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aacn ViewPoint

The Voice of Ambulatory Care Nursing

Maximize Your Volunteering Potential

Linda Brixey

"I want to volunteer." "I never get selected." "They only choose those from the in-crowd." "Nobody wants to volunteer." "I can't get anyone to participate."

Have you ever heard one of these statements? Or thought them yourself? The AAACN Board of Directors has heard your concerns and has worked to mitigate them. In 2011, we started a new process that relied on an effort to engage more members and stop the overuse of the same few.

When a volunteer or workgroup is needed, we work to identify the best candidate or candidates. We send out a blast email that requests volunteers. In the email, we include what the project is and the skill set we are looking for, as well as the expected time commitment. To our amazement, we have received more volunteers than we had opportunities! During the past two years, we have continued to use this process. We also continue to have more candidates than opportunities. This is a double-edged sword for us. We love having an abundance of volunteers, but are saddened by having to notify members when they were not selected for the workgroup or other volunteer activity.

I can only imagine the frustration of applying to volunteer and receiving a notice that says, "Thanks, but you were not chosen," not just once, but several times. Because we have been following this process for a while, it has been suggested that we provide some tips on making a successful application to volunteer.

As you apply to be our designated volunteer, tell us why you are interested, submit your CV, and be sure to include any direct or tangential experience. (For example, as the nursing supervisor, I was chosen to lead a team to explore how to implement best practices for chronic home care management in the Internal Medicine department. We were successful in training staff and effecting the needed change to improve patient outcomes.) We are looking for the expertise you can bring to the project.

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The Official Publication of the American Academy of Ambulatory Care Nursing

inside

from the president

Nurses Week: Demonstrating Our Economic Value

Suzi Wells

It is difficult for me to believe that this is my final President's Message. The past year has been one of the proudest and most fulfilling "moments" of my life! There are so many things I have come to value about serving as President of AAACN, but what I value most is having been allowed the opportunity to serve in this trusted role by you, our members.

We will all celebrate Nurses Week within our own institutions during the week of May 6-12, 2013. I would like to take the opportunity to wish each of you a very happy Nurses Week!

I can't think of a better time than Nurses Week to reflect on key accomplishments of AAACN over the past year and how these accomplishments contribute to making an economic case for nursing.

Nurses are leading in the delivery of quality patient care in a transforming health care system. The Patient Protection and Affordable Care Act (PPACA) and the Institute of Medicine's *Future of Nursing* report call for our profession to optimize its contribution to better meet the needs of all patients in the delivery of quality health care.

Nursing has done an amazing job of demonstrating its commitment to patient care, improved safety and quality, and better patient outcomes. But with the increasing call to control health care costs, it is critical that we demonstrate nursing's economic value and the return on investment. Being able to articulate our economic value will help ensure administrators, managers, physicians, policymakers, and others understand the essential role of nursing today and in the future. What better documents to reference in these conversations than the American Academy of Ambulatory Care Nursing Position Statement and Paper on the Role of the Registered Nurse in Ambulatory Care? It is well within the scope of RN responsibility to partner with other health care professionals in the development of a new model of care delivery that focuses on the prevention of illness and disease, promotion of wellness, and eliminating unnecessary costs. AAACN is developing Position Paper talking points and fact sheets that will be posted on the Web site (www.aaacn.org) to support members when talking with administrators, managers, physicians, policymakers, and others about the essential role of nursing today.

As nurse staffing levels increase, patients' risk of complications and their hospital lengths of stay decrease. This results in cost savings. Nurses directly impact these cost savings. According to a Nursing World white paper, nurse-managed care coordination and transitional care decrease cost by reducing emergency room visits, hospital readmissions, and lowering Medicare costs (American Nurses Association [ANA], 2012). According to Naylor, Aiken, Kurtzman, Olds, and Hirschman (2011), nurse-managed care coordination and transitional care programs save Medicare between $5,000 and $6,000 per beneficiary per year. Over the past year, the expert panels convened by AAACN have completed all three phases in the development of Care Coordination Competencies. These expert panels have developed the dimensions, competencies, and a model of RN Care Coordination and Transition Management for ambulatory care environments. In the coming year, AAACN will complete and release Care Coordination

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aaacn American Academy of Ambulatory Care Nursing

Many settings. Multiple roles. One unifying specialty.

Reader Services

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for your health

- The National Library of Medicine's Disaster Information Management Research Center has created a new topic page called "Coping with Disasters, Violence, and Traumatic Events" (http://disasterinfo.nlm.nih.gov/dimrc/coping.html). This information is a work in progress, but it can provide helpful hints in working with traumatized victims.

- Irritable bowel syndrome (IBS) is a functional gastrointestinal disorder with a variety of symptoms, including cramping and abdominal pain, bloating, diarrhea, and/or constipation. For more information on strategies to assist patients with IBS, check out the National Digestive Diseases Information Clearinghouse (http://digestive.niddk.nih.gov/ddiseases/pubs/ibs/ibs_508.pdf) or the educational video offered on the Mayo Clinic Web site (http://www.mayoclinic.com/health/irritable-bowel-syndrome/MM00461).

- More and more patients are using portable medical devices in the home environment. Check out the FDA's tips for consumers (http://www.fda.gov/downloads/ForConsumers/ConsumerUpdates/UCM331366.pdf), and learn how patients can live effectively with these devices and better understand instructions for usage.

- MedlinePlus.gov, a consumer health search engine, has a host of online videos with illustrations and anatomical descriptions of a variety of conditions. For a list of the available videos, check out http://www.nlm.nih.gov/medlineplus/anatomyvideos.html. These videos have illustrated diagrams as well as written and spoken explanations in a simple, easy-to-understand format.

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

Member Get-a-Member Campaign Kickoff

The 2013 Member Get-a-Member campaign kicks off April 1 and ends December 31. Members are encouraged to invite their colleagues to join AAACN by letting them know about the many member benefits AAACN provides. Download a membership application from the Web site to distribute, or ask your colleague to insert your name in the "referred by" section of the online membership application. You could be a winner of a $50 or $100 AAACN certificate, a two-year membership, or complimentary registration to the 2014 conference in New Orleans!

Instructions for Continuing Nursing Education Contact Hours

Making a Place for Integrative Care In a Changing Health Care Environment

Deadline for Submission: April 30, 2015

To Obtain CNE Contact Hours

1. For those wishing to obtain CNE contact hours, you must read the article and complete the evaluation online in the AAACN Online Library. *ViewPoint* contact hours are free to AAACN members.
   - Visit www.aaacn.org/library and log in using your email address and password. (Use the same log in and password for your AAACN Web site account and Online Library account.)
   - Click *ViewPoint Articles* in the navigation bar.
   - Read the *ViewPoint* article of your choosing, complete the online evaluation for that article, and print your CNE certificate. Certificates are always available under *CNE Transcript* (left side of page).
2. Upon completion of the evaluation, a certificate for 1.0 contact hour(s) may be printed.

Fees

Member: FREE **Regular**: $20

Objectives

The purpose of this continuing nursing education article is to inform ambulatory care nurses and other health care professionals about the practice of integrating complementary and alternative medicine in health care. After reading and studying the information in this article, the participant will be able to:

1. Outline basic information regarding the use of complementary therapies and practice of integrative medicine.
2. Identify potential resources for additional information regarding these practices.
3. Review current scope of practice regulation as it relates to nursing and complementary therapies.

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.

This article was reviewed and formatted for contact hour credit by Rosemarie Marmion, MSN, RN-BC, NE-BC, AAACN Education Director. Accreditation status does not imply endorsement by the provider or ANCC of any commercial product.

Making a Place for Integrative Care In a Changing Health Care Environment

Barbara Pacca

Over the past few years, knowledge and use of complementary and alternative medicine by health care consumers has been steadily increasing. According to information published by the National Center for Complementary and Alternative Medicine (NCCAM), 38% of adults and 12% of children in the United States have used some form of complementary therapies (NCCAM, 2007). Recent changes in our health care environment, along with increasing numbers of chronically ill patients, emphasize the need for better coordination of care and promote the patient as a partner in health care. Title IV of The Patient Protection and Affordable Care Act "directs the creation of a national prevention and health promotion strategy that incorporates the most effective and achievable methods to improve the health status of Americans and reduce the incidence of preventable illness and disability in the United States" (HealthCare.gov, 2011, 2013). The goal of the National Prevention Strategy is to improve the overall health, quality of life, and productivity of Americans across the lifespan (U.S. Department of Health and Human Services, 2011). Our focus of care is shifting to support these goals. Nurses are frequently responsible for much of the care coordination and are in a perfect position to assist patients in making safe, knowledgeable choices about their care. When your patients ask about complimentary and alternative medicine (CAM) therapies, are you prepared to answer their questions? Do you know where to look for the appropriate answers?

Health care consumers look to CAM for many reasons. One of the primary goals for many patients is to reduce or eliminate pain. When conventional medical treatments and medication do not seem effective to patients, they frequently will begin to look at other options. Other reasons patients may look at CAM therapies include: to enhance the effectiveness of conventional therapies, improve mood and affect, enhance their sense of well-being, reduce stress, improve functionality and the ability to perform activities of daily living, and provide the patient with a better sense of control over his/her life (Hart, 2008).

Assisting patients in making decisions about the most appropriate CAM modalities can be challenging. Most literature linked to conventional medicine has not addressed the use of CAM therapies or has not supported its use. Over the past 15 years, the volume of available information supporting CAM practices has grown in order to meet the consumer demand. In October 1989, the National Institutes of Health founded the National Center for Complementary and Alternative Medicine (NCCAM, 2013) to support scientific research needed to establish the safety and efficacy of CAM therapies and their roles in health and health care. In addition to providing information on research activities, NCCAM has developed educational tools for health care providers and consumers to assist them in making the right choices for their health care needs. The NCCAM Web site (www.nccam.nih.gov) contains extensive information about CAM practices of all types (NCCAM, 2011). Other educational resources can be found through professional or specialty organizations such as the American Holistic Nurses Association (AHNA, 2013), which sponsors educational programs for nurses and the *Journal of*

Holistic Nursing; Journal of Complementary and Alternative Medicine; the American Botanical Council (2013), which supports scientific research of herbal medicine; and the Healing Touch Program (2012), which supports education, research, and practice for Healing Touch Therapy. Although the term *CAM therapies* is applied to non-traditional modalities, it is more accurate to say *complementary* or *integrative* therapies. Our responsibility as traditional health care providers is to assist patients in deciding when and which non-traditional modalities will be beneficial when paired with traditional care to put the patient in the best possible position to achieve optimal health potential.

There is little documentation in the literature related to nursing scope of practice and complementary therapy modalities. The Web site of the American Holistic Nurses Association (www.ahna.org) reviews the Nurse Practice Act Project sponsored by the Nurses Service Organization; their page lists (by state) inclusion of holistic practice with links to individual state practice acts (AHNA, 2012). Nursing scope of practice in the integration of CAM therapies and conventional nursing care is governed by the same principles as traditional nursing practice. "A study conducted for the White House Commission on Complementary and Alternative Medicine Policy in 2001 found that 47% of State Boards of Nursing had taken positions that allowed for nurses to practice CAM" (Sparber, 2001). State nurse practice acts define our roles, whether we are the CAM provider or CAM educator for the patient. In addition to nurse practice acts, CAM providers are also required to meet the credentialing specific to the modality they are practicing.

It is important to recognize that there is no standardized, national system for credentialing CAM providers. This makes it especially important for nurses to gain and maintain a strong knowledge base and appropriate skills for recommending or practicing CAM therapies.

As in nursing, licensure requirements for CAM providers are determined by state regulation. Not all modalities require licensure in order for a provider to practice. Examples of CAM modalities requiring a license to practice (in most states) would be acupuncture and chiropractic. The state of Pennsylvania recently passed a licensure requirement for massage therapists. Some modalities require certification to practice; individual programs usually determine certification requirements (e.g., training to become a Reiki Master or Healing Touch Certified Practitioner). Nurses should be familiar with state practice acts and credentialing practices prior to making recommendations.

Developing a referral network of providers in your area helps you to identify reliable options for yourself and your patients. First-hand experience with a modality will give good insight into its benefits and overall influence on health along with direct interaction with a particular provider. This can be helpful with modalities that are unfamiliar or that are not well supported in the literature. For those practices you are interested in referring patients to, you can request a professional meeting to establish a provider relationship and determine a process for accepting referrals from your practice. Another resource for finding providers of a specific modality is professional organization Web sites; many of these will provide a directory by geographic area. A good example of this can be found on the Healing Touch Web site (www.healingtouchprogram.com). Many areas have annual conferences open to the public that provide education about non-traditional options for care (e.g., the Mind, Body, Spirit Expo is held in suburban Philadelphia every autumn and in New Jersey every spring). Some of your patients may be able to serve as resources for you if they already see a CAM provider. The following considerations should be made when choosing a CAM provider:

1. Education and training
2. Licensure/Certification
3. Experience in delivering care
4. Experience working with other providers, including traditional health care providers (NCCAM)

Insurance reimbursement is another consideration in choosing a modality and a provider. Licensed modalities like acupuncture or chiropractic are frequently eligible for insurance reimbursement, although not always at the same rates as conventional medical care. Modalities with certified providers may also be eligible for reimbursement.

There is wide variation on which modalities will be covered by insurance and how far that coverage extends depending on type of therapy, geographic area, and insurance company. Patients should inquire about insurance participation and coverage prior to making an appointment with a provider, as well as discuss expectations for financial arrangements so that patient and provider have clarity about this aspect of care.

As heath care reform moves us toward a more preventive model of care, complementary therapies have much to offer, providing us with care options for our patients and ourselves. Nurses and patients together, as therapeutic partners, can make informed choices about CAM therapies that could significantly impact patient care, lifestyle, and health in a positive manner. By taking the initiative to gain the appropriate knowledge, nurses can place themselves in a position to be reliable resources for patients and become experts at successfully facilitating integrative care.

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Debunking Myths Regarding Provisions of the Affordable Care Act

Sheila A. Haas

With President Obama's reelection, the Patient Protection and Affordable Care Act (PPACA) and health care reform are here to stay. However, the hard fought campaign, as well as the write-ups around the U.S. Supreme Court decision on the Individual Mandate this past summer, have generated quite a few myths and misunderstandings about the PPACA provisions and what they mean for many Americans. Patients, as well as providers, are struggling to figure out how to comply with provisions and tap into the benefits offered in the PPACA. To help senior citizens become more comfortable with provisions in the PPACA, a recent issue of AARP's *The Magazine* offered a succinct article (Howard, 2012) for readers where health care experts provided concise commentaries to assist in debunking the most common myths.

To debunk the myths, it is important to remember that the PPACA is first and foremost a bill designed to make much needed health insurance reform, so most Americans can have timely, affordable access to health care. Second, the PPACA is designed to enhance quality and decrease costs of health care. The provisions for insurance reform in the PPACA were modeled on the Massachusetts health care insurance plan and also the Bismarck Model (Public Broadcasting Service [PBS], 2008), which is used in industrialized European countries such as Germany, France, and Switzerland. This model allows private insurance companies to compete for sales of insurance in the market while at the same time limits profits and does not permit denial for preexisting conditions or denial for high expenditures due to catastrophic illnesses. Citizens in Germany and Switzerland do not go bankrupt due to medical expenses. With 50-60% of U.S. workers getting health insurance through employers and the uninsured able to purchase private insurance through state insurance exchanges, the U.S. will not have "Universal" government-run health care, but Americans will have universal access to health care insurance.

Medicare and Continuation of Coverage

In the AARP article (Howard, 2012), the first myth focuses on the belief that PPACA cuts Medicare benefits, when in fact, it prohibits cuts to Medicare and provides incentives to cut soaring Medicare costs. These savings will come from decreasing unreasonable payments to providers, taxing high-premium plans (beginning in 2018) and decreasing fraud and waste (Howard, 2012). There are actually added benefits such as free annual wellness exams, screenings, vaccines, and care coordination for persons with complex chronic diseases. Another myth is that persons on Medicare will have to get more or different insurance. This idea stems from confusion about the rhetoric around the PPACA's individual mandate. In actuality, if a person is on Medicare or has employer-based insurance, he or she can stay on those plans and no additional insurance is mandated. A third myth involves the belief that Medicare Advantage will be taken away; again, this is not true. Privately administered Medicare Advantage actually costs taxpayers about 14% more per enrollee per year. The PPACA aims to bring these costs down and provide incentives for higher quality care in Medicare Advantage plans.

As we move toward 2014, when the PPACA provisions that insurance companies cannot deny coverage for preexisting conditions in adults and state insurance exchanges are open for business, providers and health systems are gearing up for the anticipated increase of insured patients and the requirements for wellness, prevention, and primary care through establishment of Patient-Centered Medical

Homes (PCMHs) and Accountable Care Organizations (ACOs). With PPACA pay-for-performance incentives, there should be enhanced access to quality care. However, patients have bought into the myth that they either won't be able to see "their doctors" or a doctor at all. There will be no change for persons who stay in their current plans and whether or not those plans allow them to choose their doctors. The PPACA actually has provisions to attract more physicians into primary care, as well as prepare more advanced practice nurses as primary care providers.

Taxes and Fines

The U.S. Supreme Court's decision regarding the individual mandate has spawned several myths such as, "If I can't afford to buy health insurance, I'll be taxed or worse." Those who cannot afford the cheapest health insurance plan (where the cost exceeds 8% of income) will be exempt from penalty. If they do not meet the 8% test and have to pay a penalty, the penalty in the first year is $95 and will reach its maximum of $695 in 2017 (Howard, 2012). Even if the tax penalty is levied, there are no provisions for criminal prosecution or property liens on people who ignore the tax. The need for all to be insured is a means to have people seek care when they need it, rather than wait until their conditions are so extreme that they must use emergency care. The second myth about fines involves the PPACA provision that small businesses will be fined if they do not provide health insurance for employees. In reality, the PPACA penalties are only for companies with over 50 employees, and through 2013, eligible employers will receive a business credit for up to 35% of their contribution toward employee's premiums. For 2014 and beyond, the tax credit rises to as much as 50%. These credits apply to companies with fewer than 25 full-time employees whose average annual salaries are less than $50,000. Companies with more than 50 workers that don't provide coverage will be subject to a fine of $2,000-3,000 per employee per year (Howard, 2012).

National Deficit

Another myth that was touted during the presidential campaign was the idea that the PPACA raids Medicare of $716 billion. This number came from the Congressional Budget Office (CBO) estimate of $716 billion in reduced spending between 2013 and 2022 that would accrue to Medicare due to provisions in the PPACA. The provisions that would create these savings come from changes to provider payments and correcting overpayments to insurance companies that offer Medicare plans (Howard, 2012). These savings will be used to close the donut hole in the Medicare prescription drug plan and pay for preventive care and increased coverage for the uninsured. In fact, all guaranteed Medicare payments were protected in the PPACA (Howard, 2012). A follow-up myth is the idea that the PPACA will

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member spotlight

Margaret Ross Kraft

Margaret Ross Kraft, PhD, RN, affectionately known as "Peg" by her friends, began her nursing education with a diploma from Geisinger Medical Center in Danville, PA. She earned her BSN from Case Western Reserve University (formerly Western Reserve University) in Cleveland, her Master of Science (MS) degree from Northern Illinois University, and her PhD from Loyola University Chicago.

Peg began her nursing career in pediatrics and obstetrics, but was introduced to rehabilitation nursing during her BSN education. That specialty became her area of clinical practice, which naturally includes geriatrics, so she minored in gerontological nursing while obtaining her MS. After years of working in rehab and long-term care, Peg joined the Veterans Administration (VA) team, where she worked for more than 21 years in administration and informatics. At the VA, she had administrative responsibilities in ambulatory care nursing, which led to her introduction to, and subsequent membership in, AAACN. Her love of AAACN and the work of the organization remains a high priority. She has contributed to three editions of the *Core Curriculum for Ambulatory Care Nursing* on topics related to geriatric nursing and informatics. She also contributed to two informatics texts and one fundamental nursing textbook. It seems that Peg's ongoing support of ambulatory care nursing is evident in many settings.

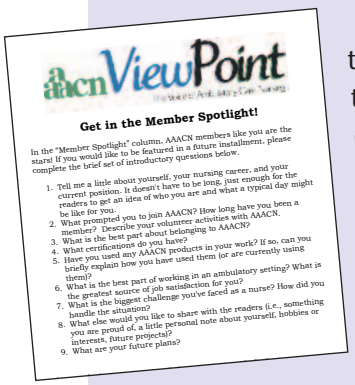
Although Peg retired from the VA after completing her PhD, she continued her journey in nursing as she joined the faculty at the Niehoff School of Nursing at Loyola University Chicago, where she currently serves as assistant professor. Peg says she has "remained a member of AAACN because [she] firmly believes that we will continue to shift health care to ambulatory/community settings and [she] wants to help prepare nurses to step into current and new roles in these settings." Her latest endeavor is serving as the newest editor of the "Perspectives in Ambulatory Care" column in *Nursing Economic$*.

While Peg gets her greatest satisfaction from seeing her students learn and grow, she appreciated the opportunity in previous positions to care for veterans who had served our country to protect the freedoms we enjoy – the freedom we have to serve in many capacities.

Her hobbies include reading, spending time with her seven grandchildren, and caring for her cats. Peg's future plans include participating in an event like one she attended several years ago – a National Institute of Nursing Research (NINR) banquet – where nurses, at the age of 85, were recognized for their active nursing practice. That is her goal – to still be active in nursing at age 85.

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*

It's Your Time to Shine!



aacn ViewPoint

Get in the Member Spotlight!

In the "Member Spotlight" column, AAACN members like you are the stars! If you would like to be featured in a future installment, please complete the brief set of introductory questions below.

1. Tell me a little about yourself, your nursing career, and your current position. It doesn't have to be long, just enough for the readers to get an idea of who you are and what a typical day might be like for you.
2. What prompted you to join AAACN? How long have you been a member? Describe your volunteer activities with AAACN.
3. What is the best part about belonging to AAACN?
4. What certifications do you have?
5. Have you used any AAACN products in your work? If so, can you briefly explain how you have used them (or are currently using them)?
6. What is the best part of working in an ambulatory setting? What is the greatest source of job satisfaction for you?
7. What is the biggest challenge you've faced as a nurse? How did you handle the situation?
8. What else would you like to share with the readers (i.e., something you are proud of, a little personal note about yourself, hobbies or interests, future projects)?
9. What are your future plans?

If you would like to be featured in a future issue, please contact Deborah Smith at dsmith5@gru.edu to receive a brief set of introductory questions. These questions can also be found on the AAACN Web site (www.aaacn.org/viewpoint). Please include a high-resolution photo with your submission.

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Additional Readings

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The Patient Story

Kathryn Koehne

It is amazing that I am beginning my fifth year writing this column. Most people would find it hard to believe that there could be so much to write about that focuses on telephone triage, but if you care for patients over the phone, you are not surprised. There is a misperception that managing patients over the phone is repetitive or routine. However, whether you work in a clinic or a call center, you know that each caller presents a new story. Every patient inquiry is a glimpse into the life of the human being who is reaching out to you as an expert, an advisor, or guide. As telephone triage nurses, we have the privilege of connecting to our patients in a unique way.

I cared for patients over the phone for nearly 15 years; I have stories. No matter how long you have managed patient calls, you have stories. When I present seminars across the country, the nurses in the audience share their stories. By sharing our stories, we are inspired and unified. We increase our knowledge about best practices, the art of verbal communication, and astute tricks of the trade. The stories validate that even though we are on the phone, we are delivering professional nursing care. "Telehealth Trials and Triumphs" will focus on stories this year.

In the Beginning

I vividly recall taking phone calls when I worked in a pediatric clinic. New parents called every day. There were questions about feeding, sleeping, and crying. There were worries about rashes, reflexes, and developmental milestones. The new-parent anxiety was palpable even over the phone. I coached many new mothers through the initial days of breastfeeding and alleviated fears about the consistency and color of newborn stools.

For those of you who take calls from these hesitant new parents, there is nothing more rewarding when you have taken the caller from great doubt and uncertainty to proficiency. Babies are often sent home 48 hours after delivery to brand new parents who are scared, tired, and coming down from the excitement of the experience. Suddenly, they feel overwhelmed by their responsibility as they walk into their homes without the support of the nursing staff who had been right outside the hospital room door. They may access information over the Internet, but then realize that they really need authentic interactive dialogue. They call a nurse.

Life Events

Telephone nurses also provide support along the continuum of care. According to the Centers for Disease Control and Prevention (CDC), the average length of stay (LOS) for hospitalized patients was over eight days in 1960. By 1980, the LOS decreased to 6.5, and today it is a brief 4.9 days (CDC, 2009). By being discharged earlier, patients are at risk. Without resources, patients may find themselves in situations that may cause a relapse or complications after being discharged from the hospital. Nurses who take phone calls from patients and families post-hospitalization are addressing inquiries about medications, activity, dressing changes, and pain. Whether the patient has had surgery, trauma, or a significant illness, patients are going home sooner and sometimes alone. When they need help, they are picking up a phone and calling a nurse.

In 2010, President Obama signed into law comprehensive health care legislation containing several provisions intended to decrease hospital readmissions (Congressional Research Service, 2010). As a result of this law, there is new pressure for hospitals to reduce readmissions. One popular intervention is to enlist nurses to contact patients after discharge. A recent study (Harrison, Hara, Pope, Young, & Rula, 2011) demonstrated that telephonic counseling delivered shortly after hospital discharge can successfully reduce readmissions.

The data is impressive, but behind all of these situations are real life stories. Patients have encountered a life-changing event and they are discharged within days and are experiencing fear or frustration during an intense recovery or rehabilitation period. In past years, they would still be under the close supervision of hospital nurses. They are now at home; when support is needed, they call a nurse or wait for a follow-up call. The phone is now a lifeline as patients heal at home.

At the End of Life

Nurses also provide comfort during the last days of life; dying at home is often a final wish. A patient's family and care team work together to keep promises and support a patient as life is slipping away. Some of you may be palliative care or hospice nurses who are the source of strength for patients and families. There are questions about comfort measures and subtle changes. The relationship between patients, families, and nurses during these sacred days are sealed with a unique bond. Until the end, there are often many calls placed from family to nurse and nurse to family. The nurse relays support so that the promise of final days at home can be met.

We Are Part of Their Story

At times, we may think that we are simply doing our job by taking calls from patients and families. A day spent on the phone may be considered a typical day for you, but these are not typical days for our callers. In some situations, a life is beginning and in others, a life is ending. In other situations, the patient is experiencing a life-altering change. These patients and families are experiencing unforgettable personal events. They have a story. We are part of that story. They may not see our faces, but they hear our voices, and in their moments of fear and doubt, they are comforted. We are nurses.

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The Patient Story

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President's Message

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Competencies for ambulatory care nursing. From what we know today, by fully utilizing nurses in a variety of roles, both access to care and cost-savings can be achieved.

Nurses must ensure that key decision-makers know that full utilization of registered nurses will improve access to care and save money, and also advocate on behalf of all nurses at all levels of the health care system. We need to stay informed on health care policy and health care financing issues that drive decisions related to nursing practice. Goal 2 of AAACN's Strategic Plan is to Enhance Our Influence. In addition to the role of the RN Position Paper and the Care Coordination Competencies, AAACN continues to build strategic alliances that assist us in expanding our influence. These alliances include participation in the following organizations.

- Nursing Organizations Alliance
- ANA as an Organizational Affiliate
- Nursing Community
- JCAHO Professional Technical Advisory Committee
- American Academy of Pediatrics Section on Telehealth Care
- NCSBN Nurse Licensure Compact Coalition
- AARP Maximizing RN Potential Workgroup
- Americans for Nursing Shortage Relief Coalition
- Health Information and Management Systems Society

Another way for nurses to increase access to care and save money is participation in data collection opportunities within our practice settings. The Repository Task Force has completed a toolkit related to research and EBP that will be available on the Web site. AAACN is also in the process of establishing a Research Task Force to support members, because we know, as nurses, we must measure the value of what we do. In ambulatory care environments, that is more important today than ever.

Most importantly, I encourage you to become involved in your professional association. AAACN is a welcoming, unifying community for registered nurses in all ambulatory care settings and we are your partner in maximizing the opportunity for you to share your voice. By becoming more involved in AAACN, you will not only connect with others in similar roles, but also advance your practice and leadership skills. Professional associations leverage the collective energy and resources of many nurses to influence policy and advocate on issues important to the profession. Our collective ability to seize opportunities and advance our profession depends on our engaged members. In ambulatory care, we have more opportunity today than ever before to advance our profession and help shape the future of health care in America.

I will turn over the role of AAACN President to my colleague and friend, Susan Paschke, at the close of our 2013 Annual Conference in Las Vegas, NV. It has been an honor to serve the association this last year. I am very proud of our accomplishments, as I hope you are, too. I look forward to my continuing work with AAACN in advancing the practice of ambulatory care nursing and staying connected to our amazing staff, volunteers, and members.

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Health Care Reform

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bankrupt America. This again is simply not true; ignoring the need to reform health care would actually bankrupt America. According to the CBO and Joint Committee on Taxation, the PPACA will reduce the deficit by $210 billion between 2012 and 2021 by decreasing subsidies to private insurance companies and cracking down on fraud, abuse, and waste, as well as reining in profits (Howard, 2012). A final myth states that the PPACA will drive up premiums. This is not so because as the young adults who are mostly healthy come into plans, their premiums will help subsidize care for less healthy persons (Brownlee, 2012). This, along with the PPACA's "medical loss ratio requirement," which dictates that 80-85% of premiums be spent on medical costs, will keep premiums down (Howard, 2012). In 2011, there were $1.1 billion in rebates from insurance companies that did not meet this provision.

Conclusion

Finally, as has been discussed in prior *ViewPoint* columns, some states have put off setting up insurance exchanges leading to the myth that, "If my state doesn't set up an insurance exchange, I can't get health coverage." Again, this is not true. If a state does not set up one or more exchanges, then the federal government, through the Department of Health and Human Services (DHHS), will set up an exchange in that state or partner with them.

Misinformation and myths will continue to confuse patients and providers. There is valuable information on government Web sites, but many do not know this or know how to access the sites. There are federal sites, such as HealthCare.gov (n.d.) and the Department of Labor (n.d.) site, which offer valuable information to consumers. There are also state sites that offer information on state insurance exchanges, such as the State of Illinois Web site (Illinois.gov, n.d.). It is essential that health care providers (especially those in ambulatory care) be knowledgeable about PPACA myths that exist and be able to respond to patient questions with simple answers and refer them to trustworthy resources to gain further information.

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Maximize Your Volunteering Potential

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When you reply to a call for volunteers, be sure to include why you want to be considered for the position, the number of years you have been a member of AAACN, and any involvement you have had being a volunteer with AAACN or any other professional groups. These involvements include: serving on a workgroup or SIG activity, presenting at the annual conference, publishing an article in *ViewPoint* or in the *Nursing Economic$* "Perspectives in Ambulatory Care" column, contributing to another AAACN publication (such as the *Core Curriculum for Ambulatory Care Nursing*), serving as a AAACN representative to a special project or initiative, or holding an elected position within the association.

Don't give up! We may have the perfect project, workgroup, or other opportunity for you just around the corner. There are new initiatives being presented to the Board of Directors all the time. Watch your email for one that may be just right for you.

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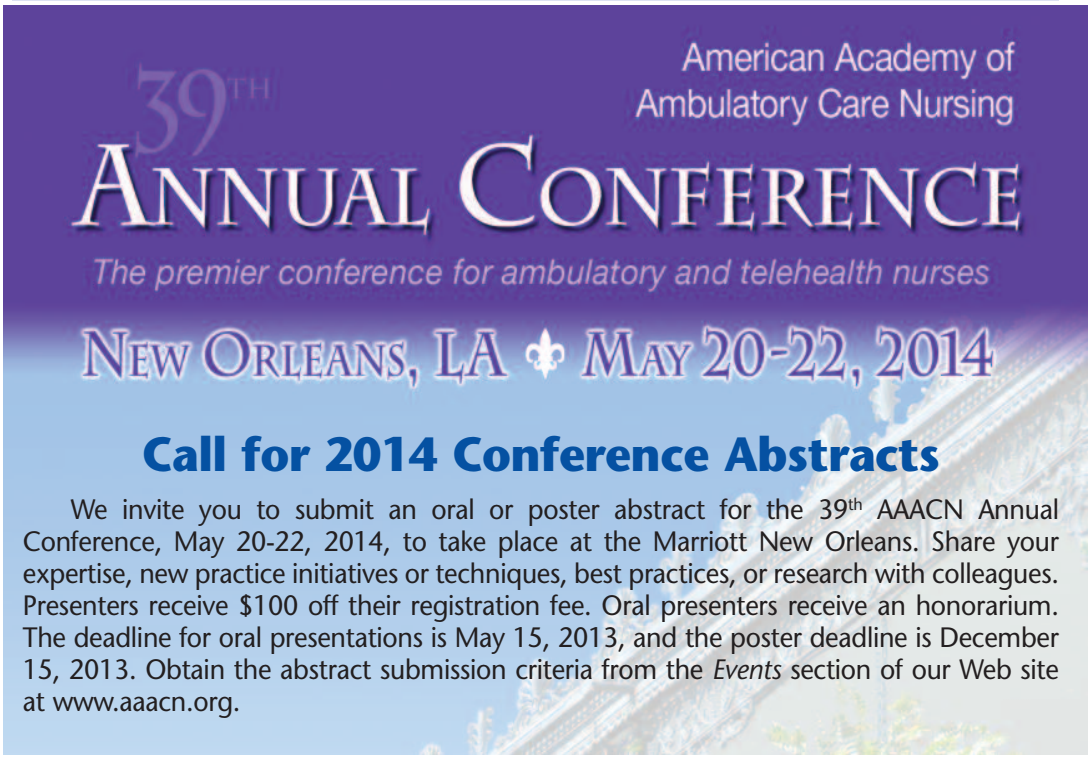

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By the time you read this copy of *ViewPoint,* it is probably too late for you to attend the Las Vegas conference. But don't worry! The audio recordings and handouts from all sessions offered at the conference will be available about six weeks after the conference in the AAACN Online Library (www.aaacn.org/library). You may purchase individual sessions or a package that includes all sessions. Prices include continuing education credit. Once you make a purchase, you have permanent access to those sessions. Past conferences, *ViewPoint* articles, and Webinars are also in the Library. We encourage you to browse the Online Library for topics of interest to you. And, if you know someone who attended the conference, ask if he or she will share content with you! Conference attendees can each offer two colleagues access to the conference sessions for free.