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aacn ViewPoint

The Voice of Ambulatory Care Nursing

Scholarships: The Gift of Support

Kathleen Martinez
Suzi Wells

schol·ar·ship /'skɑːlə˞ʃɪp/– serious formal study or research of a subject.

One of the most valuable aspects of my involvement in AAACN has been access to the high quality education offered to our members. Being involved in a national organization has given me a more global view of issues that impact the specialty area of ambulatory care nursing. Although I am active in my own community, I was unaware of many of the more global issues that impact care delivery. Attending the AAACN Annual Conference has provided me with a much broader view of the threats and opportunities facing our profession. I have had an opportunity to talk with subject matter experts from around the country, problem-solve issues with peers struggling with similar problems, and develop networks for benchmarking and best practice identification.

schol·ar·ship /'skɑːlə˞ʃɪp/– an amount of money that is given by a school, an organization, etc., to a student to help pay for the student's education.

Another valuable aspect of AAACN involvement is the support, encouragement, and recognition that is provided for members. Several years ago, I returned to school to obtain my master's degree in nursing. It had been 25 years since I graduated with my BSN. Returning to school with a family, a full-time career, and active involvement in a professional organization was a daunting prospect. I enrolled in an online program, which met the need for flexibility, but did not provide the nurture and support that is found in a more traditional setting. It has been a difficult journey, and although I receive some tuition reimbursement from my workplace, there were always other expenses – books, software, and equipment.

Last winter, I responded to a notice in *ViewPoint* encouraging members to apply for scholarships. I decided to apply for the Educational Support Scholarship. This was a very simple process that allowed me use a narrative format to list my past experience, my future dreams, and my current contributions to both my profession and AAACN. It was incredibly empowering to see all my contributions recorded in one place. It also allowed

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inside

from the president

All Around AAACN

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

Reader Services

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Susan M. Paschke

It's hard to believe summer is behind us and a new school year has begun! Just as teachers and students are excited in anticipation of all that the new term will hold for them, AAACN is experiencing some excitement of our own as we look forward to the remaining months of 2013!

Our Executive Director, Cynthia Nowicki Hnatiuk, received notification that she has been named a Fellow of the American Academy of Nursing! The Academy's 2,000+ Fellows are nursing's most accomplished leaders in education, management, practice, and research, and have been recognized for their extraordinary contributions to nursing and health care. The invitation to Fellowship includes not only the recognition of one's accomplishments within the nursing profession, but also the responsibility to contribute to the transformation of the health care system in the United States. Cyndee will be officially inducted into the American Academy of Nursing at the annual conference in October. Congratulations Cynthia Nowicki Hnatiuk, EdD, RN, CAE, ***FAAN!*** We are so very proud of you.

There is exciting news from our Special Interest Groups (SIGs) as well! In each President's letter, I try to match our current activities to one of the three goals of our strategic plan adopted in 2010 and updated annually. As I prepared to discuss the SIGs in this issue, I was reminded that they actually play a role in each of our three goals:

Serve Our Members – by offering opportunities for networking and collaborating based on a common interest or theme.

Expand Our Influence – by connecting with resources within and outside of AAACN and sharing best practices.

Strengthen Our Core – by providing experiences in SIG membership and leadership, and helping to develop potential leaders of the future.

Remember, participation in a SIG is one of your benefits of membership in AAACN!

Our first All SIG Leader conference call held in June was a great success. SIG leaders rarely have the opportunity to share ideas and best practices and this call provided that and more. The Leadership SIG presented their Advisory Group concept and shared the charter created to direct the work of the SIG. Other SIG leaders enthusiastically embraced the idea and other SIGs are now in the process of identifying an Advisory Group to help define direction and to create a charter for their groups. This is definitely best practice in action! The SIG Leaders have continued to hold bi-monthly conference calls to support each other's ideas and projects and continue to share suggestions for increasing engagement in the groups.

The Patient Education SIG and the Staff Education SIG have decided to merge into one group dedicated to the education of both patients and staff. They are in the process of identifying an advisory board that will then create a charter for the new group to define purpose, goals, and direction. The new SIG intends to complete the projects begun by each of the former SIGs – a Patient Education Toolkit and the Preceptor Orientation Guide. Current co-chairs, Wanda Mayo, Pam Sanford, Cathy Biviano, and Libby Barton, and board liaisons, Nancy May and Wanda Richards, will continue to serve in those roles for the next year. We look forward to the work of this newly formed SIG in the future!

The Tri-Service SIG has a new leadership team: CDR Sana Savage (Navy), LTC Sonya Shaw (Army), and Maj Kim Trnka (Air Force). The diminished presence of the military was definitely evident at this year's conference and this dynamic group

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Technology Survey Uncovered Member Unknowns

A technology survey was conducted earlier this year to make sure we were keeping pace with technology and meeting the needs of our members. The data from the 342 members who took the time to respond to the survey provided AAACN with valuable information on members' use of various forms of social networking including: what social media they use in their nursing practice, what technology enhancements they desire to enhance member value, and the value of the complimentary journal received as a membership benefit.

We found that 36.8% of the respondents use social media for professional reasons and 63.2% did not. Results also showed 76.4% of respondents were Baby Boomers (1946-1964), and the next largest group (18.8%) was Generation X (1965-1980). Many nurses indicated they use LinkedIn for professional networking, sharing best practices, and job opportunities. Others use Facebook to check in with professional organizations or keep up with professional contacts. A few nurses indicated they use YouTube for educational videos or presentations they are preparing.

AAACN will use your feedback to enhance our services to meet your needs. Thank you to those members who completed the survey. Below are some enhancements that members said they desired – good news, AAACN is currently offering them!

Technology Enhancements Suggested by Members	What AAACN Offers	More Information
"Would like an AAACN Facebook page for networking and organization promotion among nurses."	AAACN has a Facebook page with 1,405 fans.	Go to www.facebook.com/aaacn to "Like" us and stay in touch with AAACN through Facebook.
"Make your Web site user friendly, particularly the SIGs."	Members can find the SIG main page from four areas of the home page: • *About/Special Interest Groups* • In the *Shortcuts* area in the left margin of the home page • Using the new search feature • In the *Quick Links* area in the upper right corner	The Web site was newly redesigned as of January 2013. The site now adapts for visitors using mobile devices. The new search feature, along with the *Quick Links* and *Shortcuts* areas help visitors find what they are looking for easily. We just added the Special Interest Groups to the *Quick Links* area at the top of the home page.
Want "recorded lectures or conference where we can view from a computer." Virtual conference attendance Webinars, online learning modules	The AAACN Online Library contains recorded sessions from past conferences. Most sessions are $15 including contact hours. Members can purchase the full conference package for $199. The Certification Review Course and the Telehealth Nursing Practice Core Course (TNPCC) are also in the library.	Visit the Online Library at www.aaacn.org/library to see all current offerings. You can use the search feature to find topics of interest to you. Nurses can attend conferences virtually in our Online Library without the expense of traveling and hotel costs.
Would like "Phone text messages with important updates."	AAACN has a Twitter account (www.twitter.com/ambcarenursing). We Tweet information to our 3,925 Twitter followers, who have the ability to subscribe to text alerts when new Tweets are sent.	Join Twitter and follow us at @ambcarenursing. Adjust your mobile settings in the profile area to receive text alerts from the accounts of your choice.
"It would be interesting to participate in a group chat on a topic or have a virtual journal club on issues of concern to members." Ambulatory care nursing electronic group mailing list Professional blog	AAACN has seven Special Interest Group email lists. We call them "email discussion lists" and members can use them to ask questions, network, and discuss important topics.	Members can subscribe to any email discussion list by logging on to the Web site, then accessing the Special Interest Group page.
"I wish it could be a seamless transfer to the Online Library rather than have two usernames/passwords."	Since October 2011, members have had a single sign-on for both the AAACN Web site and Online Library.	Log on to www.aaacn.org/library and use the same username and password.
Access to nursing journals	Members receive a complimentary journal subscription to one of the following: *MEDSURG Nursing, Pediatric Nursing,* or *Nursing Economic$*. These journals include articles that offer contact hours.	The value of your complimentary subscription is between $52 and $72. Members can change their journal choice in the *My Account* area of the Web site or by contacting the National Office. Because nursing journals are a source of income for associations, providing members access to other nursing journals as a member benefit is not feasible.

From Chaos to Control: Implementation of Mass Influenza Immunization Clinics

Barbara Weber

Anne Hammer

Influenza vaccine is a safe and effective intervention that can prevent serious disease and even death; however, opinions differ on the most effective way to deliver vaccine to the largest number of individuals. This article will describe the rationale and present a process for developing standardized mass influenza immunization clinics in a primary care setting. Readers will recognize this as an example of the nursing process in action, including cycles of assessment, planning, implementation, and evaluation.

There are several important reasons for health care providers to offer annual seasonal influenza vaccination to patients. According to Fiore and colleagues (2010), these include protection from disease, promotion of herd immunity in the community, cost-effectiveness of vaccination as a preventive measure, and implementation of universal recommendations for vaccination by the Centers for Disease Control and Prevention (CDC) Advisory Committee on Immunization Practices. In the United States, annual epidemics of influenza typically occur during the late fall through early spring. Influenza viruses can cause disease among persons in any age group. Rates of infection are highest among children, while rates of serious illness and death are highest among those 65 years of age or older, those 2 years-old or younger, and those who have medical conditions that place them at increased risk for influenza complications (Fiore et al., 2010). Although vaccines are among the most cost-effective clinical preventive services, influenza disease leads to more than 200,000 hospitalizations and 36,000 deaths on average each year (U.S. Department of Health and Human Services [HHS], 2013).

The HHS Healthy People 2020 project has established ten-year evidence-based national objectives for improving the health of all Americans (HHS, 2013). The goals of Healthy People 2020 influenza vaccination objectives are to "increase immunization rates and reduce preventable infectious diseases." Target influenza vaccination coverage levels are set at 80% for children and healthy adults through 64 years of age, and 90% for high-risk adults, health care workers, and adults 65 years of age or older. The actual influenza vaccination rates are 23-40% of children, 25% of healthy adults through 64 years of age, 39% of high-risk adults through 64 years of age, 67% of adults over 65 years of age, and 45% of health care workers. These rates are substantially below target levels (HHS, 2013). Because influenza vaccine is seasonally available, mass vaccination strategies are a good approach to increase influenza immunization rates. Compared with doctor's office visits, vaccination-only clinics may increase vaccination rates (Stinchfield, 2008); patients are more likely to get vaccinated with less time spent waiting (Fontanesi, Hill, Olson, Bennett, & Kopald, 2006), and the mean cost of vaccination is lower (Prosser et al., 2008).

Denver Health, a comprehensive, integrated safety net organization serving the city and county of Denver, encompasses a 500-bed inpatient hospital with a Level 1 Trauma Center, the Denver County Public Health Department, and an Ambulatory Care Services network with a hospital-based urgent care center, specialty clinics, and community family health centers. The organization spans eight

Instructions for Continuing Nursing Education Contact Hours

From Chaos to Control: Implementation of Mass Influenza Immunization Clinics

Deadline for Submission: October 31, 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 rationale and process for planning and implementing mass influenza immunization clinics in a primary care setting. After reading and studying the information in this article, the participant will be able to:

1. Discuss the advantages of offering influenza immunizations in vaccine only mass clinics.
2. Describe key operational components needed for a successful mass immunization clinic.
3. Define steps that should be taken to ensure patient safety during mass influenza immunization clinics.

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.

Table 1.
Immunization Clinic Job Categories

Job Category	Responsibilities
RN site manager	• Clinic preparation and logistics, clinic flow, supplies, staff management
Registration/billing clerk	• Register patient following registration/billing guidelines • Collect payment • Label forms with patient information and give to patient • Direct patient to screening area
Screener (RN or Medical Assistant)	• Screen patient for flu vaccine eligibility using standardized immunization screening questions • Provide VIS and answer questions • Document screening and VIS on encounter and return to patient • Direct patient to vaccination area
Vaccinator (RN or Medical Assistant)	• Place vaccine in portable electric cooler • Review encounter form to ensure screening done/documented and patient eligible to receive vaccine • Administer vaccine and document • Keep adolescents seated and monitor them for syncope for 15 minutes following injectable influenza vaccine* • Encounter given to data entry clerk
Security	• Crowd management • Distribute numbered tickets • Monitor line, communicate wait times, answer questions
Data entry clerk	• Collect completed encounters from vaccinators • Concurrent data entry into computerized vaccine tracking system

*The *General Recommendations on Immunizations* by the Advisory Committee on Immunization Practices (2011, p. 12) states, "syncope is most common among adolescents," and "vaccine providers, particularly when vaccinating adolescents, should consider observing patients...for 15 minutes after vaccination."

geographic locations and 15 school-based health centers. This is one of the largest community health center networks in the country. Denver Community Health clinics provide primary care services (medical, dental, and mental health) to about one of five Denver residents and 35% of Denver's children.

In the past, seasonal influenza vaccination was provided to patients at appointed clinic visits and during multiple small mass immunization clinics at each site. A study by Fontanesi and colleagues (2006) supports this multifaceted approach, suggesting that the greatest advantage occurs when both routine vaccination appointments and mass vaccination clinics are used in a coordinated manner. During the 2010-2011 flu season, 27 individual small mass immunization clinics were held at a total of nine primary care clinic locations. The number of flu vaccines given per clinic ranged from only 12 to 200. Process review revealed that there was duplication, inefficiency, and lack of standardization. For example, each clinic ordered different types of supplies and different quantities of vaccine. This created confusion and extra work for central supply and pharmacy. Scheduling flu vaccine-only visits impacted the ability to schedule patients for regular provider appointments and disrupted clinic flow. It was also difficult for both staff and patients to keep track of many immunization clinic options. As a result, the Community Health Services division set out to develop a standardized, more efficient plan.

Key Stakeholders

Community Health Services nursing leadership identified a committee of key decision-makers from various departments to help determine the process for mass patient influenza vaccination. This group – comprised of representatives from nursing, immunization committee, pharmacy, patient registration, billing, and public relations – met monthly beginning in March, well before the beginning of the influenza season. The role of this committee was to provide high-level planning for mass influenza vaccination clinics. Members also provided administrative approval for our proposed mass vaccination clinic plan.

Operational Flu Immunization Task Force

In addition to the key decision-makers group, an influenza immunization task force was formed to develop the specific details to operationalize all aspects of the mass influenza immunization clinics. The task force was made up of the Director of Nursing, Immunization Program Clinical Coordinator, Clinical Nurse Educator, and Clinic RN Managers from Family Medicine, Pediatric, and Internal Medicine Clinics to ensure representation of all patient age groups. This group met twice a month starting in July until all details were finalized. Individuals who were members of both the key stakeholders and the operational task force provided coordination between the two groups.

According to Schwartz and Wortley (2006), vaccination program planning must consider issues such as coordination, staffing, clinic location and layout, security, record keeping, and communications. The operational task force developed standardized processes for the clinics based on a successful public health mass immu-

Figure 1.

Site Manager Clinic Preparation Timeline

2 weeks before clinic:
- ☐ Order supplies using mass influenza immunization clinic order template
- ☐ Order ___copies of Outpatient Encounter Record Seasonal Influenza Vaccine
- ☐ Order influenza vaccine from Pharmacist or Vaccines For Children (VFC) coordinator

Friday 8 days before clinic:
- ☐ Ensure correct amount of vaccine in clinic

Week before clinic:
- ☐ Print/Copy Forms: (All mass flu clinic forms on Intranet site)
  - ☐ Mass Flu Clinic Superbill: ___copies
  - ☐ Registration/Billing guidelines: ___ copies
  - ☐ VIS: ___ copies Inactivated Influenza Vaccine; ___ copies Live Intranasal Influenza Vaccine
  - ☐ 2nd dose instruction handout for parents of children needing 2nd dose: ___ copies
  - ☐ Flu clinic staff job descriptions: 1 for each person in each job category: Site Manager, clerks, screeners, vaccinators, security
- ☐ Ensure all supplies have arrived and are correct
- ☐ Plan clinic set-up:
  - ☐ Determine entry and exit point, registration and vaccinating areas, and best traffic flow
  - ☐ Determine vaccination station locations and placement of tables and chairs
- ☐ Review staffing list by the Wednesday before
- ☐ Ensure there is enough money to provide change to patients paying for flu immunization

Friday before Saturday clinic:
- ☐ Set up clinic including:
  - ☐ Directional signs
  - ☐ Tables, chairs, supplies, pens, and clipboards in correct locations
  - ☐ Paperwork in correct locations
- ☐ Walk through clinic after setup to ensure smooth flow

Day of clinic:
- ☐ Check staffing list and ensure all staff present; follow-up with any staffing issues
- ☐ Tour staff; orient staff to emergency equipment, emergency response, and flu clinic flow
- ☐ Hand out and review clinic schedule and job description for each staff role
- ☐ Monitor clinic flow and make adjustments as necessary
- ☐ Conduct post-clinic debriefing and complete debriefing form
- ☐ Ensure clinic cleaned up and ready for normal operation

nization model previously used for H1N1 vaccinations (Denver Public Health Department, 2009). These included a clinic preparation timeline, job descriptions, staffing template, supply list with standardized quantities of medical supplies and vaccines, process for keeping vaccines at required storage temperature, clinic set-up and flow, post-clinic debriefing process, and concurrent vaccine data entry.

One-Stop Shopping

Eight four-hour clinics were held at six different locations. Clinics were scheduled on Saturdays and offered vaccinations to all age groups, so working families could attend together without taking time off from work. The number of clinics was based on statistics about the volume of influenza immunizations given in previous years. Each clinic had the capability for vaccinating a total of 300 individuals. Site locations were spread geographically over the service area at clinics with ample parking or located on public transportation routes to provide convenient access. According to Stinchfield (2008), a multifaceted immunization program that increases access to vaccine increases vaccination rates. To improve access and increase vaccination rates, the organization provided three options for patients. These options were the mass influenza vaccine clinics, receiving influenza vaccine at their home clinic sites during provider appointments, or during immunization-only visits scheduled with a medical assistant.

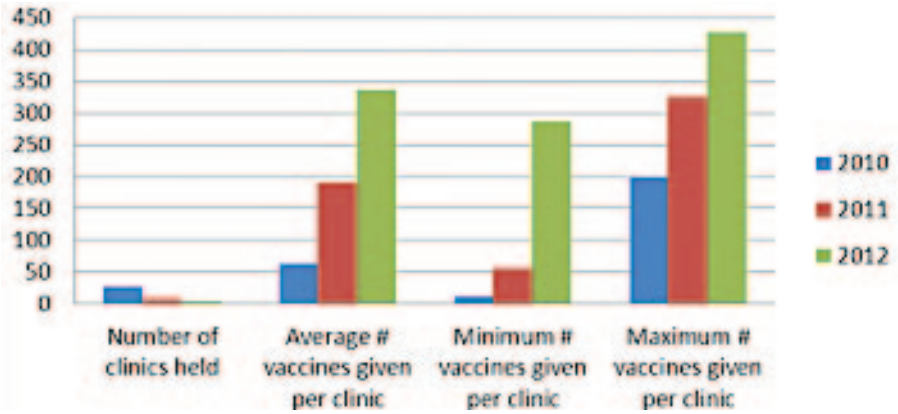
Marketing

The Managed Care and Public Relations departments developed reminder cards advertising the mass influenza immunization clinics. These were mailed to the managed care members and placed in all clinics. Immunization clinics were also marketed on a public Web site and via an influenza information recorded message that patients could call.

Staffing

Community Health Services nursing leadership initially consulted the Denver Public Health *H1N1 Vaccination Clinic Dispensing Plan* (2009) to determine the number of vaccines that could be administered per hour and the amount and types of staff needed to support this number. This helped determine the length of the clinics and staffing numbers. The *CDC Guidelines for Large-Scale Influenza Vaccination Clinic Planning* were also used to ensure that all needed job categories were identified (CDC, 2011) (see Table 1). The clinics were staffed for a maximum of 300 vaccinations with the capacity to provide 150-200 pediatric and 150-200 adult vaccines because there was no way to predict the patient mix. All clinic managers were responsible for recruiting staff to work at the mass flu clinics. To control costs, float team members and other staff who would not generate overtime were assigned first. Some clinics were able to assign their full-time staff on a Saturday and provide them with time off during the week. Names of interested staff were sent to a centralized person who assigned the correct number and types of personnel to each location using a standardized scheduling grid (available from author upon request). Staff were sent an email confirming their assigned schedule and clinic location, and the staffing schedule

Figure 2.
Comparison of 2010, 2011, and 2012 Mass Influenza Immunization Clinics



was sent to the site manager four days before each scheduled clinic. Two on-call staff members were scheduled – one clerk and one RN or medical assistant (MA) – to cover for sick calls or unexpectedly high volume. Each clinic was staffed with a site manager responsible for all aspects of the flu clinic. The site manager was the RN Manager of the location holding the mass immunization clinic. A Site Manager Clinic Preparation Timeline checklist was created to help facilitate getting supplies and vaccine to the clinic ahead of time and setting up the clinic space the night before (see Figure 1).

Staff were scheduled to arrive one hour before the publicized clinic start time. Because some staff were working at a site other than their home clinic, this allowed for just-in-time training about the clinic and their specific job responsibilities. All staff were given a tour of the clinic, including emergency procedures and location of emergency equipment, and a review of the day's schedule. The RN site manager addressed any staffing issues and reviewed job descriptions with security, screeners, and vaccinators, while the clerical supervisor reviewed the registration/billing staff job description with the registration clerks. Vaccinators transferred the vaccine from the clinic refrigerator to a portable electric cooler. Because there was a line already present one hour before the publicized start of most flu clinics, patient registration started as soon as the clerks completed their training, rather than waiting for the publicized start time.

Patient Safety

To ensure patient safety, there were separate vaccinators and screeners for adult and pediatric patients. RNs and MAs working in Pediatric or Family Medicine clinics were assigned to screen/vaccinate pediatric patients. Adult patients could be screened or vaccinated by Family Medicine or Internal Medicine clinic RNs and MAs. Pediatric and adult screeners and vaccinators worked as a team so that families would be kept together. The type and quantity of vaccine was standardized for all mass immunization clinics. Pediatric and adult vaccine was stored in separate containers in the portable electric cooler because not all vaccine was licensed for use in children, and adults were not eligible to receive live intranasal vaccine. An RN monitored vaccine temperatures every 2 hours throughout each clinic to ensure vaccine integrity.

Debriefing

A five-minute debriefing session by all staff and completion of a simple, standardized debriefing form was mandated at the end of each clinic. This form was sent to the Director of Nursing immediately after the clinic so changes could be made for the next Saturday clinic if needed.

Results

Implementation of mass influenza immunization clinics using a standardized process resulted in increased efficiency with higher numbers of vaccines administered per clinic held (see Figure 2) and anecdotal improvement in patient satisfaction and shorter wait times. In 2011, there was a 197% increase in the average number of influenza vaccinations given per clinic compared to 2010. Immediate post-clinic debriefing allowed rapid improvement in clinic efficiencies for subsequent clinics. Overall, the process worked well; however, staff had downtime at several of the clinics and several were released from their shift early. Only one clinic administered the planned maximum number of vaccines.

2012 – Finding the Most Efficient Balance

When planning began for the 2012 mass influenza immunization clinics, the Key Decision-Maker Group and the Operational Flu Task force were reactivated. These groups met a total of only three times compared with eight meetings in 2011. Their role evolved into evaluating the data from 2011 and making recommendations for changes in 2012. No process changes were recommended. Based on the number of immunizations given at each clinic in 2011 and the amount of staff downtime, the decision was made to decrease the number of clinics offered to 3, increase the length of the clinics by 30 minutes, increase the number of immunizations that could be given at each clinic to 500, and to keep the 2011 staffing levels. The three sites chosen were those that best covered the geographic area and gave the most immunizations in 2011.

Implementation of these changes in 2012 resulted in a 77% increase in the average number of vaccines given per clinic over 2011, a 420% increase in the minimum number of vaccines given per clinic and a 31% increase in the maximum number of vaccines given per clinic using the same number of staff as 2011 (see Figure 2). Staff were consistently busy through-

out the clinics and patient wait times did not increase from the 2011 average wait times of 0-15 minutes.

Summary

Provision of mass influenza immunization clinics offers another option to increase access to the recommended annual immunization. Using a standardized approach is safe and has many benefits such as: decreased committee planning time; process familiarity among staff, patients, and other departments (e.g. pharmacy, central supply), resulting in less confusion and error potential; and increased efficiency with less duplication. After evaluating 2012 data, the 2012 process will be continued for future mass influenza immunization clinics.

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Scholarships

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me to appreciate how my professional contributions through AAACN impacted my career growth and development at work. Involvement in national task forces and working on projects with peers from across the country had increased my self-confidence in my home environment and allowed me to take on more challenges and broaden my scope.

Being awarded the scholarship at this year's annual conference was great because it supplied added funds toward school. But more importantly, I felt that the work I did was recognized, valued, and supported by my peers. I know how hard AAACN members work to raise the funds to support scholarships, and I felt the love and encouragement of every member when I accepted the gift that was so graciously offered.

Scholarships are offered for conference attendance, assistance with certification expenses, excellence in ambulatory care nursing, and research and educational support. Take advantage of the support of your colleagues and this great membership benefit by applying for a scholarship in the area that matches your need. We all benefit when we share our knowledge, resources, and opportunities.

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Awards, Scholarships, and Grants

The deadline for all awards is November 15. Awards are presented at the annual conference. Download applications at aaacn.org/awards.

Excellence Awards

Two awards of $500 and a statuette recognizing two nurses who exhibit Administrative or Clinical Excellence as nominated by their peers. Self nomination is permitted.

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Scholarships range from $100 to $1,000 to enhance member education. Funds may be used for tuition or books.

NEW Candia Laughlin Certification Scholarship

One $1,000 scholarship to cover the exam fee, study materials, and other expenses related to achieving certification.

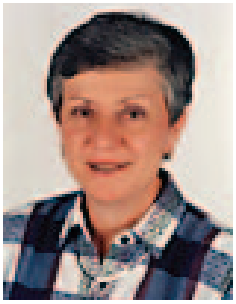
Research Grants

Funds are awarded in incremental amounts in support of research that will advance ambulatory care or telehealth nursing practice.

Beth Ann McMurtry, RN-BC, CDE, HC (center), received an Excellence Award at the 2013 AAACN Annual Conference.

NOTE: AAACN has an alliance with the DAISY Foundation, an organization that gives grants and awards to outstanding nurses who are recognized by their peers. Learn more at www.DAISYfoundation.org

member spotlight



Diane Rubeo

As a nurse of 44 years, Diane Rubeo, MSN, RN, EMBA, began her career in Poughkeepsie, NY as a diploma graduate from St. Francis School of Nursing. She later returned to school and received a Bachelor's degree in Nursing from Mt. St. Mary College in Newburg, NY, a Master's degree in Nursing from the University of Pennsylvania, and an Executive Master's degree in Business Administration from the University of New Haven.

While Diane currently works as Patient Service Manager in the Dental Department at Yale-New Haven Hospital, she has had an eclectic career beginning with inpatient nursing on a medical-surgical unit that was then known as the "wards." She moved into the Emergency Department as both staff nurse and assistant supervisor, where she reorganized the outpatient department in a community hospital that included all specialties and internal medicine. She later became an adult nurse practitioner (ANP) and accepted the nurse manager position in the Primary Care Center at Yale-New Haven Hospital in 1981. During her 20 years there, she was able to utilize both her clinical knowledge and skill as an ANP and her management experience.

It was while managing the department of internal medicine and urgent care for five years with the Yale University Health Plan — a staff model HMO — that Diane realized how much she missed the outpatient clinics and working with the medically and socially disadvantaged. She then returned to Yale in 2007 to accept the challenge to manage and oversee the dental department and its programs for adults and children. As the first nurse to ever manage the dental department at this institution, Diane's staff grew from 11 to 47 employees and from two cost centers to six throughout four facilities. Diane worked to implement all clinical, safety, and infection control standards that reflected excellence and compliance with distinction among regulatory agencies. Diane's goal was to ensure effective systems management, professional nursing and staff development, and outstanding commitment to patients.

With her educational preparation and clinical and management background, Diane says she feels "honored and blessed to have been able to contribute as [she has] in ways that support and mentor nurses and clinical staffs, create safe and quality environments, and never lose sight of [her] first and most important responsibility as a nurse for patient advocacy [as well as] provide and ensure safe, quality health, medical, and nursing care."

Diane attended her first AAACN Annual Conference, at the prompting of her director, at the College of William and Mary in Williamsburg, VA, in 1982. That experience, as well as the recognition that she had found an organization in which she could identify and that had the vision of ambulatory care nursing as a catalyst for change in the future of health care, ignited her 31 year membership in AAACN. She values and enjoys the conferences, the outstanding presentations, the collegial and collaborative relationships fostered, and the extraordinary vision of those she considers to be the pioneers in ambulatory care nursing. She has presented at conferences, enjoys receiving the *Nursing Economic$* journal as a benefit of membership, and always reads every copy of *ViewPoint* from cover to cover.

Diane believes AAACN has put ambulatory care nursing at the same professional level as other nursing specialties through its development of standards, guidelines, and continued acknowledgement and role clarity of the ambulatory care nurse and the contributions of ambulatory care nursing leaders. She has used several AAACN products as resource materials, including the *Ambulatory Care Nursing Administration and Practice Standards* and the *Telehealth Nursing Practice Standards.* As a Certified Intuitive Healer, Diane has been involved with complimentary medicine for 13 years, where she has been able to combine allopathic/conventional and complimentary modalities of healing. Her love for ambulatory care settings recognizes that one of the "greatest challenges and opportunities for nurses [is] to epitomize the roles of change agent, patient advocate, clinical and systems specialist, and integrator of health care in ways not possible in acute care settings; there is a high level of responsibility and independence in the role that is also commensurate with authority and accountability."

Some of Diane's biggest challenges as a nurse have been seeing the bigger picture and having a vision that often conflicted with the establishment. She is the type of nurse who does not ask, "why?" but rather, "why not?" She often feels challenged to be that voice that makes a difference.

On a personal note, Diane loves music, art, old movies, and comedy. She is a ventriloquist who enjoys playing golf (not at the same time of course). Her proudest moments occur when either a nurse that she hired and/or mentored succeeds in ways that allows him or her to then be her mentor. As such, one of Diane's mottos is, "The greatest compliment to me as teacher and mentor is when my students become my mentors and teachers!"

Diane plans to retire in the next 2-3 years and, hopefully, bring her dream of starting her own complimentary energy medicine practice to fruition. She wants to "pay it forward" as she implements the many modalities and programs that support and enrich the lives of those with chronic illness and cancer survivors such as herself. Finally, she wants to focus on nourishing and nurturing her nursing colleagues as they continue to care for their patients in today's demanding health system.

What a career our colleague, Diane Rubeo, has had! She is such an inspiration.

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

Overcoming Barriers: Increasing Pediatric Flu Vaccination Rates

Influenza in pediatric patients is an acute upper respiratory tract infection with significant morbidity and mortality. The Centers for Disease Control and Prevention (CDC) estimated the median coverage for those vaccinated against seasonal influenza for children ages 6 months to 17 years in the United States was 56.6% for 2012-2013 flu season (CDC, 2013). During the same flu season timeframe, 62.7% of children at Nationwide Children's Hospital received the flu vaccine.

Nationwide Children's Hospital's current strategic plan focuses on best outcomes with continued emphasis on wellness. One of Nationwide Children's wellness initiatives is to increase influenza vaccination rates in children seen in the ambulatory care areas. Our ambulatory care areas are comprised of many primary care centers and numerous specialty clinics.

Our Approach

Each year, the Influenza Vaccination Team meets to improve the flu vaccination efforts. Led by representatives from Epidemiology, Nursing, and Community Wellness, the group has clinical members from inpatient and outpatient areas, education, physicians, and marketing.

The Influenza Vaccination Team designed a two-pronged approach. Most patients expect to receive a flu vaccination at their primary care visit, but our approach is to encourage children seen in specialty clinics (such as eye, dental, allergy, etc.) to receive the flu vaccine as part of their specialty clinic visit. The second prong is to document flu vaccinations our patients receive elsewhere (private pediatrician's office, health department, etc.) The goal is to capture the true flu vaccine administration rate for our patients.

Reminding patients and families about the importance of the vaccine happens in many forms at Nationwide Children's. Utilizing interior channels for communication includes elevator posters and verbal staff encouragement. Exterior channels for communication include community publications and our Web site (www.nationwidechildrens.org). The team took advantage of a new tool on campus – digital signage billboards, which are installed in strategic "pause-points" throughout the hospital and are ideal for sharing information.

The Influenza Vaccination Team reaches out to patients specifically identified with chronic illnesses. Postcards were developed and mailed to this targeted population, asking parents to consider an appointment for a flu vaccination. In 2012, over 17,000 postcards were mailed out. The postcard was further utilized during the 2012-2013 flu season through another targeted mailing aimed at 6,000 of our youngest primary care patients.

During the 2012-13 flu season, our primary care leaders took a special interest in improving flu vaccination rates by coordinating a mobile-unit walk-in clinic. Patients were given a "hot card" with information about the clinic and where to receive the vaccinations. In January 2013, another tactic to track our patient population's vaccinations was employed by reaching out to local community physicians to obtain flu vaccination data in order to update our electronic database. This proved to be time well spent, as significant numbers of shared patients had received the flu vaccine through their community provider. In an effort to increase awareness and share resources, Nationwide Children's offered referring community physicians a toolkit of flu resources including a disc of videos and a list of frequently asked questions. Increasing awareness and preventing flu-related illness are without a doubt the goals of the Influenza Vaccination Team.

Tracking Our Effectiveness

Nationwide Children's data is obtained from electronic medical record fields that include influenza vaccine administration, historical entries, and refusal of the vaccine. Data includes inpatients, outpatients seen in specialty clinics serving high-risk children, and children seen in the primary care setting. Nationwide Children's data is collected from September 1 through March 31 for each year and targets patients ages 6 months through 18 years.

Analyzing this data weekly helped the team identify areas for improvement. It became clear that encouraging specialty clinics to administer vaccinations could help meet our goal. The data allowed the team to target high volume specialty clinics and areas struggling to meet the benchmark.

Barriers

The barriers identified below refer to the knowledge and lack of familiarity with providing flu vaccinations. For some settings, medication administration is rarely performed, and the special control requirements of vaccines (such as close temperature control and recording lot numbers) were intimidating.

- Change in workflow process
  - Determining patient eligibility
  - Ordering vaccine
  - Altering clinic flow to add vaccine administration
- No or inadequate equipment/supplies (refrigerators), Vaccine Information Statement (VIS), vaccine
- Need for vaccine billing codes to be added to the EMR
- Staff education
- Culture
  - Who is responsible for providing the flu vaccine?
  - Where should flu vaccinations be provided?
  - Is it customary for patients, families, nurses, and physicians to expect patients to receive the flu vaccine at their primary care visit, but not at their eye or dermatology appointment?

Resolving the Barriers

- Site visits
  - Reviewed current flow and made recommendations on how process could be implemented with the least disruption, answered questions, and provided education and support.
- Manager support
  - Provided resource guide with acceptable refrigerator models, thermometers, VIS, how to order the flu vaccine, and list of resource personnel (purchasing, pharmacy, coding, etc.).
- Licensed Professional Initiated Protocol (LPIP)
  - Innovative nursing leaders developed a LPIP for flu vaccine administration by ambulatory care nurses.
  - Allowed nurses autonomy to order and administer the flu vaccine without a provider order (provider must co-sign within 48 hours).
  - Flexibility allowed nurses to administer flu vaccine in the mobile unit, before or after the physician visit and when physicians were not present.
- Clinical bi-weekly meetings
  - Focus group created in the 2012 flu season included representation from teams that had not met the benchmark the previous year and teams that had done exceptionally well.
  - Allowed for sharing of stories as a working group to assist teams across the specialties.
  - Empowered the specialty areas to own the process and create an excitement behind the initiative. As areas identified their success, word spread to other areas.
- Staff education
  - An electronic education learning module was developed to provide education on the various types of flu vaccine, doses, patient eligibility, VIS, and the flu LPIP.

Recognizing Milestones

Nursing engagement has been a major success factor incorporating influenza vaccination rates into the Magnet performance measures. The infrastructure provided feedback to individual clinics and peer coaching by nursing leaders with struggling areas was invaluable.

The vaccination program has shown continued progress both qualitatively and quantitatively. Each year, we are able to engage a broader cross-section of the organization in the vaccination efforts with more areas delivering vaccine consistently. Areas that initially considered the program a distraction are building in processes to incorporate it into a smooth workflow. Initially improvement mirrored state and national trends toward improved vaccination rates. However, we are now seeing continued improvements in vaccination rates above the benchmark.

In celebration of the noteworthy efforts, the First Annual Flu Fighter Award Ceremony was held to recognize the success of the nurses working in the clinics. Ambulatory managers, clinical leaders and clinic nurses were invited to attend. Dr. Teresa Long, Columbus Health Commissioner, congratulated the outstanding work of the organization for administering over 56,000 influenza vaccines this past season. Nationwide Children's Hospital's success is demonstrated in that our flu vaccination rate from 2009 to 2012 increased from 54% to 84% (2012) in the primary care centers and from 26% to 56% in the specialty clinics.

Moving Forward

The experiences at Nationwide Children's Hospital illustrate several important factors many organizations face as they initiate community health. First is recognizing this is more than an operational change – it's a culture change. Taking responsibility for a community is very different from episodic care.

The focus group's expectation is to expand and continue to meet for the upcoming 2013-2014 flu season to assist in coaching and problem-solving. New members in the focus group will include those from areas initially identified due to their potential outreach that had previously struggled with barriers highlighted above. A notable success is that these areas proactively approached the Influenza Vaccination Team as they now see the feasibility for implementation.

The Influenza Vaccination Team will continue to support the hospital to exceed benchmarks while fostering the culture change surrounding the expectations of community wellness. Partnering with primary care physicians within and outside of the Nationwide Children's network will be a strong focus for the 2013-2014 flu season as we look to care for our children with chronic illness in the outpatient setting. In our journey, we must not only care for the patients within our system, but also reach out to all children in the community.

Reference

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Amanda Wodzisz, BSN, RN, *was a Program Manager in Healthy Weight and Nutrition, Nationwide Children's Hospital, Columbus, OH, at the time this article was written.*

Perspectives of Patients Used in Health Care Planning

A small but very interesting study conducted by S. Kangovi, a Robert Wood Johnson Foundation (RWJF) Clinical Scholar, and colleagues (2013) found "that current approaches to getting patients from low-socioeconomic groups to seek preventive and primary care in physicians' offices or accountable care organizations instead of hospitals are often ineffective," (RWJF, 2013). The Patient Protection and Affordable Care Act signed by President Obama in 2010 assumes that when patients have health insurance they will access primary care early and as needed for health care and prevention. In actuality, even with Medicaid coverage, patients often seek care in the emergency department (ED). Kangovi and colleagues' (2013) study involved interviews of 40 Medicaid patients in an urban setting who used the ED instead of primary care sites. Interviews were done by community health workers who were known and trusted by these patients.

Themes that emerged in the patient interviews fell into 3 categories: cost, convenience, and quality. It appears from patient quotes that they have done an excellent job of identifying the barriers and doing what works best for them. In terms of cost, the co-pay for primary and specialty care visits is a barrier and they must take time off from work for one or more visits. In addition, they cannot qualify for Medicaid transportation, which requires a 72-hour notification when seeking same-day access in primary care. In addition, there is a convenience factor when they go to the ED they see a doctor; this is not always the case in same-day access primary care and, if admitted to the hospital, their problems are treated quickly and aggressively. "The [primary care doctor] never treated me or my husband aggressively to get blood pressure under control. I went to the hospital and they had it under control in four days. The [physician] had three years," (Kangovi et al., 2013, p. 1198). This statement also conveys the belief that quality of care is better in the ED and hospital.

To better understand patient perceptions of barriers to using ambulatory care, Kangovi and colleagues (2013) divided patients into two groups. First were patients who experienced a traumatic health problem that not only affected their health status but this "event set off a cycle of social dysfunction, mental illness, and disability that drove their repeated hospital visits," (RWFJ, 2013). The second grouping was "most often highly functional caregivers for social networks strained by poverty and illness. These people often put off caring for themselves," (RWJF, 2013) and when confronted with illness, chose the ED.

So where do we go from here? This study clearly indicates the need to hear the voices of patients so that health care settings and systems are designed to meet patient needs for convenience, cost, and quality. Certainly this study needs to be replicated in other geographical areas and also with patients who obtain health insurance through state insurance exchanges. The Institute for Healthcare Improvement (IHI, 2009) has recognized the impact that socioeconomic factors, along with comorbidities, can have on patients' choices and management of their health care needs. ED departments have begun to delve into the group of patients they see as "frequent flyers" and often the reasons are socioeconomic. The issue of perceived quality needs to be addressed in ambulatory care settings where evidence-based guidelines should be used; population health management data and teams should be available so that patients can see most, if not all, practitioners in one visit; and patients should have individualized care plans that move electronically to whoever is caring for the patient. Patients should also have a voice in design of these care plans so that they accurately reflect patient values, preferences, and goals.

This study also indicates that there are issues that require national policy changes such as the Medicaid regulations regarding transportation to and from health care settings. The Centers for Medicare & Medicaid Services (CMS) is considering bundling payment for health care, but health care settings (especially ambulatory settings) need to move away from the fee-for-service mentality that values multiple visits to specialists and for testing each with a separate cost, and move toward aligning/bundling testing and provider visits so that patients are not forced to take time off of work for multiple visits and testing. Ambulatory care organizations need to look at alternative arrangements such as hours of care, including early morning and late evening/night. For the low income poor where parents often work two or more jobs, the most common time for ED visits is 2 a.m., when one or both parents and child are home and able to get to the ED.

Dr. Kangovi evolved this study from her assessments of issues in practice. Ambulatory care nurses need to consider issues such as those raised in this study (Kangovi et al., 2013) and replicate their qualitative research design that offers the opportunity to get the patient's perspective. There is a new funding mechanism that highly values the patient perspective: Patient Centered Outcomes Research Institute (PCORI), which may be a vehicle for funding for such qualitative research.

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Recruit Colleagues and Win!

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

President's Message

continued from page 2

has set a goal of having a Tri-Service networking event at the 2014 conference in New Orleans. Military members make up approximately 15% of the AAACN membership and they are often on the cutting edge with implementation of models of care and practice that become best practices.

The Leadership SIG embraced the concept of Communities of Practice (CoPs) almost a year ago and the Leadership Advisory Group was instrumental in piloting our first attempt at using this model and associated technology to enhance communication and collaboration among members. Thank you to the members of this group for their willingness to step "out of the box" and work with this new format.

Former Leadership SIG Chair Kathy Mertens presented a session at this year's conference explaining CoPs and discussed the pilot project. Diane Resnick, the current Chair, continued to support the pilot project; however, challenges to those using the platform were identified and the product's "user unfriendliness" made it difficult to work with as a communication tool. The expense of converting to another platform at this time was not an option.

The good news is that our current database company will be able to offer us a CoP option in about one year. As a result, the board decided to delay the transition from SIGs to CoPs until the new platform is available. Current discussion lists are working well at offering members opportunities for networking and sharing of information and will continue to be functional until the CoP networking platform is a reality.

The Pediatric SIG, under the leadership of Sheila Whelan and Joyce Partner, has also embraced the Advisory Group and charter concept and is considering holding monthly conference calls to strengthen the networking development of the SIG.

Updates on the Telehealth SIG, chaired by Alma Johnson and Christina Hendrix, and the VA SIG, chaired by Jane Murphy, will be available in a future edition.

I can be reached at spaschke@vnaohio.org if you have questions or issues you would like to discuss. Enjoy the autumn season!

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

2014 Conference Flyer Available

The annual conference education program has been finalized. Download a preliminary flyer at aaacn.org/conference. The flyer contains all of the session titles/topics, hotel and city information, as well as the early bird deadline date and rates. We are proud to say we have "held the line" on registration costs and are offering the same prices as last year!

Someone to Hear Their Stories

If you manage patient situations over the phone, you might agree that most calls are fairly straightforward and predictable. Over the years, I have taken thousands of calls in which the caller is inquiring about symptoms, seeking information, or sharing a concern. Amidst the volumes of calls, some calls have made me wonder, *Why did this person call me*? You have most likely had those types of phone calls, too. I will share three experiences I have had and what I discovered as a result of them.

A Cat Call

I was working one evening and received a call from a woman who had a tentative tone. She started by sharing that her niece was visiting and brought her cat with her. As she spoke slowly, I wondered if this would be a cat scratch call, but I stopped myself from jumping to conclusions. The woman continued to introduce her story, and I was growing more curious as to where she was leading me. She began telling me that the cat seemed ill. Then I wondered if she would want to know if humans could catch illnesses from animals. (I had gotten that question before.) I stopped myself from being presumptuous. Then she arrived at the reason for her call – she wanted to know if I could help her determine what was wrong with the cat. She was complimentary as she told me that she calls frequently and that the nurses are always so "helpful and spot-on." She assumed that we could triage cats. I apologized and encouraged her to call a veterinarian. She agreed but said that since the cat was visiting, she did not know who would take the call, and she trusted us. I had to reiterate that the nurse line was for humans only. The caller said she understood but seemed disappointed.

Green Face

A woman called around Halloween and shared that as part of a costume, her husband painted his face green. She said that the paint label indicated that the paint was washable, but it was not coming off. Frantically, she said, "This is not funny!" I did not laugh, but perhaps she could sense my smile. I began the triage process and asked, "What have you done so far to try to remove the paint?" She shared that she had used abrasive cleanser, bleach, nail polish remover, and turpentine, and she described his current hue as sickly faded green. She explained that he had a professional presentation in the morning, and they were panicked because he looked gravely ill. Although their aim was to remove the paint, my concern shifted to the chemical exposure. I asked her how her husband was and asked to speak to him directly. I inquired how he felt after being exposed to so many chemicals on his skin. He was alright, but described his skin as feeling irritated. Consequently, I transferred this call to Poison Control. It was essential that they review the cleaning agents that were used and provide safe recommendations to remove the paint.

A Pocket Pet

One evening, I received a call from a mother who was whispering on her cell phone. She shared that she was with her five-year-old son at a birthday party. He had been jumping, climbing, and sliding on an inflatable playground for over an hour. Initially I thought that I would be triaging an injured child. I asked for her son's demographic information, but she said he was fine and she just needed to ask a question. Her voice was stressed. She disclosed that her son had been running around and stopped for a minute to declare, "I hope Sissel is having fun." I asked an unusual triage question, "Who is Sissel?" The mom was nearly breathless as she explained that Sissel was a gerbil, and her son had tucked him in his back pocket. The mom observed that the back of the boy's jeans were now wet. She apologized, "I call you all the time for my kids when I need your help. I didn't know who else to call." She sounded like she was going to cry and her questions bubbled forth. She asked how to handle this emotionally with her son. She inquired about the gerbil's remains in the boy's pocket, and the exposure to her son and others. She queried whether it was necessary to decontaminate the entire playground; this would ruin the party. I never experienced this question before, and there was no reference to access for answers. I collaborated with my nursing colleagues and the on-call pediatrician, and we designed a plan for this situation.

We Are a Call Away

These are a few of my stories. You have your dilemma calls, too. We may ask, "Why do they call us?" I now say, "Why *wouldn't* they call us?" Our patients and families view us as trusted professionals and resourceful experts. They have catastrophes and quandaries, and they know we will not minimize their concerns or dismiss their stories. We may not always have the answers, but we can listen, mutually problem-solve, and offer support and guidance. We have a relationship with our patients and their families. When they experience a crisis, they call us.

Kathryn Koehne, BSN, RN-BC, C-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*

Author's Note: *Identifiers have been removed from these stories to maintain patient privacy.*

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

health bytes

- Atrial fibrillation, an irregular heart rhythm, is noted in our aging population. When a new diagnosis is made, share this information, which includes an online tutorial from the National Heart, Lung, and Blood Institute with your patients and their family members: http://www.nhlbi.nih.gov/health/health-topics/topics/af/

- With the beginning of school sports this fall, help patients and family members become more aware of the potential for traumatic brain injuries resulting from concussions. Share this information from the Centers for Disease Control and Prevention on concussion signs and symptoms: http://www.cdc.gov/concussion/pdf/Fact_Sheet_ConcussTBI-a.pdf

- October is Health Literacy Month and a time for caregivers to reevaluate their efforts to assist patients and family members to better understand information that they are given. For information on the teach-back technique, slides for staff to review, and samples, refer to: http://www.nchealthliteracy.org/toolkit/tool5.pdf

- Domestic violence is a pattern of behavior in which one person behaves in a way to obtain power or control over an intimate partner. Help your patients to know that there is help available by calling 1-800-799-SAFE. More information is available at the National Domestic Violence Web site: http://www.thehotline.org

- Yoga is a mind-body practice using breathing, certain postures, and meditation to decrease stress while promoting relaxation. For more information, refer to the National Center for Complementary and Alternative Medicine, National Institutes of Health: http://nccam.nih.gov/health/yoga

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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.

Readership Survey Delivers Gratifying Results

Kitty Shulman

Early in 2013, the editorial staff of AAACN's official publication, *ViewPoint*, conducted a short membership survey asking for feedback regarding its columns, CNE articles, and ideas for the future. You responded with a host of content ideas for us to think about. At the recent AAACN Annual Conference in Las Vegas, the *ViewPoint* Editorial Board held a meeting, in which we reviewed the survey responses.

Overall, your enthusiasm concerning our current direction was very gratifying. The columns were well received and have been read on a regular basis. There were many suggestions for new columns from the survey responders and from our Editorial Board members. Some ideas put forth:

- Create a column patterned after "Dear Abby" that provides a forum for asking advice with a management focus,
- Publish alternating columns to serve our many membership constituencies, such as the military/VA/pediatrics Special Interest Groups (SIGs) and the Legislative Committee,
- Consider a column on how to manage disruptive patients,
- A column on compassion fatigue would be useful,
- Best practices/competencies/quality improvement would be a good focus for a column,
- Content on care management could be provided in each issue, and
- Virginia Beeson inspired the idea of installments focused on stories of courage.

As with any new endeavor, we will need volunteers to develop and write these columns with guidance from the Editorial Board. If you have an interest, please let me know.

As an example, an idea for a safety forum surfaced from member Sarah Muegge. You will be hearing more about "Safety Corner" from Sarah in our next issue of *ViewPoint* and in the AAACN monthly enews. She will be asking for your participation in this new effort.

The continuing nursing education (CNE) articles in *ViewPoint* were found to be valuable by over 82% of responders. Additional ideas were offered for topics that readers would like to see in future issues. Some of those ideas will be added to the *ViewPoint* Manuscript Wish List, which is located on the AAACN Web site (www.aaacn.org/viewpoint). In the future, we will add some additional content direction to the Wish List so we can guide potential authors in providing articles that engage our members.

As we move forward, the *ViewPoint* Editorial Board and staff hope that you will continue to get much enjoyment, knowledge, and inspiration from its pages!

Please let me know if you would like to assist in developing and leading any of the proposed column ideas or if you have an idea for a manuscript.

Kitty Shulman, MSN, RN-BC, *is the Editor of* ViewPoint. *She can be contacted at kittyshulman@earthlink.net*