2009, and can be printed from www.cdc.gov/vaccines/pubs/vis/vis-facts.htm.

Cost Variance and Patient Access to Vaccine

The Agency for Healthcare Research and Quality estimated that an average of $566 million per year is spent on health care for shingles and its complications (CDC, 2008). Other reports list that when PHN is involved, there are higher health care costs and productivity losses (Dworkin, White,

O'Connor, Baser, & Hawkins, 2007). This makes exploring the reasons for not utilizing the vaccine a primary concern. According to the CDC (2013), the vaccine cost to health care providers is approximately $159.32 for a single dose. Adding health care office administration fees and any other office charge could bring a self-pay price to $200-300 per vaccination. Most adults are not accustomed to paying this amount for a single vaccine. By comparison, adult vaccine private sector costs per dose are approximately $11 for influenza, $63.47 for pneumococcal, $59 for hepatitis B ($177 for the three-dose series), $65.03 for hepatitis A ($130.06 for the two-dose series), and $90.55 for varicella ($181.10 for the two-dose series).

As a provision of the Affordable Care Act (ACA), insurance plans taking effect after September 23, 2010, are required to cover the total costs of ACIP recommended vaccines, which is a great benefit for those who meet shingles vaccine criteria (Healthcare.gov, 2012). Costs involved with insurance plans in effect prior to that date will vary and the only way to know if complete or partial coverage is provided is by contacting the specific plan.

For persons relying on Medicare only for health care benefits, the process is not as clear. Medicare Part B generally does not offer vaccines for preventing diseases, but has made exceptions for influenza, pneumococcal, and hepatitis B. The shingles vaccine is treated as a prescription benefit under Medicare Part D. Copayments may be involved. The potential amount of a patient's co-payment varies (www.medicare.com/vaccination-coverage/shingles-vaccine.html).

The lack of easy accessibility of the shingles vaccine can be a challenge for some consumers. Many offices/clinics do not stock the vaccine due to the strict storage and handling requirements. Zostavax comes in single dose 0.65 ml vials which are to be stored frozen at a temperature of approximately +5°F, until it is reconstituted with a diluent. The diluent should not be stored frozen, but stored at room temperature (68-77°F) or in a refrigerator (35-46°F). Once Zostavax is removed from storage, it is mixed with the diluent and administered subcutaneously, preferably in the upper arm. This process is to be completed within 30 minutes of being removed from freezer storage; otherwise, the potency of the vaccine is lost. You cannot refreeze a reconstituted vaccine. The most common side effects of the shingles vaccine are redness, pain, tenderness and swelling at the injection site, and headaches. As for all vaccinations, patients are monitored for unusual or severe problems. If an adverse event does occur following the shingles vaccination, it should be immediately reported to the Vaccine Adverse Event Reporting System that is maintained by the CDC and FDA (800-822-7967; www.vaers.hhs.gov).

Many patients are now being sent with a prescription to their local pharmacy to have the shingles vaccine administered by the pharmacist. The pharmacist's role has expanded to include vaccinations, and as of 2009, 50 states allow pharmacists to administer vaccinations (the specific vaccines allowed will depend on individual state laws). According to the Herpes Zoster Vaccine Pocket Information Guide, at least 47 states and the District of Columbia allow pharmacists to give the shingles vaccine (IAC, 2012). Pharmacists are among the most accessible health care professionals in the community, so their expanded role creates the potential to increase ACIP immunization recommendations.

Conclusion

Shingles is a potentially debilitating disease with complications that may affect a person's ability to function for years, particularly with PHN. A vaccine is available which can prevent the disease altogether, or at least lessen the course if it does occur. Contraindications to receiving the vaccine do exist, but it is mostly barriers such as lack of education of patients and providers, difficult access to the vaccine, and high costs that have prevented adults from receiving the vaccine. Nurses and other health care professionals have opportunities to decrease barriers by implementing programs to identify eligible patients, provide education on costs, and guidance to easy vaccine accessibility.

Nurses should continue to monitor the ACA's impact on improving accessibility of the shingles vaccine by decreasing costs to the patient. Secondly, as accessibility of the vaccine improves, nurses should continue to track the varying age recommendations by different agencies as to when to begin administration of the vaccine.

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Editor's Note: See page 16 for an article about how one facility successfully delivered the shingles vaccine to over 150 veterans, written by AAACN members.

Recruit Colleagues And Win!

The best advertisement for membership in AAACN is our members. Members who value the education and networking AAACN offers find it easy to tell colleagues why they should join AAACN. Under the annual Member-Get-A-Member campaign, members can win $50 and $100 certificates and be entered to win registration to the May 19-22, 2014, New Orleans conference. Download a membership application from the Web site, write your name in the "referred by" section, and start sharing with your colleagues, letting them know why they should become members of AAACN! Who knows? You could be our next winner.

President's Message

continued from page 2

of the set of education modules and the subsequent recognition of his or her competence to perform the role of care coordinator/transition manager. More details will be available in future letters.

I'd like to share some updates about the strategic plan and other important initiatives.

Strategic Goal 1 – Serve Our Members

In addition to the work around care coordination, AAACN continues to work with Gannett Education to create an online certification review course developed and taught by our team of instructors. Members and non-members could access the course at various times throughout the year according to their own schedules. This would be in addition to the "on the road" courses, DVD, the course at the annual conference, and the site licenses available at present.

The lack of nurse-sensitive indicators for ambulatory care has been identified as an issue, especially in Magnet facilities and those seeking Magnet designation. AAACN has convened a task force charged with identifying the appropriate ambulatory care indicators to measure quality of care. The American Nurses Association will provide a resource to assist with this project under board liaison, Nancy May.

Strategic Goal 2 – Expand Our Influence

Another task force has been selected to develop a white paper to describe the need and the criteria for an Ambulatory RN Residency Program for new graduates and RNs new to the specialty of ambulatory nursing. This initiative addresses Recommendation 3 of the IOM Future of Nursing report, which supports the implementation of residency programs.

AAACN submitted two nominations for the Nurse at Large position on the Joint Commission Board of Commissioners for a three-year term. The candidate will be selected at their fall board meeting.

Strategic Goal 3 – Strengthen Our Core

Promoting our strategic message is key to continuing to identify who we are as ambulatory care nurses and to increasing our membership. Despite many settings and multiple roles, we are one unifying specialty! If every member encouraged one person to take advantage of the ability to connect with others in similar roles and to advance his or her professional practice and leadership skills through membership, imagine what we could do to advocate for ambulatory care nursing! And if you haven't volunteered for a task force, committee, or other project yet, it's not too late!

Enjoy the summer weather – find some time to relax and rekindle your soul and your spirit. Exciting times are ahead for all of us in health care and especially in ambulatory care nursing! Thank you for the privilege of serving as your President.

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Marketing Opportunities

Advertise with AAACN and reach more than 2,600 nurse managers and supervisors, nurse administrators and directors, staff nurses, educators, consultants, NPs, and researchers – the ideal audience for your sales and marketing message!

Contact Marketing Director Tom Greene at tom.greene@ajj.com or 856-256-2367 for more information.

member spotlight

Glenda Wright

Ever since she was 18-years-old – only shortly out of high school – Glenda Wright, MHA, BS, BSN, RN, has been in health care. She has been an RN since 1985, and her employment background is 29 years in the Emergency Room and two years in Maternal Child. As the Divisional Educator at Tampa General Hospital Ambulatory Care in Tampa, FL, Glenda presently serves 11 sites and will add four more before the end of 2013. She oversees education requirements for all levels of staff, from physicians to registration staff and all those in between. She truly loves her job and has been in her current division for the past four years.

While AAACN membership was not her first organizational affiliation, Glenda is also a member of the Emergency Nurses Association and the Association for Nursing Professional Development. When she joined the Ambulatory Division, she felt that as the Educator, it was her opportunity to be part of an organization that supports ambulatory care nursing. Her membership with AAACN began four years ago, when she became involved with the Staff Education Special Interest Group (SIG); she is currently writing a chapter for the preceptor guidelines. The aspect of AAACN Glenda appreciates most is the networking component. Glenda is working on her Nursing Professional Development Certification. She has used articles from *ViewPoint* to develop an education training program with her Vice President and Director on the use of non-licensed personnel, medical assistant technician (MAT), in the Ambulatory Division. She included cross training of staff for site centers as well. In the primary care center, she is participating in the implementation of the Medical Home Model and the MATs will facilitate the patient care flow of the centers.

Working in a designated ambulatory care setting is a new experience for Glenda, as is having the support of management in achieving educational goals. That, along with appreciation of education as a whole by management, is a big job satisfier for Glenda. She says, "I enjoy the change in my setting and the new challenges that come with it."

The biggest challenge Glenda has faced as a nurse is maintaining all the daily changes in health care and medicine, but she enjoys the outcomes – excellent patient care. Her approach to challenges has been to attend as many educational updates as time permits, read a lot, ask a lot of questions, and conduct research.

On a personal note, Glenda has been happily married for 25 years. She is very involved in her church as a Children's Church Director and Administrative Member/Secretary. She enjoys time off from work and loves being with her family. She also enjoys people, getting to know them, and loves and appreciates her job.

Glenda's future plans include completion of her certification, publishing two articles, and establishing a computer education lab at one of her organization's ambulatory sites.

Deborah A. Smith, DNP, RN, *is an Associate Professor, Georgia Regents University (formerly Georgia Health Sciences University), College of Nursing, Augusta, GA, and Editor of the "Member Spotlight" column. She can be contacted at dsmith5@gru.edu*

Nurses Week Celebrations at Kaiser Permanente Downey

At Kaiser Permanente in Downey, CA, we celebrated Nurses Week in style all week long. Under the guidance of our chief Nurse Executive, Patty Clausen, ambulatory and in-patient services combined forces to provide an outstanding variety of activities.

We kicked off the week with birthday cake on Monday in honor of Florence Nightingale. Jerry Spicer, Vice President Regional Patient Care Services, presented DAISY Awards to some of our outstanding nurses. Staff were encouraged to wear white or their original nursing uniforms. On Tuesday, Our Healing and Holistic Health Conference provided staff with a very enjoyable educational experience. We hosted a "Par-Tea" on Wednesday, which offered staff a chance to relax and enjoy a soothing cup of tea and cookies. Thursday was recognized as ice-cream day. To end the week, we saw a "Walk in My Shoes Report" on Friday. At this event, various members of administration and management reported on the day they spent side by side with a nurse at work.

Nurses at Kaiser Permanente dressed in white during Nurses Week 2013. It was a blast from the past seeing these uniforms! Pictured (l-r): Mary Janssen, RN; Terri Aimerito, RN; Cathy McFarlane, RN; and Renee Haynes, RN.

Throughout the week, exciting raffle prizes were offered during the events. Staff also received a very useful trunk organizer, a set of personal earphones, and THRIVE Store gifts from administration.

Yes, it was a great week to be a nurse. Here at Kaiser Permanente, we "Kicked up and Partied!"

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PCMH in the U.S. Air Force

continued from page 1

and patients, and deliver comprehensive care with coordination among providers (Berenson et al., 2008).

The military also embraced this model. Military health care faces many of the same challenges of the U.S. health care system in serving a large population of active and retired servicemen and their families. Unlike the general health care system, however, the military follows orders. Initial development of PCMH was in response to patient and staff concerns (Kosmatka, 2011). Implementation of the PCMH model was later mandated, and implementation was expected to occur in a defined time period of four years.

Patients were concerned about the difficulty of getting an appointment, as well as the difficulty of being able to consistently see the same provider. Concerns of USAF physicians included the desire to build continuity with their own patients, the need for adequate and consistent support staff, the desire for a currency-based practice rather than a business-based practice, and the desire for greater control over their own practice. "Currency-based" versus "business-based" practice refers to the need to remain current on trauma and critical care skills necessary to provide complex medical care for war injuries at deployed locations, in comparison to a business-based practice concerned with the right mixture of various types of appointments and securing accurate billing codes for those appointments. The result of these frustrations was the exit of many family physicians from the USAF in response to a lack of control on how to manage their patients. There was also frustration felt by other staff members, including medical technicians who were not being used to the full scope of their practice and ambulatory care nurses concerned about their clinical practice being limited to telehealth with minimal direct contact with patients.

The USAF initially called its version of the model "The Family Health Initiative" when implementation began in August 2008, but adopted the PCMH nomenclature when the Assistant Secretary of Defense mandated implementation across all three branches of service in 2009 (Office of the U.S. Assistant Secretary of Defense, 2009). The goals of PCMH in the USAF are to create an enjoyable and productive practice environment, deliver world-class and evidence-based quality care, and, in the process, retain current staff, recruit new personnel, and maximize use of skills at all levels of clinic staff (Kosmatka, 2011). A focus on prevention, proactive rather than reactive care, and a greater emphasis on disease and case management are all hallmarks of the USAF's PCMH. The USAF embraced the PCMH model and invested in major system redesign to implement the program in all of its primary care sites in a phased-in approach through 2012.

Challenges and Concerns

As with any major program redesign, considerable staff training was required to implement the changes. Fortunately, the implementation was made easier by training, resources, and the oversight provided by a USAF PCMH implementation team. Previous models, such as Primary Care Optimization and Clinical Practice Optimization, had limited success in the USAF due to several factors. One was the inefficient use of staff and lack of accountability, which limited the success of those models to the level of the medical treatment facility (MTF). Another factor was that MTFs were given unrealistic timelines for success. Therefore, the required metrics did not drive desired behavior, and the model was not given time to mature. In contrast to previous models, with PCMH, there is an expectation for MTFs to maximize patient involvement, use the entire health care team, maintain continuity of staff within teams, maximize continuity between patient and provider, and communicate within teams utilizing tools such as huddles and routine care coordination team meetings.

Implementation

Implementation occurred in several phases. The **initial phase** treated the first few MTFs as pilot programs. After the pilot programs, implementation continued across the Air Force Medical Service.

The **second phase** involved subject matter experts on a multi-disciplinary team conducting site visits at MTFs where they reviewed processes and made recommendations to incorporate concepts of a Medical Home. The multidisciplinary team included a senior officer consultant, physician, nurse, group practice manager, and enlisted consultant for clinical and administrative functions. The team visited the MTF approximately eight weeks prior to the planned PCMH implementation date to describe the "ideal state" and to assist the MTF with planned process changes that would be required. A tracking tool was developed after the first visit, which was used to focus MTF efforts and provide accountability for needed actions.

Once the PCMH team made its first visit to the MTF, the real work began for that site. In addition to the PCMH team's implementation plan, there were additional actions required at each MTF, including process changes, training, and team building, which were vital to the success of the program. The concept of daily team huddles was encouraged to communicate schedules, review the day's patients, and to foster an environment where staff could communicate openly with each other. Training was also essential, including getting to know the capabilities of the medical technicians and the civilian staff. Getting to know each other, setting team goals, setting expectations, and providing opportunities to succeed were all encouraged as part of the process. A second visit then occurred at the implementation date to follow up on progress made with previously recommended changes and to reinforce further work on planned process changes.

After implementation, telephone conferences were held every two weeks for sites that had begun implementation to provide guidance from the team of experts as needed, and to provide discussion between MTFs that had met success with implementation.

The group practice manager (GPM) whose work began with the team 2-3 weeks before the actual on-site

visit was a key factor in managing provider templates. The GPM evaluated historical demand of clinic access, and then projected and forecasted how to build provider appointment templates in order to meet that demand. The clinic's health care delivery team was encouraged to "know" their patient population by accurately assessing and providing access to treatment. Booking guidelines/templates were designed to make it easier to schedule patients with "their" primary care manager (PCM) or PCM team (the team that the patient is specifically enrolled to) rather than cross-book to a different PCM. In that way, increased "continuity" was "built" into the system.

Continuity of care became one of the primary metrics followed across the Air Force. Care coordination conferences – inter-disciplinary meetings to discuss the provider's panel of patients – were encouraged on a periodic basis (recommended monthly, but occurred based on team preference). These conferences were intended to tap into the unique skills of each team member to provide the best care possible to patients.

The USAF utilizes registered nurses called health care integrators (HCIs), who are experts at identifying the nature of the population enrolled to that facility and facilitating implementation of clinical practice guidelines and PCMH measures which target the unique needs of that MTF. For example, the HCI might provide demographic information about the patients enrolled to a particular PCM team, revealing more retirees than active duty on that team, leading to an emphasis on chronic care management for that patient population. They might also provide information about the number of tobacco users, or number of women in that population who have not received mammograms, or the number of patients with diabetes who have not received their annual retinal exam. The care coordination conference can then be used to discuss clinical preventive services targeted to specific patients, and the role that each member of the health care delivery team plays in helping the patient receive those services.

The **third phase** occurred approximately two months after implementation. At that time, a visit by a senior military health care leader was conducted to monitor progress of the team's previously recommended changes, provide further guidance for trouble-shooting problems, and meet with senior MTF leaders to ensure their continued buy-in and leadership support. The next step in implementation was an on-site visit by a General Officer approximately six months after implementation to further reinforce the importance of the program, to assist with challenges, and to laud successes. All visits emphasized the importance of the program, encouraging leaders at all levels, from General Officer down to every member of the health care delivery team, to share the mandate to implement the program in accordance with PCMH guidelines and in the allotted time.

Evaluation

The **fourth phase** included an implementation evaluation with a variety of metrics and incentive programs. Measures of success were evaluated by senior Air Force leaders, and included metrics to evaluate continuity, access, satisfaction, ambulatory case mix, Healthcare Effectiveness Data Information Set (HEDIS) measures, and frequency of patients seeking care beyond the MTF and their health care team.

Metrics Used

Continuity metrics were foundational, and forced a change in appointment booking and appointment protocols. Cross-booking, which is booking appointments with other providers and teams besides the PCM a patient is enrolled to, is now allowed only in exceptional circumstances.

Access is measured by whether or not each provider has 90 bookable appointments per week that are centrally available to the appointment clerk. Providers are not required to "make up" appointments for leave or Temporary Duty (TDY), as they had been under previous models. This metric was designed to promote better "first-call resolution" and to decrease involvement of other clinic staff.

Satisfaction will continue to be monitored with the same patient satisfaction survey as used under previous models (the Service Delivery Assessment), but an additional staff satisfaction survey was added to evaluate perceptions of providers, nurses, and medical technicians.

The Ambulatory Case Mix is a measure of success developed to drive the behavior of seeing more complex patients and doing more procedures in the Family Health Clinic. It involves a combination of weighted scores for patient complexity, diagnosis, and billing codes, and is intended as a way to compare pre-/post-PCMH for the same provider.

HEDIS is a tool developed by National Committee for Quality Assurance (NCQA) and used by more than 90% of America's health care plans to measure performance on important dimensions of care and service (NCQA, 2012). HEDIS consists of a total of 75 measures across eight domains of care, only some of which are routinely reported in USAF MTFs. HEDIS metrics have been monitored for many years, but a HEDIS composite score was developed as a measure of success for PCMH implementation to see the overall picture of success.

Lastly, non-PCMH utilization is measured by billing records, with emergency room/urgent care utilization rates and specialty care utilization expected to decrease with continued PCMH success.

Outcomes. Initial evaluation has shown success in many of these measures. Continuity has improved, with overall increases seen at all facilities and patients being able to see the specific provider they are enrolled to as high as 95%. Prior to PCMH implementation, the response rate to the question, "Would you recommend to a friend," dipped below 50% for the first time. Post-implementation patients were pleased with improved access to care and seemed to embrace continuity with providers more quickly than expected (Kosmatka, 2012). According to anecdotal reports at USAF facilities, provider and technician staff satisfaction has improved. Nurse satisfaction has not had the

same improvement, largely due to a consistent and sometimes inappropriate telehealth burden, and a redistribution of nurse staffing in the PCMH model.

Providers are pleased with the greater control of their schedules and improved continuity, caring primarily for those patients in their empanelment. Initial disease management (DM) efforts are showing improved process/outcome measures with an expectation of further improvement with maturation of PCMH, focused training (DM course in development), and greater access to actionable data through use of computer tools for the health care delivery team. ER/UCC utilization declined from seven visits out of 100 enrollees per month in 2011, to six visits out of 100 per month in 2012; however, more improvement to fewer than three visits out of 100 per month is the goal (Kosmatka, 2012). After all sites had the PCMH model in place, emphasis shifted to ensure that all program elements were implemented.

NCQA Recognition

The **final phase** included evaluation and potential recognition by National Committee for Quality Assurance (NCQA) in 2011-2012. Each site completed an assessment of the program elements and reported on the extent of element implementation (0-100%) for meeting NCQA criteria as a PCMH. TRICARE Management Authority requested 45 clinics (15 each from Army, Navy, and Air Force) apply for NCQA Provider Practice Connections® (PPC)-Patient Centered Medical Home™ (PCMH) recognition. The Air Force selected 15 sites for formal evaluation in fall 2011.

The evaluation process began with a self-scoring readiness assessment by the practice. When ready, the practice completed the NCQA's Web-based Survey Tool, responding to questions and attaching supporting documentation to verify responses. Data sources could include documented processes and procedures, reports, records or files, and materials such as patient education brochures and Web sites. Once complete, the practice submitted the Survey Tool to NCQA for evaluation. The 2008 NCQA document, *Standard and Guidelines for Physician Practice Connection®-Patient Centered Medical Home™* (PPC®-PCMH™), utilized nine standards for evaluating quality patient care. The standards included important aspects of care, such as access and communication, patient tracking and registry functions, care management, patient self-management support, test tracking, referral tracking, performance reporting and improvement, and advanced electronic communications (NCQA, 2008).

NCQA evaluated all data and documents submitted by the practice against the standards and awarded the practices with an overall score that can range from 1-100. To be recognized, a practice site must demonstrate implementation of the nine PPC®-PCMH™ standards and meet a minimum number of "must-pass elements." The practice would have also earned one of three levels of achievement, with level three being the highest, based upon how well they performed the functions required in each element of the standard. This allowed practices with a range of capabilities and sophistication to successfully meet the standards' requirements according to the needs of their patients and their practice's resources. All 15 USAF sites that submitted applications for NCQA PPC®-PCMH™ recognition achieved Level 3 Recognition status, the highest level possible.

Challenges to Overcome

Ongoing challenges include the mobility requirements of military staff, leading to continuous requirements for training new personnel in PCMH principles. Additionally, maintaining the momentum of change and sustaining the improvements made will require continued efforts from a management standpoint.

Finally, once all 15 sites had successfully implemented the program elements, changes in patient outcomes could validly be attributed to the program by using a pre- and post-assessment of patient outcomes comparing them before and after program implementation. Future research will focus on evaluating patient outcomes for one group of patients, those with Type-2 diabetes, before and after program implementation.

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Note: *This article includes information from Col. Andrews regarding her experience working with Defense Department medical programs. It does not imply endorsement by the Department of Defense or the U.S. Air Force.*

Telehealth Experts Educate Nurses at Texas Women's University

Pictured (l-r): Mari Tietze, Raffi Kilejian, Lynda Hatley, Muy Seng, Christina Martinez, Linh Nguyen, Rebekah Knop, Rachel Kriswell, and Stephanie Woods.

Past Presidents Suzi Wells, MSN, RN, and Traci Haynes, MSN, RN, BA, CEN, along with Maureen Espensen, MBA, BSN, RN, Editor of the *Telehealth Nursing Practice Essentials* textbook, shared their expertise in telehealth nursing with under-graduate nursing students who are taking the first-ever telehealth nursing elective course at Texas Women's University (TWU). Dr. Stephanie Woods, Associate Dean for the Dallas Campus of TWU has partnered with a telehealth company that provided a small grant to support the offering of the course. Dr. Woods contacted Maureen through the National Office to invite her to speak with her class. Dr. Woods and Dr. Mari Tietze used the *Essentials* textbook in the development of their course.

Suzi, who was connected to the class through Skype, discussed various telehealth solutions that can be utilized across the health care continuum. She described why RNs are in the right profession to do telehealth because of their knowledge and critical-thinking skills. Suzi explained the role of AAACN in telehealth, the expansion of the role of telehealth nurses, accountable care organizations (ACOs), a medical home, and more. Maureen, who participated via conference call, discussed the role of the professional nurse in telehealth and shared the importance of the nursing process and use of decision support tools. The instructors for the course had not included decision support tools in the development of the course. Maureen's information prompted the addition of this topic to the course. Traci also addressed the class via conference call. She covered the role of AAACN in the education and professional development of nurses who are active in or interested in telehealth nursing. She demonstrated the many ways AAACN supports nurses aspiring to be telehealth nurses. She clearly articulated to the students that ambulatory nursing is a specialty.

When asked if nurses could be hired directly into ambulatory care upon graduation, Suzi and Traci explained the importance of having experience prior to taking a telehealth job. They acknowledged that experience requirements may change over time, but that for now the students should focus on getting experience upon graduation. When the students were asked what they learned from the AAACN leaders, they commented on how many nurses were involved in the telehealth field, the use of technology, how important telehealth is currently and will become as medical care continues to grow. One student said the experts "helped to show just how much telehealth can impact medicine and in ways that I hadn't given much thought. Previously I would have most associated it with post-op or post-discharge check up calls but it is so much more than that and the speakers helped to broaden my understanding of telehealth and its importance." The students realized how helpful telehealth is in providing care to those in both urban and rural areas, and also that telehealth is evolving and becoming more widely used. When asked how likely the students would consider telehealth opportunities in their future, responses indicated they were excited about the opportunity, they found telehealth intriguing and would like to learn more, and one student said, "I like the idea of using technology advanced equipment to provide the best care for patients. I would really like to see how it all happens in a telehealth clinic setting and speak to a telehealth nurse to truly assess how likely I am to pursue telehealth nursing."

Dr. Woods said, "This interaction with AAACN leaders was an amazing opportunity for our undergraduate students. The use of technology allowed us to connect these wonderful role models with future nurses. I could not be more pleased in the outcome!" It is hoped that this initial collaborative effort will continue over time, and that AAACN leaders will impact the future offerings of telehealth content at TWU and that other schools will be interested in similar approaches. TWU college of nursing plans to continue offering this undergraduate course on an ongoing basis. For advanced practice, TWU will offer a graduate level "Telehealth and Remote Monitoring in Post-Acute Care Delivery" course with an interprofessional, population health-based focus including hands-on experience using a telemedicine cart. This reflects TWU's commitment to teaching innovative practices for the benefit of population health improvement.

Save the Date • May 19-22, 2014

Plan to enhance your knowledge, meet new colleagues, and have some fun in the city of New Orleans on May 19-22, 2014. We are planning an outstanding program tailored to the current hot topics in ambulatory care nursing. Some topics to be presented include: ACOs, Chronic Conditions, Motivational Interviewing, Reducing Readmissions, Telehealth, and Using Protocols.

Watch the Web site for a preliminary flyer with more information on the 2014 conference.

health bytes

● Summertime is the perfect opportunity to enjoy the beach, the lake, the patio, or the backyard. Be aware though of the harmful effects of the sun, including sunburn, skin cancer, and melanoma. Direct your patients to the sunburn information on MedlinePlus (http://www.nlm.nih.gov/medlineplus/ency/article/003227.htm), which includes a webcast of the effects of sun on the skin.

● The National Fire Protection Association brings you information on safety when around fireworks. A flyer with information (http://www.nfpa.org/~/media/Files/public%20education/fireworkssafetytips.ashx) is included on their Web site.

● Poison ivy, poison oak, poison sumac, oh my! The Federal Drug Administration has a flyer available (http://www.fda.gov/downloads/ForConsumers/ConsumerUpdate/UCM143611.pdf) to offer tips on outsmarting poison ivy and other poisonous plants.

● Summer picnics with family and friends along with potato salad and deviled eggs are definitely a highlight of summer! The Centers for Disease Control and Prevention offer a podcast (http://www2c.cdc.gov/podcasts/player.asp?f=2775446) on safety with eggs and avoiding salmonella poisoning.

Carol Ann Attwood, MLS, AHIP, MPH, RN,C, *is a Medical Librarian, Patient Health and Education Library, Mayo Clinic Arizona, Scottsdale, AZ. She can be contacted at attwood.carol@mayo.edu*

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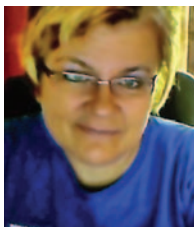
A Simple Effort Leads to Great Appreciation

The "Telehealth Trials and Triumphs" column is focusing on nurse and patient stories this year. I have been receiving feedback from several readers who have their own stories to share. Last month, a supervisor from a nurse telephone triage service in Massachusetts contacted me and shared a poignant story. It was moving and validates why it is crucial for registered nurses to manage triage patient calls.

The supervisor, Brenda Glover, has written the introduction to this patient situation. Her introduction reflects how proud she is of the professionalism of her staff. As a supportive manager, Brenda recognizes and celebrates excellence in nursing practice. Together, this supervisor and her team practice the art and science of telephone triage nursing.

Telephone Triage: More than a Call

Brenda Glover



As a supervisor for a telephone triage company, I encourage the members of our team to view a situation from the caller's perspective. It is possible to get into a routine of dealing with the same types of calls, shift after shift, and become insensitive. However, we acknowledge that patients and families would not call if there were not a need. No matter how simple the problem may seem to us as nurses, it could be a mountain to our caller.

Our team of nurses is exceptional as they often go beyond normal procedures to meet the caller's needs. The care they demonstrate in treating each caller as an individual is phenomenal, and it shows in so many ways, demonstrating that the smallest effort can change an outcome. One of our nurses, Michele Murphy, recently shared an experience that shows this level of compassion.

It took just a couple of extra minutes of Michele's time to make a difference to this mother, and Michele realized her value to her callers that day. Amazing! Even though we are not at the bedside of the patient, or even in the same room, we make a difference.

Humbled...and Forever Changed

Michele Murphy

It was shortly after 8 a.m. when I received a call from a mom regarding her five-year-old son who had started with croup in the early hours of the morning, which exacerbated his asthma. I could sense that this mom was knowledgeable and experienced in managing the symptoms and the treatment of croup and asthma. As our conversation continued, she shared that she had been up all night, and that her son was doing well with steamy showers, cool air, and albuterol nebulizer treatments. She was exhausted and shared that in the past, her son needed steroids and was thinking he would need steroids ordered again with this exacerbation. She was hoping to get the first morning appointment so they could get some rest. I wanted to help, but informed the mom that this particular office did not provide available appointments for scheduling nor did it have walk-in hours. The only option I could offer was to encourage her to call the office after 8:30 a.m. for an appointment. No sooner had I said that did I hear the mom again say, "Please, miss. Can you help me?" And then she further disclosed, "My son and I have been up all night. We are very tired, and my daughter is receiving hospice care at our home. If you could set up this appointment, it would be immensely helpful to us all."

The tears filled my eyes for this mom and her family. At this point, I did what any other nurse would have done and telephoned the back line of the office. The office was able to give the mom the first morning appointment with her own provider. When I relayed this to her, she was very appreciative. I ended the triage call with this mom. As the tears streamed down my face, I thought, you just never know the road another is walking on the other end of the telephone line...

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Do you have a story that has been memorable or has had an impact on your practice? If you would like an opportunity to share it in the "Telehealth Trials & Triumphs" column, contact Kathryn Koehne at krkoehne@gundluth.org

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Going the Extra Mile

Due to the increased demand for shingles vaccine among veterans within the VA system, nursing administration at The Villages Outpatient Clinic (TVOPC), discussed the idea of a Saturday Shingles Clinic in order to meet the needs of veterans. A taskforce was developed in which a team of pharmacists, nurses, administrative staff, and VA police met to discuss the creation of this clinic.

According to the Centers for Disease Control and Prevention (CDC, 2012), "The vaccine for shingles is recommended for use in people 60-years-old and older to prevent shingles. This is a one-time vaccination. There is no maximum age for getting the shingles vaccine. Anyone 60 years of age or older should get the shingles vaccine, regardless of whether they recall having had chickenpox or not. Studies show that more than 99% of Americans ages 40 and older have had chickenpox, even if they don't remember getting the disease."

On December 1, 2012, the Saturday Shingles Clinic came to fruition, and with the support of the taskforce, 93 patients were seen and given the shingles vaccine. The success of this first Saturday Shingles Clinic led to the opportunity for a second clinic. On December 8, 73 veterans also received their shingles vaccine. A grand total of 166 veterans were given the vaccine. The patients were very appreciative of the opportunity to attend the Saturday Shingles Clinic. Comments by our veterans include:

Staff of The Villages Outpatient Clinic provided vaccinations to 166 veterans during the Saturday Shingles Clinics in December 2012.

> "Thank you so much for coming in on a Saturday for us!"
> "You are very efficient!"
> "This was a wonderful thing you did for us!"

This program increased access to care and decreased patient wait time for the vaccine by four months! The interdisciplinary collaborative effort by TVOPC staff to go "the extra mile" and help our veterans is reflected in the success of the Saturday Shingles Clinic.

Reference

Centers for Disease Control and Prevention. (2012). *Vaccines and preventable diseases: shingles (herpes zoster) vaccination.* Retrieved from http://www.cdc.gov/vaccines/vpd-vac/shingles

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Editor's Note: *See page 4 for another article on the shingles vaccine, which offers continuing nursing education credit.*