

ViewPoint

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Technology Competencies for Today and the Future Nurse Leader

Michele M. Hasselblad

Technology as a healthcare disruptor is not a new concept for ambulatory care nurse leaders. We have witnessed significant changes in the past several decades transitioning from the tactile comfort of paper charting to electronic health records, advanced decision support tools, risk calculators, and the capability to deliver care across large geographies via telehealth or even patient portals. Technology permeates nearly every aspect of medicine and nursing practice. We can most certainly expect many continued advancements, particularly with use cases for artificial intelligence (AI) as one key technology that will impact how we care for patients and do many other work tasks. But AI is not the only development on the horizon, as we can expect continued advancements in patient wearables, remote monitoring, patient education tools, and other virtual care options. In addition to technological tools, the volume of data sets available to nursing leaders to inform decision making can be overwhelming and distracting. It is imperative that nurse leaders are prepared to meet current and future advances in technology with confidence, including the meaningful analysis and use of data. The purpose of this column is to explore necessary digital competencies for nurse leaders to successfully navigate the future of modern health care.

The American Organization for Nursing Leadership (AONL) released guiding principles to support a framework for understanding the role of nurse leaders in navigating digital transformation (AONL, n.d.). The first principle is focused on developing digital competencies at all levels. This enables the structural transformation necessary to implement new technology into the various workflows in our organizations to include administrative, clinical, and educational functions. Key to this competency statement is the strategic imperative that we continually prepare our workforce to adopt new technologies, due to the rapid pace of change that is a hallmark of the technology sector. This requires a solid change management framework, attention to generational differences of our workforce in terms of learning styles and needs, and an awareness of how we can mitigate change fatigue. Additionally, while many digital tools are aimed at enhancing quality, safety, or efficiency, there are also risks associated with many types of digital tools that can threaten these ideals. Nurse leaders must ensure teams keep the safety and privacy of patients as a top priority (Booth et al., 2021).

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Our History Informs Our Future



Stephanie Witwer

As AAACN celebrates its 50th anniversary, I am amazed at the courage, wisdom, and leadership of the nurses who started this fine organization, the progress we have made in the face of significant obstacles, and the promise of a bright and hopeful future. As your lead editor for *Celebrating 50 Years of Ambulatory Care Nursing Excellence*, I have had the opportunity to get a brief glimpse into what our founders were thinking about and what they saw as the pathway forward for ambulatory care nursing. This is an excerpt from an early newsletter describing the second meeting of the group:

It was 1976 and the room at the Doubletree Inn was filled to capacity and the overflow of nurses spilled out into the hallway. It was early morning, and the gathering was about to lead to the formation of a brand-new organization for nurse leaders in ambulatory care settings. Officially the group was gathered for a broader seminar held in conjunction with the University of Arizona School of Nursing, but unofficially the group was plotting a new organization, the American Academy of Ambulatory Care Nursing Administrators (AAANA). This bold group of nurses were envisioning a professional nursing organization that would meet the specific needs of nurses in ambulatory care settings. Soon to be first president, Kaye McGaw boldly stated, "When you consider that 90% of the health care given in the U.S. is for ambulatory patients you get an idea of how important the area of [ambulatory care nursing administration] will become in the next 5 years, especially with pressures increasing to cut health care costs."

Our founders had lofty goals:

- **Grow the membership and increase member involvement.** The membership in 1980 stood at 322. Our founders knew this was not a large enough base from which to grow a stable and active organization. Every year since our founding this has been an emphasis, and it still rings true today.
- **Offer outstanding education.** Our founders' philosophy was that to be influential you have to understand the perspectives of others. To accomplish this goal, early conferences included economists, anthropologists, business leaders, nurse leaders, and practicing nurses actively inventing ambulatory care.
- **Strengthen the organization's financial position.** In order to have a strong financial base, additional revenue opportunities were needed. Very early, our leaders identified the paucity of resources designed specifically for ambulatory care nurses and they began work on the first publication of *Ambulatory Care Nursing Administration and Practice Standards*, published in 1987. This was the first-ever publication that explored standards of practice in ambulatory care, and it quickly became the go-to resource for practices across the country. It experienced strong sales and led to a series of implementation workshops and follow-up publications. This text not only

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supported AAANA members trying to implement standards of practice but also raised the image of AAANA and contributed to its financial stability, paving the way for the organization's rebranding as AACN in 1993.

- **Legislative advocacy and influence.** This was a priority from the very beginning of the organization, with legislative committees and groups supporting key legislation, publishing position statements, serving on high-level committees, and designing new care models. In the early 1990s, AACN supported reimbursement pilots and advocated for legislation that paved the way for Medicare and Medicaid reimbursement for advanced practice nurses. This quote from Ellen Marzalek, 1981 President, is as true today as it was then:

I began to wonder why we as nurses have done such a poor job of educating both administrators and physicians about who we are, what we do and what services we provide to patients. I wondered why we have not pushed harder for direct reimbursement to prove the credibility and value of our services. Why do we wait for a crisis to occur and then react, why as a group are we not more proactive?

AACN has supported many successful legislative efforts over the years. While some are not yet successful, the organization has always recognized the importance of advocacy.

- **Collaboration.** AAANA recognized the importance of collaboration, becoming a member of the National Federation for Specialty Nursing Organizations (NFSNO), the Nurses Coalition for Legislative Action (NCLA), and the Nursing Organization Liaison Forum (NOLF). AAANA provided expertise to the Joint Commission for Accreditation of Hospitals (JCAH, later JCAHO, TJC), and partnered with the Medical Group Management Association. Associations and partners changed over the years, but the focus on collaboration was always strong.
- **Scientific investigation.** The organization has always stressed the importance of taking a rigorous scientific approach, first to define what ambulatory care nursing is, followed closely by the need to define its value. A quote from 1980 President Sandra Reifsteck: "Clarification of the purpose of ambulatory nursing must be our goal. Planning is essential, appropriate data must be gathered and analyzed and standards developed." In 1988, President Elizabeth Murphy created a standing research committee that was charged with "establishing AAANA as a foundation for scientific investigation to advance ambulatory nursing administration and practice."

Despite repeated, cataclysmic changes in our environment, such as multiple, sweeping changes in healthcare financing, public health crises, societal violence, unrest, limited access to care, immigration policy, consolidation of healthcare entities, and professional shortages, our founders and their successors have remained true to these initial ideals.

As I stand on the shoulders of others and prepare to transition to tomorrow's leaders, I am proud to report on a few of the accomplishments for 2024-2025.

Goal #1: Advance Our Science

Our Research Committee (Chair Margo Halm PhD, RN, NEA-BC, FAAN) has been firmly re-established and has/is:

- Determined AACN research priorities.
- Launched our first-ever research/evidence-based practice/quality improvement grant program.
- Completed the ambulatory care nursing scoping review and is preparing findings for publication.
- Providing education/consultation/mentorship for members conducting research.
- Exploring the addition of a Research Special Interest Group.

AACN has published the second edition of the *Ambulatory Care Nurse-Sensitive Indicator Industry Report* with instrumental leadership from Rachel Start, PhD, RN, NEA-BC, FAAN, Immediate Past President, and numerous other editors and internal and external experts and partners.

We have launched the *Journal of Ambulatory Care Nursing*. This is the culmination of 4 years of work on the part of many, with particular thanks to Kathleen Martinez, MSN, RN, CPN, CIC (President, 2021), who activated the vision and Susan Fowler, PhD, RN, CRRN, NE-BC, NPD-BC, FCNS, Editor, who brought this vision to reality.

Goal #2: Set the Standard for Excellence

Our Publications Committee (Chair Cara Spencer, PhD, RN, FNP-BC) is leading our new resource initiatives, including development of the:

- Fifth edition of the *Core Curriculum for Ambulatory Care Nursing*
- Sixth edition of the *Ambulatory Care Nursing Review Questions*
- *Scope and Standards of Practice for Professional Telehealth Nursing*

Other task forces and groups are also active, and we are excited to see some of their work come to fruition, including:

- A mentorship program
- Initial offering of Diversity, Equity, Inclusion, and Belonging Conference Scholarship
- Workplace well-being programming
- New awards to recognize members: National Daisy Awards and AACN Hall of Fame Award

Goal #3: Transform Health Care for People and Communities

Through efforts of the Advocacy Committee (Chair Leondra Weiss, MN, ARNP, FNP-BC, AMB-BC, C-EFM), AAACN has:

- Developed an Advocacy Platform.
- Worked on tactics to advance this platform.

AAACN has several national partners. The Commission for Nurse Reimbursement is actively promoting reimbursement for nurses. This is also an area of strong interest for AAACN. AAACN leaders participated in activities on Capitol Hill in 2024, raising awareness of reimbursement issues, with AAACN specifically representing the ambulatory care viewpoint. Another Hill activity is currently planned for 2025.

AAACN is also in the initial stages of developing a demonstration project along with the Center for Nursing Classification and Clinical Effectiveness at the University of Iowa and Epic to test the ability to implement standard nurse interventions and outcome descriptors and codes to the billing pathways. We believe this is a critical missing piece to the current national nursing reimbursement strategy.

In 2024-2025, AAACN members have provided subject matter expertise to three national organizations who are designing products that support ambulatory care nursing practice. The Board hopes to grow this work in the future.

Goal #4: Evolve Our Organization

AAACN has undergone two major technology upgrades in the past year. One of those was a complete change in our membership platform. This has required countless staff hours during the upgrade and more as staff is learning about new operating systems. The second upgrade was our Community/Special Interest Group platform. You may have noticed a new look and structure to the Community, but this platform also offers higher level capabilities that we will explore in 2025.

Many in ambulatory care nursing are facing a period of significant uncertainty, with workforce reductions impacting nurses and other professionals across the field. The AAACN Board of Directors and *ViewPoint* Editorial Board wish to recognize the dedication of our ambulatory care workforce and honor the vital role you play in shaping care where life happens. Thank you.

For many years, AAACN has had an education/scholarship fund that has partially supported scholarships. This fund was not growing and certainly did not have the capability to support our research grant goals. The Board has taken a bold step to create a restricted fund, now called the Scholarship/Research Fund. We have moved some of the organizational assets into the fund so that it can grow to support scholarship and research activities. We hope that through fundraising activities and donor support, this new restricted fund can help to propel ambulatory care nursing research forward.

I will be the first to admit that I did not know AAACN's rich history, but I would be remiss if I did not point out that despite widespread change in health care, our environment, and society, the values upon which the organization was built are unchanged. The strategies not completed by our predecessors can still be accomplished by us, with our new tools, knowledge, resources, and technologies. We can define ambulatory care nursing value, we can achieve reimbursement, we can provide the best quality care for people and communities, and we can "*Shape Care Where Life Happens.*" ●

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Go to <https://forms.office.com/r/WBBBc9E7mY> and answer five questions related to articles in this issue of *ViewPoint* to be entered in a drawing for a free educational session in the AAACN Online Library. Enter for your chance to win by submitting your answers by June 10.

Congratulations to Stephanie Boone, who won a free session for answering questions for the Quarter 1 issue of *ViewPoint*!

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Nursing Professional Development Practitioner Immersion Approach within an Ambulatory Care Specialty

Amanda K. Shimko
Rosemarie L. Passamonte

Keywords: quality improvement, nursing education, outpatient, interdisciplinary, professional development

Learning Outcome: After completing this education activity, the learner will be able to explain how the structured phases of the immersion approach in ambulatory care support sustainability and continuous quality improvement, enhancing patient care in outpatient services.

According to Hobbick (2024), ambulatory care as a specialty has evolved over the last century, with health care shifting its focus from hospital-based care to a larger focus on health promotion and preventative care. As demands for this specialty continue to evolve with changes in technology and healthcare needs, the importance of the ambulatory care nursing profession continues to grow (Hobbick, 2024). Therefore, ambulatory care-specific nursing professional development (NPD) resources that support quality improvement initiatives, education, and training have become critical for the successful development, implementation, and sustainability of evidence-informed practices, as well as the evolution of the ambulatory care nurse role and improved patient outcomes.

The ambulatory care setting of the academic medical center and teaching hospital featured in this article, as a part of a large integrated healthcare system in the Northeast, comprises numerous outpatient services that vary in size, structure, and workflows. Consistent with the ambulatory care nursing characteristics highlighted by the American Academy of Ambulatory Care Nursing (n.d.), workflows within

this institution focus on the care continuum and coordination of patient care, patient advocacy and education, and the use of the nursing process related to the multifaceted needs of a patient. This ambulatory care setting is organizationally designed with a centralized ambulatory care NPD team made up of five full-time Professional Development Managers and two full-time Clinical Nurse Educators whose collective role is to work closely with approximately 100 outpatient clinics.

The role of the Ambulatory Clinical Nurse Educator in particular is to develop individual or clinic-wide educational programs in response to identified needs; support the orientation process for clinical staff; conduct annual staff competency assessments; provide educational offerings that incorporate new workflows, equipment, policies, procedures, regulations or technology; participate in nursing committees; and facilitate quality and process improvement initiatives, including the development and maintenance of policies and procedures. Though there is some overlap between the job duties of the Professional Development Manager and the Clinical Nurse Educator, the role of the Professional Development Manager

further includes engaging in leadership strategic planning, leading process and quality improvement projects, participating in hiring and evaluating ambulatory care staff performance, assisting in the budgetary process, and acting as the direct report for the Clinical Nurse Educator.

Due to the diverse specialties and nuances of each clinic in this setting, this professional development team identified a need for a unique immersive and interprofessional approach to address standardization, efficiency in workflows, and staff and patient satisfaction. Thus, the purpose of this project was to design and implement this approach by utilizing a centralized Ambulatory NPD practitioner, specifically in this setting, a Clinical Nurse Educator, to identify opportunities for new initiatives within a specialty clinic, initiate pilots for implementation, and develop measures for successful future sustainability at the local level, upon conclusion of the immersion.

The Immersion Approach

Prior to initiating an immersion approach in an ambulatory care clinic, requests for assistance are submitted by nursing leaders seeking to improve organizational workflows that can

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elevate clinical practice and patient outcomes within their clinic. These submissions are reviewed by the NPD team and the Ambulatory Associate Chief Nursing Officer, who collaboratively prioritize the requests based on implications for quality of care, patient outcomes, and safety. The review process includes consideration of concerns raised by nursing leadership and clinical staff, safety reports, and patient outcome data as applicable. Once a request is approved and a specialty area is selected, a team of interprofessional nursing and leadership representatives within that specialty is identified. These representatives form a group termed the “teamlet.” This group consists of a patient-facing staff nurse representative; clinic leadership including the Nurse or Practice Manager, Nurse Director, and Medical Director; and the NPD team. Participation and communication within the teamlet are an integral aspect of each phase of the immersion approach, along with involvement of various roles within the specialty area and across the hospital as needed.

To guide this approach, the NPD practitioner utilizes the concepts within the NPD scope and practice model from an internal perspective to assess and diagnose the need for resources and new workflows, plan for improvement, implement a collaborative approach, and evaluate outcomes (Harper & Maloney, 2022) while including a unique focus on future sustainability. The immersion approach is divided into four phases: *Orientation and Discovery*, *Planning*, *Implementation*, and *Sustainability*, with each phase being critical to the success of the immersion approach.

Orientation and Discovery

The Orientation and Discovery phase initiates the immersion of an NPD practitioner into a single specialty area to become better acclimated with staff, current workflows, and available resources. Areas of focus for this

phase include identifying needs for standardization, nurse education and resources, nurse autonomy, and departmental organization. This phase allows for an internal perspective on staff dynamics, including how various roles in the clinic work on an interprofessional level and how the nurse is supported in the evolving ambulatory care nurse role. Associated workflows and obstacles, potential knowledge gaps, opportunities for standardization, patient outcomes, and staff and patient feedback also may be evaluated during this phase. This evaluation process includes directly shadowing nurses’ daily routines, observing current clinic workflows, receiving direct feedback from staff regarding requests for educational resources and aspects of their role needing improvement, reviewing existing patient satisfaction results and feedback for the specific clinic, and evaluating available reports related to staff utilization of best practices and documentation.

The purpose of this phase is for the NPD practitioner to achieve full comprehension of the role of the nurse in this environment. This perspective allows for a more thorough and insightful assessment by the NPD practitioner when determining where both ambulatory care and hospital-wide professional development resources could be best utilized to achieve the determined immersion goals for a specific clinic, as defined by immersion findings. The length of this phase typically ranges from 2-12 weeks and is directly impacted by the familiarity of the NPD practitioner with the specialty area and staff, and the breadth of needs identified. At the conclusion of this phase, the NPD practitioner presents their findings and initial process improvement recommendations (PIRs) to the teamlet for feedback and discussion. This transitions to the second phase, Planning.

Planning

The Planning phase begins by finalizing and prioritizing the initial list of PIRs with the help of the teamlet. These PIRs are examined for their level of influence on effective patient care, regulatory compliance, financial outcomes, and overall efficacy of the nursing role, and subsequently addressed in accordance with prioritization preference, as defined by the clinic’s leadership team.

The NPD practitioner continues the Planning phase by creating a unique collaborative taskforce for each PIR based on the details, needs, and scope. The taskforces include applicable teamlet staff along with other affected roles within the department, such as providers, staff nurses, or uncensed professionals. Additionally, participation from various ambulatory care and hospital-wide resources were included as needed, such as informatics colleagues, quality and safety representatives, or input from applicable hospital committees.

Each taskforce meets at regular intervals to plan the details for the next phase, Implementation. The Planning phase for each PIR lasts various lengths of time depending on complexity and may range anywhere from 4-12 weeks. Once the Planning phase is complete, the Implementation phase begins.

Implementation

The Implementation phase initially includes pilot periods testing new workflows as needed for each PIR. This is followed by service-wide implementation and evaluation for adjustments as needed, typically lasting 3-6 months overall based on the various facets of the PIR. Based on the total number of PIRs, pilots and implementation dates are staggered to prevent overwhelming staff and patients with coinciding initiatives. This process should continue until all PIRs are fully planned and implemented. Once all PIR initiatives are in a stable state after

Table 1.
Center for Infertility and Reproductive Surgery (CIRS) Clinic Sustainability Tracking Tool Sample Data

Fiscal Year 2023 Quarterly Data: CIRS/IVF							
Initiative #1	Nurse Smartphrase Use: Protocol/Plan of Care Instructions						
Details	Nurse sending Protocol/Plan of Care Smartphrase to patient via PG prior to cycle start for fertility patients						
Goal	90%						
Q1 Total	25	Q2 Total	25	Q3 Total	25	Q4 Total	25
Q1 Met	25	Q2 Met	25	Q3 Met	25	Q4 Met	24
Q1 %	100%	Q2 %	100%	Q3 %	100%	Q4 %	96%
Comments							
Initiative #2	Nurse Smartphrase Use: Trigger Instructions						
Details	Nurse sending Trigger Instruction Smartphrase via PG to patient using a trigger injection prior to egg retrieval						
Goal	90%						
Q1 Total	25	Q2 Total	25	Q3 Total	25	Q4 Total	25
Q1 Met	24	Q2 Met	25	Q3 Met	25	Q4 Met	25
Q1 %	96%	Q2 %	100%	Q3 %	100%	Q4 %	100%
Comments							
Initiative #3	Standardized Nurse Visit Documentation Use						
Details	Nurse documenting Nurse Visits with standardized Reason for Calls/Note Smartphrases/charges (if applicable)						
Goal	90%						
Q1 Total	25	Q2 Total	25	Q3 Total	5	Q4 Total	4
Q1 Met	N/A	Q2 Met	19	Q3 Met	2	Q4 Met	3
Q1 %	N/A	Q2 %	76%	Q3 %	40%	Q4 %	75%
Comments	Will begin to track in Fiscal Year 2023-Quarter 2						

implementation, the immersion approach transitions to the Sustainability phase.

Sustainability

In the Sustainability phase, the NPD practitioner disengages from the immersion approach, and local nurse leaders initiate the use of a unique benchmark-based Immersion Sustainability Tool designed to allow for continued monitoring and assessment and for achieving full adaptation and success of the immersion initiatives. The tool was created in a spreadsheet format based on quality assurance and performance improvement processes (Centers for Medicare & Medicaid Services, 2024).

The first page of the Immersion Sustainability Tool includes a template for outlining the details of each initiative resulting from the immersion approach by defining how each one will be monitored and measured for

success. The defined measures may include patient medical record and nurse documentation reports and audits, as well as routine review of clinic resources to ensure that updates reflect current practice. The template also consists of the quantity of items to be reviewed, the criteria that constitutes meeting effective implementation of each PIR, and the identified nurse leader responsible for completing this monitoring.

Monitoring is completed and data is inserted quarterly by nursing leadership on to the second page of the tool (as shown in Table 1) to produce measurement goal percentages. Goal percentage benchmarks are grouped into three categories: Green (90%-100%: Meeting Goal), Yellow (60%-89%: Need for Increased Monitoring), or Red (0%-59%: Need for Additional Assessment and Interventions). If an initiative measures four consecutive green quarters, monitoring for the ini-

tiative is no longer needed. A yellow quarter requires increased monitoring of the initiative during the subsequent quarter to review additional data by capturing a greater sample size. If two consecutive yellow quarters occur, this is to be considered the equivalent of one red quarter. One red quarter requires a root cause analysis for further assessment of why the benchmark is not being met and what steps can be taken toward improvement. This assessment includes data related to users, timing, staff feedback, and extrinsic factors to determine any cause(s) of noncompliance.

With this additional information, the nursing leadership and professional development team can determine necessary interventions for future success, such as remediation and/or improvement to workflows as needed during the subsequent quarter. If two consecutive red quarters occur, a brief re-immersion of the NPD practitioner

Table 2

Phases of the Immersion Approach within the Center for Infertility and Reproductive Surgery (CIRS) Clinic

Orientation and Discovery	Planning	Implementation	Sustainability
<p>Phase 1: Orientation and Discovery (3 months)</p> <ul style="list-style-type: none"> Clinical Nurse Educator shadowed the clinic's staff nurses (experiencing patient encounters, trialing current nursing workflows, exploring the current resources utilized and attending staff meetings). Clinical Nurse Educator met with nursing leadership and Professional Development Manager weekly for 1 month and biweekly thereafter, and on an ad hoc basis with other hospital resources (i.e., Compliance, Informatics, and Quality & Safety). Clinical Nurse Educator presented findings to the teamlet, along with the following proposed PIRs: <ul style="list-style-type: none"> Standardization <ul style="list-style-type: none"> Creation of standardized patient fertility cycle protocol instructions and in vitro fertilization trigger instructions with the utilization of electronic health record templates Creation of new or updated generalized patient educational pamphlets Creation of a new patient nurse phone visit, including a structured new patient nurse follow-up call, a new visit type created in the electronic health record to allow for easier scheduling and documentation, a standardized template for the nurse phone visit documentation, and standardized and updated new patient instructions and expectations Nurse Education and Resources <ul style="list-style-type: none"> Development of a unit-specific nurse orientation guide Nurse Autonomy <ul style="list-style-type: none"> Creation of a nurse-driven protocol to allow the nurse to work to the top of their scope of practice. This included ordering routine and required orders with co-signature of the provider and follow up on basic testing, all of which was outlined with specific inclusion and exclusion criteria for the nurse to follow within their scope of practice. Standardization of documentation and billing for nurse-only patient visits Creation and planning of routine educational seminars for the nurses, such as a genetics presentation on requirements and testing for using donor gametes, embryology presentation on workflows in the lab, CIRS Medical Fellow lecture series on various topics related to the specialty, and in-services on nursing procedures completed in the clinic Departmental Organization <ul style="list-style-type: none"> General organization of resources and workflows within the clinic, including patient and staff educational resources, planning for regular updates of this material, evidence-based updating of policies related to CIRS, and transition of any outstanding paper documentation to the electronic health record PIRs were discussed and finalized by the teamlet and divided into three priority groups. 			
<p>Phase 2: Planning (~1-3 months for each PIR, overlapping as applicable)</p> <ul style="list-style-type: none"> The teamlet identified the necessary members to make up the taskforces for each PIR. Each taskforce met weekly to strategize a detailed approach for implementation. <ul style="list-style-type: none"> For example: standardized patient instructions were crafted into electronic templates, orientation materials were developed, new workflows were created, protocols were outlined. 			
<p>Phase 3: Implementation (~3-6 months for each PIR, overlapping as applicable)</p> <ul style="list-style-type: none"> Pilots were initiated as needed, followed by service-wide implementation for each PIR. <ul style="list-style-type: none"> For example: pilot nurse teams utilized the new patient nurse phone visit workflow and standardized patient instruction templates prior to initiating clinic-wide whereas tools including the nurse driven protocol, nurse orientation guide, and educational seminars initially went live clinic-wide without the need for a pilot period. Continuous feedback was collected from staff and when applicable, from patients, to inform any necessary changes or updates that would help achieve workflow optimization. 			
<p>Phase 4: Sustainability (Ongoing)</p> <ul style="list-style-type: none"> NPD team assisted nursing leadership in developing a unique Sustainability Tracking Tool by inputting clinic-specific details onto the template and reviewing its use. Use of the Sustainability Tracking Tool by nursing leadership to ensure a seamless transition and continuous application of implemented PIR initiatives, independent of the Clinical Nurse Educator (Table 1 displays the use of the tool by CIRS nursing leadership.) Nursing leadership reports quarterly results to the Assistant Chief Nursing Officer and the NPD team is consulted if needed based on outcomes. 			

NPD=nursing professional development, PIR=process improvement recommendation

into the specialty area is considered to allow for a more in-depth and firsthand root cause analysis. Once all initiatives reach the point of no longer needing sustainability monitoring, the immersion approach is considered successfully implemented and the use of the Immersion Sustainability Tool is concluded. At this point, the Sustainability phase is complete.

Implementation of the Immersion Approach

This approach was first implemented in the Center for Infertility and Reproductive Surgery (CIRS) specialty clinic within a large academic medical center. The approach began with the teamlet meeting to review the plan, objectives, and role responsibilities that would be anticipated prior to entering phase one. The CIRS teamlet consisted of the Clinical Nurse Educator, Professional Development Manager, Nurse Director, Nurse Manager, Medical Director, and Charge Nurse.

During the Observation and Discovery phase, initial observations and assessment findings were obtained via nurse feedback and direct observations of the Clinical Nurse Educator. Initial nurse feedback included reports of high call and patient portal message counts on similar topics not addressed in initial resources provided to patients, reports of excessive nurse documentation time for nurse visits and sending instructions to patients, requests for educational seminars on relevant topics, and requests for improved organization of nursing clinic resources. Direct observations from the Clinical Nurse Educator included the lack of an existing standardized nurse orientation for new hires, non-standardized patient instructions being utilized, transcription errors in patient instructions sent to patients, a need for a nurse-driven protocol with clear criteria to ensure nurses are working within and to the top of their scope of practice, non-standardized note documentation for nurse-only visits, incor-

rect or missing documentation and billing of nurse only visits, and unclear patient expectations regarding clinic processes and timing. Table 2 displays an overview of the phases of the immersion approach, established PIRs, and how each phase was implemented within this specialty clinic.

Within the setting of this academic medical center, this immersion design is initiated in one clinic at a time and led by one of the two centralized Ambulatory Clinical Nurse Educators. The Clinical Nurse Educator leading the immersion approach dedicates 80% of their time to this project during the Orientation and Discovery phase and approximately 60% of their time during the Planning and Implementation phases, while allowing their remaining hours to be spent on unrelated Ambulatory Clinical Nurse Educator responsibilities. The Clinical Nurse Educator then disengages for the final Sustainability phase. Throughout the process, the second Clinical Nurse Educator is fully dedicated to maintaining other educator responsibilities while not actively engaged in an immersion. The two Ambulatory Clinical Nurse Educators alternate leading immersions across the ambulatory care department, not allowing for overlap of immersions until the preceding immersion has reached its Implementation phase and any associated pilots are underway. Clinical Nurse Educators are not assigned a new immersion until their previous immersion has reached its Sustainability phase.

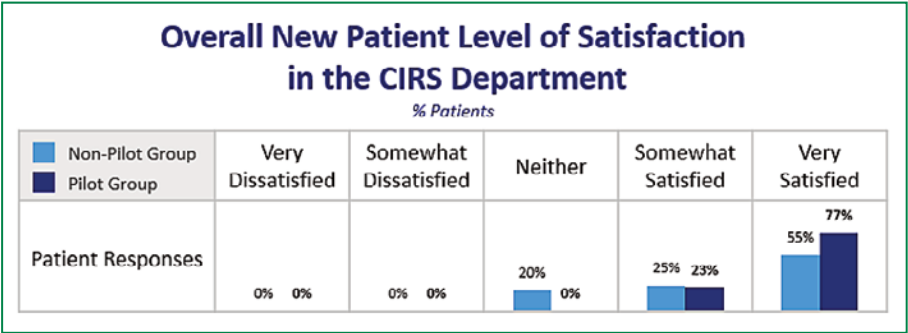
Outcomes

As depicted in Table 1, during the first quarter in which the sustainability tool was implemented within the CIRS, percentages produced all fell within green parameters, requiring no additional interventions. In the second quarter, Initiative #3 produced a percentage in the yellow category, prompting additional monitoring in the subsequent quarter. In the third quarter, Initiative #3 produced a per-

centage in the red category, prompting a root cause analysis of reports collected that quarter. The root cause analysis completed by the Nursing Leadership team identified the need for additional nursing education on nurse visit documentation requirements. After this education was provided to the nursing team, Initiative #3 produced an improved percentage the following quarter. This initiative will continue to be monitored and reviewed until four consecutive green quarters have been achieved. Data were shared regularly with the NPD team and the Associate Chief Nursing Officer to ensure the tool was being utilized correctly and interventions were being implemented as needed. Additionally, local nursing leadership shared data with their nursing staff on a quarterly basis to relay successes and identify areas needing improvement, sharing any applicable resources that could assist in improving outcomes.

In addition to monitoring successful application of each individual initiative, staff and patients were polled for the purpose of collecting specific data regarding their outcomes and effects, and the overall immersion approach. For example, clinic-administered patient satisfaction surveys were reviewed pre- and post-implementation of the standardized fertility cycle protocol instructions. These instructions were sent to patients by the nursing staff, providing them with information related to their upcoming fertility protocol plan of care. Based on these patient satisfaction surveys, the average percentage for a positive response on the question "Did nurses explain things in a way that you could understand?" improved from 85.7% in October 2021 (pre-implementation) to 96.2% in March 2022 (post-pilot implementation). With reference to the New Patient Nurse Phone Visit initiative, new patient experience feedback was received from both a pilot group ($n=15$) and a non-pilot group ($n=20$). Compared to the non-pilot group,

Figure 1.
Poll Results During a 3-Month Pilot Period



patients in the pilot group reported overall higher levels of satisfaction related to the new patient experience (see Figure 1).

The nurses included in this pilot who utilized the updated patient resources and workflow were polled pre- and post-implementation. These nurses reported increased satisfaction, increased efficiency and usability, decreased documentation time, and improved communication with new patients when utilizing the new workflows and resources. Additionally, all CIRS nurses and associated department leaders were polled following the entirety of the immersion approach. The nurses reported increased engagement, improved resource availability as it related to their role, and increased efficiency of nursing workflows. Moreover, 100% of nurses and department leaders reported higher satisfaction levels related to the NPD practitioner's collaboration with clinical staff during the immersion approach as well as increased satisfaction levels related to the resulting initiatives.

Limitations

There are limitations that could be addressed in future evaluations of this immersion approach. Increased sample sizes in pre- and post-immersion implementation data collection would allow us to measure statistical significance in survey-driven information related to both employee and patient satisfaction levels. Additionally, though positive financial outcomes are antici-

pated due to improved workflow efficiency, a more focused study would need to be conducted to determine the financial impact of this approach. Though this approach has been applied to other clinics since its introductory implementation, data for completion in subsequent areas are not available at this time.

Conclusion

As ambulatory care nursing continues to expand as a specialty, it is crucial to be able to provide at-the-elbow support from a centralized NPD practitioner for each specialty clinic. This immersion approach allowed for a centralized ambulatory NPD practitioner to garner the internal perspective of a specialty clinic staff nurse to better identify workflow practices in need of optimization and secure the success of resulting initiatives led within these clinics. Additionally, the use of a comprehensive Sustainability Tracking Tool, maintained internally by local nursing leadership, allowed for the NPD practitioner to be able to disengage from the clinic's immersion approach and apply this approach to additional ambulatory care settings.

During the immersion process, four key areas of focus were used to categorize initiative recommendations: standardization, nurse education and resources, nurse autonomy, and departmental organization. The use of these categories should be considered

during any immersion approach to help guide classification of findings. This immersion approach can be adapted to any specialty clinic for both small- and large-scale professional development needs. Following the completion of the immersion approach in the CIRS, this model has been successfully applied to two additional specialty clinics within the same academic medical center thus far.

In summary, this model has allowed the Ambulatory NPD practitioner to become more adaptable within complex specialty areas across the organization. The debut of the immersion approach within the CIRS resulted in improved patient experience and satisfaction, improved nurse/patient relationships, improved efficiency of documentation and nursing workflows, streamlined communication between patients and staff as well as between nurses and other roles, improved satisfaction of nursing and clinic leadership, improved nursing engagement in the role of the ambulatory care nurse, and improved and standardized quality of content within resources available in the clinic. As such, the immersion of the NPD practitioner proved to be a beneficial aspect to this educational approach, yielding improvements within this clinic. This approach will continue to be utilized within the many ambulatory care specialty clinics across this academic medical center, thereby supporting ambulatory care nursing. ●

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Epinephrine Response Time in Ambulatory Care: Timeliness in Access and Delivery

*Danita Wabeke
Monica Miller*

Keywords: epinephrine auto-injector, access and delivery, ambulatory care, competency, practice improvement

Learning Outcome: After completing this education activity, the learner will be able to describe the development and implementation of an education plan used to improve the quality of care in patients experiencing an anaphylactic reaction.

This article describes the work of educators in a Midwest Veterans Administration health system to improve the quality of care by conducting a gap analysis, providing just-in-time education, and partnering with nursing staff, pharmacy, leadership, and home care colleagues to achieve improved safety quality of care.

Anaphylaxis is a serious, life-threatening hypersensitivity reaction, either generalized or systemic, that is typically rapid in onset and can cause airway or circulatory challenges (Loprete et al., 2024; Muraro et al., 2022). Anaphylaxis may present as a variety of combinations of symptoms ranging from mild to fatal anaphylactic shock. It is an immune-mediated reaction, most commonly an IgE-dependent mechanism, usually occurring when an individual is exposed to a trigger, such as food, insect stings, or medications (Kramer & Batt, 2021).

An anaphylactic reaction is a critical emergency requiring immediate recognition, evaluation, and intervention to ensure optimal management. A mild presentation may progress rapidly to fatal anaphylactic shock within seconds to minutes. A patient may experience various reactions from the same trigger

from one episode to another. The signs and symptoms of an anaphylactic reaction include respiratory distress, hypotension, tachycardia, cyanosis, urticaria, angioedema, nausea, vomiting, diarrhea, and abdominal pain (Alvarez-Perea et al., 2017). Skin reactions occur in most every case of anaphylaxis, followed closely by cardiovascular and respiratory manifestations.

Acute management of anaphylaxis begins with removal of exposure to the trigger if identifiable. A rapid assessment of airway, breathing, circulation, and mental status should ensue, followed by observation of skin characteristics (Dhami et al., 2017). Prompt administration of epinephrine, the first-line medication of choice for initial treatment (Shaker et al., 2023), should be given without delay, resulting in symptom resolution and improved outcomes (Lieberman et al., 2023). Epinephrine is the medication of choice due to its vasoconstrictor effect, reverting airway edema and hypotension (Dodd et al., 2021). Hesitation in timely administration of epinephrine can lead to hypotension, persistent reactions lasting for hours or days that do not fully resolve, and increased hospitalizations and mortality rates (Dodd et al., 2021).

Epinephrine administered out of the hospital is best given by an epinephrine auto-injector (EAI). Optimally, epinephrine is injected intramuscularly in the vastus lateralis muscle. The EAI treats anaphylaxis promptly and safely in the out-of-hospital setting (Maher, 2022). The ability to immediately administer epinephrine via an EAI with limited training has had a positive impact on patient outcomes. In the ambulatory care setting, EAI's must be immediately accessible to healthcare staff to avoid potential delays in treatment (Westermann-Clark et al., 2022).

Gap Analysis and Needs Assessment

At a midwestern Veterans Health Affairs Medical Center, a knowledge gap was identified in which staff members in the ambulatory care setting did not possess the skills to properly administer an EAI in their workspace. Two nurse educators at the facility collected quantitative data through unannounced rapid response simulations and mock code drills, revealing a lack of confidence and competence among 88% of nurses in 12 ambulatory care clinics while using the EAI.

Accreditation Statement

This educational activity is jointly provided by Anthony J. Jannetti, Inc., and the American Academy of Ambulatory Care Nursing (AAACN).

Anthony J. Jannetti, Inc., is accredited as a provider of nursing continuing professional development by the American Nurses Credentialing Center's Commission on Accreditation.

Statement of Disclosure

The authors, editor, content reviewers, and education director have no relevant financial relationships to disclose.

Table 1.
Levels of Kirkpatrick's Model for Learning Evaluation

Level 1	Reaction	<ul style="list-style-type: none"> • Engagement • Relevance • Satisfaction 	To what degree participants reacted favorably to the learning
Level 2	Learning	<ul style="list-style-type: none"> • Knowledge • Skills • Attitude • Confidence • Commitment 	To what degree participants acquired the intended knowledge, skills, and attitudes based on their participation in the learning event
Level 3	Behavior	<ul style="list-style-type: none"> • Critical behaviors • Required drivers 	To what degree participants apply what they learned during training when they are back on the job
Level 4	Results	<ul style="list-style-type: none"> • Initiative outcomes • Organizational outcomes 	To what degree targeted outcomes occur as a result of learning events and subsequent reinforcement

Kirkpatrick, 1994, 2024

Data were collected during each simulation and drill using a Mock Code Scoring Sheet, a facility-developed data collection tool that grouped information into categories for evaluation, including problem recognition, use of equipment, medication administration, and team dynamics. Participants were numerically scored based upon actions observed during the simulations and drills. Data supported that 88% of nurses within the 12 clinics did not properly use the EAI during the simulation of an anaphylactic rapid response. Data alerted the ambulatory care nurse educators that training and competency validation were needed to provide nurses with the skills necessary to perform high-quality patient care.

This high-risk, low-volume skill was prioritized as an immediate education need, leading to the creation of face-to-face focused training and competency sessions in the ambulatory care clinics. The desired outcome was for all registered nurses and licensed practical nurses in direct patient care in the ambulatory care setting to administer epinephrine competently during an emergency. By addressing this problem through training, the need for process improvement was identified. At the beginning of training, the broad significance of this problem had yet to be fully recognized, as it would continue to cascade into

multiple process improvement initiatives throughout the institution at multiple levels and service lines during the ensuing 12 months.

Education Planning and Delivery

Collaborative planning for process improvement included the American Heart Association nurse educator, clinical managers, and pharmacy. A literature review was performed, and the resulting evidence was appraised to identify current practice guidelines for rapid response processes. The education plan included multiple strategies to enhance learning, including pretraining materials distributed to all ambulatory care nurses, didactic information presented via group discussion, review of a clinical scenario, hands-on skill demonstration with return demonstration, a quiz covering the didactic information, and examination of the automated medication dispensing machine. Sharing of learner experiences in a relaxed setting contributed to participation and engaged learning. Executive leadership stakeholders supported the allocation of resources needed for training. Time proved to be the greatest barrier in the ambulatory care setting with the workaround being multiple small group training sessions. Training and competency validation were completed by 306 nurses in the ambulatory care setting.

Learning Evaluation

Training effectiveness was measured using the four levels of Kirkpatrick's model (see Table 1) for learning evaluation (Kirkpatrick, 1994). The first level, reaction, was determined by participant's post-training questions and discussions of case scenarios. It was the staff's high level of engagement that led them to ask detailed questions during the training. Those questions opened the door to the process improvements that followed.

The second level, learning evaluation, was two-fold. In the first phase, staff received pre-training reference resources in addition to attending face-to-face training. During the second phase, a hands-on skills demonstration and return demonstration, observed by the educator, were completed by all staff. All of the ambulatory care nursing staff completed the full training, and 100% passed both the written evaluation and skills demonstration portions of the training sessions. At the end of the sessions, staff verbalized an appreciation for the training and confidence to use the EAI.

The third level of Kirkpatrick's model, behavior, was assessed by determining if there was application of the education in the clinical setting during simulation drills and actual rapid responses. This was evaluated by nurse educators and clinic managers. There were no rapid responses in the three quarters following the training sessions that required the administration of epinephrine in the ambulatory care clinics. Educators realized that monitoring for application of the knowledge remained an essential component of the initiative. As they rounded throughout the 12 ambulatory care clinics, they randomly brought out a trainer EAI, asking nursing staff to provide a demonstration. All return demonstrations were performed correctly. The EAI also was reinforced at an ambulatory care clinic medication skills fair through the use of a poster

that provided nursing staff the opportunity to demonstrate correct placement of the EAI.

Kirkpatrick's model elaborates on the need to influence behavior rather than leaving it to chance (Kirkpatrick, 2024). Level four requires an evaluation of the outcomes. The four levels of Kirkpatrick's model contributed to the development of system-wide initiatives that resulted in a change in practice.

Ongoing Process Improvement

The EAI training was a simple skill yet a high priority for the ambulatory care setting. An interactive training session led to an elevated level of staff engagement. Questions asked during the question-and-answer session led the staff to access the electronic medication station to view the EAI in storage. What happened next heightened this routine training and competency to a multi-faceted, system-wide, and high-acuity patient safety initiative. Upon opening the medication station drawer, it was noted that EAI trainer pens were commingled with EAI's, increasing the potential risk for patient harm. Nurses in the training took immediate action, notifying pharmacy within minutes. That same day, an interdisciplinary evidence-based practice initiative team was convened. All medication stations in the healthcare system, including inpatient and outpatient areas, were examined and corrected; pharmacy technicians were retrained on stocking procedures.

During the 2 months that the EAI training and competency were being conducted, one of the ambulatory care nurses experienced an anaphylactic reaction. The employee arrived before the start of the workday, earlier than most of her fellow coworkers. Placing her supplies in her office, she made her way down the hallway and immediately collapsed. A provider with an early start was the only individual present and found her unresponsive on the hallway floor. The provider was unable to access the

stored epinephrine located in the medication station. Lack of accessibility and timeliness of delivery of EAI's became a second challenge to be addressed. The same interdisciplinary team convened over the next several weeks. Through multidisciplinary collaboration, EAI's were moved to a centralized location in the ambulatory care settings for emergent situations. They would continue to be stocked in the medication station as well. "Location, location, location" (Tsoulis & Shaker, 2022) may aid in the early use of EAI's to manage out-of-hospital anaphylaxis and improve outcomes.

The evidence-based practice initiatives were shared at an executive leadership council meeting. After the presentation, the ambulatory care nurse educators were requested to present the EAI training and competency to the Home-based Primary Care (HBPC) staff of 45 nurses. During this training, it was noted that various types of EAI's were distributed for use by nurses in HBPC. It was immediately recognized that this practice was a patient safety issue due to the high risk and low frequency of the need for epinephrine in the home environment. Some research has suggested modifying auto-injectors to guide people through their use by using voice prompts and color-coding caps. Such changes have been deemed to have an increase in the proper administration of the EAI device while decreasing the time between recognition of anaphylaxis and administration of epinephrine (de Silva et al., 2021). New EAI's may have difficulty in gaining market share since Mylan's EpiPen® has the benefit of name recognition. In addition, training and administration for each EAI is different (Westermann-Clark et al, 2022). There are advantages to improving safety and usability in novel designs of new products; however, differences in administration can lead to patient errors when the device is used infrequently. Once again, the collabora-

tive team was tasked to standardize the EAI's used by the HBPC staff.

What started as a routine competency opened the door for multiple opportunities to elevate nursing knowledge and practice, leading directly to improved safety while delivering care. Evidence-based practice improvements included the storage and location of EAI's, increased access and availability, and standardization of EAI's in HBPC. Nurse educators used the opportunity to engage ambulatory care staff in systems thinking when considering the multiple impacts of the patient safety initiatives. Staff also partnered in developing a poster accepted for presentation at a national conference. Staff were recognized at a quality award ceremony; pride in their professional accomplishment was evident.

Conclusion

Data utilization is essential to guide training. Often, education is interdisciplinary and multi-faceted. Routine training is not routine at all when both educators and staff display a mutual engagement and passion for knowledge and practice. For the educator, how one teaches is as critical as what is taught. It is essential to instill the mental model in learners whereby they feel confident to ask questions about safety in procedures. This confidence in the ability to speak up enables learners to identify and report practices and processes that do not work reliably and heightens their awareness in recognizing experiences with a potential for improvement. ●

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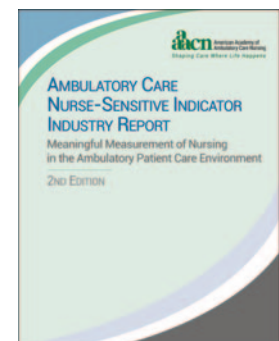
Ambulatory Care Nurse-Sensitive Indicator Industry Report: Meaningful Measurement of Nursing in the Ambulatory Patient Care Environment, Second Edition

Editors: Rachel Start, MSN, NEA-BC, RN, FAAN, Rebecca Dellefave, BSN, RN, MS, Ann Marie Matlock, DNP, RN, NE-BC, Stephanie Witwer, PhD, RN, NEA-BC, FAAN

Far expanded from the first edition, the updated report contains many added tools and supports, as well as expanded measure sets and statements of advocacy. This timely report includes a description of current state of healthcare industry, quality measurement, ambulatory nursing specific practice and meaningful measurement of ambulatory nurse contribution to patient and quality outcomes, as well as a compilation of tools and resources for ambulatory care nurses and other healthcare professionals.

Value to Your Practice:

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Ambulatory Care Nursing Leadership Restructuring: Moving to a Triad Leadership Model to Support Professional Practice

Justin B. Montgomery
Emily Dirkse

In response to shifting demographics, payment patterns, technological advances, and the needs and wants of patients, healthcare delivery models are changing. Episodic inpatient management of complex and chronic health conditions is unsustainable, and often unwanted, thus shifting to ambulatory care clinics and the home (American Hospital Association [AHA], 2024). This shift is both cost-effective and improves patient satisfaction (AHA, 2024; Odell et al., 2018). The change in settings for patient and clinician interaction requires a shift from physician-centric outpatient practice to team-based care models that utilize the skills of each unique discipline in delivering evidence-based, high-quality, safe, equitable, and patient-centered care (National Academies of Sciences, Engineering, and Medicine, 2016, 2021). Nurses practicing to the full extent of their licensure are prepared to meet many of these evolving needs as an integral part of the ambulatory care delivery team (Mobley et al., 2023).

Problem Statement

There are multiple possibilities for nurses to support outpatient team-based care delivery, and many have been known for years. Engelke identified the ambulatory care nurse as “the link between episodic care provided on inpatient units and preventative and follow up care provided at home” (1980, p. 1813). First published in 2001, the *Core Curriculum for Ambulatory Care Nursing* is now in the fourth edition (Laughlin & Witwer, 2019). The *Core Curriculum* defines the many current practice patterns and competencies needed for nursing in outpatient settings (Laughlin & Witwer, 2019). There is a demand for nursing expertise on ambulatory clinic teams and necessary resources for developing that expertise (American Academy of Ambulatory Care Nursing [AAACN], n.d.; Mobley et al., 2023). However, across most hospital and clinic locations, little has changed over the years, indicating structural barriers remain (Mobley et al., 2023).

The American Nurses Credentialing Center (ANCC) Magnet® designation is recognized as evidence that a hospital has a practice environment where nursing excellence, within interdisciplinary teams, is ingrained in the culture. Structural empowerment of nursing is a foundational component of the Magnet Model (ANCC, n.d.). Evidence of structural empowerment for Magnet designation requires nurses

to have a meaningful voice in the leadership of clinics in which they practice (ANCC, n.d.). Further, structural empowerment is known to increase registered nurse (RN) performance and commitment to the organization (Fragkos et al., 2020). Regardless of an organization's Magnet designation status, structural empowerment is intricately connected to advancing the role of nursing in ambulatory care settings. However, there is wide variation in how structural empowerment is accomplished and little data supporting any of the current models.

Local Context

Driven by high patient demand, a rural academic medical center that is part of a larger health system started a journey to increase its team-based outpatient care approach. The academic medical center is a 460-bed facility that cares for some of the most complex patients in the nation. The medical center case-mix index is in the top 5% of the country. That complex case-mix contributes to many of the 1.6 million outpatient visits performed each year. Highly skilled team-based care is critical to meet the needs of these patients.

The medical center ambulatory care nursing leadership team was charged with driving ambulatory care RN practice to be at its full scope as part of the teams caring for these patients. However, due to wide variation in the ambulatory care nursing leadership reporting structure, responsibility scope, and supporting resources, repeated efforts to accomplish this goal were unsuccessful. Clinic leadership structures did not have nursing leadership involved in goal setting nor operations of frontline teams. Systematic change across organizational charts was needed to move ambulatory care nursing practice forward.

Intervention

This need for change coincided with the arrival of a new Chief Nursing Officer (CNO) who strongly supported the triad leadership model. The CNO sponsored a project team that included the vice president of ambulatory nursing, a program specialist, a Lean Six Sigma Black Belt performance improvement consultant, and the director of ambulatory nursing. The AAACN *Ambulatory Care Nurse Executive Toolkit* (2021) provided the content for the restructuring. The framework and tactics for moving to the



new structure were based on the eight stages of change management described in *Leading Change* (Kotter, 2012). The project team developed a four-phased approach to restructuring ambulatory care leadership from a dyad to triad team. These four phases matched nurse leaders with existing physician and administrative leads across the ambulatory care organizational chart. The restructuring had two critical boundaries: it could not increase total full-time equivalent (FTE) nursing leadership positions or expense, and ambulatory care nurses must report through nursing and the CNO.

The first phase was defining current and future state. Organizational charts of current state reporting structures were created. These charts demonstrated span of control, defined as number of direct and indirect reports, and supporting resources. At the start of this work, 21% of ambulatory care nursing staff reported through the CNO. Three out of 17 nurse managers reported through the CNO, and the rest reported through administrative directors. There were no standard FTE reports for managers, with a range of four reports to as many as 61. Similarly, no consistent resources for support of managers existed. Some had supervisors and leads; others had no support. There was one nurse educator for over 500 staff and a half-time quality assurance nurse. It was clear that the structure or system to achieve goals was ineffective, contributing to earlier failures.

Lacking defined span of control benchmarks for ambulatory care nurse leaders, the CNO set expectations for a nursing director to supervise four to five nurse managers with approximately 250 indirect reports. Additional considerations for span of control included geographic range of clinics, total administrative and provider teams to partner with, and a final "Would I take this job?" appraisal by staff knowledgeable of the areas. Nurse managers would have approximately 50 direct and indirect reports with the same span of control considerations. Using sticky notes on a wall across multiple meetings, the project team was able to create a future state proposal that was FTE and budget neutral and moved ambulatory care frontline nurses to report through the CNO.

Phase two focused on engaging senior leadership for support of the restructuring. A four-slide presentation was created that included the background for the proposal, revised organizational charts, financial impact, and implementation timeline. In parallel with the presentation was the development of a communication plan outlining when and how key stakeholders would be engaged. The presentation was first reviewed with the system level Chief Executive Officer and Chief Operating Officer and then presented to the academic medical center senior administrative and physician leadership. The plan received unanimous support to move forward.

With senior leadership support, the project team began socializing the plan with frontline leadership teams. While

generally supported, there were more questions and skeptics about the plan in conversations with directors, managers, and section chiefs. Example concerns included the size of a nurse manager's scope and lack of administrative oversight of frontline nurses' hours and their budget implications. Successful nurse leaders in the current ambulatory care environment must have the ability to forge authentic connections, manage change, approach problems curiously, and inspire teams to pursue nursing practice excellence (Stuart-Pesevic & Talarico, 2024). This restructuring required all these skills and more time than anticipated to foster buy-in among frontline leaders.

The original boundaries of keeping the project FTE and budget neutral and ensuring nurses report through the CNO were critical to the success of this phase. Having only two boundaries allowed flexibility in partnering with frontline leaders to assure ambulatory care nursing leadership had a meaningful voice in clinic operations while working collaboratively with interdisciplinary partners. Phase two was completed in March 2024.

Phase three started a repeating approach of hiring or promoting to a level of the organizational chart, then having those leaders create the next level and hire or promote into the positions that would report to them. Specifically, the existing ambulatory director was promoted to a senior director who then led the hiring process for the four ambulatory directors. The hiring process included normal hiring practices for job posting and recruitment; however, considerable work went into partnering with administrative and physician leads to agree on areas of responsibility before posting positions. Hiring of the four ambulatory directors was completed in May 2024, ending phase three.

The four directors then repeated the same pattern for hiring nurse managers. Having only the two "non-negotiables," nursing directors partnered with their new triad team to set areas of oversight for managers. Phase four was complete in July 2024 with either a nurse manager position posted or existing managers resetting span of control as needed.

Evaluation

To date, 81% of nurses report through nursing and the restructuring was FTE and cost neutral. Further indicators of success are emerging. Director and manager span of control is more consistent. Six of 11 departments included nursing directors for the first time in developing strategic goals. Nurses are providing input into the development of department budgets for the coming fiscal year, including needs for nursing staff. Ambulatory care nursing participation in the central shared governance councils has gone from two participants in previous years to nine, currently. There are six new clinic-based nurse practice councils in addition to the original three. Clearly, nursing is gaining a



Figure 1.
Phases of the Restructure Work



voice in clinic operations and becoming more involved with nursing practice activities in the medical center.

Significant challenges remain. Once the restructure is complete, directors and managers will have adequate front-line leadership and ancillary support. In the interim, there is a high burden on current leaders to ensure ongoing safe and patient-centered care is provided. Role confusion among administrative and nursing leaders has created strained team function in some departments. However, the project and leadership teams continue to adapt and advance the work with unwavering focus.

Five more phases are planned to secure the right front-line and ancillary support for the strained nurse leaders. These phases have a target completion date of December

2025. See Figure 1 for additional phases. Once complete, an annual retreat will be scheduled to review the structure and ensure it is continuing to meet the needs of patients, staff, and the organization.

The pursuit of a professional practice environment for nurses in the ambulatory care setting is increasingly important as more care shifts to the outpatient space. Enabling nurses to practice at the top-of-license provides an engaging environment for nurses to work within and positively impacts patient care efficiency and effectiveness. Making radical change to promote the ideal ambulatory care practice environment takes thoughtful planning, methodical and skilled change management, and sponsorship at the highest levels of organizational leadership. Our organization's journey demonstrates change to a triad model is possible as a foundation for structural empowerment of ambulatory care nurses. ●

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Technology Competencies

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Nurse leaders must be stakeholders in the design and implementation of new technologies to ensure these tools will support nurses in their practice and deliver the desired outcomes of improving quality, safety, and efficiency, while meeting regulatory requirements. They must be advocates for innovation, driving the adoption of new technologies within their organizations. This requires nurse leaders to maintain awareness of technology trends to better anticipate and lead initiatives to enhance care delivery. Collaboration with information technology departments, vendors, and other stakeholders is crucial to ensure nurses are represented and have an opportunity to advocate to ensure successful implementation and integration of technology solutions. Without this collaboration, nurses suffer with poor workflows that only add to their burden of documentation, nurse leaders spend countless hours optimizing poorly designed systems, and ultimately patients lose when they have less quality interaction with their nursing team.

Data Management

In the information age, data is a powerful ally. The AONL (n.d.) recommends nurse leaders develop competencies to identify data needs across all domains to include administrative, clinical, operations, research, and education. The skills to collect, categorize, and analyze the enormous amount of data that healthcare systems generate are vital to making use of this data to empower nurse leaders to lead evidence-based initiatives, monitor performance metrics, and implement strategies that improve quality of care. Additionally, expertise in data management enables nurse leaders to contribute to research and innovation. By analyzing patient data, they can identify opportunities for best practices, develop protocols to streamline care, and mitigate risks to patient and staff safety. Data proficiency ultimately aids nurse leaders to more effectively allocate resources and base their decisions on a foundation of data-informed evidence.

Cybersecurity

With the proliferation of digital technologies in all sectors of society, we have seen the inevitable challenge of cybersecurity. This has become perhaps one of the most significant threats to patient safety and privacy when we consider recent attacks on large healthcare systems and the crippling effect to caring for patients in the aftermath of an attack. Ensuring the confidentiality, integrity, and availability of patient information is vital; therefore, nurse leaders must be knowledgeable regarding cybersecurity protocols to safeguard their organizations from breaches. It is also imperative that nurse leaders ensure their team members are savvy in recognizing attempts at security breaches and are well-versed on the organizational policies to respond quickly and appropriately should their system be the victim of a cyber-attack.

As nurse leaders, we sit at the intersection of clinical and operational practice and must be engaged in developing our downtime and recovery plans to ensure there is both short-term and long-term planning in place. Too often, the focus of large systems may be primarily based in the acute setting; however, the ambulatory care delivery system is crucial to avoid unnecessary visits to emergency departments in crisis or hospital admissions due to delays in treatment. Ambulatory care nurse leaders must be proactive to ensure their high-priority clinics and treatment facilities are prepared for prolonged downtimes with robust plans to continue critical patient care activities.

Health Informatics

The fast-paced nature of technological advancements necessitates continuous learning and professional development. The COVID-19 pandemic provided an example of the accelerated use of technology as virtual care via telehealth exploded and has now become part of the normal care delivery in ambulatory care practice. At the beginning of the pandemic, few clinicians and staff were able to utilize the technology; however, within a relatively short period of time due to necessity, there was widespread adoption. While effective, crisis learning is not optimal. When we consider the guiding principles identified by AONL, though broad in nature, they include competencies in healthcare informatics that many nurse leaders may not have today as we did not learn them in our graduate programs of study given the rapid evolution of technology and informatics as an important discipline within the healthcare sector. This requires nurse leaders to recognize their current level of competency to seek opportunities to close gaps on learning needs (Morse & Warshawsky, 2021).

As the healthcare landscape continues to evolve, the role of nurse leaders becomes increasingly complex and dynamic. Mastering technology competencies is essential for nurse leaders to navigate these changes, enhance patient care, and drive organizational success. We also must consider the changing workforce as Generation Z is entering into the workforce and will soon be followed by Generation Alpha, the first wholly digital generation. By embracing technological proficiency, nurse leaders can lead with confidence, inspire their teams, and make a meaningful impact on the future of health care. ●

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The Role of the Healthcare Quality Professional in the Ambulatory Care Setting

Jennifer Woodle-Barnes

The healthcare quality professional (HQP) plays a vital role in the successful operation of healthcare organizations. As healthcare delivery systems continue to adopt models designed to reward cost-efficient and high-quality care, the demand for expertise in healthcare quality continues to grow (Schrimmer et al., 2019). In addition, healthcare delivery continues the transition to a value-based care model, which includes focusing on quality, provider performance, and patient experience.

The National Association for Healthcare Quality (NAHQ), as a leader in the field and committed to the advancement of healthcare quality, developed the NAHQ Healthcare Quality Competency Framework™ (NAHQ, 2019). This is a defined set of standardized competencies for the HQP. The eight areas of the HQ Essentials include: Performance and Process Improvement, Population Health and Care Transitions, Health Data Analytics, Patient Safety, Regulatory and Accreditation, Quality Review and Accountability, Professional Engagement, and Quality Leadership and Integration (NAHQ, 2019; Schrimmer et al., 2019).

The most reputable certification for healthcare quality professionals is the Certified Professional in Healthcare Quality (CPHQ) credential. It is the only accredited certification in healthcare quality and is endorsed by The Joint Commission (Miltner et al., 2021). While not a requirement in many organizations to serve in a staff level healthcare quality role, the certification may be a requirement at the executive quality leader level.

The position name and role function(s) of the HQP may vary among organizations. For example, the HQP title is interchangeable with quality management (QM) profes-

sional. The primary elements of the role may include but are not limited to serving as the content expert in applying performance measurement and process improvement, improving patient safety and reducing risk in patient care processes, ensuring compliance with accreditation standards, promoting infection control and prevention, and providing utilization management and/or medical staff support.

Organizations may have individual quality professionals for each focus area, or they may have a more “generalist” quality management role that serves as a consultant for any quality or patient safety related concern. If there is an area of expertise required, the generalist QM professional may reach out to a quality team member with that specific skill set (e.g., infection preventionist, patient safety specialist).

The HQP plays a significant role in the ambulatory care setting, especially in primary care. Quality measures, performance improvement, patient safety, and clinic practice efficiency are key elements of a successful primary care team. The Healthcare Effectiveness Data and Information Set (HEDIS) is one of healthcare’s most widely used performance improvement tools. HEDIS includes more than 90 measures across six domains of care: Effectiveness of Care, Access/Availability of Care, Experience of Care, Utilization and Risk Adjusted Utilization, Health Plan Descriptive Information, and Measures Reported Using Electronic Clinical Data Systems (National Committee for Quality Assurance, 2025). Primary care teams are evaluated based on their performance with the HEDIS measures; therefore, ongoing review and action are expectations.

Lean Six Sigma (LSS) is a powerful methodology to examine the causes of low-value care and waste in complex healthcare settings. Examples of LSS methods that can

••••• Diverse Roles in Ambulatory Care •••••

be applied are interdisciplinary process mapping, voice of the customer and brainstorming for value, pilot testing using Plan-Do-Study-Act cycles, and sustainability planning (Wilson et al., 2019). The QM professional can support clinical teams with improving their care processes, setting HEDIS measure performance goals, and facilitating the process improvement teams that aid in achieving the set goals.

The registered nurse with an ambulatory care/primary care background plus healthcare quality expertise is a valuable asset in the ambulatory care setting. The ability to integrate an understanding of primary care practices and the dynamics of population health management, coupled with patient safety and process improvement expertise, promotes a cohesive, interprofessional relationship focused on positive patient outcomes. This is an example of a practical approach. A particular primary care panel may exhibit sub-optimal quality metric scores for hypertension or diabetes management (e.g., too many cardiovascular patients with blood pressure greater than 140/90 and/or hemoglobin A1c value greater than 9 in patients with diabetes). The primary care team, in collaboration with the QM registered nurse, can initiate a performance improvement project by performing a data deep dive to identify contributing factors and

implement patient-specific and/or population-focused improvement strategies.

There are a variety of quality improvement methods and tools available to promote positive patient outcomes for clinical teams. To cite a few, data stratification/analysis may be utilized to identify any healthcare quality gaps in demographic populations at risk. LSS tools (e.g., 5 Whys, fishbone diagram) then can be utilized to explore contributing factors and identify root causes that may impede a patient in reaching optimal health (e.g., food or housing insecurity, transportation issues). When identifying improvement strategies, it is imperative to perform a literature review for evidenced-based and/or best practices and then set realistic, measurable targets (e.g., 100% may not be a viable target, depending on the measure). Additionally, quality metric data should be tracked over time to monitor effectiveness of the actions performed on the outcome measure. The ideal state is that when structured quality improvement strategies are established in daily practice, the success and sustainability of positive patient outcomes may be achieved.

In conclusion, healthcare quality registered nurses may play an integral role, not only in a corporate healthcare set-

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AAACN News

AAACN's Next Board Fellow



Nicholas Snow

We are thrilled to welcome Nicholas Snow, DNP, MS-HPL, BSN, RN-C, NE-BC, as AAACN's 2025-2026 Emerging Professional Board Fellow. With a background in ambulatory care, Nicholas currently serves as a nurse manager at the University of Utah Health. Nicholas is excited to bring his experience, passion, and dedication to

this role and is looking forward to making a meaningful impact in our field.

Ambulatory Care Nurses Week 2025

Making Strides Across the Nation

Ambulatory Care Nurses Week 2025 was a resounding success, highlighting the dedication, compassion, and expertise of nurses who make a difference every day in outpatient settings. Throughout the week, healthcare organizations demonstrated their appreciation for ambulatory care nurses, and 146 people laced up their sneakers to join the first-ever Virtual 5K Walk/Run, uniting participants from coast to coast. Participation and donations supported the AAACN Scholarship & Research Fund, empowering future leaders in ambulatory care nursing.

AAACN leaders, members, and staff celebrated Ambulatory Care Nurses Week.



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Healthcare Quality Professional

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ting, but specifically in the ambulatory care setting. Their expertise in patient safety, performance and process improvement, and accreditation survey requirements positions healthcare agencies for success and provides a mechanism for continuous process improvement. ●

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