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aacn ViewPoint

The Voice of Ambulatory Care Nursing

38th Annual Conference Rocks Las Vegas

The AAACN 2013 conference opened with a performance by a Michael Jackson impersonator. Attendees were dancing and recording the energetic performance on their cameras, phones, and tablets. Everyone loved this exciting way to kick off the conference.

Keynote speaker Virginia "Ginny" R. Beeson, MSN, NEA-BC, expressed the need for courageous leadership in today's rapidly changing world. Ginny shared why courage is such an important leadership skill and gave examples of situations that require courageous leadership. Attendees left with the tools to become a more courageous leader.

Everyone made new acquaintances while discussing "hot topics" in ambulatory care nursing during the networking luncheon. Once a "hot topic" was identified, discussions ensued on determining a unique approach to the workplace challenge.

This year, the topic of the Town Hall was Patient and Nurse Wellness. Facilitator Traci Haynes, MSN, BA, RN, CEN, along with a panel of nurses, shared their stories along with their thoughts on a healthy work environment and its relationship to a nurse's health and wellness. Using floor microphones, attendees shared the importance of nurses taking care of themselves, as well as serving as role models of wellness for their patients.

more conference highlights on page 10

700 nurses attended the conference.

136 nurses learned about quality measurement, meaningful use, pay-for-performance, and more at the pre-conference workshop.

23 nurses helped construct a manuscript outline, prepare a plan to publish, and learned ethical and professional principles associated with publishing at the pre-conference workshop.

141 nurses prepared for certification by attending the all-day Ambulatory Care Nursing Certification Review Course.

48 nurses enhanced their telehealth nursing skills by attending the Telehealth Nursing Practice Core Course.

ALL nurse attendees met new colleagues, networked, enhanced their knowledge, and left reenergized about their practice.

The Official Publication of the American Academy of Ambulatory Care Nursing

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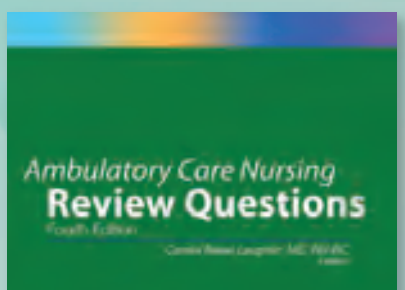
Hot Off the Press!

The *Ambulatory Care Nursing Review Questions* has been updated to reflect the latest content outline of the ANCC ambulatory care nursing certification exam. All questions are based on the *Core Curriculum for Ambulatory Care Nursing* (3rd edition.) Use it to test your knowledge prior to taking the certification exam.

See page 14 for details.



from the president

AAACN and You – 2013

aaacn American Academy of Ambulatory Care Nursing
Many settings. Multiple roles. One unifying specialty.

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Susan M. Paschke

I feel honored and blessed to be serving as your AAACN President for the coming year! I love our organization and would not be the ambulatory care nurse and leader that I am today without the many role models and mentors I have had the privilege of knowing and working with through my association with AAACN. They helped facilitate connecting me with other members in similar roles – a great way to advance my nursing practice and leadership skills.

My colleagues and mentors, E. Mary Johnson and Corinne Hofstetter, introduced me to AAACN 27 years ago. Little did I know how beneficial that introduction would become! I got involved with the local networking group, the Cleveland Academy of Ambulatory Care Nursing (CAACN), and became part of its leadership within a short time. I joined the national organization and soon after became a member and eventually the chair of the AAACN Membership Council, a role I held for a number of years. I will never forget my first AAACN conference in 1995 – someone asked me to run for the Nominating Committee! After serving 2 terms, my favorite volunteer opportunity arose. In 2000, I had the privilege of becoming an instructor for the Ambulatory Care Certification Review Course. Imagine travelling the country, meeting other ambulatory nurses, and learning as much from them as they learned from me. Overseeing 36 courses in 19 different states in a 12-year span was quite a ride!

I was looking for a way to say "thank you" for all the great experiences and opportunities AAACN had afforded me when I was asked to run for the board. It seemed like the perfect way to share my time and talent with the organization that had helped me grow in both my personal and professional life. And when the time was right, I agreed to run for President and the rest, as they say, is history! So the first thing I'd like you to think about is this: If someone invites you to be on a committee or Special Interest Group (SIG) or to run for office, give it careful consideration; if there is a project or task force that speaks to you, get involved. You will not regret it. And AAACN will benefit from your knowledge and experience, and you will enhance your leadership skills!

These are exciting times for ambulatory care nurses and we have a tremendous opportunity to demonstrate our expertise and value in the health care arena. Health care is in a state of transformation as the country determines how the Patient Protection and Affordable Care Act (PPACA) will be implemented. Much has been written about care coordination and transitions of care since the 2010 IOM report *The Future of Nursing,* which states that registered nurses in ambulatory care settings play a key role in the health care system of the future, and according to Haas (2013) "are ideally positioned to serve in the care coordinator/transition manager role." I look forward to the continued progress of our Care Coordination/Transition Management competencies for Registered Nurses, developed in 2012 by the expert panels convened by AAACN.

Strategic Plan Update

I would like to update you on the progress of the Strategic Plan adopted by the Board of Directors in 2010. Under the leadership of past presidents Linda Brixey and Suzi Wells, we have accomplished great strides in our planning efforts. However, there is still much to be done as we continue to serve our members, expand our influence, and strengthen our core.

Strategic Goal #1 – Serve Our Members

I am excited to report that effective March 2013, AAACN has begun to slowly phase in AAACN Communities of Practice (CoP) to facilitate and enhance Special

continued on page 13

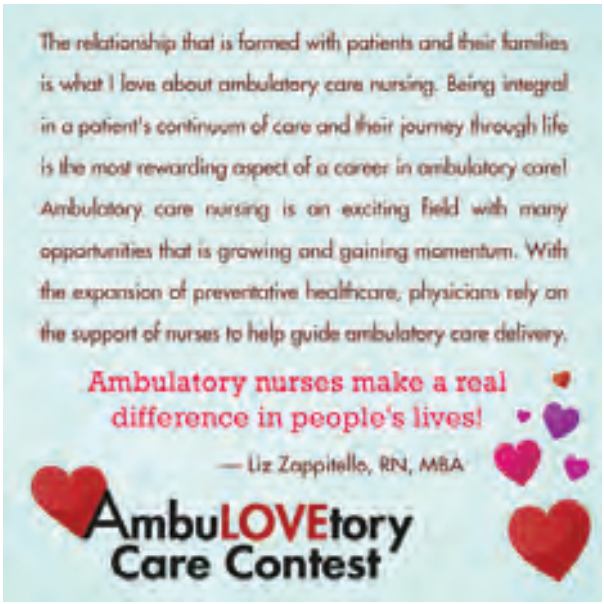
AmbuLOVEtory Care Contest Winner Announced

Congratulations to Liz Zappitello, RN, MBA, winner of the AmbuLOVEtory Care Contest! Liz works at St. Mary's Heart & Vascular Center in Duluth, MN. The AmbuLOVEtory Care contest ran from March 12-19 on the AAACN Web site. Nurses entered the contest by telling us what they loved about ambulatory care nursing, and one nurse was selected to win a copy of the *Core Curriculum for Ambulatory Care Nursing* (3rd Edition). Liz's entry was selected from 160 contest entries!

Liz was thrilled to win! She told us:

"I am so excited. This totally made my day! I have used the professional practice materials from AAACN and found them invaluable both within my department and in articulating ambulatory nursing needs at an organizational level. The *Core Curriculum* has been on my wish list and I'm very happy to be receiving it!"

Thank you to everyone who entered the contest. You promote a greater appreciation for the specialty that we all ambuLOVE!



Follow AAACN on Facebook (www.facebook.com/AAACN) and Twitter (www.twitter.com/AmbCareNursing) for the latest ambulatory care news and future promotions.

Instructions for Continuing Nursing Education Contact Hours

The Evaluation of a Professional Nurse Contribution Ladder in an Integrated Health Care System

Deadline for Submission: June 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 1.3 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 Professional Nurse Contribution Ladder (PNCL) in health care systems. After reading and studying the information in this article, the participant will be able to:

1. Identify the need for the Professional Nurse Contribution Ladder (PNCL).
2. Describe how the PNCL was introduced in Stormont-Vail Health*Care* in Kansas.
3. Explain the benefits of the PNCL as established from this study.
4. Discuss the modifications needed to improve the PNCL.

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.

The Evaluation of a Professional Nurse Contribution Ladder in an Integrated Health Care System

Theresa Tetuan
Beth Browder
Ruth Ohm
Mike Mosier

Highly skilled nurses are greatly needed in the ambulatory and home care settings due to the decreased length of hospital stays and patients requiring more acute care outside of the hospital setting. The nursing shortage continues, with over one-third of the nursing workforce over 49 years of age. Health care organizations must remain competitive, understand what employees are seeking from the work environment, and promote professional development of the direct care provider workforce in order to have a better chance to recruit and retain nurses (Krugman, Smith, & Goode, 2000; Nevidjon & Erickson, 2011). "One way to position health care institutions to be that employer of choice may be to find ways to provide generation-specific satisfaction and fulfillment to their nurse employees" (Wieck, Dols, & Landrum, 2010, p. 8).

Nursing requires specialized knowledge and skills; however, to progress within the profession, lifelong learning is required (Lannon, 2007). Benner (1984) stated that the nurse progresses through five stages of professional growth: novice, advanced beginner, competent, proficient, and expert. Each nurse must take personal responsibility for professional development to match his or her learning needs and experience level (Twaddell & Johnson, 2007). Formal education programs that meet the needs of nurses from four generations can be difficult and expensive to provide. One strategy that may facilitate professional growth for all may be professional ladders. Professional ladders promote ongoing professional growth, which unifies a workforce that has diverse educational preparations and experiences into a cohesive team (Krugman et al., 2000). They also assist in ongoing organizational recruitment and retention efforts. "Ladders" have been described as clinical, career, professional, or contribution depending on the outcomes to be met. The focus of the clinical ladder assists nurses to develop clinical and other skills. The career ladder supports the growth of skills needed to advance within the organization. The definition of a professional and contribution ladder is to promote increased professional development and leadership with additional criteria demonstrating support to the organization and the community. Most of the literature on ladders focuses on nurses in the hospital setting; little is known about their effectiveness in the ambulatory care environment, and even less is known about a ladder that effectively envelops both settings in an integrated system. Ambulatory care nurses reported that the career ladder encouraged nurses to act as preceptors as well as increasing their involvement in process improvement, interdisciplinary and leadership activities (Nelson & Cook, 2008). Nelson, Sassaman, and Phillips (2008) confirmed the incorporation of an ambulatory care ladder helped to recognize and motivate RNs and supported a highly functioning work team.

Barriers and benefits associated with ladder use have been identified. Incorporation of a ladder fosters professional growth and skill development, recognizes clinical excellence, improves quality of care, offers monetary compensation for advancement, encourages personal responsibility for individual career development, involves more nurses in unit/hospital

Figure 1.

Goals of the PNCL Ladder

• Promote excellence in clinical practice to assure quality patient and family care in all clinical settings.
• Develop and recognize excellence in leadership and facilitate career advancement.
• Encourage personal and professional development.
• Support retention and recruitment.
• Empower professional nurses as a valuable member of the health care team.
• Align with SVHC's mission, which is, "Working together to improve the health of the community."

Figure 2.

Description of the PNCL Eligibility Criteria According to Levels of the Ladder with Years of RN Employment and Experience in Relation to Benner's Work

Level	Basic Eligibility	Skills Present	Benner's Work
2	One year of RN experience, with a minimum of six months at SVHC	Demonstrates independent performance and uses experience to guide actions	*Advance Beginner Level.* Further knowledge and experience are needed.
3	Three years of RN experience, with a minimum of three years at SVHC	Has a good working background knowledge and is able to visualize long-range goals	*Achieved Benner's Competence Level. Incorporating Benner's Proficient Level.* Can apply past experiences and modify plans to take appropriate action.
4	Five years of RN experience, with a minimum of three years at SVHC	Has an intuitive grasp of situations and is able to incorporate nursing experiences and knowledge to demonstrate outcomes	*Expert Level Attained.* Continued life-long learning is necessary to maintain.

activities, improves staff satisfaction, and decreases turnover (Bjork, Hansen, Samdal, Torstad, & Hamilton, 2007). However, nurses express concern that participation in a ladder does not demonstrate competency, conflicts with personal obligations, and requires too much paperwork, time, and energy. Nurses state they are unable to complete requirements during scheduled work hours, and the criteria are not relevant to work setting (Goodrich & Ward, 2004; Nelson & Cook, 2008).

Stormont-Vail HealthCare Professional Nurse Contribution Ladder (PNCL)

For more than 125 years, Stormont-Vail HealthCare (SVHC) has been caring for generations of northeast Kansans. The organization achieved Magnet® recognition in 2009. At the time of the study, 900 RNs were employed. Currently, SVHC employs 1,290 registered nurses, inclusive of APRNs, in the inpatient (n = 1074) and outpatient settings (n = 216). SVHC is an integrated heath care system with a 586-bed acute care hospital and the Cotton-O'Neil Clinic, a multi-specialty group consisting of more than 200 physicians, offering a broad array of primary and specialty care on the main campus and satellite clinics in 11 neighboring cities.

In 2003, the RN Retention Committee was formed to incorporate best practices for the recruitment and retention of professional nurses. According to information obtained from nursing satisfaction and exit surveys, nurses reported that they were not recognized for extra duties such as participating on committees, conducting process improvements, and teaching/mentoring of others. A review of evidence-based practice literature revealed a nursing ladder would benefit the recruitment and retention of professional nurses. In August 2006, the chief nursing officer (CNO) convened a committee of 13 professional nurses from various departments, including one from ambulatory care, to form the Professional Nurse Contribution Ladder (PNCL) Committee and to determine goals of the ladder (see Figure 1). A contribution ladder was chosen to fit the mission of the organization. The criteria emphasize participation in shared governance and community service in addition to personal and professional growth activities. The committee decided to disassociate ladder membership from the evaluation process that is linked to annual raises in order to reward nurses who demonstrate an increased commitment to their professional development, the organization, and to the community in which they work. In May 2007, educational sessions were held and the PNCL criteria, and application forms and handbooks were distributed to staff and made available on the organization's intranet.

In accordance with Benner's work (1984), the transition to an expert nurse takes time, knowledge, and experience. With this theory in mind, the committee identified three levels for ladder participation: Levels 2, 3, and 4 (see Figure 2). Initially, a nurse who did not meet basic eligibility or did not choose to participate was defined as a Level 1; this term was later

excluded, and not represented in the ladder. A basic tenet of the PNCL is that each professional nurse will enter the ladder based on current knowledge and skills, move at his or her own developmental pace, and attain/maintain his or her optimal ladder level. In this way, the nurse will continue to evaluate his or her practice and demonstrate lifelong learning.

Currently, members of the PNCL critique the submitted portfolios. If all the criteria for the Level are met, the application is approved. If the portfolio is not approved, interviews with the applicant are scheduled to discuss the information provided and determine if a particular criterion is met. Those who meet the Level criteria are recognized at an annual ceremony with a certificate, a pin with the PNCL Level inscribed, and a monetary bonus. A nurse may submit an application with current information every two years. The Level applied for with each submission is independent of previous applications. For example, a nurse may achieve Level 4; however, with a successive application, the nurse again has the option to meet criteria for Level 2, 3, or 4.

The ladder includes eight focus areas: Basic Eligibility, Committee Involvement, Process Improvement, Professional Development, Leadership, Community Involvement, Research and Evidence-Based Practice, and Education of Others. Criteria for each focus area are established for all three Levels. A copy of the PNCL may be requested from the author.

The purpose of this study was to assess nurses' attitudes toward the ladder by both the participants and non-participants; determine the perceived barriers and benefits toward participation; discover relationships between participation, job satisfaction, and retention; and determine predictors of participation.

Methods

Design and Data Collection. The design was a cross-sectional, anonymous, voluntary online survey using SurveyMonkey®. Exempt status by the organization's Institutional Review Board was designated. All RNs were sent an email with information regarding the survey and a link to the survey. Participation in the survey constituted consent. There were 900 registered nurses invited to complete the online survey; 359 responded for a 39% response rate. Not all participants answered every question. Sixty-five (18%) of the respondents worked in ambulatory care.

The Professional Nurse Contribution Ladder Instrument included a 25-item modified Likert scale attitude measure (Cronbach's $\propto$ = .961), an 8-item modified Likert scale job satisfaction measure (Cronbach's $\propto$ = .899), a 1-item "likelihood to stay" measure, a 24-item benefits and barriers measure, an 8-item organization purpose measure, and a 9-item demographic measure. All modified Likert scales were five points ranging from "completely disagree" to "completely agree." Opportunities for nurses to enter comments about the PNCL were provided. Data collection began November 15, 2008, and concluded December 19, 2008. Nurses were notified of the survey by email, posters, and organization newsletters. Those who received recognition for completing ladder criteria were classified as ladder participants (total n = 130; ambulatory care nurses n = 21); the remaining nurses were classified as non-participants (total n = 219, ambulatory care n = 44).

Data Analysis

An alpha level of .05 was used for all statistical analyses. The data were analyzed using the following statistical procedures: descriptive analyses for all independent and dependent variables, t-tests were used to determine the statistical difference between participation and non-participation in the PNCL in mean attitudes, job satisfaction, and retention scores. Higher means indicated a positive effect of participation. Logistic regression was used to determine the odds ratio for factors influencing the decision to participate.

Table 1.

Significance of Attitude, Job Satisfaction, and Likelihood to Stay Between Participants (Yes) and Non-Participants (No) in the PNCL

	N	Mean	SD	T test (df)	P-value
Attitude					
Yes	130	3.86	.68	8.42* (330.29)	<.001
No	219	3.14	.91		
Job Satisfaction					
Yes	128	4.40	.61	1.504 (342)	1.34
No	216	4.29	.64		
Likelihood to Stay					
Yes	129	4.02	1.424	1.199 (344)	.231
No	217	3.82	1.433		

*Equal variances not assumed

Table 2.

Rank of Difficulty to Meet PNCL Focus Area (Easiest to Hardest)

Rank	Focus Area of PNCL
1	Basic Eligibility
2	Process Improvement
3	Professional Development
4	Leadership
5	Community Involvement
6	Education of Others
7	Committee Involvement
8	Research

Results

Age, Years of Nursing, Years of Employment, Work Site, Hours Worked, Shift, Children at Home and Education. Nurses who participated in the ladder

were more likely to be older, were experienced nurses, and worked primarily days in full-time positions. There were not significant statistical differences found in worksite, highest nursing degree, or educational degree. There was also not a significant statistical difference found in nurses who had children at home under 18 years of age. Many of the nurses who were close to retirement commented that they did not see a need for the PNCL.

General Attitudes Toward the Contribution Ladder. Results of the t-test indicated the group that had completed the ladder had greater knowledge and more positive attitudes toward the PNCL than those who did not participate (see Table 1). Nurses' comments reflected both positive and negative perceptions of the PNCL, as indicated by the following examples. Positive: "I feel like the PNCL makes me feel like all my extra work is worthwhile," "At the end of a long day, with momentarily weary feet, hearts, and souls, it is uplifting to be reminded that our efforts are appreciated," and, "I felt that by participating in PNCL, I became much more in touch with my contribution as a nurse." Negative: "The organization should not have a ladder," "The ladder is only realistic for nurses that don't have family responsibility," and, "The ladder does not take into consideration those nurses who work at the clinic."

Job Satisfaction. A significant statistical difference was not found in job satisfaction between those who participated and those who did not (see Table 1). Limited variability may obscure finding differences between groups as the mode was 5 and the mean for job satisfaction was 4.5 out of a 5.0 scale. A nurse commented, "The ladder is a great benefit for nurses, another enhancement to want to work at SVHC. It makes me feel like the organization is directly assisting and facilitating professional growth."

Likelihood to Stay. There was not a significant statistical difference found in likelihood to stay between those who participated in the PNCL and those who did not (see Table 1).

Hardest to Meet Criteria. The hardest to meet criterion are shown in rank order in Table 2. A nurse commented, "All criteria are attainable; it is the commitment of time and energy to give that is optional." Other comments were, "Research is just beginning here, and there are no opportunities yet," and, "There are no committees to join."

Benefits and Barriers of Participation. The top reasons stated for participating in PNCL were personal reward, monetary reward, professional growth, and professional recognition. Comments included, "The money was nice, but I participated mainly for my own personal satisfaction," and, "I feel the ladder recognizes what we already do and doesn't necessarily change what is already excellent care." Non-participants in PNCL identified time involvement on non-work hours, not ready to invest time, family commitments, and eligibility requirements as the top barriers to participation in the PNCL.

Discussion

The survey provided evidence that many nurses have a positive attitude toward the PNCL. Also most nurses, regardless of participation in the PNCL, responded positively to job satisfaction (83%) and retention indicators (68%) for the organization. Benefits of and barriers to participation were identified, and comments shed insight on specifics that may be addressed to encourage more participation in the PNCL in the future.

Modification of the PNCL

As a result of the survey, two RNs from the ambulatory care setting were added to the PNCL Committee in order to ensure criteria were added to the ladder that met ambulatory care nurses' roles. The PNCL was revised with attention given to responses related to the survey questions associated with the criteria most difficult to attain and to the barriers of participation. Following each award cycle (once a year), the PNCL Committee will make changes to the ladder to help clarify and to add/delete criteria as a result of questions that arose from the applicants or the committee members conducting the review. Changes that have been made include clarifying criteria in quantitative terms (e.g., number of committee meetings attended in a specific time frame), adding additional criteria from which to select to meet each level, or moving more difficult criteria to a higher level of the ladder. The revisions to the ladder include:

Eligibility Criteria: Initially, SVHC's Organization Operating Committee determined that nurses who were PRN or employed fewer than 40 hours per pay period were not eligible for the ladder. However, in response to information received from the survey and continued inquiries of interest by those employees employed less than 40 hours per pay period, the Operating Committee has allowed them to apply.

Committees: To assist ambulatory care nurses to meet the criteria, nurses were referred to Shared Governance Councils and/or encouraged to form committees based on a common need (e.g., Professional Practice Committee and Clinic Process Improvement Committee). Clinic nurse managers were also asked to recommend RNs as committees were formed.

Process Improvement: Additional items were added to provide nurses with a knowledge base for process improvement.

Professional Development: In Level 2, the 45 total continuing nursing education (CNE) contact hours required was decreased to 30 hours with direct relationship to primary area of practice.

Leadership: Initially, the leadership criteria focused on preceptorship and functions of a charge nurse. This limited the clinic nurse, as these opportunities were infrequent. Additional criteria, such as completion of contact hours in leadership, were added to all three Levels, allowing non-management nurses opportunities to participate.

Community Involvement: Items that demonstrate a leadership role in a community event were added to all Levels. This supports the Stormont-Vail Health*Care* mission, "Working together to improve the health of the community."

Research: This area received the largest number of changes after participants stated it was the hardest to achieve. Items were added to all levels to promote increased knowledge in research and evidence-based practice and to encourage research activities followed with dissemination of outcomes.

Education of Others: Original criteria focused on peer education done in the hospital setting. Activities for educating peers in the ambulatory care setting were added, including presenting information on new medications, procedures, or emerging medical trends.

Conclusion

The goals of this study were to assess nurses' attitudes toward the ladder by both the participants and nonparticipants; determine the perceived barriers and benefits of participation; discover relationships between participation, job satisfaction, and retention; and to determine predictors of participation. A limitation to the study was that the survey was conducted with a convenience sample with a modest response rate. Study findings indicated most nurses were satisfied with their jobs. Experienced day shift nurses, including those in ambulatory care, were more likely to participate in the ladder. Findings showed that the participants' desire for personal reward was the main benefit of taking part in the ladder, followed by monetary reward, professional growth, and recognition. Barriers to participation included a lack of time during work hours, lack of opportunities, and family commitments. Additional exploration of ways to reduce these barriers needs to be done.

Cotton-O'Neil Clinics' fiscal year 2007 RN turnover rate was 8.33% when the PNCL was implemented. In 2012, it was 1.96%, which suggests the ladder implementation may have supported nurse retention. This study also found a need to better inform nurses of the purpose of the ladder to improve interest and to offer criteria that nurses in all settings could achieve. The ladder was revised to encourage more nurses within the organization to participate and to specifically include criteria that ambulatory care nurses could meet.

The PNCL focused on the professional development of the nurse to enhance excellence in the work setting as well as to provide impetus for staff to give back to the organization and the community. Staff participating in the ladder are volunteering for committees and seeking new education and process improvement initiatives. Stormont-Vail Health*Care* has created a culture in which nurses are encouraged to grow professionally through their own personalized plans. Since the onset of the PNCL, an APRN and LPN ladder have been developed as well as six ancillary department ladders.

An annual Excellence in Nursing award ceremony is held during National Nurses Week to honor those nurses who are successful in achieving PNCL status. As of 2012, 338 registered nurses participated in the program (including 37 ambulatory care nurses). Of the 37 nurses, 19 have renewed at the same level and 7 nurses advanced to the next level. The highest levels achieved for ambulatory care nurses were: Level 2 = 23, Level 3 = 13, and Level 4 = 1.

Nurses must view the ladder as a valuable resource for professional development; however, administrative support to facilitate criteria achievement during scheduled work time is crucial. Ladder criteria must be relevant to nurses in all clinical settings and development of additional criteria for the ambulatory care nurse should be considered. More research is also needed to determine the effect of the contribution ladder as a long-term investment in professional development, job satisfaction, and retention.

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telehealth
trials & triumphs

The Impact of Telephone Triage Nurses

Patient stories are the focus in this year's column. In this issue, I will share a few stories from nurses that illustrate the significant impact telephone care has on the lives of the patients who call for advice and guidance. Many nurses may not feel empowered in their day-to-day practice, yet these stories illustrate how telephone triage nurses are influential and that their advice is really quite powerful. As you read these real-life scenarios, you will get a sense of the degree of respect and trust our patients have for the role of telephone triage nurses. We need to be cautious, but not underestimate our own value.

A Jet Lands

A nurse who manages phone calls for a pediatric clinic received a call from a flight attendant. As we are all aware, we cannot make phone calls while in flight, but the airline staff can make calls in emergency situations. A woman was travelling with her young infant and had been exclusively breastfeeding until boarding the plane. She decided to bring formula while travelling, as she did not feel comfortable nursing her young infant in close proximity to other passengers. So, she decided to give her infant formula for the first time at an altitude of 32,000 feet. Within the first few ounces, the mother came to notice pink bumps on the infant's cheeks and chin. The baby was content so the mother continued to allow the baby to drink the formula. However, she began noticing that the reddened blotchy areas were spreading. Then the infant began wheezing. Initially it did not appear that the baby was in distress, but the situation was quickly becoming an emergency.

The mother alerted the flight attendant who was alarmed about the infant's appearance. With no medical personnel on the plane, she placed a call to the clinic nurse. The nurse thoroughly assessed the infant through the mother and flight attendant. Their assessment responses indicated that the infant needed emergent care.

The three-hour flight would need to be re-routed. In response to the nurse's recommendation, the plane would land at the nearest airport. There was an emergency team available upon landing to manage the infant.

A Cruise Ship Returns to Port

A nurse at a call center received an inquiry from a health attendant on a cruise ship. Apparently, one of the passengers was experiencing a significant headache. On this particular cruise, there were no physicians on staff and the patient requested that the health attendant call the telephone nurse advisor line that the patient utilized to access care advice. A nurse received the call and within the first few questions, it was apparent that this patient needed to be seen immediately in an emergency setting. The patient was experiencing a severe headache with visual changes and had a fever. The patient was alert and was communicating appropriately, but was concerned as this was the "worst headache" he ever experienced. This was an emergent situation. The nurse informed the passenger, family member, and health attendant that the patient needed emergent care. The health attendant said that he would inform the captain to "turn the cruise ship around."

Curbside 9-1-1 Care

A nurse at a physician's office received a call from a woman driving from a conference to her home. She was in the midst of a three-hour drive and was still two hours from home, and she was experiencing worsening abdominal pain. The caller explained that all day she had been experiencing abdominal discomfort, but it was intensifying. She had considered going to the local emergency room but was unfamiliar with the health system and said she "just wanted to get home" and go to the hospital where she and her family receive care. However, one hour into the drive, the pain intensified to an excruciating level.

The telephone triage nurse directed her to pull over to the side of the road to be safe during the assessment. The caller described intense and constant pain. Her breathing was pant-like and she sounded tearful. The nurse was sensing that the patient was in trouble and obtained the woman's location and accessed the 9-1-1 dispatcher. The nurse reassured the caller and said she would stay on the line with her while they awaited emergency help. The nurse coached the woman through relaxation techniques and offered encouragement. The call concluded when the nurse heard the sirens and the voice of an ENT say, "We're here to help you…you'll be OK."

At times, as nurses, we may feel like we do not have influence, but are we underestimating the true impact we have on our patients and the public? These are just three situations that illustrate the important role nurses play in the lives of their callers. The decisions and advice these nurses gave was responsible for dramatic actions – a commercial jet landed, a cruise ship returned to port, and a woman halted her drive and received curbside assistance. Every day nurses in offices, clinics, and call centers are providing advice to inquiring callers and lives are significantly impacted.

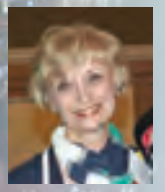
Kathryn Koehne, BSN, RNC-TNP, *is a Nursing Systems Specialist, Department of Nursing, Gundersen Lutheran Health Systems, and a Professional Educator, Telephone Triage Consulting, Inc. She can be contacted at krkoehne@gundluth.org*

Margarita Gore Receives the Above and Beyond Award

President Suzanne Wells presented the President's Above and Beyond award to member **Margarita Gore, MBA, BSN, RN-BC.** Suzi recognized Margarita as a loyal member who has served the association in many roles, including serving on the Program Planning Committee, a member of the Ambulatory Nursing Definition Task Force, the leader of a Special Interest Group, a representative on an important external committee, and a presenter at five AAACN conferences. Suzi said, "Margarita has been involved in so many AAACN initiatives that everyone knows her name."

Suzi described Margarita as someone who has "caring in her blood. She started as a medical assistant, became an RN, obtained her BSN, and then obtained her Masters. During her distinguished career she served 10 years in the United States Army Nurse Corps. She is a certified ambulatory care nurse and someone who is dedicated to AAACN." The Above and Beyond award is given at the discretion of the President and is the highest recognition provided by AAACN.

New Perpetual Certification Scholarship Named for Candia Baker Laughlin

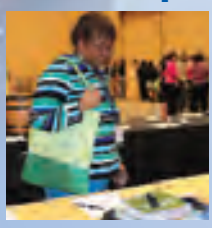


Candia Baker Laughlin, MS, RN-BC, was surprised to hear her name announced during Opening Ceremonies when she learned that a $1,000 perpetual Certification Scholarship will be instituted in her honor and will be awarded annually to a nurse member seeking certification. The scholarship will cover the exam fee, study materials, and other expenses related to achieving certification.

The Board of Directors felt the scholarship would be a lasting tribute that represented Candy's commitment to nurses achieving certification, as well as honor all of the work she has done to educate ambulatory and telehealth nurses around the world. President Wells recognized Candy for traveling around the country on weekends teaching the *AAACN Certification Review Course* on her own personal time. She also commended Candy for serving as Editor on two editions of the *Core Curriculum for Ambulatory Care Nursing* and for singlehandedly revising the *Review Questions* publication. Candy was also presented with a bound copy of the 3rd edition *Core*.

Members who wish to apply for this new scholarship can download the application from the Awards section of the Web site. The deadline for all awards and scholarship applications is November 15.

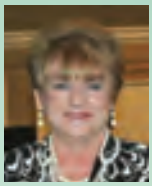
Silent Auction Raised Over $4,000 for the Scholarship Fund



The 14th annual Silent Auction raised $4,600 in support of the Awards and Scholarship Fund. Jewelry, nursing items, a Kindle, purses, and many other items generated high bids from attendees. Thank you to everyone who participated in the auction.

Excellence Award Winners

Two distinguished members were recipients of the *Nursing Economic$* Foundation Excellence Awards:



Sharon Holland, RN-BC, was nominated by her colleagues for the Administrative Excellence Award for being a wise leader, a fair and dependable supervisor, and a trusted friend. She was described as an expert in all things Joint Commission. She led the redesign of primary care practices to focus on purely patient-centered processes. She has also worked diligently to ensure all nursing staff are prepared for changes in the workflow associated with the implementation of a Patient Centered Medical Home. She was described as the epitome of an administrative genius and someone who is adamant about doing what's best for the patient.

Beth Ann McMurtry, RN-BC, CDE, HC, was described by her colleagues as a high achiever always quick to take on new roles and responsibilities. She was vital to her facilities' primary care redesign and the implementation of a Patient-Centered Medical Home. She is the type of nurse that others not only learn from, but also inspire to be.

Beth Ann has total passion for her patients and the nursing profession, and has developed tools to ensure patients with chronic illnesses receive excellent care, appropriate education, and timely follow up.

Both Excellence Award winners are from Scott and White Healthcare in Temple, TX.

ViewPoint Writer's Award

Kitty Shulman, Editor of *ViewPoint*, announced **Sarah Muegge, MSN, RNBC,** as the recipient of the *ViewPoint* Writer's Award for her article, *"Practice the Right "Rights": A Strategy Promoting Effective Immunization Delivery,* which was published in the September/October 2012 issue of *ViewPoint*. Sarah works at Cox Health in Springfield, Missouri. Sarah received complimentary registration to the conference as her award.

AAACN Inducts New President

2012-2013 President Suzanne Wells, MSN, RN, passed the responsibility for leading the association over to **Susan Paschke, MSN, RN-BC, NEA-BC,** at Closing Ceremonies. Susan presented Suzi with a gold membership card denoting lifetime membership in AAACN. Susan said, in her President's Address during Closing Ceremonies, "I never wanted to be a nurse and now I can't imagine being anything else! I thought I wanted to be a teacher, or a guidance counselor, or a psychologist – who knew that I'd have the chance to do all three and then some just by becoming a nurse!"

Virtually attend the Las Vegas Conference! You can "virtually" attend sessions from the April 2013 Las Vegas conference by purchasing the sessions of interest to you in the Online Library at www.aaacn.org/library. Sessions include audio recordings and Power Point handouts. Contact hours are included. Sessions will be available for purchase by July.

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New Board of Directors Takes Office

The 2013-2014 Board of Directors took office at Closing Ceremonies. Pictured (back, l-r): Deb Cox, Director; Judy Dawson-Jones, Secretary; Cynthia Nowicki Hnatiuk, Executive Director; Nancy May, Director; Wanda Richards, Director; and Carol Andrews, Treasurer. Pictured (front, l-r): Susan Paschke, President; Marianne Sherman, President-Elect; and Suzi Wells, Immediate Past-President.

Poster Winners

Attendees learned from and cast their votes for the best posters out of 75 exceptional posters prepared and presented by their colleagues. Ribbons were presented for first, second, and third place as follows:

1st Place:
Improving Clinic Efficiency and Satisfaction by Implementing a New Position
Kimberly Watson, LPN
Virginia Commonwealth University Medical Center, Richmond, VA

2nd Place:
Vital Signs: Routine or Vital in the Ambulatory Care Setting
Donna Karp, BSN, RN, RVT
Michele Thiessenhusen, RN
Froedtert Hospital, Milwaukee, WI

3rd Place:
Call Us for Care and We'll Be There: Developing a Daytime Pediatric Nurse Triage Call Center
Rashidah K. Hasan, BSN, RN
Mary E. Sizer, MSN, RN, CPN
Daneen Smith, MSN, RN
The Children's Hospital of Philadelphia, Philadelphia, PA

The 2013 Conference Program Planning Committee would like to thank all poster presenters. Posters displayed at the annual conference will be posted on the AAACN Web site for members to access by July 1. Log in as a member, then click on "Professional Development/Poster Presentations" from the home page tabs.

Scholarships

Kathleen Martinez, BSN, RN, CPN, of Children's Hospital, Colorado, was the recipient of an education scholarship to assist her in obtaining her Masters degree. **Diane Lapars, LPN,** of the Cleveland Clinic, was awarded a conference scholarship to attend a Pre-Conference workshop

Accountable Care Organizations: Elements of Success

Although much has been written about the Patient Protection and Affordable Care Act's (PPACA) provisions to assist hospitals, physicians, and other caregivers to improve access, safety, and quality while decreasing costs of health care, there is much variability in the acceptance, strategies, and implementation of accountable care organizations (ACOs). On March 31, 2011, more than 2 years ago, the U.S. Department of Health and Human Services (DHHS) proposed new rules to assist with provision of better coordinated care for Medicare patients through ACOs. ACOs provide incentives for teamwork and coordination of care across settings including ambulatory care, acute care and long-term care. "The Medicare Shared Savings Program will reward ACOs that lower growth in health care costs while meeting performance standards on quality of care and putting patients first. Patient and provider participation in an ACO is purely voluntary" (DHHS, 2011).

Although ACOs are supposed to decrease costs and increase quality of care, the epicenter of their mission is the goal that the ACO be a patient-centered organization where patients and providers are true partners in care decisions. The ACA specifies that an ACO may include the following types of providers:

- ACO professionals (i.e., physicians and hospitals meeting the statutory definition) in group practice arrangements,
- Networks of individual practices of ACO professionals,
- Partnerships or joint venture arrangements between hospitals and ACO professionals, or
- Hospitals employing ACO professionals, and
- Other Medicare providers and suppliers as determined by the Secretary (DHHS, 2011).

Shared savings are also a major part of the ACO. Medicare would continue to pay providers and suppliers for specific items and services, but it would also develop benchmarks for each ACO against which its performance will be measured to assess whether it qualifies for shared savings, or should be held accountable for losses.

Ambulatory care nurse leaders need to be aware of the challenges and controversies that surround establishment of ACOs, as well as expected performance parameters and outcomes, so that they can assume leadership in planning and implementing ACOs. In a recent *Wall Street Journal* article, Christiansen (who developed the concept of "Disruptive Innovation") and colleagues from Harvard (2013) argue that ACOs will fail because they are founded on three "untenable assumptions." First of all, ACOs cannot change physician behavior. Physicians need to move to increased use of evidence-based protocols and to provide care in less expensive settings. Second, ACOs won't automatically change patient behavior. Currently, many ACOs let patients choose their providers, including specialists. This has been done to avoid consumer dissatisfaction with use of "gatekeepers" who authorize access to specialists or procedures. Gatekeepers have been traditionally employed by HMOs to contain costs. Finally, "ACOs will not save money on a grand scale.... No dent in costs is possible until the structure of health care is fundamentally changed," Christiansen and colleagues (2013) conclude.

Christensen's predictions are in line with the Robert Wood Johnson National Commission on Physician Payment Reform Report (2013). They list the following factors that are drivers of the high cost of U.S. health care (p. 2-3):

- *Fee-for-service reimbursement.* Under this model, physicians are reimbursed for each service they provide. Pay is not necessarily linked to outcomes.
- *Reliance on technology and expensive care.* The federal government and private insurers reimburse technology-intensive procedures at higher rates than services focused on evaluating patients or managing the care for chronic (illnesses.)
- *Reliance on a high proportion of specialists.* The U.S. has a high ratio of specialists to primary care physicians. The higher-intensity, higher-cost practice of specialists makes their care particularly expensive. The current payment system favors high cost procedures over time spent on evaluation or management of care.
- *Paying more for the same service or procedure when done in a hospital setting as opposed to an outpatient setting.* For example, Medicare pays $450 for an echocardiogram done in a hospital and only $180 for the same procedure in a physician's office. While physician salary and related expenses account for 20% of health care spending, the decisions they make influence an additional 60% of spending.
- *Systemic issues.* Specifically, the skewed incentives of fee-for-service payment.

Managed Care magazine did an interview with Clayton Christensen in 2009. According to Christensen, three fundamental investments are needed in health care:

> Investment in diagnostics, business model innovation, and the creation of a new system. Diagnostics that precisely diagnose disease pay off very handsomely in affordability down the road. The business model of medicine, such as the hospital and the doctor's office, were put into place 100 years ago in response to conditions that existed 100 years ago. We need to replace them with innovative business models that will do a much better job of focusing the right resources on the right problem. And because health care is a systemic problem, only companies that have the scope to wrap

their arms around the whole system are going to be able to change it. A few institutions, Intermountain Healthcare, Kaiser Permanente, Geisinger Health System, and a few others like these, are integrated fixed-fee sorts of providers that are really building on what HMOs originally were. They have the scope to rethink the creation of new systems that have disruptive business models (Managed Care, 2009).

In a *WSJ* article, Christiansen and colleagues (2013) build on the ideas expressed in the 2009 interview and offer several suggested reform solutions:

- Consider opportunities to shift more care to less-expensive venues, including, for example, "Minute Clinics" where nurse practitioners can deliver excellent care and do limited prescribing. New technology has made sophisticated care possible at various sites other than acute-care, high-overhead hospitals.
- Consider regulatory and payment changes that will enable doctors and all medical providers to do everything that their license allows them to do, rather than passing on patients to more highly trained and expensive specialists.
- Going beyond current licensing, consider changing many anticompetitive regulations and licensure statutes that practitioners have used to protect their guilds. An example can be found in states like California that have revised statutes to enable highly trained nurses to substitute for anesthesiologists to administer anesthesia for some types of procedures.
- Make fuller use of technology to enable more scalable and customized ways to manage patient populations. These include home care with patient self-monitoring of blood pressure and other indexes, and far more widespread use of "telehealth," where, for example, photos of a skin condition could be uploaded to a physician. Some leading U.S. hospitals have created such outreach tools that let them deliver care to Europe. Yet they can't offer this same benefit in adjacent states because of U.S. regulation.

Christiansen and colleagues (2013) have apparently read and accepted recommendations made in the Robert Wood Johnson 2010 Report: *The Future of Nursing: Leading Change, Advancing Health.*

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Sheila A. Haas, PhD, RN, FAAN, *is a Professor, Niehoff School of Nursing, Loyola University of Chicago, Chicago, IL. She can be contacted at shaas@luc.edu*

President's Message

continued from page 2

Interest Group (SIG) networking and the sharing of information. What is a CoP? It is *a group of people who share a concern or passion for something and interact regularly to learn how to do it better.* The Leadership SIG, their Advisory Group, and past Chair Kathy Mertens agreed to pilot this new concept and the technology that goes with it. A special session at the annual conference was held to educate and demonstrate the capability of the CoPs to leaders and members of the other SIGs, committees, and task forces to promote the use of this interactive tool.

In addition to the CoPs, the AAACN Web site (www.aaacn.org) has an entire new look and functionality! If you haven't been there lately, I encourage you to visit and try out some of the enhancements for yourself.

Research and evidence-based practice will be highlighted in a new toolkit soon to be added to the resources available on the Web site. In addition, plans for an ambulatory nurse sensitive indicators task force are in progress.

Strategic Goal #2 – Expand Our Influence

AAACN has become a member of the Nursing Alliance for Quality Care (NAQC) – a bold partnership among the nation's leading nursing organizations, consumers, and other key stakeholders to address the disparities and inefficiencies in health care quality and safety. Thank you to Eileen Esposito, who will serve as our representative to this important group.

Strategic Goal #3 – Strengthen Our Core

Membership and member retention are the highest ever in 2013! We are pleased to have over 2,600 members. Thanks to all our members who are committed to AAACN and who are working to invite new members to join us as the organization that encompasses many settings and multiple roles in one unifying specialty of ambulatory care.

Looking Ahead

During the next year, I plan to use this column to keep you informed of the progress of our strategic goals and initiatives. However, we can't accomplish them without you, our members. Opportunities to volunteer are plentiful – if you find something that "speaks" to you and your practice, join in! You'll be glad you did.

Thank you for this opportunity to serve as the AAACN President this year!

Susan M. Paschke, MSN, RN-BC, NEA-BC, *is Chief Clinical and Quality Officer, Visiting Nurse Association of Ohio, Cleveland, OH. She can be contacted at spaschke@vnaohio.org*

aaacn news

Sheila Haas Appointed to ANA Care Coordination Panel

Sheila Haas

AAACN member and Past President Sheila Haas, PhD, RN, FAAN, has been appointed to the American Nurses Association (ANA) Care Coordination Quality Measures Panel – Steering Committee. The panel will focus on developing a framework for measuring the contributions of registered nurses engaged in care coordination. Dr. Haas also serves on the AAACN Care Coordination Expert Panel that is developing AAACN Care Coordination Competencies for Ambulatory Care Nursing.

Norris E. Burton Represents AAACN at NSNA Conference

Member Norris E. Burton, MSN, RN-BC, ONC, represented AAACN at the National Student Nurses' Association annual conference in Charlotte, NC, in April.

Sheryl Gordon Reviews APIC Infection Control Publication

AAACN member Sheryl Gordon, MSN, RN, was selected to review the Association for Professionals in Infection Control and Epidemiology (APIC) free online resource titled *Infection Prevention for Ambulatory Care Centers During Disasters.*

Eileen Esposito Appointed NAQC Representative

Eileen Esposito

Member Eileen Esposito, DNP, RN, was selected to serve as the AAACN representative to the National Alliance for Quality Care (NAQC). NAQC is a bold partnership among the nation's leading nursing organizations, consumers, and other key stakeholders to advance the highest quality, safety, and value of consumer-centered health care for all individuals, their families, and their communities.

Mary Anne Bord-Hoffman Provides Expertise to Joint Commission on Sample Medication

Mary Anne Bord-Hoffman, MA, MN, RN-BC, a member of AAACN, was selected to participate in a two-hour Joint Commission stakeholder conference call to discuss critical issues related to sample medications and the Medication Management standards.

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Corporate members receive recognition in *ViewPoint*, on AAACN's Web site, and in various conference-related publications, as well as priority booth placement at AAACN's Annual Conference. For more information about Corporate Member benefits and fees, please contact Marketing Director Tom Greene at tom.greene@ajj.com or 856-256-2367.

health bytes

- Nip it in the bud! Seasonal allergies can mean misery for your patients! Direct them to self-care tips at the following Web sites: National Jewish Health, Centers for Disease Control and Prevention (CDC), and National Institute for Allergy and Infectious Diseases (NIAID)/National Institutes of Health. Also, you can print handouts for your patients on the difference between a cold and allergies in English or Spanish from http://www.niaid.nih.gov/topics/allergicdiseases/documents/coldallergy.pdf

- The National Osteoporosis Foundation Web site has information for you to share with your patients on osteopenia and osteoporosis. Learn more about changing recommendations for Vitamin D and calcium, prevention strategies, and the importance of weight-bearing exercise at http://www.nof.org/learn

- Help to protect the most vulnerable population in your practice – abused children. Check out information that you can share from Prevent Child Abuse America at http://www.preventchildabuse.org/publications/index.shtml or the Child Welfare Information Gateway at https://www.childwelfare.gov/preventing/preventionmonth/tipsheets.cfm

- The National Osteoporosis Foundation Web site has information for you to share with your patients on osteopenia and osteoporosis. Learn more about changing recommendations for Vitamin D and calcium, prevention strategies, and the importance of weight-bearing exercise at http://www.nof.org/learn

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*

Editor's Note: *In consideration of the ever-present changes in health care in the 21st century, the "For Your Health" column has changed its name to "Health Bytes." The same great content, delivered in bytes of connected links, will continue to offer health care topics and resources for you and your patients.*

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

National Nurses Week – How Did You Celebrate?

Every year, National Nurses Week (May 6-12) focuses attention on the diverse ways America's 3.1 million registered nurses work to save lives and to improve the health of millions of individuals. This year, the American Nurses Association (ANA) selected "Delivering Quality and Innovation in Patient Care" as the theme. The ANA supports and encourages National Nurses Week recognition programs through the state and district nurses associations, other specialty nursing organizations, educational facilities, and independent health care companies and institutions.

Annually, National Nurses Week begins on May 6, marked as RN Recognition Day, and ends on May 12, the birthday of Florence Nightingale, founder of nursing as a modern profession. Traditionally, National Nurses Week is devoted to highlighting the diverse ways in which registered nurses, who comprise the largest health care profession, are working to improve health care. From bedside nursing in hospitals and long-term care facilities to the halls of research institutions, state legislatures, and Congress, the depth and breadth of the nursing profession is meeting the expanding health care needs of American society.

How did you make this Nurses Week an extra special one for your colleagues? Send your photos and stories to us at aaacn@ajj.com. We'll share our favorites online and here in *ViewPoint!*