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Reforming Nursing Reimbursement: A Critical Step Toward a Sustainable Nursing Workforce

Melissa Mills

The Health Resources and Services Administration (HRSA) projects nursing workforce shortages across the United States. through 2036. By this date, there will be a shortage of more than 300,000 registered nurses and nearly 100,000 licensed practical nurses (HRSA, 2022). If these numbers alone are not frightening, consider the implications to patient care and the healthcare delivery system at large. While there is much debate about whether there is an actual shortage or if nurses are leaving the profession due to unfavorable working conditions, one thing is clear – the undervaluation of nurses, both financially and professionally, contributes to this significant workforce crisis.

The current nursing reimbursement model, in place since the 1930s, fails to recognize the actual value of nursing care and is the crux of the current nursing crisis plaguing our country. Two nursing leaders, Rebecca Love and Sharon Pearce, tackled this problem directly in early 2023, launching the Commission for Nurse Reimbursement, a nonprofit organization aiming to modernize the economic model for nursing services. This article illuminates the historical context of nursing reimbursement, its current shortcomings, and potential solutions to ensure a sustainable nursing workforce and improved patient care.

History of Nursing Reimbursement

Before the 1930s, nursing was women's most prominent economic vehicle, creating jobs, independence, and professional opportunities. Nurses were often self-employed and directly compensated for their services, seeing patients in their homes. However, the passage of the Social Security Act in 1935 led to the inclusion of nursing costs within hospital room and board rates.

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Shaping Care Where Life Happens

You Have Something to Offer: Put Yourself Forward!

Chrystal Lewis

The main takeaway from my experience serving as the AAACN Emerging Professional Board Fellow to date is to put yourself forward. We all have something to contribute, even when we are "new" to the group/specialty/organization. Your previous experience is transferrable. I personally have grappled with imposter syndrome my whole career, resulting in me feeling like an "outsider." AAACN is the most welcoming professional organization I have been part of.

I was introduced to AAACN by my colleagues, Charlene Platon and Sierra Kane, a few months after starting my day job as a nurse scientist supporting ambulatory care. I joined AAACN in February 2023 to learn a lot quickly about ambulatory care. I wanted to know the key priorities for ambulatory care nursing and the universal opportunities for improvement. My previous ambulatory care nursing experience was limited to COVID-19 parking lot swab and vaccination nursing. I was amazed at how much I learned from the forums; a community daily digest email was a quick 5-minute educational read for me every morning. The AAACN community freely shared their ideas, policies, and problem solving in ways that I had not previously encountered in a professional organization.

I attended the AAACN Annual Conference in April 2023 where I met the previous three Fellows, several members of the Board of Directors, and Research Committee members. Throughout the conference, I heard over and over: "Join a Special Interest Group! Get involved!" I found myself lurking in the AAACN online communities and forwarding daily digests to folks I knew who were working on a particular topic or could answer a particular question. When I saw the call for Board Fellow applications, I hesitated to the point I almost missed the deadline. My imposter syndrome suggested that I did not have anything to contribute. I grappled with feeling like I was "too new" to ambulatory care and not "enough" of an ambulatory care nurse since I was not a frontline nurse or nurse manager. But I re-read the call for applications and fixated on the statement, "Must have 5 years or less experience in ambulatory nursing at the time of appointment." I was astonished when I was selected for an interview and when my interviewers remembered meeting me at the conference the prior April.

My Board mentor is Rachel Start, AAACN Immediate Past-President and an experienced nurse executive. Our mentorship relationship has a nice give and take. We are both learning from each other. I also regularly talk to the previous AAACN Board Fellow, Na Lim Heo. I did not realize when I started my Board Fellowship journey how much I had to offer to AAACN, the Board of Directors, and my mentor.

My experience over the past 7 months proved to me that we all have something to contribute. There is a lot of exciting work going on in AAACN. I encourage everyone to put yourself forward for what fits for you. There are numerous opportunities: join a Special Interest Group (SIG), join a committee, register as a subject matter expert, write for the Core Curriculum, etc. I also learned most Board members previously received AAACN Above and Beyond awards for work

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they did for SIGs or committees before they were elected to the AAACN Board of Directors. The AAACN Board is aware of and appreciates all the work the SIGs and committees do. Through the fellowship experience, I learned AAACN is receiving increased requests to talk to nurses who work in certain fields. Some of these requests are quite specific, and AAACN looks to the subject matter expert database to identify a member in that field; that could be you! I also encourage you to talk to and network with Board members at the annual conference. These seemingly minor interactions are key interactions for Board members.

When I was appointed to the AAACN Board Fellow position, I thought I would be an observer of the Board process. However, I am routinely *participating* in (not just observing) Board meetings, Research Committee meetings, and membership engagement meetings. The AAACN Board Fellow experience demonstrated to me the amount of commitment it takes to be an elected officer on a board. I already have found ways to continue to be engaged with AAACN when my Board Fellow experience concludes. I encourage everyone to put yourself forward and find the type of engagement in AAACN that works for you. ●

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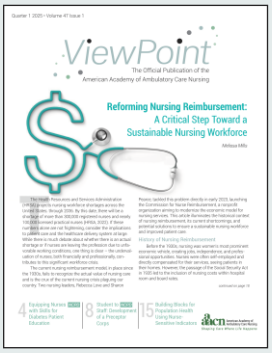

New this year! Go to https://forms.office.com/r/k480gGafsz and answer five questions drawn from articles in this issue of *ViewPoint*. All participants will be entered in a drawing for a free session in the AAACN Online Library. Enter for your chance to win by submitting your answers by March 10.

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1.2 contact hours

Criteria for Awarding NCPD Contact Hours

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Equipping Nurses with Essential Skills for Diabetes Patient Education

Jicel Espinosa-Williams

Keywords: diabetes, nurse, patient, education, training/class

Learning Outcome: After completing this education activity, the learner will be able to discuss the impact and the implementation of a specialized diabetes education class that equips nurses with knowledge to effectively navigate the multifaceted landscape of diabetes management.

Diabetes, a widespread health concern, affects individuals across various ethnic groups. In 2023, the American Diabetes Association (ADA) reported that over 38 million Americans live with diabetes and approximately 98 million adults have prediabetes. It is crucial to educate patients on diabetes management to prevent associated complications. Diabetes is a complicated disease process that causes kidney disease, heart disease, gum disease, and slow healing wounds and amputations, and impacts patients across the lifespan and continuum of care. Depending on the practice setting, nurses may encounter diabetes in different capacities. Inpatient nurses often focus on treatment of acute complications, while ambulatory care nurses often focus on educating patients about self-management and prevention of complications.

Transitioning from the inpatient to the outpatient care setting can be challenging for nurses. Inpatient nurses may find their knowledge of chronic diseases such as diabetes is inadequate for the patient teaching necessary in ambulatory care. It is imperative that nurses seek information to help them provide the care and education patients need in the ambulatory care setting, particularly for complex chronic disease populations.

Nurses who practice in the outpatient setting can impact patients and be advocates for preventive care. As a result of improved patient education, patients can be more involved in their own care, improving their health and preventing complications. Ambulatory care nurses must be equipped with the skills needed to effectively educate and advocate for patients. To advance the skill set and knowledge of the ambulatory care nurse, a clinical nurse educator developed a class to empower nurses with the skills and knowledge necessary to assist patients in managing diabetes.

One in four veterans lives with type 2 diabetes, more than double the rate in the general population, making diabetes care particularly important for ambulatory care nurses working in the Veterans Affairs (VA) system (Wooldridge et al., 2023). The class was implemented at a large southeastern VA facility that serves more than 110,000 veterans yearly. This facility has 134 inpatient beds, a 120-bed community living center, and a 60-bed residential rehabilitation program domiciliary. The facility provides acute care, complex specialty care, advanced diagnostic services, and a large multispecialty outpatient clinic. Specialty health services include mental health, dental services, vision care (ophthalmology and optometry), neurology, nutrition counseling, foot care (podiatry), orthopedics, endocrinology, cardiology and more. Primary care services are offered at eight ambulatory care locations.

Literature Review

Albagawi and colleagues (2023) conducted a cross-sectional study in Saudi Arabia, surveying nurses from four public hospitals. The study assessed nurses' perceived knowledge about diabetes and their actual knowledge using the Diabetes Self-Report Tool (DSRT) and the Diabetes Basic Knowledge Tool (DBKT). Results revealed nurses' perceived knowledge was higher than their actual knowledge, with perceived knowledge averaging 60% and actual knowledge averaging 47.3%. Knowledge deficits were identified in areas such as complications, pathology symptoms and management, diabetes medications, and diet or nutrition related to diabetes.

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One reason for this deficiency was lack of attendance at diabetes education trainings, since nurses perceived themselves as already knowledgeable. Albagawi and co-authors (2023) also highlighted that inadequate diabetes knowledge levels have been observed in other developed countries, such as the United States and the United Kingdom.

Gucciardi and colleagues (2020) conducted a randomized controlled trial in which teams consisting of a nurse and a dietitian provided education to patients with type 2 diabetes at primary care sites in Ontario, Canada. The study included 771 total patients, divided into a control group and an intervention group, with 487 patients receiving the intervention. Study outcomes showed a significant decrease in A1C levels among the intervention group, which helped patients meet their A1C targets.

Sechabe and co-authors (2020) conducted a mixed methods study of nurses' knowledge about diabetes, incorporating both quantitative and qualitative data. This study employed a practice-based, learner-centered approach, focusing on identifying what nurses needed to develop a diabetes education program. The program focused on management of type 2 diabetes in adults within a primary care setting, covering medication management, principles of primary care, and guidelines for managing type 2 diabetes. Challenges included a lack of knowledge regarding initial assessment and treatment management as well as uncertainty about where and why to refer patients. The study revealed nurses had not attended any diabetes training since being hired, highlighting the importance of additional training to improve nurses' ability to provide high-quality diabetes care.

Uguru (2023) conducted a quality improvement project focusing on equitable care for patients with lower social determinants of health, such as having limited education, living below the poverty line, lacking access to healthy foods and effective health care, being uninsured, being unhoused, or having a history of incarceration. Nurses implemented targeted interventions, including patient education on home blood glucose monitoring, development of care plans, monthly outreach through telehealth visits, and referrals. Results indicated 66% of participating patients achieved an A1C reduction below 7% after 6 months. Uguru (2023) highlighted the crucial role of nurses in improving chronic disease management, such as diabetes. The article emphasized how nurses are uniquely positioned to engage patients in managing their chronic diseases, thereby reducing complications.

The literature review identified the value of nurse education on diabetes management and specific elements to include in education.

Methods

A class to provide education for nurses was created in collaboration with certified diabetes educators at the VA to ensure up-to-date information was used and the course was not duplicative with existing training material in use at this VA. The foundation for creating a comprehensive class to equip nurses with critical knowledge involved using the latest guidelines from the ADA, the Department of Defense (DOD), and other evidence-based sources. Recognizing diabetes as a specialized field was essential.

Guidelines

According to ADA guidelines, diabetes can be diagnosed if a patient has an A1C level above 6.5% and fasting blood sugar levels of 126 mg/dL or higher. The DOD guidance (2023) states that diabetes can be diagnosed with two fasting plasma glucose tests showing levels higher than 126 mg/dL on two separate occasions, an A1C level above 6.5%, or a 2-hour plasma glucose level higher than 200 mg/dL on a 75g oral glucose tolerance test (OGTT). However, the OGTT is not commonly used.

The VA nutrition guidelines for diabetes self-management (2023) recommend the "rule of 15" as the standard of care for treating low blood sugar. If a patient's blood sugar is less than 70, the nurse should administer 15 grams of fast-acting sugar, recheck the blood sugar in 15 minutes, and if the glucose level remains below 70 mg/dL, repeat the treatment with another 15 grams of fast-acting sugar. In cases where the blood sugar is less than 55 mg/dL, the nurse should administer 30 grams of fast-acting sugar. The rule of 15 treatment guidelines have been instrumental within the VA to help patients with hypoglycemia recover rapidly.

Class Development

To provide nurses with diabetes management skills, the Sugar and Spice Diabetes Education for Nurses class was developed. Sugar and Spice is a 1.5-hour session centered around two patient scenarios and emphasizing fundamental diabetes knowledge. The topics covered in the class include differentiating between types of diabetes, recognizing signs and symptoms of hypoglycemia and hyperglycemia, providing diabetes education for newly diagnosed individuals, and addressing basic nutrition principles such as using the nutrition plate and reading labels. Furthermore, the class delves into the treatment of hypoglycemic episodes and explores diabetes complications.

Each class began with a pre-survey to evaluate nurses' existing knowledge and comfort levels with various diabetes-related topics. A game-based online learning platform was used as a fun and competitive way to evaluate participants' comprehension at the end of the class, along with a post-survey. The game was displayed on a screen for all participants to view questions and responses, and participants could

respond using their phones to earn points. The post-survey results illustrated participants enjoyed playing this game as it helped them recall all the information learned from the class. To gauge the application of gained knowledge in current practice, a 3-month follow-up survey also was completed. This collaborative approach helped equip nurses with the tools necessary for successful diabetes patient education.

Outcomes

Sugar and Spice was piloted at the author's VA facility in January 2022. Since then, the class has been offered bimonthly to all nurses in the inpatient and outpatient settings. Using Kirkpatrick's training evaluation model, we evaluated participant reaction (level 1), learning (level 2), and behavior (level 3). The Kirkpatrick Model (Kirkpatrick Partners, n.d.) describes *reaction* as participant feedback on the training received. *Learning* refers to acquired confidence and knowledge, while *behavior* refers to participant ability to apply knowledge to practice.

Since the first class in 2022, 509 clinical employees have attended the class. Of these attendees, 266 responded to the survey. Participants were asked to rate the class using a rating scale with five stars. The average rating was 4.92. The survey also asked participants to rate their confidence in providing patient education (see Figure 1). Of the 266 survey respondents, 254 indicated *very confident* or *confident*. The data collected from this question showed an increased confidence in 95% of participants.

On the pre-course survey, 73 of 266 respondents (27%) indicated they were not confident in one or more of the following topics: knowing the differences between type 1 and type 2 diabetes, reading nutritional labels, treating a hypoglyemic episode, and knowing the differences between carbohydrates and proteins. In the post-survey, only 7 of 266 respondents (2.6%) indicated they still had a knowledge deficit. At the end of the class, 97.4% of all respondents indicated they were very confident or confident in educating patients in all the topics covered. Finally, respondents were invited to provide free text responses to questions requesting feedback about the course (see Table 1).

To evaluate whether the course ultimately affected nursing practice, participants also were sent a post-survey 3 months after the class. Of 504 participants, 49 completed the survey. As illustrated in Figure 2, 44 respondents (89%) indicated they had applied the new knowledge to their practice. The survey also invited those who had applied knowledge from the class to their practice to explain how their clinical practice improved as a result of the class. A sample of participant replies are shown in Table 2.

Figure 1.
Course Participants' Confidence in Providing Patient Education

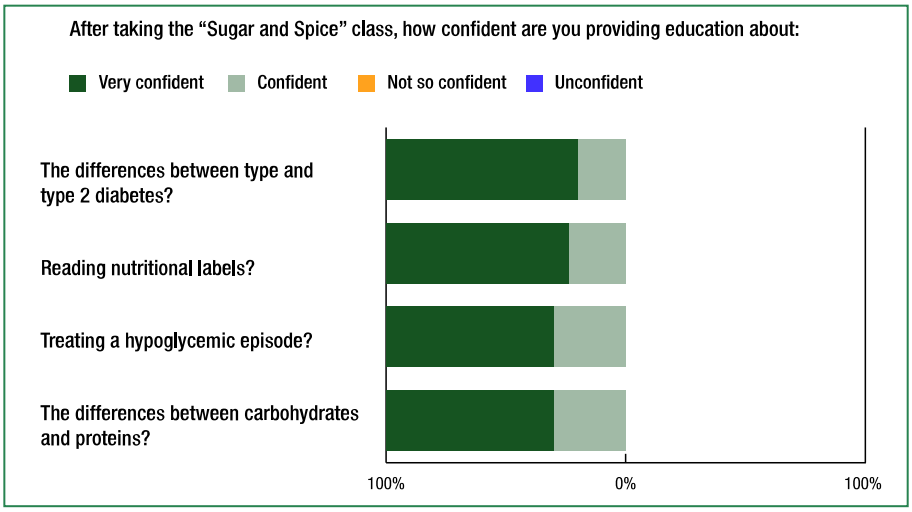

Table 1.
Course Benefits and Feedback

What part of the training was most beneficial to you?
• Discussing hypo- and hyperglycemia
• Explaining how blood sugars and insulin work in your body
• How to treat episodes of hypoglycemia and reading food labels
• I love the game! The entire course was beneficial and a nice refresher.
This course could be improved by:
• Class was excellent.
• Copy of presentation and handouts
• Example of a meal or two we can advise our patients about. I have trouble with that.
• I think it was the best class I've taken in a while. Very interesting.

Figure 2.
Application of Course Education to Practice

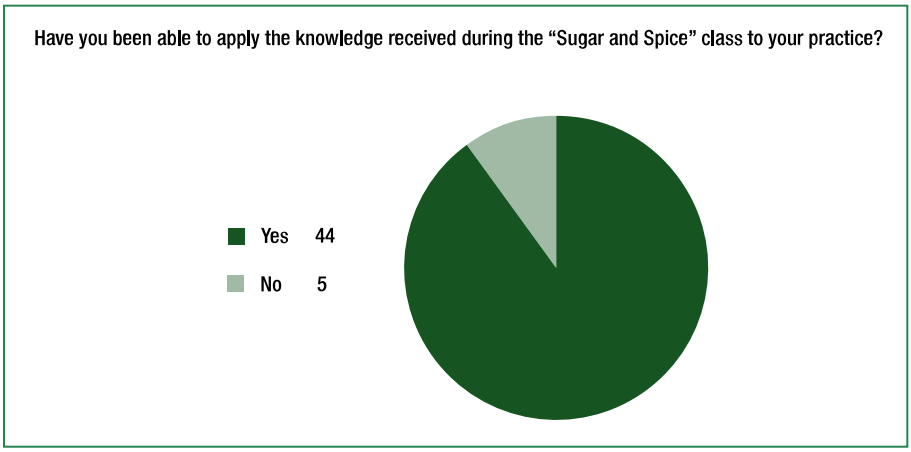

Table 2.
Examples of Applying Course Education to Practice

• The training gave me more knowledge to be able to correctly and effectively educate my patients.
• The ability to thoroughly explain to the veteran what changes need to be made and why.
• I feel more confident educating patients about carbohydrates in their meals, also about hypoglycemia/hyperglycemia and their medications.
• This training impacted me because I learned how to apply benefits and healthy diets for my patients and what I should do in emergency situations.
• Many of the inpatient veterans have diabetes, so it was effective to apply the practice from day to day. Educating patients about their disease process and supplying them with the resources needed to better manage their diabetes is a win-win!

Discussion

The results of this project highlight an opportunity for improvement in the basic skills needed for diabetes education among nurses. Although they play a crucial role in managing and educating patients with diabetes, nurses may have opportunities to enhance their essential knowledge and skills. Knowledge deficits may go unrecognized by the nurses themselves.

The implementation of a specialized diabetes education class has shown promising results, enhancing the care provided by participating nurses. The positive impact of the Sugar and Spice Diabetes Education for Nurses class underscores the need for such educational programs. Nurses who completed the class demonstrated improved confidence in diabetes management.

Providing diabetes education classes for nurses caring for patients with diabetes in the outpatient setting could be a pivotal step toward addressing knowledge gaps. Such programs would ensure nurses are equipped with the necessary knowledge and skills to educate and manage patients with diabetes effectively. Diabetes education for nurses may lead to improved patient outcomes, reduced complications, and overall better management of diabetes in healthcare settings.

It is crucial that nurses ask for additional training when they recognize a need for it. Encouraging a culture where continuous learning is valued and where nurses seek further education is essential. When nurses are confident in their knowledge and skills, they are better positioned to provide comprehensive and effective care. As health care continues to evolve, ensuring nurses are well prepared to handle chronic conditions like diabetes is essential. This article highlights the importance of continued education and the positive impact it can have on both nurses and patients.

Limitations

There are several limitations to the transferability of this initiative to other practice settings. First, not all participants responded to the survey, which means the experiences and perspectives of those who did not respond are unknown. Additionally, the study was conducted in a single VA healthcare system, which may not reflect the experiences and outcomes of nurses in other healthcare settings or regions. Consequently, results may not be applicable to different populations or healthcare environments. Future studies should consider a more diverse and broader sample to enhance the applicability of the findings.

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1.3 contact hours

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Student to Staff: The Development of a Preceptor Corps

Stephanie Stewart

Keywords: preceptor, emotional intelligence, staff training, toolkit

Learning Outcome: After completing this education activity, the learner will be able to discuss the preceptor corps as a workforce development tool that can be used to improve employee performance and ensure consistency in the onboarding process of new employees.

With a strategic goal of workforce development to improve employee performance and ensure consistency, a Federally Qualified Healthcare Center (FQHC) began its journey to develop a preceptor corps to support the nurses and medical assistants at its 30 diverse ambulatory clinics. The goal of the corps was to develop a team of trained preceptors capable of assisting in the onboarding of new nurses and medical assistants, ensuring continuity across all sites.

A preceptorship is a short-term relationship between a student or novice and an experienced clinician. During this relationship, the clinician provides individual attention to the student's/novice's learning needs within a safe learning environment. Preceptors use a different skill set than a clinical nurse to support students and new employees (American Academy of Ambulatory Care Nursing [AAACN], 2017). As there is a unique skill set in use during the preceptorship, the clinician should receive training on a variety of topics (Hugo-Van Dyk & Botma, 2021). This training should support the clinician in a manner that reduces stress and improves their ability to provide coaching and feedback, set goals, and resolve conflict while creating a learning environment tailored to individual learning needs. A novice who is paired with a trained preceptor develops self-confidence in their skill set to provide the best care for patients (Hugo-Van Dyk & Botma, 2021).

Program Development

The program was developed with a quality improvement (QI) method focused on reducing variation and improving workflow processes and using the *Preceptor Guide for Ambulatory Care Nursing* (AAACN, 2017) as a foundation. Literature was searched to identify the application of precepting programs in the ambulatory care setting. Nursing administration identified stakeholders, including the organization president, chief financial officer, nursing director, charge nurses, and nursing educators. Stakeholders were interviewed to inform the program creation and identify potential barriers to implementation. Interviews also identified the structure of the QI process by identifying the organizational infrastructure: the human, facility, and financial resources to be allocated to program development and sustainment. The Nursing Education and Workforce Coordinator completed the program development with the assistance of the nursing administration team for program content review. The Nursing Education and Workforce Coordinator was responsible for creating the preceptor program, developing training materials, and managing the program.

The preceptor program included medical assistants and nurses. An email was sent to the site leadership to nominate one medical assistant and one nurse from each office site. The charge nurse completed an evaluation of employees nominated using a 5-point Likert scale. Evaluation sections included: leadership, enthusiasm, teaching ability, work ethic, clinical experience, role-specific evaluation, and familiarity with corporate policies. Evaluation criteria were influenced by the seven competencies/roles of the preceptor: teacher/coach, role model, leader/influencer, facilitator, socialization agent, evaluator, and protector (Harper et al., 2021; Ryan et al., 2024). To be eligible, an employee had to have 1 year of experience with the corporation. Medical assistants had to have current certification or registration, and nurses had to have unencumbered nursing licenses. The

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employee had to be in good standing with no write-ups or counseling issues within the previous 6 months.

The final step in the selection process was review and approval by the Director of Nursing and Assistant Director of Nursing. Employees who had received excellent reviews and held the required licensing were reviewed by the Nursing Director, Assistant Director, and Workforce Coordinator. During the final review, the candidate's attendance record and employee file were reviewed to ensure that all qualification criteria were met.

Participants were notified of selection and scheduled for a 5-hour training class. The course agenda was developed using the guidelines identified in the Nurse Preceptor Toolkit (Advisory Board, 2023) and vetted with key stakeholders. The course included didactic education with interactive exercises, such as role-playing and feedback, which have been demonstrated to promote positive outcomes (Advisory Board, 2023; Peters et al., 2023). The class was divided into three focus areas. The first portion of the class focused on self-reflection and the introduction and development of emotional intelligence. The second portion addressed the primary roles of the preceptor. The third focused on building a toolkit for precepting.

Focus One: Self-Reflection

Emotional intelligence is the ability to manage your emotions and empathize with the emotions of those around you (Turjuman & Alilyyani, 2023). The seven signs of emotional intelligence are emotional resilience, emotional regulation, self-awareness, social awareness, communication, interpersonal skills, and conflict management. Emotional intelligence development is a continual process that advances with ongoing practice and cannot be attained in one class. However, the goal of the class was to create awareness of the concept, as there is a positive relationship between emotional intelligence and working quality (Turjuman & Alilyyani, 2023).

Class activities focused on concepts of self-awareness, communication, interpersonal skills, and conflict management. Participants completed a visual, auditory, reading, and kinesthetic (VARK) questionnaire to identify learning preference and discussed methods to teach skills using multiple modalities (VARK, n.d.). Class participants also engaged in discussions about generational differences and the increase of digital natives in the workforce. Role-playing was used to practice conversations related to conflict with technology, such as the use of cell phones and other smart technologies in the work area. Finally, all class participants completed Myers-Briggs assessment (Myers, 1962). This assessment, which was selected because of budget limitations and ease of use, is a simple tool to encourage self-reflection and recognition of interpersonal differences.

Focus Two: Roles of the Preceptor

The AAACN *Preceptor Guide for Ambulatory Care Nursing* (2017) describes three roles of the preceptor, including role model, socializer and educator. The role of the evaluator also was included in the program, as it is important to have a method to gauge students' performance. Roles were clearly defined to avoid role confusion and ambiguity.

The preceptor is a role model. As such, a preceptor exemplifies the skills and behaviors that should be emulated by the person being precepted. The Workforce Coordinator facilitated a group discussion to provide participants with an opportunity to collaborate on skills and behaviors they should be displaying. Through this discussion, preceptors identified the top behaviors they felt were important for them all to model. Top behaviors were identified as being on time, dressing appropriately, not using cellphones outside of the breakroom, using professional language during communication with providers and patients, and displaying a positive attitude.

Socialization is not limited to interactions among people, but also includes the organization's culture. New team members and students should be introduced to their peers and their new role. Socialization plays an important part in the dynamic of the preceptor-student relationship, as the preceptor shares some of the values and beliefs of the profession and organizational culture (McCloughen et al., 2020).

The third role of the preceptor is an educator. Preceptors may be identified first by their ability to meet and exceed role expectations. Preceptors cannot just be competent at their job; they also must be able to teach the required skills. These may be soft skills such as communication, or hard skills such as sterile technique. Preceptors are responsible for guiding team members through their skills competency sheets and must be capable of assessing learning needs and setting goals to attain them.

Finally, preceptors must be evaluators. Without evaluation, there is no guidance for improvement. Preceptors must have the skills to provide feedback and coaching. This is especially important for novice team members who are learning a role with the goal of performing the role independently. Preceptors should complete ongoing evaluations as well as skills validation during the preceptorship period, with a final summative evaluation to verify overall performance (Failla & Stichler, 2023).

Five evaluation tools were reviewed with preceptors. The first was a general preceptor form to be used for all newly hired team members. The second was for medical assistant extern students. The third was for nursing student clinical rotations. The fourth was an evaluation for the novice to complete about their preceptor. The final form was a chart audit to be completed on everyone except nursing students since they do not document in

the electronic medical record. The chart audit was included as an objective measure of work completed.

Focus Three: Building a Toolkit

The last portion of the training focused on preceptors building a department-specific toolkit to be referenced during the precepting process. Preceptors play a key role in the new employee's transition into the practice setting. It is important they provide structure with a standardized process to support this transition (Failla & Stichler, 2023). The creation of a toolkit was a proactive approach to meeting learners' needs with the purpose of promoting training structure and standardization. As specialty departments within the organization varied, including pediatrics to obstetrics, behavioral health, and family practice, there was too much variety to create a standard product. Instead, participants were separated into similar practice sites to work on this group activity.

The first form the groups were challenged to complete was a list of common diagnoses specific to their patients. Each diagnosis had standing orders associated with it and any resources (internal or external) the patient may need. For example, a common diagnosis for Family Practice may be diabetes. The associated standing order would be the frequency of hemoglobin A1C checks, point-of-care finger sticks, etc. The resources include the diabetic educators if the hemoglobin A1C is above a specific level.

Other forms included Commonly Used Medications (specific to department), Treatments and Procedures, Lab Tests and Diagnostics, and Daily Procedures. The form for commonly ordered medications encouraged the preceptor to focus on special insurance considerations (Vaccines for Children Program) and required documentation related to the medication. Other forms encouraged preceptors to review standing orders and provider-specific expectations, such as supplies for a specific procedure. The daily procedures form focused on environmental and workflow items that need to be completed with daily, weekly, or monthly frequency. An example of information on this form is monitoring refrigerator temperatures or cleaning schedules for exam rooms. The development of this site-specific toolkit empowered preceptors to provide long-term dissemination of best practices and standing orders. The toolkit acts as a living document for preceptors that can be modified to meet the evolving needs of the clinical site. Treating the toolkit forms as living documents that can evolve to meet the changing needs of the site allows this resource to grow and remain relevant within the organization.

Program Maintenance

The maintenance plan for the preceptor program included scheduled follow-up meetings with the Workforce Coordinator to review evaluations and discuss feedback and any needs. Emails were to be sent quarterly to remind everyone of the evaluations form purpose and to submit the evaluations. Charge nurses were to be engaged early for onsite leadership support.

A stipend plan was developed in conjunction with the preceptor project to compensate participants for the time involved in precepting. Participants also were required to complete a designated number of hours based on role to qualify for payment: 120 hours for nurses and 320 hours for medical assistants. The time requirement for medical assistants was higher because they are responsible for precepting all new nursing and medical assistant staff. Additionally, the organization regularly hosts medical assistant externs who need to complete around 120 hours of practical experience during their externship. In contrast, nurses spend 40-80 hours precepting new nursing staff and precept nursing students approximately 20 hours per semester.

The Workforce Coordinator sent monthly emails for the first 4 months to engage preceptors and get a status check from participants. The first follow-up meeting was scheduled at the 4-month mark, and a second meeting was scheduled at 8 months. Meetings were scheduled before office hours to avoid interruption in patient care activities. The response rate to emails and the engagement in meetings was low, with less than half of participants attending and even fewer actively participating. Due to low participation, additional virtual meetings were not scheduled.

Further follow-up to identify barriers or questions for the preceptors was completed via email. Emails included copies of all evaluation forms and a reminder of each form's purpose. Submitted evaluations were reviewed and follow-up information was requested from the preceptor for any rating below a 3. Emails also notified preceptors if they had met the required number of hours for the preceptor stipend. The response rate for emails was better than virtual meetings but was still lower than desired.

In the first month of the program, the charge nurses received a briefing on program objectives and the importance of their support in the program's success. Acknowledging charge nurses as the nursing leaders on site, they received education on the various forms and were encouraged to actively follow up with new team members to complete preceptor evaluations. Charge nurses were engaged regularly for support and assistance in identifying potential issues.

Findings

The preceptor corps has been functioning for over 18 months. The original training included 10 nurses and 19 medical assistants representing 15 sites. Two additional training courses were held to account for attrition. The additional training included three nurses and eight medical assistants. Currently, there are seven nurses

and 17 medical assistants trained as preceptors representing 17 sites, including the float pool. During the 18-month timeframe, more than 9,000 hours of precepting were reported. This includes 67 new employees and more than 100 nursing students and medical assistant student externs.

Throughout the 18-month program, three nurses and five medical assistants did not take on precepting responsibilities. Three sites are located in rural areas and experienced no turnover. Two sites experienced leadership turnover and lacked a charge nurse to assign the precepting responsibility to the appropriate staff. In both instances, an office manager who was unaware of the preceptor program assigned the new personnel to be precepted by other staff members. The onsite preceptors did not escalate the issue until much later. The other three preceptors did not participate in the program because their site leadership declined to host nursing students or medical assistant externs.

Retrospectively, the data for a 6-month period was reviewed to evaluate if the number of team members who had completed new hire orientation corresponded to the number of preceptor evaluations submitted. It was discovered that there were many new personnel who had not completed a preceptor evaluation. When a review of missing evaluations was completed, it was found that some team members had never been paired with a preceptor. In some cases, this was the result of there being no preceptor assigned to that office site, while in other cases, the new hire was paired with someone other than the preceptor. Some preceptors also forgot to complete the evaluation.

A review of the evaluations that were submitted suggested there may have been a bias toward subjective positivity rather than objective accuracy. This was found in comparisons among reported performance of medical assistants during their externship period, new hire orientation evaluations, and job performance. In some cases, evaluations were requested from the Nursing Director related to concerns that were elevated by the site leadership. The submissions were largely missing the chart audit documentation form, with notes on the evaluation that stated there were no issues when charts were reviewed. For example, during the time of medical assistant X's externship, she was rated as competent and exceeding expectations in all areas. Meetings with the school program director at the site indicated no performance issues. However, after medical assistant X was hired as a full-time employee, she was consistently unable to perform basic tasks independently that she was rated as having completed competently during the externship. These findings indicated preceptors required additional training in how to complete formative and summative evaluations.

Next Steps

These findings caused a shift in management of the preceptor corps. The original plan was that all sites would have a nurse and medical assistant preceptor. However, not all sites had staff qualified or desiring to precept. The first change initiated was to require preceptors to travel to other sites as needed to complete the onboarding of new staff. This step was initiated in the program's first year because of turnover and site needs. Stakeholders did not request a change in the number of preceptors at this point. The nursing administration and workforce coordinator decided to focus on retaining the currently trained preceptors, focusing on having at least one preceptor in the larger sites and having a medical assistant in the float pool that could be assigned to a site based on staffing needs.

A significant change, emphasizing early communication on a routine schedule, was initiated following the audit. In conjunction with nurse educators, a strategy to identify struggling employees early in the onboarding process was devised. This strategy was an adaptation of the 30-60-90-day plan of follow-up typically used by human resources (Leonard, 2023). The 30-60-90-day plan serves as a structured timeline with specific goals and objectives. This structure was used to provide a clear set of expectations for the purpose of the follow-up meeting and the goal of each interaction.

A tracking system was developed so all nurse educators and the preceptor corps manager could see the status of newly hired team members. During new hire orientation, nurse educators scheduled a 30-day follow-up meeting with new medical assistants and nurses. The purpose of the 30-day meeting was to verify the completion status of the skills competency checklist, identify any practice issues, and collect completed evaluations if the new hire had been deemed competent. If the employee was not deemed competent at the 30-day meeting, they were placed on a performance improvement plan with additional training directed by the nurse educators. At the time of this meeting, the preceptor should have completed 10 chart audits on the new hire. The chart audit is an objective measure of job performance. Preceptors were instructed not to complete the audits in 1 day. Instead, audits should be completed over the course of 30 days to allow for coaching opportunities and demonstration of documentation proficiency. The goal of the meeting was to identify at-risk team members and provide support.

The 60-day follow-up was completed by the preceptor corps manager. The purpose of this meeting was to allow employees to express their feelings about their relationship with their peers and integration into the work culture. The meeting goal was to gauge the employee's socialization within the site and the organization.

The 90-day meeting was completed virtually by nurse educators. The purpose was the resolution of all previously identified gaps in practice. Additionally, the meeting provided a safe platform for the employee to voice any new concerns or questions related to practice. The goal of this meeting was to verify the team member had successfully integrated into the work environment. The 30-60-90-day plan has met with early success and improved reporting of challenges of the newly hired staff and preceptors. Additional follow-up will be needed to determine if this process can be maintained over time in an ever-changing healthcare system.

Conclusion

The preceptor corps was created with a strategic goal of workforce development to improve employee performance and ensure consistency. The QI process framework was employed to address the organization's structure, process, and outcomes. The primary goal of the preceptor corps was to cultivate a team of trained preceptors capable of assisting in onboarding new nurses and medical assistants, ensuring continuity across all sites. Outcomes indicated a need for a more structured formative and summative evaluation, resulting in the creation of the 30-60-90-day plan. This plan is undergoing rapid cycle improvement to further improve outcomes for the organization. Continuous evaluation and adaptation will be key to ensuring the preceptor corps effectively supports the onboarding process and contributes to overall organizational success.

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Diabetes Patient Education

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Conclusion

The provision of basic diabetes education to nurses is an investment in quality patient care and outcomes. A well-informed nursing workforce is essential for delivering patient-centered education, support, and guidance to individuals with diabetes. As we strive for excellence in healthcare, prioritizing basic diabetes education for ambulatory care nurses is imperative. Nurses must be equipped with the knowledge to navigate the multifaceted landscape of diabetes management.

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The Role of the Certified Diabetes Care and Education Specialist

Leila Salic-Davidson
Ellen Rippl

A diabetes educator, also known as a Certified Diabetes Care & Education Specialist (CDCES), is a healthcare professional who teaches people with diabetes how to independently care for and manage this chronic condition. Many licensed and certified professionals are eligible to become a CDCES, including nurses, dietitians, pharmacists, physicians, and occupational and physical therapists. To become a CDCES, professionals must have a minimum of 2 years professional experience in their primary discipline. Additionally, applicants must have at least 1,000 hours of experience providing diabetes care and education. Finally, individuals pursuing a CDCES certification must obtain a minimum of 15 hours of continuing education specific to diabetes. Once these requirements are met, applicants are eligible to sit for an extensive exam to earn the CDCES credential (Certification Board for Diabetes Care and Education, n.d.). The credential must be renewed every 5 years, through continuing education or exam recertification, to ensure diabetes educators are staying informed regarding the latest updates and breakthroughs in diabetes medications, supplies, and technologies.

Patient Education

Diabetes educators play a crucial role in diabetes education by providing relevant and evidence-based education that fosters self-management strategies and promotes lifestyle changes for people living with diabetes. They facilitate education and support people with prediabetes or diabetes to manage the condition through a patient-centered approach, while offering individualized support. Diabetes is a complex condition requiring ongoing learning and understanding. A CDCES can help a person and their family learn the ins and outs of diabetes to help encourage self-management through behavior and lifestyle changes.

Diabetes educators support people with diabetes in setting individualized goals to improve diabetes management as well as overall health outcomes. These goals might include behavior modifications such as medication adherence, regular glucose monitoring, and following a carbohydrate consistent diet. Ideally, these behaviors will lead to a reduction in hemoglobin A1C as well as fewer complications related to diabetes. Complications from diabetes can affect a person's heart, kidneys, eyes, nerves, and more.

When seeing a CDCES, individuals will learn about diabetes, how to administer medications, and how to use diabetes supplies like blood glucose meters and continuous glucose monitoring systems. There are seven key self-care behavior areas of diabetes self-management education and support (DSMES): healthy coping, healthy eating, being active, taking medication, monitoring, reducing risks, and problem solving (Powers et al., 2020). As a person's life changes, so does their care management plan, which is why it is crucial for a person with diabetes to receive ongoing education and support from a CDCES. Additionally, diabetes educators can address lifestyle questions regarding the day-to-day challenges a person living with diabetes may experience.

Along with key self-care behavior areas, there are also four key times when a person with diabetes should be referred to an educator for DSMES: at diagnosis, annually and/or when treatment targets are not being met, when complicating factors develop, and finally, when transitions in life and care occur (Powers et al., 2020). Consultation with a CDCES, education, resources, and ongoing support are key tools for a person living with diabetes to have in their diabetes toolbox.

Interprofessional Collaboration

Diabetes educators are an integral part of the collaborative care team for a person with diabetes. They work in partnership with the person with diabetes, their family, and a myriad of healthcare professionals, including primary care providers, dietitians, care managers, social workers, behavioral health professionals, clinical pharmacists, as well as specialty care providers, to provide optimal patient-centered care. A CDCES assesses, educates, advocates for, and collab-

orates with the person with diabetes and their healthcare providers to ensure individualized care and education is provided.

Diabetes educators collaborate with other members of the healthcare team in several ways. They help educate or train staff or other healthcare professionals. They communicate with referring providers about the patient's care plan, progress, and needs. They also work with other team members to ensure recommendations and medical orders are followed up in a timely manner as well as address any barriers, such as physical, emotional, environmental, psychological, or social barriers. Finally, CDCESs help coordinate care by entering referrals to other specialties and assisting with scheduling appointments as needed.

Role Opportunities

As with many industries, there has been a shift toward virtual care in the post-COVID era. This has allowed greater flexibility for diabetes educators as well as their patients and clients. With advancements in telehealth, diabetes educators are no longer confined to working in clinic settings. While some positions do require educators to be completely on-site, other positions offer hybrid schedules (partially on-site, partially remote) or fully remote work. The ability to provide virtual visits through telehealth is also beneficial for patients in helping them maintain consistent appointments with a diabetes educator. This is essential, especially when busy schedules are commonly perceived as a barrier for proper diabetes management.

Advancements in technology over the years also has allowed for greater opportunities for diabetes educators. While CDCESs largely are employed within healthcare systems, educators are starting to find opportunities outside traditional roles in places such as private practice or diabetes technology companies, which manufacture diabetes supplies such as insulin pumps and continuous glucose monitors. For example, insulin pumps became more widely available in the 1980s, approximately 20 years after the first one was initially developed in the 1960s (Kesavadev et al., 2020). However, they largely have increased in popularity since the late 1990s to early 2000s; the first continuous glucose monitor was approved for professional use in 1999 (Hirsch, 2018). Collectively, these advancements helped propel the CDCES profession to its current state.

Diabetes educators aim to have a positive impact for the person living with diabetes, their families, and the healthcare system overall. Some of the benefits of diabetes self-management education and support include improved quality of life, promotion of healthy behavior changes, reduction of diabetes-related complications, and greater cost-effectiveness. Research has shown the benefits of DSMES and medical nutrition therapy are as effective as the oral diabetes medication metformin, but without the potential for side effects. People who utilize these services also are more likely to have lower healthcare costs (Powers et al., 2020).

Ongoing diabetes care and education from a CDCES can help support people with diabetes through their journey from initial diagnosis to ongoing maintenance. By working together, diabetes educators can help make day-to-day life with diabetes more manageable for those living with it as well as foster the skills needed to support self-management and goal setting. Due to the progressive nature of diabetes, it is imperative that people with diabetes seek out support and education from a CDCES in an effort to successfully manage their diabetes.

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Building Blocks for Population Health Using Nurse-Sensitive Indicators: An Exemplar

Amy Fulwood
Marcia Potter
Elizabeth Anderson

This article describes how ambulatory care nurses at a large Veterans Health Administration (VHA) outpatient clinic located in Florida identified nurse-sensitive indicators (NSIs) to help overcome challenges and create success. This Florida clinic serves approximately 16,000 patients, of which 78% are 65 years or older. Primary care nurses (PCNs) work in teams with each assigned as many as 1,200 patients. PCNs using care coordination methods and tools play a key role in reducing costs, improving care and quality of life, and strengthening collaboration across disciplines.

The Challenge

Prior to this initiative, the role of the registered nurse (RN) in VHA clinics had not been standardized, which contributed to barriers such as lack of time and resources. For patients, barriers include limited access to care. Additionally, RNs had difficulty quantifying roles in care coordination transition management (CCTM) in terms of patient outcomes. No specific measure for patient engagement existed.

The Improvement Journey

Utilizing Six Sigma quality improvement methods and the plan-do-check-act cycle, multiple small iterative projects allowed PCNs to make changes on their road to sustained success. Starting with standardization of a PCN appointment grid, they were able to shift from a reactive model to a proactive care model focused on chronic disease management, post-discharge contact, wellness, and prevention. Next, over a 90-day period, PCNs identified and reviewed the top 5% of high-risk panel patients. This step tested a defined electronic medical record (EMR) template to increase patient engagement and add several NSIs, including nursing care interventions for diabetes mellitus (DM), hypertension (HTN), cardiovascular risk, tobacco usage, and women's health. PCNs assessed how and when to apply preventive measures such as mammograms, colonoscopies, vaccination types, teaching opportunities for chronic obstructive pulmonary disease (COPD), and screening for behavioral health needs. Results from this pilot showed an increase of 97% in care coordination documentation within the first 45 days and an increase of 215% over the next 30 days.

Following the pilot, leaders created two separate training academies, one for RNs and one for licensed practical nurses (LPNs), to integrate new practices and allow each role to function at the top of their license and competencies. Expanded improvement goals included standardizing the role of PCNs, pursuing a rate of 25% RN bookable hours weekly to increase patient contact and access, increasing patient awareness and engagement in chronic disease management, using motivational interviewing techniques, spreading the use of the EMR template, increasing RNs' ability to manage complex chronic conditions, and standardizing CCTM documentation and population health processes.

As staffing levels stabilized, and with the intensified training academy, leaders reviewed each team's baseline metrics. Telework was established and implemented for those completing the program. Training consisted of three segments and used case studies to build discussion skills:

1) CCTM basics, eliminating silos, targeting high utilizers, integrating population health into daily practice, adjusting daily schedules to manage competing priorities while achieving 25% RN bookability and patient education.
2) Understanding how to use patient data to evaluate the progress of individuals with DM, COPD, HTN, and congestive heart failure (CHF).
3) Case study practice sessions and review and implementation of new telework practices.

Table 1.
Congestive Heart Failure Outcomes

Villages DX COPD-CHF	FY22	FY24	Difference	% Difference
Uniques with DX	518	680	162	31%
Uniques with inpatient admit for DX	43	31	-12	-28%
Admissions for DX	91	41	-50	-55%
Readmissions	48	10	-38	-79%
Readmit Rate	53%	24%	-28%	-54%

CHF=congestive heart failure, COPD=chronic obstructive pulmonary disease, DX=diagnosis, FY=fiscal year

Table 2.
Cost Avoidance for Congestive Heart Failure

Total Admissions FY24	Total LOS	Total Cost	Average Cost per Admit	Average LOS per Admit	Cost Avoidance	BDOC Avoidance
41	194	$913,165	$22,272.32	4.7	$846,348.05	179.8

BDOC=bed day of care, FY=fiscal year, LOS=length of stay

high-risk population changed. Outcomes from HTN RN visits stabilized blood pressure readings, reducing office visits and hospitalizations, and resulting in 4% improvement in HTN sustained for more than 17 months. These results are above the VHA regional and national benchmarks.

PCNs also focus on reducing readmissions for patients with CHF, the group with the highest readmission rates. Stoplight education is used for CHF patients to guide symptomology and advise patients when to contact primary care or seek urgent care. PCNs now collaborate with primary care pharmacists during nursing visits for medication adjustments and education, and with the social worker and nutritionist to assist with education or support for social needs like food insecurity. Tables 1 and 2 show CHF outcomes and cost avoidance, respectively. Outcomes included a reduction in readmissions by 29%, with a cost avoidance of $846,348 and bed days of care avoidance of 179.8. The 2-day discharge phone call metric improved by 18%.

Sustaining and Measuring Change

The RN Academy is offered for new PCNs, followed by orientation support in their new roles. A population health audit tool measures outcomes from the CCTM EMR note, verifying how the RN encompassed whole patient care. Additional work aids include a visual aid template for whole person systems review during the nursing visit to aid nursing documentation, and a Microsoft Teams tool for communication and resource sharing.

Prior to the pilot and new academy, a baseline measure of nursing turnover was 28%. Over the first year after training, the turnover rate declined to 4%. RN feedback during this period indicated the change in structure and process improved nurse satisfaction. RNs indicated they learn from each other and now use new sources of data, schedule nurse follow-up visits and patient teaching, and are better prepared to navigate population health management.

> Nurse-sensitive indicators measure tasks and interventions that only RNs can perform within their scope of practice.

Post-pilot patient data also revealed success. Metrics are monitored every 30 days, allowing leaders and teams to adjust the new interprofessional practices. High-risk veterans are provided education, instructions, and support from an RN by face-to-face appointment, phone, or video contact through the Virtual Visit platform (VVC). As PCNs have used new tools and provided disease-specific education, such as proper techniques for taking blood pressure, which medications and how and when to take them, use of breathing and mindfulness techniques, use of HTN, COPD, DM, or CHF stoplight calendars (red-yellow-green), and prompting patients to keep daily documentation, the data for this

The Value of NSIs

NSIs measure tasks and interventions that only RNs can perform within their scope of practice. NSIs are measurable signs demonstrating the outcomes of nursing care. This evidence shows the quantifiable value of a nurse and, in the ambulatory care setting, helps drive change, measure quality of nursing care, and generate reimbursement. The NSIs used in this initiative are nurse turnover rate, CCTM nursing notes entry, HTN, CHF, 2-day dis-

charges, pharmacy algorithm RN decision tree for identifiable issues, patient engagement with the EMR template, RN and LPN Training Academy, redesigned workflow, and telework policy and procedure.

Summary

The redesign of nursing standard work requires improved processes, resources, and tools that impact qualitative and quantitative results. Leadership buy-in is critical, as is the support of all stakeholders. Enlisting the interprofessional team and service line supervisors helps to shift the roles of the PCN and the nursing care team. The goals of the pilot initiative were demonstrated, and the new nursing practices have become standard nursing work. Leaders and teams are spreading this practice across North Florida/South Georgia VA primary care clinics, a system covering 40,000 square miles across 50 counties with 136,000 patients enrolled in primary care. Standardized nursing visit grids and the new CCTM practices pave the way to more access and better care.

We recommend the following actions for other ambulatory care nurses who wish to use this exemplar as a model. Review the clinic setting to determine which factors from this exemplar are similar. Start small and continue to iterate process improvements over time. Identify ways nursing practice and patient care are impacted at each location and define a measure for each practice. Finally, organize how information will be structured and entered and how reports will be analyzed and communicated. ●

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Reforming Nursing Reimbursement

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While needing nurses to improve the deplorable conditions that plagued the system at this time, hospital leaders strived to remove the economic power from nurses, who were predominantly women. Leaders looked to the hotel industry and adopted a model similar to housekeeping services in hotels. The cost of these services was rolled into the rate the customer paid for the room. This new reimbursement model marked the beginning of the inclusion of nursing services in the room rate, removing nurses' economic power and making them an invisible part of the healthcare delivery system (Welch, 1975).

In 1983, another change in health care further exacerbated reimbursement issues for nurses. The passage of the Medicare Prospective Payment Systems incentivized shorter hospital stays and moved much of the care healthcare professionals delivered in hospitals into the community. This reimbursement method worsened hospital patient acuity, increased workloads for hospital nurses, and created a system that further decimated nurses' perceived value as highly skilled and educated healthcare professionals (Guterman & Dobson, 1986).

Despite the efforts and early research of influential nursing leaders like Cathryne Welch, Carole Jennings, and Claire Fagin, who advocated for reimbursement reform as early as the 1970s, the current system has remained essentially unchanged for nearly 100 years (Fagin, 1982; Jennings & Jennings, 1977; Welch, 1975). Nursing care continues to be treated as a fixed cost, bundled into room rates, and charged the same for similar nursing units regardless of the actual nursing care required. This outdated model fails to recognize the complexities and value of nursing care, contributing to the undervaluation of nurses and the ongoing workforce sustainability crisis.

Current State of Nursing Reimbursement

Regardless of the industry, businesses cut costs to increase revenue. Like any other company, hospitals must evaluate their bottom line or profitability after all expenses are deducted from revenues. The current reimbursement system views nurses as an expense. So, when the hospital's net profits fall below targets, the administration looks to cut costs. In nursing care, this means fewer nurses, higher nurse-to-patient ratios, poorer patient outcomes, and increased nurse stress and burnout (Gutsan et al., 2018). These symptoms of an inadequate nursing economic model led nurses to leave the bedside. While some might think this is related to executives wanting to line their pockets and increase revenue, it is more a product of the healthcare reimbursement system itself.

This perverse nursing reimbursement model incentivizes hospitals to cut their nursing workforce and increase workloads. It creates a "do more with less" system without reducing administrations' expectations of nursing services or the level of their skilled and life-saving care. This misalignment of incentives has dire consequences for nurses' job satisfaction and patient outcomes. Due to excessive workloads, nurses experience burnout, job dissatisfaction, and an increased risk of nursing care errors, such as incorrect medication administration. Patients suffer from reduced quality of care, higher morbidity, and increased mortality rates.

The current system's lack of transparency also hinders hospitals' ability to accurately assess nurses' economic value. By bundling nursing costs into room rates, the system fails to recognize the direct impact of nursing care on patient outcomes and overall healthcare costs. This lack of awareness perpetuates the undervaluation of nurses and undermines efforts to improve nurse staffing and working conditions.

Reforming Nursing Reimbursement

This 100-year-old problem requires a fundamental shift in the nursing reimbursement model to address the nursing shortage and ensure the sustainability of the nursing workforce (Welton, 2024). This shift involves recognizing nursing care as a billable service, separate from room and board costs. By billing based on the actual nursing care provided, hospitals can better understand the cost and benefits of nursing care. This transparency can incentivize hospitals to invest in adequate nurse staffing, thereby improving working conditions, the nursing workforce's stability and sustainability, and better patient outcomes (Welton, 2024).

Several potential avenues for reforming nursing reimbursement exist, and researchers who sit on the board of the Commission for Nurse Reimbursement are leading the way. One option is to utilize current procedural terminology (CPT) codes to bill for nursing care in outpatient settings. Another option is to adjust diagnosis related group (DRG) codes for inpatient care to account for nursing time and complexity. The Commission recognizes there are many ways to address the need for alternative payment models for nursing care and strives to bring together experts from across the country to continue researching potential solutions. The Commission's primary goal is to spur conversation, problem-solving, and innovation to initiate reform, allowing for a more accurate reflection of the value of nursing care in the reimbursement process (Longyear & Mills, 2024).

Nurses: The Time Now for Advocacy and Change Is Now

The Commission for Nurse Reimbursement (commissionfornursereimbursement.com), founded and led by nurses and healthcare executives, sees nurses as the sole leaders in this monumental change. Nurses have a powerful collective voice that can drive reimbursement reform. By uniting and advocating for change, nurses can raise awareness of the undervaluation of nursing services and its impact on the workforce and patient care. Nurses must engage with hospital leadership, policymakers, legislators, and the public to promote the importance of reimbursement reform and educate them on the current state of the nursing workforce.

While many nurses view themselves as only a single person with limited power, the Commission brings them together as a powerful group of nurse volunteers to amplify and unify their voices and to provide a platform for collective action. Through Legislative Summits, Legislative Task Force events, membership, and other grassroots initiatives, the Commission cultivates and culminates the power of nurses to modernize the reimbursement structure and heal the broken system.

Preparing for the Future

Reforming nursing reimbursement is a critical step toward addressing the nursing shortage and ensuring the sustainability of the nursing workforce. Hospitals can better understand nursing's true value by recognizing nursing care as a billable service, separate from room and board costs. This transparency will incentivize hospitals to invest in adequate nurse staffing and improve working conditions, leading to better patient outcomes and a more sustainable workforce.

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AAACN News

Congratulations to New AAACN Leaders


Andrea Petrovanie-Green

Andrea Petrovanie-Green, MSN, RN, AMB-BC, Magnet®, ANA Consultant, will serve as the next President-Elect of AAACN. She will serve as President-Elect for 2025-2026 before assuming the role of AAACN President in spring 2026. The AAACN Board of Directors (BOD) appoints the President-Elect, ensuring selection of the most qualified member to lead AAACN.

A member for 25 years, Ms. Petrovanie-Green has served in numerous leadership roles, including Director and Secretary on the BOD, elected member of the Leadership Development and Nominating Committee, Special Interest Group (SIG) Co-Chair, and reviewer for the *Scope and Standards of Practice for Professional Telehealth Nursing*. She also has been an active participant in many AAACN conferences.


Mary Blankson

Mary Blankson, DNP, APRN, FNP-C, FAAN, Chief Nursing Officer at Community Health Center, Inc., has been elected to the AAACN BOD for a 3-year term. A member since 2016, Mary has served as an appointed Board member and contributed in roles such as Co-Chair of the Future Volunteer Leadership Task Force and as part of the team that developed the Nurse Executive Toolkit. An active participant in AAACN conferences, Mary also has shared her expertise as a presenter.


Amy Cadoret

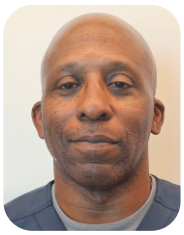
Amy Cadoret, MHA, MSN, NEA-BC, AMB-BC, Associate Nursing Officer at Vanderbilt University Medical Center, has been elected to the BOD for a 3-year term. A member since 2017, Amy is a passionate advocate for diversity, equity, inclusion, and belonging, and has served as Chair of the Inclusion and Belonging Committee for 3 years. She has been an active AAACN conference attendee and presenter and was the recipient of the 2022 Administrative Excellence Award.


Gregory Kopp

Gregory Kopp, MN, MHA, RN, AMB-BC, CENP, National Program Manager for Nursing Clinical Practice at the Department of Veterans Affairs, Office of Integrated Veterans Care, has been elected to serve a 3-year term on the BOD. He has been a dedicated volunteer leader over the past decade, holding leadership roles such as Co-Chair of the AAACN/Academy of Medical-Surgical Nurses Handoff Toolkit Task Force, Chair of the Advocacy Committee, where he championed the importance of advocacy, and most recently, Chair of the 2024 Program Planning Committee.


Jessica Polk

Jessica Polk, DrPH, MPH, BSN, RN, Director of Clinical Integration Programs at Wellstar Clinical Partners, has been elected to serve a 2-year term on the Leadership Development and Nominating Committee, which identifies qualified AAACN members to run for elected offices and oversees the annual election and awards/scholarships process. She has been active since joining AAACN in 2019, serving as the inaugural Emerging Fellow Board Member and as a member of the Care Coordination and Transition Management Course Evaluation Assessment Task Force.


Patrick Turpin

Patrick Turpin, MSN, CNS, RN, Primary Care Manager for the Veterans Administration, was elected to the Leadership Development and Nominating Committee for a 2-year term. A member since 2018, he has attended several conferences and held multiple leadership roles, including Chair of the RN Residency White Paper Review and Update Task Force and Co-Chair of the newly created Federal Nursing SIG.

Congratulations to our incoming leaders!

How Did You Celebrate Ambulatory Care Nurses Week?

Ambulatory care nurses celebrated national Ambulatory Care Nurses Week February 3-7, 2025, with appreciation posts flooding social media platforms in recognition of this dynamic, diverse, and inspiring nursing specialty. Visit www.aaacn.org/events/ambulatory-care-nurses-week for a recap of the activities and celebrations held during this special week. We celebrate and congratulate ambulatory care nurses everywhere, all year long!