We would like to thank the American Academy of Ambulatory Care Nursing (AAACN) for supporting us as representatives for ambulatory care nursing on the National Quality Forum (NQF) Emergency Department Transitions of Care project. The NQF, under contract with the department of Health & Human Services, provides multi-stakeholder guidance on priorities for performance measure development. The quality of health care is determined by comparing individual or population performance with a known ideal standard or accepted benchmark.

As representatives of AAACN, we approached our role with this group from the viewpoint of primary and community care bringing a passion for improving systems of care. It was heartwarming to see the strong support for quality transitions across the continuum from so many stakeholder groups.

This project had two goals:

- Develop a quality measurement framework based on evidence through stakeholder meetings and research that defines and identifies examples of care quality for transitions into and out of the emergency department (ED).
- Improve person-centered care, value, and cost efficiency by improving the management of ED transitions.

This work was accomplished through review of the existing literature, input from a diverse group of stakeholders (physicians, advanced practice nurses, RNs, pharmacists, consumer advocacy groups, emergency medical services, the Joint Commission, insurance, electronic health record representatives), and expert advice and analysis from the NQF staff.

Since our task was to develop a framework in an area that has not yet had significant measure development, our work product included key domains and information required for quality transitions. Although this may sound abstract, it is quite practical; for example, one domain identified key information that must be transmitted both to and from the ED in order for a safe transition to occur. In the ED, nurses must prepare for the patient’s discharge and arrival. Nurses often complete necessary care delivery, access additional allied continued on page 3
A Year in Review — Progress and Prospects

This time last year I began the role of AAACN President looking forward to ensuring that AAACN had another successful year. With the help of you, the owners, customers, and workforce of the organization, the Board of Directors (BOD), our wonderful Chief Executive Officer (CEO), and colleagues at Anthony J. Jannetti, Inc. (AJJ), we have indeed had a successful year. In this final message as President, I will share our accomplishments and take a brief look at the future.

Progress

To meet the needs of members, provide up-to-date information and support, advance practice, and create opportunities for members to share their expertise, 4 organizational teams have been formed or rejuvenated. One is the Legislative Team, which is tasked with keeping members updated and informed of important policies and issues related to ambulatory care nursing. Another is the Nurse Sensitive Indicator (NSI) Team, which will provide updates and information on the development process and progress in the use of NSIs. The Opening Reception/Silent Auction Team will work to organize a wonderful evening reception, perfect for introductions, networking, and fun, to start off our annual conference. And finally, a Nurse Executive Team was also formed this year, comprising members who hold nurse executive positions. The focus of this group is to explore the needs and facilitate the success of nurse leaders in the ambulatory care arena.

I have other exciting news to share on a variety of fronts. We have begun to revamp the AAACN website to modernize it and make it more user friendly. Stay tuned as these changes take place. Another change this year illustrating our growth is the decision to update our peer-reviewed newsletter. ViewPoint will not only be getting a new look, but will also be provided in a digital format. Evidence suggests that the nurse role in Care Coordination and Transition Management (CCTM) is critical to quality care and positive outcomes throughout the healthcare arena. To help broaden understanding and execution of this important role across the continuum, AAACN will be convening an invitation-only CCTM Summit of nursing and other healthcare leaders in May.

Major resources released this past year include the Ambulatory Care Registered Nurse Residency Program, the Preceptor Guide for Ambulatory Care Nursing, and the Ambulatory Care Nursing Orientation and Competency Assessment Guide. In addition to the soon-to-be-released revised Scope and Standards of Practice for Professional Telehealth Nursing, work is in progress to identify resources to meet the telehealth education needs of our members. Two major projects are well underway; the revision of the Core Curriculum for Ambulatory Care Nursing and the Care Coordination and Transition Management Core Curriculum. Indeed, we are making great progress on our strategic goals — serving our members, expanding our influence, and strengthening our core.

This past fall, the bylaws were updated and this included changes to make the process for selection of the AAACN President and BOD more transparent. AAACN membership (11% increase) and conference attendance this past year was the highest ever and has led to financial surplus and security for the organization. Because we are in a financially sound position and all evidence points to a continued positive trend, the BOD has made the decision to reinvest some of that capital in the growth and development of the organization. We have doubled the CEO hours, an investment that will allow greater opportunities and accomplishments. Along with approving an increase in AJJ staff hours, continued on page 3
we have also approved an additional full-time support staff position. These staff changes have already made life easier in a variety of ways, including formatting of reports, communication, conference calls, webinars, and project assistance for task forces. SIG leaders and AAACN representatives and members who have been looking for information and support have already seen a positive difference.

One great accomplishment of the past year was filling the CEO position. We had a difficult time finding the right person — someone with extensive organizational experience and acumen, and an understanding of nursing. After an extended search by AAACN and AJJ, the BOD is extremely confident that the right person was appointed to this important position: our very own Linda Alexander, who served as AAACN’s Director of Association Services.

Prospects

AAACN is clearly thriving, largely because of members such as those of you reading this message. Ambulatory care nursing has been, and will continue to be, in the spotlight and continuing to evolve. With this comes continued growth, increasing demands for new and updated resources, shared expertise, and professional collaboration. Managing these demands requires attention to policy, finance, member input, leadership and volunteer needs, and staff time and attention. Luckily, AAACN is maintaining strong and expert leadership in both our management services and the incredible nurse members/leaders. Thus, I am sure our new challenges will continue to be met and will spur even further growth of the organization.

It has been an incredible honor to serve this organization as President. I look forward to serving AAACN in other roles in the future. In May 2018 at our 43rd Annual Conference in Orlando, Florida, it will be with great confidence and optimism that I hand the reins over to our new President for 2018-2019, Kathy Mertens, and our new BOD.

Liz Greenberg, PhD, RN-BC, C-TNP, CNE, is Associate Clinical Professor, Northern Arizona University, Tucson, AZ

Welcome New AAACN Staff

Please welcome our new Director of Association Services, Jennifer Stranix. Jennifer has spent the last 20 years in the association industry, working directly with a volunteer Board of Directors and managing all aspects of daily association operations.

Stephanie Witwer, PhD, RN, NEA-BC, is Nurse Administrator, Primary Care, Mayo Clinic, Rochester, MN. She may be contacted at witwersg@gmail.com

Alesa M. Mobley, PhD, APN, CPHQ, is Adult Nurse Practitioner and Adjunct Assistant Professor, Rowan University, Glassboro, NJ.

Corporate members receive recognition in ViewPoint, on AAACN’s website, 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.
Capturing the Effectiveness of the Registered Nurse in Ambulatory Care

With the enactment of the Patient Protection and Affordable Care Act (PPACA, 2010), millions of consumers who did not have access to health care in the past are now able to access the healthcare system. According to a study conducted by the Kaiser Family Foundation (2014), an estimated 57% of previously uninsured private plan enrollees would gain coverage under the ACA law. Because of the increased number of eligible insured individuals, healthcare organizations are now pressed to use their current staff more creatively to meet the needs of a growing population presenting with more complex diseases. To care for more patients with fewer resources, it is imperative that all healthcare practitioners be allowed to practice to the full extent of their education and licensure. All clinical staff should be used in a cost-efficient manner that elicits the desired patient outcomes. Therefore, it is essential to review current care delivery models, including the function of a RN in the ambulatory care setting, and explore ways to more fully implement the role.

To increase negotiating leverage, healthcare systems across the country are acquiring independent physician practices at an astounding rate. According to Kuramoto (2014), consolidation and mergers with similar practices is a viable strategy for dealing with the new challenges emerging in health care. Practice mergers develop to attain better economies of scale with group purchasing power, improved affordability of information technology, increased market presence, and better negotiation with insurance payers related to their key strengths. As a result of these mergers, practices are often scattered across large geographic areas, which challenges organization leaders when allocating clinical support and supervision to ensure patient safety and quality care.

Inadequate supervision of clinical support staff is a patient safety issue that plagues many healthcare leaders who are tasked with managing a large geographic area. According to Haas and Gold (1997), it is important to examine the role of supervision when facilitating change and promoting the success of care delivery models that use unlicensed assistive personnel in ambulatory care. In most ambulatory care clinic settings, clinical support staff supervision and training was the responsibility of the doctor and, in many cases, nonclinical operations managers. Often ambulatory care clinics are staffed with medical assistants with LVNs and RNs being a scarce commodity. The disparity in this care delivery model is the absence of the RNs and any accountability for clinical support staff competency, including any required compliance with environment of care standards.

The Institute of Medicine’s (IOM) Future of Nursing Report (2011) challenges nurses to partner with other healthcare professionals in leading the transformation of health care by both recognizing and using the RN to the full extent of their education and licensure. According to Mastal and Levine (2012), the capabilities of the RN often are unseen, undervalued, and underutilized in many health care organizations. The authors also wrote that “whenever [an] RN is present, there is an increase in patient satisfaction, enhanced documentation, improved collaboration between physicians and nurses, and also the improved health and well-being of the patient when directing them to the appropriate level of care” (p.295).

According to the American Academy of Ambulatory Care Nursing’s (AAACN) Position Statement on the Value of the Registered Nurse in Ambulatory Care (2017), ambulatory care nursing is a unique realm of specialized nursing
practice. The RN is uniquely qualified to influence the organizational standards related to patient safety and care delivery in the outpatient setting. Ambulatory care nurses are knowledgeable professionals who function well in a multidisciplinary, collaborative practice environment. RNs also utilize critical thinking skills to interpret complex information and guide patients and families back to health and well-being (Swan, Conway-Phillips, & Griffin, 2006). The Position Statement (AAACN, 2017) also states that RNs enhance patient safety and are essential and irreplaceable in the provision of patient care services in an ambulatory care setting.

**Methods**

The purpose of this evidence-based practice project was to evaluate the effectiveness of the Registered Nurse Practice Coordinator (RNPC), a new RN role created for the ambulatory care setting in our organization. The role was created in 2014 after a review of baseline data showed variations in practice across the areas where RN support was not present. This baseline data included environment of care audits, significant events in the clinics, and discussion with the ambulatory care nursing team. During the timeframe of this project, there were two RNPCs assigned to 20 clinics. These clinics were a combination of primary, pediatric, and specialty care.

The overall RNPC role expectation was to provide clinical supervisory support across a large geographic region of ambulatory care practices within an academic health system. The RNPC was created to be responsible for assisting with clinical quality, staff education, and clinical resource support for the clinical staff. The RNPC is expected to collaborate with the outpatient department managers, clinical staff, and physicians to enhance quality care by ensuring consistent clinical practices as they relate to regulatory standards and institutional policies and procedures. Initially, the physicians felt that the coordinators should participate in patient care when the clinics were running behind schedule; however, both the nursing and non-clinical leadership determined that each clinic should be staffed appropriately to handle its volume of patients, and the RNPCs should have a specific set of responsibilities that did not include direct patient care.

Under the direction of the ambulatory care nursing leadership, the RNPCs were, and still are, assigned to a group of clinics based on a staffing index with an Exertion Number (EN) created to equally assign responsibility to the RNPC. EN = (total miles from UCLA x .5) + (total number of clinical staff [MA, LVN, RN] x 2). The EN afforded a mathematical balance across all clinics by weighing the number of staff against the distance to the clinic from the home office and taking into account the size of the practice. Based on the number of staff in each clinic, type of service provided, and the driving distance from the home office, it was determined that a total index number of 150 was suitable as a maximum index per RNPC. Assignment of EN greater than 150 proved to be too great a number of staff for one RNPC to supervise while allowing for consistent completion of job duties and planned visibility in the clinics. This equated to a 1:9 ratio of RNPC to ambulatory care clinics. The job duties of the RNPC included assisting in the development and review of ambulatory care nursing competencies, coordinating new-hire orientation, and providing clinical education as it relates to best practices and/or evidence-based practices in ambulatory care.

Thirty clinics were involved in the RNPC evaluation project. Twenty clinics had an RNPC—two RNPCs covered 10 clinics each—and another 10 clinics did not have an RNPC. In addition to the two RNPCs, project participants included five physicians, 20 practice managers, five operations directors, one immediate RNPC supervisor, and two ambulatory care nursing administrative support personnel. Once IRB approval was received, project volunteers, due to their role and association with the RNPC role, completed the informed consents and project questionnaires, returning them to the investigator via email. The investigator blinded the questionnaires using a number in place of their name and aggregated the data by analyzing the answers to each question. Keywords were entered into a spreadsheet and those used more than five times by project participants were selected to identify themes regarding their perception of the RNPC role (available upon request from the author).

After the investigator presented the project to the participants associated with the chosen practices, detailed information was collected on the role of each practice coordinator, including job description, practice setting, work hours, and scope of work. All participants received an information letter and the appropriate audit tool described below.

In order to validate the effectiveness of the new RNPC role, the project investigator created three different tools that were completed by the participants. These three tools helped to evaluate the implementation effectiveness of the role. The first tool was the Self-Evaluation Questionnaire completed by each RNPC to assess the role (available upon request from the author). The second tool was the Practice Coordinator Effectiveness Rating Interprofessional Colleague Assessment questionnaire (see Figure 1). This tool focused on gathering insights regarding the RNPC role from the perspective of the practice manager, physicians, ambulatory care nursing department colleagues, and the RNPC’s immediate supervisor. The third tool was the Practice Coordinator Observation Form (see Figure 2), which focused on direct performance observations of the RNPC of their job duties and tasks. Using the Practice Coordinator Observation tool for documentation, direct observations by the investigator took place while RNPC-A and RNPC-B performed quality of care audits. The RNPCs were observed on two separate occasions, one-month apart, performing quality of care assessments and interacting with clinical staff and practice managers. Specific attention was paid to the actual communication of information to both the practice manager and staff and their responses to that information. For example, an
unlabeled multi-dose vial of medication was found in the medication refrigerator. The RNPC immediately informed the practice manager of the findings and educated both the manager and the staff on the implications and actions required to correct this finding. The education was accepted well by all present and the RNPC went on to document this occurrence on the audit tool.

The RNPC position has four job functions: (1) coordination of clinical staff, (2) staff education, (3) consulting, and (4) performance improvement. The coordination role provides assistance with implementation of new programs through education and training, ensures consistent standards of care are maintained across ambulatory care practices, and serves as a clinical resource to the practice managers. As staff educator, the RNPC identifies educational needs based on low-volume, high-risk outpatient procedures and recognized trends from quality reports. The consulting role collaborates with both practice managers and physicians providing direction on executing institutional policies, guidelines and other processes that affect the clinical support staff.

Among performance improvement (PI) activities conducted by the RNPC are quality of care audits defined as performing observations, data collection, and evaluation of improvement efforts.

One of these PI activities, done on a monthly basis, is the patient safety standard audit. The organization’s ambulatory care Quality of Care audit tool assists the RNPC in monitoring compliance with the environment of care and its regulatory requirements. The tool is used by the RNPC to review the practice compliance related to medication storage, infection control, expired supplies, Point of Care Testing control performance, and medication refrigerator temperature monitoring. It was adapted from the Association for Professionals in Infection Control and Epidemiology (APIC) Infection Control in Ambulatory Care (Friedman & Petersen, 2004) and the Centers for Disease Control and Prevention (CDC) Guidelines for Vaccine Storage and Handling (CDC, 2017). The tool was used to compare practices with a practice coordinator to those without one during the project.

The investigator received a total of 2 responses to the Self Evaluation (100%). Twenty responses to the practice effectiveness tool, were returned for a response rate of 70%. After an analysis of the Self Evaluation responses, keywords revealed the RNPC considered the role to be that of an educator, mentor, advisor, coordinator, and change agent, which matched the job description and the original intent of the role. A thematic data analysis of the responses to the practice effectiveness tool revealed patterns in the keywords used to describe the perceptions of those who work with the RNPC. The results of this analysis indicated clear role delineation between the practice manager and the RNPC. The responses revealed that the RNPCs provided education, regulation supervision, and environment of care assessments that enhanced the quality of patient care. When comparing the role of the RNPC to the practice manager, the participants agreed that the manager’s role was more operational and the RNPC role more clinically focused.
An analysis of the Practice Coordinator Observation Form revealed that the RNPC provided support and direction in an area that was previously missing in the clinics. The RNPC excels in providing staff education, regulatory compliance surveillance, and conducting environment of care assessments that enhance the quality of patient care. The results from the tool’s Staff Education component described how the RNPC was observed actively teaching skills to clinical staff. Upon receiving this training, staff reported increased confidence in their ability to perform assigned tasks, and the improved skills were validated by the physicians, who stated that staff had more confidence and improved task-related performance. Consultation results described the RNPC strengths as more clinically focused as evidenced by the following example: One respondent answered “Practice Coordinators are an integral part of the patient care team, and we include them in all decisions that may affect patient care. It is very helpful to have an RN available to answer clinical workflow questions when trying to improve efficiency.” The environment of care audits were compared prior to the implementation of the new role and during the next 12 months with the new RNPC (see Table 1). The results underscored the work the RNPC was doing to improve the environment of care. For instance, review of the infection control standards revealed compliance of 61% and 64% in October 2014 prior to the implementation of the RNPC as compared to 100% after implementation of the role. These findings confirm what nurse leaders recognized was deficient in the clinics. The RNPC promoted quality care and ensured consistency in clinical practices, in addition to providing support, leadership, and direction for patient care activities in accordance to organizational goals.

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The role of the RN P C has demonstrated that it can improve quality, safety and regulatory compliance in ambulatory care clinics. The data supported the goal of the RN P C’s role effectiveness by providing support for ambulatory care clinical staff, increasing the visibility of nursing leadership in the remotely located clinics, and delivering enhanced support for non-clinical managers on clinical practice related issues. In addition, the RN P C provides a level of professional nursing practice in ambulatory care through standardizing clinical orientation and staff competency validation which, in turn, enhances the safety and quality of care in the clinic environment. This role provides effective continuity and enhanced relationship building across ambulatory care clinics and the organization.

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### Summary

The role of the RNPC has demonstrated that it can improve quality, safety and regulatory compliance in ambulatory care clinics. The data supported the goal of the RNPC’s role effectiveness by providing support for ambulatory care clinical staff, increasing the visibility of nursing leadership in the remotely located clinics, and delivering enhanced support for non-clinical managers on clinical practice related issues. In addition, the RNPC provides a level of professional nursing practice in ambulatory care through standardizing clinical orientation and staff competency validation which, in turn, enhances the safety and quality of care in the clinic environment. This role provides effective continuity and enhanced relationship building across ambulatory care clinics and the organization.

### References


### Table 1.

Results of Environment of Care Audits Reflecting Clinic Compliance Before the RNPC was Implemented and Clinic Compliance with RNPC Over 1 Year

<table>
<thead>
<tr>
<th></th>
<th>RNPC A average % compliance for 9 clinics</th>
<th>RNPC B average % compliance for 9 clinics</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No RNPC Oct 2014</td>
<td>6 months w/ RNPC April 2015</td>
</tr>
<tr>
<td>Infection Control</td>
<td>64%</td>
<td>100%</td>
</tr>
<tr>
<td>Point Of Care Testing</td>
<td>78%</td>
<td>100%</td>
</tr>
<tr>
<td>Medication Safety</td>
<td>62%</td>
<td>100%</td>
</tr>
<tr>
<td>Utility Room/ Supplies &amp; Storage</td>
<td>44%</td>
<td>98%</td>
</tr>
<tr>
<td>Refrigerators and Freezers</td>
<td>72%</td>
<td>100%</td>
</tr>
<tr>
<td>Exam Rooms</td>
<td>86%</td>
<td>93%</td>
</tr>
</tbody>
</table>

(October 2014–October 2015)
Re-Emergence of Syphilis and Recognition in the Ambulatory Care Setting

When is the last time you encountered a patient with syphilis or even considered the need for testing for syphilis? If you work in obstetrics or in a setting where routine testing for sexually transmitted infections (STI) is indicated, your answer may be very different than clinicians working in other ambulatory care clinical settings or specialty practices. The prevalence of syphilis in the United States is rising. The rate of primary and secondary syphilis increased 22% between 2011 and 2013 after a 90% decline in the disease from 1990 to 2000 (Stamm, 2016). The Centers for Disease Control and Prevention (CDC) showed a syphilis rate of 27.4 cases per 100,000 people in 2016, which is up from 2015 statistics of 23.2 cases per 100,000 people (CDC, 2017b). Syphilis is a reportable disease across the United States, which helps local health departments manage local statistics and provide data to the CDC for national statistics.

Ambulatory care nurses are well positioned to screen and identify patients at risk for this disease by being mindful of the serious sequelae that can occur with untreated syphilis. Could the patient in your neurology office with unexplained muscle movements or the patient presenting with upper respiratory symptoms have syphilis? Value in health care is paramount and ordering unnecessary testing may have clinical and financial implications. However, given the prevalence of syphilis in many of our communities, maintaining appropriate clinical suspicion will require clinicians to weigh the need for screening with the significant harm and expense the disease may incur. Syphilis affects all age groups and racial demographics and, while currently most prevalent among men who have sex with men, is also found among patients identifying as heterosexual (CDC, 2017b). The prevalence of any STI increases the risk for other types of STIs. There is a correlation between syphilis and HIV infection (CDC, 2017b).

What is Syphilis?

Syphilis is an STI and can also be passed from mother to baby during pregnancy. Risk factors include, but are not limited to, being infected with other STIs, using illicit drugs, being a man who has sex with men, living in an area with high rates of syphilis, and being a sex worker (U.S. Preventive Services Task Force [USPSTF], 2016). There are 4 phases of syphilis. The initial stage presents with a small, painless sore to the genital area, but sores may also be present on the lips, in the mouth, or anus (USPSTF, 2016). Secondary syphilis can present with a rash or sores on the palms of the hand or soles of the feet (CDC, 2017a). Systemic symptoms such as headache, enlarged lymph nodes, fatigue, or sore throat may also be present. Because of the vagueness of the systemic symptoms and the fact that these symptoms will resolve even without proper treatment can often delay treatment for patients unsuspecting of syphilis (USPSTF, 2016). The rash on the palms of the hands is important to recognize, despite the clinical setting, as it is not common to see skin changes in this location. Patients with latent syphilis are asymptomatic but able to pass the infection (CDC, 2017a). In the third stage of syphilis, or late-stage syphilis, patients are likely to have more organ involvement with damaging effects on the brain, heart, nerves, and joints, to name a few. Paralysis and blindness can occur. At any stage of syphilis, patients may experience changes in personality, memory changes, movement disorders, or loss of coordination (USPSTF, 2016). Sadly, syphilis can be fatal in patients left untreated with late-stage syphilis (USPSTF, 2016).

Screening for syphilis can be done by a simple blood draw. Penicillin remains the gold standard treatment for syphilis and the dosage varies depending upon the length of exposure. Patients with a stated allergy to penicillin should be assessed for severity of the allergy to determine if alternative treatments should be explored. A recent study compared doxycycline/tetracycline to ceftriaxone as substitute options for penicillin and found that ceftriaxone may be a better alternative for syphilis treatment in those with a penicillin allergy (Liu, H., et al., 2017). Treatment for syphilis should occur in all patient populations, including those with congenital syphilis and during pregnancy. Syphilis is associated with increased risk of miscarriage, stillbirth, and congenital abnormalities, hence the need for screening during pregnancy.

Let us not forget the national misfortune that occurred between 1932 and 1972, where treatment for syphilis was intentionally withheld from infected black men, also called the U.S. Public Health Service Syphilis Study. Penicillin was determined to be the drug of choice for syphilis in 1947 yet this study continued until 1972. There is now a nationally mandated program providing lifetime medical and health benefits to the widows and offspring of the black men who were affected by this Tuskegee Study (CDC, 2015).

No matter the setting, we have the opportunity to be mindful of syphilis and remember that it is not a disease of the past. The CDC reported cases of syphilis in every state across our country in 2016. What you can do to be more aware of syphilis in your community?

References


continued on page 11
Legislative Efforts to Curb the Opioid Epidemic

It has been 100 years since the first federal law controlling the sale and distribution of opiates in the United States was passed in 1914 under the Harrison Narcotics Tax Act (Rettig & Yarmolinsky, 1995). Previously, opioid-containing products were sold directly to the public as patent medicines, but growing state and local concern around opioid addiction led the federal government to act. An important legal interpretation of the Harrison Act regarding physician prescription of opiates was made in the Supreme Court decision Webb vs US (1919). It prevented physicians from prescribing opiates for maintenance (i.e., treatment of addiction).

The Vietnam War brought about a resurgence in opiate use and increased the visibility of addiction. One major purpose of the Comprehensive Drug Abuse Prevention and Control Act of 1970, also known as the Controlled Substances Act, was to reverse some of the strictures of the Harrison Act of 1914. The 1970 act sought “to clarify for the medical profession...the extent to which they may safely go in treating narcotic addicts as patients. There are relatively few practicing physicians in the U.S. today who treat narcotic addicts because of the uncertainty as to the extent to which they may prescribe narcotic drugs for addict patients” (Rettig & Yarmolinsky, 1995, ch.5, para. 15). This new act recognized addiction as a medical problem requiring treatment and led to the expansion of methadone clinics in the United States (Rettig & Yarmolinsky, 1995).

Today, buprenorphine (Suboxone) has been prescribed by physicians in primary care clinics for 10 years as an alternative to methadone to treat opioid use disorder. The Substance Abuse and Mental Health Services Association, a branch of the U.S. Department of Health and Human Services, developed an evidence-based treatment of opioid use disorder, medication assisted treatment (MAT). MAT is a combination of buprenorphine prescribing with counseling and behavioral therapy (SAMHSA, 2016a).

Because it is a partial opioid agonist combined with naloxone, buprenorphine is safer than methadone, easier to dispense, and, when used in clinic-based primary care settings, reduces the stigma and increases patient access to basic medical care in addition to behavioral health and addiction or chronic pain treatment. Increasing access to primary care for patients with opioid use disorder is important because of the high rates of comorbidities in that population such as viral hepatitis, human immunodeficiency virus infection, and acquired immunodeficiency disease (SAMHSA, 2016a).

The current opioid crisis in the United States requires improved access to prevention and treatment options. The Comprehensive Addiction and Recovery Act, signed into law July 22, 2016, expanded for 5 years the prescribing privileges for office-based buprenorphine treatment clinics to include nurse practitioners and physician assistants (American Society of Addiction Medicine, n.d.).

AAACN recently participated through the Nursing Community Coalition in sending a letter to Congress in support of H.R. 3692, the Addiction Treatment Access Improvement Act. The letter thanks the bill’s authors, Representative Paul Tonko (D-NY) and Ben Ray Lujan (DNM), for introducing the bill to the House of Representatives. The bill is an amendment to broaden the Controlled Substances Act, eliminating the 5-year time limit and expanding the category of non-physician providers from nurse practitioners (NP) and physician assistants to include all advanced practice registered nurses (APRN) providing care to those suffering from opioid addictions, namely clinical nurse specialists (CNS), certified nurse midwives (CNM), and certified registered nurse anesthetists (CRNA). The ability of these new categories of APRNs to fully register for MAT will still be determined by each state’s specialty scope of practice laws (Nursing Community Coalition, 2017).

Whereas NPs and CNMs have practice and prescriptive authority in 50 states (whether dependent or independent), CRNAs and CNSs face hurdles toward fully practicing within their scope in multiple states (National Council of State Boards of Nursing, 2017). For instance, CNSs have independent and dependent prescription authority in 39 of the 50 states, with no prescriptive authority in New York, Washington, and Florida (National Association of Clinical Nurse Specialists, 2016). These same 3 states have significantly increased opioid death rates according to the Centers for Disease Control and Prevention (CDC) (2017a). This potentially expanded practice is a reminder of last year’s ViewPoint Health Policy Update column urging all nurses to support the full scope of practice for APRNs to meet the Institute of Medicine’s Triple Aim goals (Fuller, 2016). Knowing the scope of practice laws in your state for registered nurses and advanced practice nurses and advocating at the state level for full scope of practice legislation will help bring this expanded practice option to all APRNs.

In addition to enacting treatment expansion approval at the national level, some states are approaching the opioid addiction epidemic by limiting supply of prescription opioids. “We now know that overdoses from prescription opioids are a driving factor in the 15-year increase in opioid overdose deaths. The amount of prescription opioids sold to pharmacies, hospitals, and doctors’ offices nearly quadrupled from 1999 to 2010, yet there had not been an
overall change in the amount of pain that Americans reported. Deaths from prescription opioids — drugs like oxycodone, hydrocodone, and methadone — have more than quadrupled since 1999” (CDC, 2017b, para. 2). The likelihood of developing an opioid use disorder increases with each additional day of a person’s first opioid prescription (Shaw, Hayes & Martin, 2017). Legislation limiting opioid prescriptions started in Massachusetts in 2016, with a 7-day supply limit for first-time opioid prescriptions. According to tracking by the National Coalition of State Legislatures (NCSL), by August 2017, 24 states had enacted some type of legislation limiting opioid prescribing (NCSL, 2017).

One tool that assists providers in safe prescribing is the Prescription Drug Monitoring Program (PDMP), a statewide electronic database to check for a patient’s prescription history to help prevent overlapping prescriptions in the same class. Varying by state, the PDMP is housed by a specified statewide regulatory, administrative or law enforcement agency. The data from the database is available to individuals, like healthcare providers, who are authorized under state law to receive the information for purposes of their profession (U.S. Department of Justice & Drug Enforcement Agency, 2016).

Ninety-one Americans die every day from an opioid overdose (CDC, 2017b). To address this worst-case scenario, all states have expanded public access to the life-saving opioid antidote naloxone. By July 15, 2017, all 50 states and the District of Columbia had passed legislation designed to improve layperson naloxone access and 40 states plus the District of Columbia have passed an overdose Good Samaritan law that provides some protection from arrest or prosecution for individuals who report an overdose in good faith (Davis, Chang, Carr, & Hernandez-Delgado, 2017). An excellent resource for learning and teaching patients about opioid overdoses is the SAMHSA Opioid Overdose Toolkit (2016b).

Considering the number of Americans touched by the opioid epidemic, it is likely that regardless of your practice setting, you work with patients affected by this public health crisis. Educating yourself on the national and state laws and regulation surrounding all aspects of opioids (production, distribution, prescribing, safety, dispensing, prevention, and treatment) will empower you to best serve your patients and their families. Advocating for laws that protect patient health and dignity and implementing new programs under those laws are as much a part of our work as nurses as is our direct care of patients.

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A Voice for Ambulatory Care Nurses: Creation of an Ambulatory Care Professional Practice Council

The Academic Health Center (AHC) at Indiana University Health (IUH) Indianapolis supports multiple ambulatory clinics across several campuses. As the shift of healthcare delivery changes from inpatient to outpatient, and the cost, technology, and patient focus is on wellness versus the disease state, the ambulatory care services are more complex than those offered in a community-based practice. Nationally, patients are discharged from the acute care setting to the community faster, requiring vocal ambulatory care nurses to design the care and services their patients will receive.

This column describes the creation and implementation of a cross-campus Ambulatory Professional Practice Council (APPC) shared governance forum. Focused on the goal to advance the art and science of ambulatory care nursing across the patient care continuum, the council’s purpose is to define and strengthen the role of ambulatory care nurses. The APPC is vested in supporting not only ambulatory care nurses but all of the clinical support roles. The Council’s mission is to provide exceptional patient care and satisfaction, at the lowest cost possible, across all of the outpatient clinics.

The council provides a mechanism to define, implement, and foster the highest standards of nursing practice, as well as providing a forum for shared governance, collaboration, advocacy, accountability, and autonomy for ambulatory care nursing practice. By doing this, the council ensures that all practices are ethical, theoretically sound and based on the most current evidence.

Background

The AHC of IUH consists of 2 adult facilities and 1 children’s hospital. In 2012 ambulatory care leaders of both the adult and pediatric facilities expressed a strong desire to participate in the organization’s Magnet re-designation, which was traditionally an inpatient focused activity. As a direct result, an Ambulatory Care Magnet Committee was established. The director of pediatric ambulatory care services and an ambulatory care clinic manager were invited to join the organization’s Magnet Steering Committee, which ensured that ambulatory care nursing was represented as the organization prepared for the upcoming Magnet survey.

As the ambulatory care committee began to gather exemplars for the Magnet components and sources of evidence, it became excitingly apparent how ambulatory care nursing contributed significantly to improving patient outcomes at every level and would be a great partner in the re-designation process. The Magnet Recognition Program through the American Nurses Credentialing Center (ANCC) recognizes “quality patient care, nursing excellence, and innovations in professional practice” (ANCC, 2014, p.1). A component of Magnet designated organizations is the presence of a shared governance model that begins at the unit level, which includes all staff and is linked to the organization as a whole. As first steps, in June 2012, the Riley Hospital ambulatory care nurses formed a Pediatric Ambulatory Care Professional Practice Council and one of the adult clinics formed their own professional practice council. These councils were the foundation for the academic health center APPC.

Year 1: 2014/2015

The development and growth of shared governance have been described within hospital systems; however there is a significant gap in the literature regarding shared governance within ambulatory care systems (Meyers & Costanzo, 2015). After our organization achieved Magnet re-designation, it became apparent that ambulatory care nurses needed to have a voice in their daily practice and could make significant contributions to positive patient outcomes. The most logical platform to accomplish this step was the development of an Ambulatory Professional Practice Council.

The first step toward achieving our shared governance council model was to develop a charter. The charter for the academic health center APPC included mission and vision statements that were consistent with the American Academy of Ambulatory Care Nursing (AAACN) Nursing Practice standards and its vision. Furthermore, AAACN’s position statement on the role of the registered nurse emphasized the importance of RNs in ambulatory care settings, and that RNs are best prepared to facilitate the functioning of inter-professional teams across the care continuum, coordinate care with patients, and mitigate the complexities in care delivery (AAACN, 2017). The charter also defined the criteria and expectations of all members. The founders of the council sought and received validation from the system chief nursing officer that the council’s direction was aligned with the organization and nursing practice. In so doing, the APPC ensured legitimacy and support for a major paradigm shift that would occur within the medical practices. Endorsement from key stakeholders was received and the first meeting of the APPC was held October 8, 2014.

Ambulatory care is logistically complex and more challenging than acute care due primarily to less support provided in managing care than in hospitals (Haas & Swan,
Four major goals were identified by the APPC in the first year:
1. Standardize job descriptions for all clinical roles in ambulatory care.
2. Establish a standardized orientation plan for all clinical roles.
3. Create a comprehensive plan to measure competencies for all roles.
4. Design and implement an educational offering to engage and educate nurses about AAACN certification.

Council leadership decided early on that establishing a process to meet the first year goals was imperative for its success. Sub-work groups were formed to address each item and reported their progress at the monthly council meetings. In April 2015, the council engaged a Lean Six Sigma transformation officer to help focus and improve the efficiency of the council. This approach was extremely helpful and assisted members to understand the process of the project and aligned all involved toward the common goals (Sprankle, Hamlin, Grayem & Musitano, 2015). The APPC became the link that connected ambulatory care nurses with each another and with the hospital system.

All 4 goals were successfully met in the first year. The goal for standardizing orientation evolved into a more focused approach to develop a robust triage orientation program. The success of the first year of work was disseminated to AAACN colleagues via 3 posters at the 2017 annual education conference.

**Year 2: 2015/2016**

Since the inception of the APPC, a major initiative undertaken had been to identify a nursing-sensitive quality indicator (NSI). The question posed was “How best can ambulatory care nurses develop metrics to demonstrate their positive impact on patient outcomes?”

The traditional NSIs in the inpatient world (central line-associated bloodstream infections, catheter-associated urinary tract infections and pressure ulcers) do not necessarily apply in the outpatient setting. The APPC decided that a NSI focused on educating the patient on the importance of utilizing a primary care physician (PCP) would be meaningful to both adult and pediatric specialty clinics. This patient education idea led to the utilization of the emergency department and/or a specialist for routine medical care. For 2 months in 2015, the project was piloted in 3 specialty clinics collecting data on 934 patients. The data showed that patients did connect with a PCP after receiving the materials and education provided by the staff in the specialty clinic. Out of the 934 patients surveyed, 22 patients established care with a new PCP and 101 patients scheduled an appointment with their PCP after not being seen within a 12-month timeframe.

The second phase of this project incorporated documentation of PCP usage or education about the importance of having a PCP into the electronic medical record (EMR). Standardizing the process within the EMR will allow electronic auditing and consistency in collection of data. This NSI measure continued in 2017.

In 2016, the APPC began the work of standardizing an approach for telephone triage orientation. A research study comparing experienced and novice telehealth nurses on measures of competency and self-confidence was approved by the organization’s Institutional Review Board. The data collected indicated an improvement in scores for new triage nurses who went through the orientation program. The experimental group surpassed the experienced triage nurses in competence as measured at the completion of their orientation. Upon review of the competency scores for both groups it was decided all ambulatory care nurses could benefit from the information presented in the classes; this content is now delivered through self-paced, web-based training. After viewing the 6 modules, each ambulatory care nurse will complete the competency measures and the data will be analyzed to evaluate the effectiveness of the online education. This will conclude part 2 of the study and hopefully results will be presented to ambulatory care nurses in 2018.

**Summary/Next Steps**

As a result of the creation of the APPC, IUH ambulatory care nurses have quantified and shared their impact on patient outcomes through the NSI project and triage orientation study. Three posters were presented at the 2017 AAACN annual conference and the Telephone Triage study data was presented at the Canadian Association of Ambulatory Care Nursing at their 2017 annual meeting. Through recognition by senior leadership, ambulatory care nurses now hold a seat on the system-level Professional Practice Council. Ambulatory care provides a great opportunity for transformational leadership in the era of health care reformation. In our organization, it began with the development of a Professional Practice Council that provided ambulatory care nurses with a voice in their practice. Ambulatory care nursing is constantly changing and evolving. As members of this professional group it is our responsibility to ensure our voice is heard.

**References**


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The Patient’s Story

Have you ever become frustrated when a person you are talking to finished your sentences? Are you ever disappointed when you find yourself conversing with someone who is distracted and not listening? Have you ever been stopped mid-sentence as someone rushed through questions or assumed they knew your responses? You cannot tell your story because you are interrupted or disregarded. These communication glitches are annoying in conversations with friends, family members, and co-workers, but when it occurs between a patient and nurse, there may be deleterious outcomes.

This article is the fourth in a series that focuses on implementing the concept of curiosity in nursing practice. Having a sense of inquiry can lead you to explore, investigate, and assess patients more comprehensively in both in-person and virtual encounters. This mindset is crucial for care delivery, especially when the nurse and patient are not sharing the same space. When physical presence is missing, the nurse and patient both have to rely on a deeper and more connected dialogue. This month, I will focus on how the patient’s story can be captured through a sense of inquiry during telehealth encounters.

The Story Within Telehealth Encounters

In a busy clinic or call center there may be a sense of urgency in managing telehealth encounters to quickly get through volumes of voicemail and electronic messages while juggling other tasks (e.g., refills, prior authorizations, nurse appointments). The demands that nurses face on a daily basis are substantial, but allowing the environmental stressors to compromise telehealth encounters can lead to inefficient and inadequate care. The story needs to be heard for optimal patient-centered outcomes.

Curiosity Enhances Communication

Nurses must possess exemplary communication skills in both in-person and virtual dialogue with patients. By its nature, telephone encounters create a challenge as you do not share the same physical space as the patient. You are not able to use your sense of sight and touch in the assessment process. Derkx et al. (2009) found that telephone triage nurses must focus on patient-centered communication and identified that patients are most satisfied when the nurse is able to acknowledge their physical or emotional needs and provide necessary reassurance. Ernesater, Winblad, Engstrom, and Holstrom (2012) reviewed malpractice claims following telephone calls managed by telenurses and found that communication failure was the most common cause of errors.

It is crucial to ask open-ended questions and listen deeply to understand the patient’s situation. Think about when you have observed an exceptional interview. The interviewer is not distracted, rushed, or presumptuous. Capturing the patient’s story will require effective dialogue; the nurse must use open-ended questions and listen with focus.

Listening is important in communication. It is responsible nursing practice and requires concentration of attention and mobilization of all the senses for the perception of verbal and non-verbal messages emitted by each patient. By listening, nurses assess the situation and the problems of the patient; they enhance his/her self-esteem and integrate both the nursing diagnosis and the process of care at all levels (Kourkouta & Papathanasiou, 2014. p. 66).

As you guide the conversation with your questions, it is important to allow the patient time to describe what they are experiencing. As they speak, engage in active listening by not only hearing the words but also empathizing with situation and reflecting on the information. Saying things such as “I understand,” “go on,” “this must be difficult,” and “what I hear you saying is…” indicates to the caller that you are listening without distraction. You are building rapport and trust as the story is unfolding.

The Patient’s Record Contains Part Of the Story

Reviewing the patient’s record reveals more of the story. This does not mean that you have to do a thorough chart review with every telephone encounter but it is important to consider relevant information such as the patient’s problem list, medication list, and allergies. A patient recently shared a perspective: “It would be nice when a nurse is on the phone with me that she knew a little about me. Many times I want to ask them if they even looked at my record...it’s all there. We could save so much time.” As described, reviewing the patient’s record can lead to a more fluent and effective encounter. Hubers, Keizer, Giesen, Grol, and Wensing (2012) explored the impact of telephone triage nurse consultation and found that not only are quality communication skills necessary but there is value in being aware of the patient’s history and completing adequate documentation in order to make appropriate decisions.
Health Portals Abbreviate the Story

I would be remiss if I did not address health portal communication. Patient portals were introduced and adopted by a few large healthcare organizations in the late 1990s but development was accelerated by meaningful use (MU) criteria of the Centers for Medicare & Medicaid Services Electronic Health Record Incentive Program (Irizarry, DeVito Dabbs, & Curran, 2015). Patient portals are being used with increased frequency to book appointments, record symptoms, and communicate with providers. Rybolt (2017) reports that 45% of patients at small practices and 30% of patients at national and regional health systems use portals, but it is projected the adoption and usage will increase.

Health portals can be effective for some types of communication between patient and team, but there are limitations. When a patient attempts to relay symptoms though a portal, the nurse cannot see, touch, or even hear the patient. The patient’s voice is absent and the ability to obtain a comprehensive assessment is substantially compromised. Not only is accuracy impaired, efficiency is lost as the nurse and patient need multiple exchanges and the patient’s story is nearly impossible to capture.

Although portals are appropriate for accessing visit summaries, completing surveys, or requesting prescription renewals, symptom management should ideally be completed by a voice-to-voice connect with the nurse and patient. When patients submit questions about symptoms, it is appropriate to advise the patient to call the clinic. If the message identifies symptoms that the nurse assesses to be potentially urgent, the nurse should call the patient. It is only through verbal dialogue that the nurse can capture a more complete patient story and provide optimal care.

References

Christine Ruygrok Appointed to AAACN Board of Directors

Christine Ruygrok, MBA RN-BC, has been appointed as a Director on the Board of Directors effective at the close of the AAACN 2018 Annual Conference. Christine will complete the remaining one-year term of Kristene Grayem, MSN, CNS, PPCNP-BC, RN-BC, who will vacate her Director position to serve as President-Elect of AAACN. Christine has been an active member of AAACN since joining in 2012. Congratulations, Christine!

Care Coordination Transition Management Toolkit

The passage of the Affordable Care Act has impacted the delivery of health care in our healthcare organizations. Healthcare systems are accountable for providing better patient care, improving the health of populations, and reducing costs. One way to achieve these aims is through improved care coordination and management of transitions.

The new Care Coordination and Transition Management (CCTM) Toolkit was developed by the CCTM Toolkit Task Force as an interactive online tool that provides evidence-based resources for implementing CCTM structure, process, and outcome tools into practice and supports nurses in their roles of care coordination and transition management.

The CCTM Toolkit offers useful tools that support the 9 core dimensions of CCTM, as well as resources for pediatrics. The toolkit will feature organizational exemplars of CCTM, current CCTM resource information, and a large volume of evidence-based tools that support CCTM in health care. AAACN members will soon be able to access the interactive CCTM Toolkit on the AAACN website, which will allow members to contribute and share current information and resources to support the role of CCTM nurses and core curriculum.

Stay tuned for this exciting new resource to debut in 2018! Members of the CCTM Toolkit Task Force will share more information when they present the session, “Using a Collaborative Approach to Build the Care Coordination and Transition Management (CCTM) Toolkit,” at the AAACN Annual Conference in May.

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Congratulations to New AAACN CEO Linda Alexander

Linda Alexander has been appointed as our new AAACN Chief Executive Officer. Some of you may know Linda from her current role as AAACN Director of Association Services. Linda brings over a decade of association management experience to her new role. She began employment at our management company, Anthony J. Jannetti (AJJ), as the Public Relations and Marketing Manager where she launched her work with AAACN. Linda also served as the Managing Editor for publications and online marketing, and Conference Manager. Prior to her AAACN director role, Linda served as the Business Development Manager for AJJ.

“I am so excited and honored to be named the next AAACN CEO,” said Linda. “I look forward to continuing to work closely with our Board of Directors, volunteer leaders, and staff to advance the mission of this incredible professional nursing association.”

Her official appointment will begin in May at the 2018 AAACN annual conference. You may contact Linda at linda@aaacn.org.

AAACN Conference Connection

We are looking forward to seeing many members at the Annual Conference in May. Check your email for:
- Important conference reminders
- Downloading session handouts
- Accessing the conference app
- Evaluating conference sessions to earn your contact hours

conference.aaacn.org