Redefining and Categorizing The Perceived Value Of the RN in Ambulatory Care

Robin E. Matutina
Susan B. Hamner
Rosemarie Battaglia

The role of the RN in the outpatient setting is ever evolving, especially in light of new initiatives, including health care reform, the medical home model, and meaningful use standards. Expectations of other health care professionals regarding the role of the RN in the ambulatory setting may vary from clinic to clinic and from organization to organization. Today’s health care arena demands that RNs utilize their multi-dimensional skill set and scope of practice in an efficient and fiscally responsible manner.

In 2005, the American Academy of Ambulatory Care Nursing (AAACN) explored the value of ambulatory care nurses in the workplace (Conway-Phillips, 2006). This study, conducted among members of the specialty organization, found that the nurses viewed themselves as adding value in the following areas:

- Patient/family education
- Telephone/clinic triage
- Patient care and coordination of care
- Leadership/management
- Collaboration with the medical staff
- Patient advocacy
- Staff education
- Compliance with regulatory/accrediting standards
- Financial benefits (for example, by preventing hospital admissions and inappropriate use of emergency departments)
- Continuity of care
- Access to care
- Quality initiatives
- Research

Conway-Phillips (2006) also found that the majority of ambulatory care settings (54%) were not collecting data (other than patient satisfaction) regarding performance improvement indicators to evaluate the effectiveness of the RN.

As a starting point for role clarification in the outpatient clinics, the authors of this study wanted to examine the value of the registered nurse in the current health care climate at the Medical University of South Carolina as compared to the Conway-Phillips (2006) study.

continued on page 8

Contact hour instructions, objectives, and accreditation information may be found on page 10.
Four Themes Found in The Future of Nursing

In November, I was fortunate to attend the Nursing Organizations Alliance (NOA) Fall Summit. We heard from Michael Bleich, PhD, RN, NEA-BC, FAAN, on the Institute of Medicine (IOM) Future of Nursing report (IOM, 2010). Dr. Bleich is the Dr. Carol A. Lindeman Distinguished Professor at Oregon Health & Science University, School of Nursing. He provided an overview of the key points of the report and our progress toward implementing the recommendations, the challenges we face, and topics we need to address to move forward as a profession. It was disturbing to hear from Dr. Bleich that only 1 in 10 nurses are familiar with the report. While it is daunting to take on the 671-page read of the IOM report, The Future of Nursing, I found the 18-page summary to be a good read. Both the full report and the summary version are available online (http://www.nap.edu/catalog/12956.html). I recommend reading the summary and encouraging your nurse colleagues to do the same.

There are eight recommendations in the IOM Future of Nursing report. Dr. Bleich grouped them into four key messages that are important to all nurses.

Key message one is to promote the practice of nursing to the fullest extent of education training and licensure.

- The first recommendation of the IOM report is: “Remove scope of practice barriers.” Each nurse needs to participate at the state level to promote legislation that will allow nurses to work, practice, and be compensated for expertise fully functioning within licensure. The National Council of State Boards of Nursing and State Action Coalitions are working to address restriction of the practice on advanced practice registered nurses (APRNs). There does not seem to be a good rationale for restricting the practice of the APRN. It is incongruent that an APRN who functions independently and prescribes medication in one state finds that just across the state line he or she must work under the direct supervision of a physician to perform the same task. The nurse’s competency has not changed – only the law governing practice.

- The national level, Medicare programs need to expand coverage to include the APRN in reimbursement plans. Much of the Medicare language is physician centric in nature, leading to reduced or no coverage for services provided by the APRN. Much rhetoric has been heard from physician groups regarding care variation. In a 2000 study, “Primary Care Outcomes in Patients Treated by Nurse Practitioners or Physicians: A Randomized Trial,” the conclusion was that the care provided by the nurse practitioner and physician group were comparable (Mundinger et al., 2000). The American Nurses Association (ANA) has responded with recommendations to improve the language for stronger recognition of the value of the APRN in the new proposed Medicare rules. AAACN supports these recommendations as an ANA affiliate member.

- The second IOM recommendation also fits this key message in that it challenges nurses to expand their influence through opportunities to lead and diffuse collaborative improvement efforts with physicians and other members of the health care team, recognizing the expertise the nurse brings to conduct research and to redesign practice environments and health systems (IOM, 2010).

The second key message found in the IOM report, The Future of Nursing, was stronger educational standards for nurses.

There are four of the IOM recommendations related to this key message. This topic has been debated for over fifty years with no real progress. The plans include transitions into the continual learning and higher degrees.

continued on page 13
Health literacy is believed to be a stronger predictor of health outcomes than social and economic status, education, gender, and age (Egbert & Nanna, 2009). The Institute of Medicine (IOM) (2004) defines health literacy as “the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions” (p. 32). At Tampa General Hospital (TGH), clinicians strive to incorporate patient and family education as an integral part of patient care in both the inpatient and outpatient settings. The TGH Patient Education Council identified the need for a centralized location for patient education materials that would provide access to information for both patients and their families. In 2004, the council proposed that a portion of the hospital medical library become a patient and family education resource center (PERC).

Design and Implementation

Over the next five years, the TGH Foundation sought funding for a kiosk and computers, and after obtaining a private grant for $20,000 from Verizon, the PERC plan was implemented. The process included development of an administrative policy, designing the desktop and kiosk, ordering materials and equipment, and selecting Web-based patient education databases. The TGH Technology Department was consulted for equipment purchases, setup, and providing safe but limited Internet access for the PERC. A simple patient/family survey card (see Figure 1) was designed to obtain user feedback (see Table 1), with English printed on one side and Spanish on the other.

The Patient Education Council developed and implemented a unique PERC without startup financial support from the hospital. The TGH PERC is a freestanding kiosk with computer cubicles on both ends and space for 100 pamphlets in the center. The pamphlets cover TGH’s most prevalent diagnosis-related groups and preventive medicine topics. The kiosk is located in the main lobby across from the Registration Center, an area of high flow and visibility.

Maintenance

Medical Library personnel and TGH volunteers provide the kiosk’s minimal maintenance. Library personnel monitor which pamphlets require restocking and reordering. The librarians also keep a running total of pamphlets taken, which in the beginning enabled the Patient Education Council to determine which pamphlets would benefit consumers the most (see Table 2). The Head Librarian reports to and

continued on page 4
is an active member of the Patient Education Council. Only a minimal amount of time is required from TGH volunteers. A hospital volunteer desk is located next to the Patient Education Resource Center, which permits volunteers to request toner for the printers when needed and direct customers in calling the hospital's information system department with computer technical difficulties. The PERC is a fixed expense absorbed by the hospital. The budget covering toner, paper, and staff was less than $200 this past fiscal year.

**Education Materials**

The educational materials selected by the Patient Education Council are all current materials from the National Institutes of Health. All printed materials are bilingual and on a sixth grade (or lower) reading level. The National Institutes of Health not only provides these pamphlets free of charge, but they also pay for all shipping costs. All pamphlet stocks are stored in TGH’s medical library. Since the kiosk’s implementation, the librarian tech has taken over ordering pamphlets.

**Outcomes**

Evaluating how the PERC is used and determining the level of user satisfaction occurs in two ways. First, the number and type of professionally printed brochures taken are counted and recorded monthly. Secondly, short voluntary PERC satisfaction survey cards are collected and results are analyzed. Additionally, TGH participates in the Press Ganey patient satisfaction surveys. Press Ganey scores related to patient education increased since the program was implemented in 2009. Although this increase cannot be solely attributable to the PERC, it may have been influenced by it. In an article on promoting health literacy via MedlinePlus® and kiosk availability at the University of Tennessee/Baptist Hospital, it was reported that the kiosk created a means for patients to discuss health matters with their providers and for the providers to stress the importance of complying with diet, exercise, prescriptions, and follow-up (Teolis, 2010).

**PERC Expansion and Growth**

TGH’s grantor has expanded funding for two additional PERCs in specialty areas of Tampa General Hospital. The second PERC is located in our Emergency Department (ED). The third PERC will be in the Neonatal Intensive Care Unit (NICU). Each PERC is strategically and conveniently placed to attract the greatest number of users. The Patient Education Council reviews appropriateness of materials on a monthly basis at their meetings, ensuring all materials are on or below a sixth grade reading level.

### Table 1.
**Collected Responses from Voluntary Survey Cards, February 2009 – December 2009**

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>No answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Were you able to find what you were looking for?</td>
<td>81.4%</td>
<td>15.3%</td>
<td>3.4%</td>
</tr>
<tr>
<td>Did you use the computer?</td>
<td>Yes</td>
<td>No</td>
<td>No answer</td>
</tr>
<tr>
<td>Did you take brochures?</td>
<td>Yes</td>
<td>No</td>
<td>No answer</td>
</tr>
<tr>
<td>How long did you have to wait to use the computer?</td>
<td>No wait</td>
<td>5 minutes</td>
<td>10 minutes</td>
</tr>
<tr>
<td>Did you print anything?</td>
<td>Yes</td>
<td>No</td>
<td>No answer</td>
</tr>
<tr>
<td>How many topics?</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Are you a…</td>
<td>Patient</td>
<td>Visitor</td>
<td>Employee</td>
</tr>
<tr>
<td>Would you recommend the use of the Center to others?</td>
<td>Yes</td>
<td>No</td>
<td>No answer</td>
</tr>
</tbody>
</table>

### Table 2.
**PERC Complete Inventory Outcomes, February 2009 – December 2009**

<table>
<thead>
<tr>
<th>Topic Category</th>
<th>Number of Pamphlet Topics</th>
<th>Used Number of Pamphlets</th>
</tr>
</thead>
<tbody>
<tr>
<td>Men’s &amp; Women’s Health</td>
<td>12</td>
<td>411</td>
</tr>
<tr>
<td>Tests &amp; Procedures</td>
<td>23</td>
<td>1020</td>
</tr>
<tr>
<td>Nutrition</td>
<td>3</td>
<td>42</td>
</tr>
<tr>
<td>Safety &amp; Wellness</td>
<td>16</td>
<td>517</td>
</tr>
<tr>
<td>Infectious Disease</td>
<td>4</td>
<td>215</td>
</tr>
<tr>
<td>Cardiovascular &amp; Stroke</td>
<td>25</td>
<td>886</td>
</tr>
<tr>
<td>Dermatology</td>
<td>4</td>
<td>201</td>
</tr>
<tr>
<td>Endocrine &amp; Diabetes</td>
<td>18</td>
<td>756</td>
</tr>
<tr>
<td>Eye, Ear, Nose, &amp; Throat</td>
<td>2</td>
<td>108</td>
</tr>
<tr>
<td>Gastrointestinal</td>
<td>4</td>
<td>80</td>
</tr>
<tr>
<td>Musculoskeletal</td>
<td>13</td>
<td>659</td>
</tr>
<tr>
<td>Nephrology</td>
<td>1</td>
<td>43</td>
</tr>
<tr>
<td>Psychiatry &amp; Mood Disorder</td>
<td>3</td>
<td>67</td>
</tr>
<tr>
<td>Palliative Care</td>
<td>2</td>
<td>25</td>
</tr>
<tr>
<td>Poison</td>
<td>15</td>
<td>600</td>
</tr>
</tbody>
</table>
have a positive impact on health and well-being for users, reduce medical errors, and reduce medical expenses by promoting healthy lifestyles and managing chronic diseases. By continuing to analyze and report user satisfaction, proposals for improvements can be identified and evaluated for use in future plans as the program continues to expand.

References

Suggested Readings

Linda Northrop, BA, RN, PCRN, is a Clinical Nurse, Tampa General Hospital, Tampa, FL.
Renée Meehan, RN, BSN, MA, CDE, is a Diabetes Nurse Specialist, Tampa General Hospital, Tampa, FL.
Barbara Hatfield, RN, CNS, MSN, is a Clinical Nurse, Tampa General Hospital, Tampa, FL.

Send Us Your News
AAACN ViewPoint welcomes news from AAACN members. If you have a news item, photo, or success story you would like published, send it along with your name, email address, phone number, and other comments/suggestions to: Katie Brownlow, AAACN ViewPoint, Managing Editor, East Holly Avenue, Box 56, Pitman, NJ 08071-0056; Email katie@ajj.com

Covering Healthcare Call Centers and the Telehealth Industry
Get your FREE subscription at: www.answerstat.com/subscribe
Also, check out Medical Call Center News at www.medicalcallcenternews.com
Prevention and Early Detection of “Never Events” Within Ambulatory Settings to Enhance Quality and Safety and Prevent Financial Losses

In the last ViewPoint “Health Care Reform” column (Haas, 2011), accountable care organizations (ACOs) that include patient centered medical homes (PCMHs) or ambulatory care settings created by the Patient Protection and Affordable Care Act (PPACA) were defined and discussed. Within ACOs and PCMHs there are incentives, the proverbial ‘carrots,’ to increase safety and quality of care. However, there are also penalties for not enhancing quality and safety; the proverbial ‘sticks.’ A new, final Centers for Medicare and Medicaid Services (CMS) rule required by Section 2702 of PPACA will disallow federal funding under Medicaid effective July 1, 2012, for certain “never events” that State Medicaid Programs are required to define. The events to be defined are health care-associated conditions (HCACs) and other provider-preventable conditions (OPPCs) (CMS, 2011).

Never events include adverse (sentinel) events that are clearly identifiable and measurable, and serious events (resulting in death or significant disability), which are usually preventable (U.S. Department of Health and Human Services, Agency for Healthcare and Research and Quality [AHRQ], 2011). Hospital-acquired conditions (HACs), such as wrong site surgery for which Medicare already denies payment to hospitals, must be included in the State Medicaid Program definition of HCACs. The new OPPC designation is intended for conditions more likely to occur in settings outside hospitals such as outpatient or office-based surgery centers, skilled nursing facilities, and ambulatory practice settings (specifically office-based practices). OPPCs must be determined from evidence-based guidelines (CMS, 2011). It is expected that public reporting on incidence of never events in settings outside of hospitals will also be publicly reported – another ‘stick’ to enhance accountability.

The National Quality Forum (NQF) is a nonprofit organization that strives to improve the quality of American health care by establishing goals for performance improvement, endorsing national standards for measuring and reporting on performance, and promoting the attainment of national safety goals through education (NQF, 2011a). Using a consensus model, the NQF has been the organization working with the AHRQ to name and define the never events specified in CMS rules. The NQF Board recently approved a list of 29 serious reportable events (SREs) in health care in their 2011 Consensus Report. Of these 29 events, 25 were updated from 2006 and four new events were added to the list (NFQ, 2011b). This newly expanded list of serious reportable events (never events) is available and it provides health care professionals with an opportunity to improve patient safety. Table 1 shows the updated NQF never event list.

Currently, never events or HCACs are publicly reported, with the goal of increasing accountability and improving the quality of care. Public reporting began with NQF dissemination its original list of never events in 2002; 11 states have mandated reporting of these incidents whenever they occur, and an additional 16 states mandate reporting of serious adverse events (including many of the NQF never events) (AHRQ, 2011). Not only must the health care facilities report the events, they are accountable for correcting systematic problems that contributed to the event, with some states (such as Minnesota) mandating performance of a root cause analysis and reporting its results (AHRQ, 2011).

So what does this mean for ambulatory care nurse leaders? Ambulatory settings performing surgery, interventional radiology, or infusion therapy will, in about six months, be denied payment for never events that occur. Many of the never events listed in Table 1 are rare (AHRQ, 2011), but in 2009, data from Minnesota’s public reporting indicated that falls in hospitals account for 30% and pressure ulcers 39% of adverse events (Minnesota Department of Health, 2009). Both pressure ulcers and falls of patients and caregivers in ambulatory settings are potential never events across most patient populations. Never events should not occur because there are evidence-based methods of preventing them and detecting them early.

First and foremost, ambulatory care nurse leaders need to be involved in proactively planning for development and implementation of evidence-based guidelines to prevent potential never events in their settings. If guidelines are not already in place, then work should begin on developing guidelines for those high-volume, high-cost events such as falls and pressure ulcers. Please note that pressure ulcers can begin in as little as four to six hours, so procedure areas where patients are immobile for such time frames should have guidelines in place to provide for a full body skin assessment at the beginning of a visit as part of early detection of current or potential areas of breakdown and should address positioning and repositioning as well as appropriate support surfaces. Ambulatory care nurses should also be at the table when Electronic Medical Record (EMR) documentation screens are developed for care provided by nurses in ambulatory settings, so that there is opportunity for nurses to document assessments, interventions, evaluations, and outcomes in the EMR.

continued on page 8
# Table 1.
Serious Reportable Events in Health Care – 2011 Update

<table>
<thead>
<tr>
<th><strong>1. SURGICAL OR INVASIVE PROCEDURE EVENTS</strong></th>
<th><strong>2. PRODUCT OR DEVICE EVENTS</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Surgery or other invasive procedure performed on the wrong site</td>
<td>• Unintended retention of a foreign object in a patient after surgery or other invasive procedure</td>
</tr>
<tr>
<td>• Surgery or other invasive procedure performed on the wrong patient</td>
<td>• Intra-operative or immediately post-operative/post-procedure death in an ASA Class 1 patient</td>
</tr>
<tr>
<td>• Wrong surgical or other invasive procedure performed on a patient</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Patient death or serious injury associated with intravascular air embolism that occurs while being cared for in a health care setting</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>3. PATIENT PROTECTION EVENTS</strong></th>
<th><strong>4. CARE MANAGEMENT EVENTS</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Discharge or release of a patient/resident of any age, who is unable to make decisions, to other than an authorized person</td>
<td>• Patient death or serious injury associated with a medication error (e.g., errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation, or wrong route of administration)</td>
</tr>
<tr>
<td>• Patient death or serious injury associated with patient elopement (disappearance)</td>
<td>• Any Stage 3, Stage 4, and unstageable pressure ulcers acquired after admission/presentation to a health care setting</td>
</tr>
<tr>
<td></td>
<td>• Artificial insemination with the wrong donor sperm or wrong egg</td>
</tr>
<tr>
<td></td>
<td>• (NEW) Patient death or serious injury resulting from the irretrievable loss of an irreplaceable biological specimen</td>
</tr>
<tr>
<td></td>
<td>• (NEW) Patient death or serious injury resulting from failure to follow up or communicate laboratory, pathology, or radiology test results</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Patient suicide, attempted suicide, or self-harm that results in serious injury, while being cared for in a health care setting</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>5. ENVIRONMENTAL EVENTS</strong></th>
<th><strong>6. RADIOLOGIC EVENTS</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Patient or staff death or serious injury associated with an electric shock in the course of a patient care process in a health care setting</td>
<td>• (NEW) Death or serious injury of a patient or staff associated with the introduction of a metallic object into the MRI area</td>
</tr>
<tr>
<td>• Any incident in which systems designated for oxygen or other gas to be delivered to a patient contains no gas, the wrong gas, or is contaminated by toxic substances</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Patient or staff death or serious injury associated with a burn incurred from any source in the course of a patient care process in a health care setting</td>
</tr>
<tr>
<td></td>
<td>• Patient death or serious injury associated with the use of physical restraints or bedrails while being cared for in a health care setting</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>7. POTENTIAL CRIMINAL EVENTS</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed health care provider</td>
<td>• Death or serious injury of a patient or staff member resulting from a physical assault (i.e., battery) that occurs within or on the grounds of a health care setting</td>
</tr>
<tr>
<td>• Abduction of a patient/resident of any age</td>
<td></td>
</tr>
<tr>
<td>• Sexual abuse/assault on a patient or staff member within or on the grounds of a health care setting</td>
<td></td>
</tr>
</tbody>
</table>

References

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

Redefining the Value of the RN
continued from page 1

In addition to the initiatives outlined above, the outpatient clinics at this organization are in the process of implementing three other major changes: (a) the hiring of Certified Medical Assistants for the first time, (b) the implementation of a new electronic medical record system, and (c) changes in the workflow processes. These changes in the care delivery model increase the need for role clarification across all health care disciplines.

Method
In 2010, a convenience sample was made up of ambulatory care registered nurses employed in adult and pediatric primary care and specialty clinics (including family medicine, pulmonary, urology, internal medicine, dermatology, transplant, rheumatology, and more) at a teaching hospital located in Charleston, South Carolina. Permission to conduct the study was obtained from the Institutional Review Board. Staff nurses were asked to participate by email response to an online survey created on SurveyMonkey®. Participation was voluntary. Forty-four surveys were returned (return rate of 28%).

Procedure
The instrument selected was the “Value of an Ambulatory Care Nurse” survey used in the Conway-Phillips (2006) study. Permission to use the survey was received from Cynthia Hnatiuk, Executive Director of AAACN. The survey was comprised of the following three items:

1. Describe the value that you provide to your employer/workplace as an ambulatory care nurse.
2. Is your workplace collecting data regarding performance improvement indicators to evaluate the effectiveness of the registered nurse role in ambulatory care settings?
3. If yes, what performance indicators are being used?

Data was analyzed both quantitatively and qualitatively. Quantitative analysis included measuring a percentage response for the dichotomous question. Qualitative analysis was conducted by classifying responses into categories established by the research team. The authors used the AAACN standards as the basis for categorizing the responses (AAACN, 2010). In order to code the responses, the authors met together and reviewed each individual response. The main points from each response were then recorded, and agreement was reached among the three authors as to which category the response matched. For example, responses in one of the categories, Nursing Process, elicited the following responses: Direct Patient Care (8 responses), Patient Assessment (5), Critical Thinking (4), Medication Administration (4), Providing Quality Care (3), Support (3), Implementing Plan of Care (2), Triage of Patients/Problems (2), Clinical Skills (2), and Problem-Solving (1).

Some RNs responded with compound sentences or sentences with multiple adjectives, nouns, and verbs that needed to be broken down into segments that were then filed into different categories. Nevertheless, a single phrase, adjective, noun, or verb within a sentence was assigned a single category and not placed into more than one category. Categorization required consensus among all three authors, including: a staff nurse who is also a PhD candidate, a nurse educator, and a nurse manager. Descriptors of the standards were used to categorize the response.

Results
The responses to the statement, “Describe the value that you provide to your employer/workplace as an ambulatory care nurse,” are summarized in Table 1.

In answering the second question, “Is your workplace collecting data regarding performance improvement indicators to evaluate the effectiveness of the registered nurse in ambulatory care settings?” 49% responded, “Yes,” and 51% responded, “No,” which was similar to the earlier survey. In response to the third question, “If yes, what performance indicators are being used?” there were a total of 27 indicators listed with the most frequent response being “Patient Satisfaction Surveys” (26%). This was also the most frequent response in the 2005 survey.

Some indicators were very general (central line infections, medication reconciliation), but were only listed once. Other indicators were clinic-specific, such as indicators for patients with baclofen pumps. It was evident from some comments that not all nurses were clear on what is meant by “performance indicators” with regard to RN effective-
ness. Others were not sure if performance indicators were being measured in their area.

**Summary**

In the 2005 survey, 31% of nurses identified patient/family education as value added. In contrast, in the 2010 survey, nurses identified health teaching/health promotion in only 8% of responses. However, these nurses listed the work they do in the areas of assessment, phone triage, or care coordination, which can involve patient teaching. The number one response (20% of total responses) included activities associated with the nursing process: assessment, planning, implementation, outcomes, and evaluation. With the new emphasis on achieving outcomes in care, it is possible that nurses are recognizing the value of the nursing process as the key foundation for decision-making and evaluation to achieve patient goals. Nurses also responded that their experience and education were valuable attributes to the organization and to quality patient care (16% of responses) (as shown in Table 1). More specifically, “Experience/Education” responses revealed that in addition to initial education, personal commitment to ongoing professional development through continuing education and certification was an important component.

One nurse stated that she provides value through “critical thinking skills, triage, communication, and education to patients and families” and that RNs “possess a body of knowledge to help address medical conditions, establish plans of care, assess current conditions, and formulate preventive care.” Other values that were illuminated in the nurses’ responses included the concept of wellness care. By teaching patients value in self-care, exercise, nutrition, safety, and disease management, nurses place a measure of control back in the lives of their patients and enhance their sense of well-being, comfort, and quality of life. Additional important values cited included “making a difference, delivering compassionate care, and establishing a trusting relationship with patients and families.”

Some nurses also mentioned their role in preventing hospitalizations. One nurse stated that, “We are able to prevent patient admissions due to our vigilance in identifying problems early and taking appropriate preventive nursing interventions.” In addition to preventing costly hospitalizations, outpatient nurses also “provide cost containment, cost and time efficiency in regards to nursing practice, prevention of wasted resources, prevention of ‘mistakes’ or adverse patient related events.” These statements compare with findings in another study by Chinaglia and colleagues (2002). That study found a nurse-managed outpatient clinic decreased hospitalizations by 70%, improved the functional status and quality of life of the patients, and decreased medical costs (Chinaglia et al., 2002).

It is clear that RNs recognize their value and are able to articulate the role they play in the care of the ambulatory patient. Further investigation needs to address the link between the actual nursing care activities as defined by the AAACN *Scope and Standards of Practice* (2010) and the achievement of improved patient outcomes.

Although much of the focus and research related to the RN’s impact on outcomes is based on the inpatient experience, it is the authors’ belief that additional financial benefit to the health care system is achieved with improved health outcomes in the ambulatory setting as well. There is demonstrated evidence in inpatient settings that indicators, such as bloodstream infections with central lines, ventilator-associated pneumonia, and urinary tract infections, are decreased and patient outcomes are improved when RNs are providing care (Easing, Hobson, & White, 2005; Elpern et al., 2009; Goulette, 2001; Mark, Harless, & Berman, 2007). There is currently a lack of research and literature examining the role of the ambulatory RN in health promotion, health maintenance, and chronic care and the benefits derived from this care. In fact, a literature search of the years 1993 through the present resulted in only 20 publications (approximately one publication per year), and of those 20 publications, only four may be considered research studies: a qualitative study (Baghi, Panners, & Smolenski, 2007), a four-part survey study (Haas & Hackbarth, 1995a, 1995b; Haas, Hackbarth, Kavanagh, & Vlasses, 1995; Hackbarth, Haas, Kavanagh, & Vlasses, 1995), and two other survey studies (Conway-Phillips, 2006; Quirk, 1998) including the original survey study (Conway-Phillips, 2006) that we modeled.

---

**Table 1.**

2010 Survey Responses

*Describe the value that you provide to your employer/workplace as an ambulatory care nurse.*

<table>
<thead>
<tr>
<th>Category</th>
<th>AAACN Standard</th>
<th>Number of Responses</th>
<th>Percentage of Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing Process</td>
<td>1, 2, 3, 4, 6</td>
<td>34</td>
<td>20%</td>
</tr>
<tr>
<td>Experience/Education</td>
<td>8</td>
<td>28</td>
<td>16%</td>
</tr>
<tr>
<td>Coordination of Care</td>
<td>5a</td>
<td>21</td>
<td>12%</td>
</tr>
<tr>
<td>Leadership</td>
<td>16</td>
<td>16</td>
<td>9%</td>
</tr>
<tr>
<td>Collaboration</td>
<td>11</td>
<td>15</td>
<td>9%</td>
</tr>
<tr>
<td>Health Teaching/Health</td>
<td>5b</td>
<td>14</td>
<td>8%</td>
</tr>
<tr>
<td>Resource Utilization</td>
<td>15</td>
<td>13</td>
<td>8%</td>
</tr>
<tr>
<td>Performance Improvement</td>
<td>7</td>
<td>10</td>
<td>6%</td>
</tr>
<tr>
<td>Ethics</td>
<td>12</td>
<td>9</td>
<td>5%</td>
</tr>
<tr>
<td>Professional Practice</td>
<td>9</td>
<td>7</td>
<td>4%</td>
</tr>
<tr>
<td>Environment/Safety</td>
<td>14</td>
<td>3</td>
<td>2%</td>
</tr>
<tr>
<td>Research</td>
<td>13</td>
<td>1</td>
<td>0.5%</td>
</tr>
</tbody>
</table>

continued on page 10
The recent changes in health care delivery with increased focus on fiscal accountability, achievement of outcomes, and appropriate resource utilization present an opportunity to translate the assessment, planning, and interventions of the outpatient RN into measurable patient care outcomes and economic benefits. The information gained will assist organizations to better understand and utilize the professional registered nurse. It is expected that improvements in patient safety and patient outcomes will also be achieved.

References


Robin E. Matutina, PhD(c), RN-BC, CPN™, CPON®, is an RN III, Medical University of South Carolina, Charleston, SC.

Susan B. Hamner, MSN, RN, is a Clinical Education Specialist, Medical University of South Carolina, Charleston, SC.

Rosemarie Battaglia, MSN, RN, is a Nurse Manager, Children’s Hospital, Medical University of South Carolina, Charleston, SC.

Acknowledgement: The authors would like to acknowledge all the outpatient nurses who participated in the survey and Shannon Richards-Slaughter, PhD, for her editorial contributions.
Self-Care is Your Responsibility

The Basics

Establish a consistent exercise routine and incorporate activity during your workday; plan movement at least every two hours. According to recent studies (Katzmarzyk, Church, Craig, & Bouchard, 2009), an exercise program alone will not counteract the risk of a sedentary job, but moving throughout the day is beneficial. It is important to have a 5-minute movement break every hour. Do not work through your breaks. To maintain good health, you should leave your workstation and move – go outside for a brisk walk or go up and down stairs. Simply standing up and doing a quick run in place or a few jumping jacks may look unusual, but will have a powerful benefit. These movement ‘bursts’ will reduce the impact of prolonged sitting.

As stated in Part I (Koehne, 2011), there is a metabolic effect caused by long-term sitting. As a telephone triage nurse, you may be managing many calls every day, but you are not moving as calls are processed. Your mouth moves as you talk and your upper body will be used to document the calls by writing or typing, but this expends minimal physical energy. According to most calorie burn calculators, sitting at a desk burns 60-110 calories (depending on variables such as gender, age, and weight). The longer you engage in this type of work, the amount decreases to one calorie per minute. There is great potential for weight gain when you transition from an active nursing job to a more stationary telephone triage position. We all have heard of ‘freshmen fifteen.’ Have you experienced the ‘telephone nurse twenty?’

Many nurses who spend the majority of their time managing patients by phone report a weight gain. Often they report that when they were “running around the hospital” they burned off more calories and now they do not have this opportunity. If you have experienced this phenomenon common to telephone triage nurses, evaluate your diet. As nurses, you know the basics of proper nutrition. Awareness of the change in your caloric needs and making adjustments is the first step. A nutritionist may be a great resource if you are finding that this is a constant struggle.

Self-Care is Your Responsibility

Even if your employer does not provide a formalized ergonomic assessment and workstation evaluation as described in Part I (Koehne, 2011), you still can prevent injuries. For example, you can make adjustments to your chair, computer screen, lighting, telephone, and desk. It is important to take micro-breaks. These include adjusting your posture, stretching your back and shoulders, and resting your hands. These breaks, when done consistently throughout the day, can reduce the incidence of overuse injury. It may be helpful to post pictures of workstation stretches in your view to serve as a reminder. Then engage in activity during your breaks – take a walk, lift some hand weights, or do a little yoga. And don’t forget to fidget. Scientists have proved that fidgeting, which is defined as non-exercise activity, burns calories and increases blood circulation (Levine et al., 2005). Fidgeting includes foot tapping, head bobbing, and pacing. You make look restless, but it is for your health!

Your Eyes Matter Too

Even if you are not suffering from a metabolic or musculoskeletal disorder, you may be experiencing other computer-related symptoms. The American Optometric Association (2011) identified Computer Vision Syndrome, symptoms of which may include eyestrain, headache, dry eyes, and neck and shoulder pain. Over 50% of computer users report one or several of these symptoms. Reducing glare and adjusting screen brightness may prevent eye strain. It is also helpful to raise or lower the screen so it is positioned 4-5 inches below eye level. Additionally, it is important to look away from the screen for 20 seconds every 20 minutes, and to avoid computer use while on break. Remember to blink frequently to retain eye moisture. By implementing these practices, you will reduce the impact of the computer on your eyes. Typically, any visual changes are temporary and only occur when the computer is in use. Once the user is no longer visualizing the screen, the symptoms resolve. However, it is important to report any visual concerns to your health care provider and have regular eye exams. According to a survey completed by over 1,000 optometrists, approximately 10 million eye examinations are performed annually because of visual disturbances caused by computer use (Sheedy, 1992).

AAACN Takes a Stand

Although OSHA has become increasingly involved in promoting computer workstation safety in recent years, there are no federal or state level standards that enforce workstation wellness for employees. However, the American Academy of Ambulatory Care Nursing (AAACN) has taken a bold step to establish a standard that promotes a “safe, efficient, hazard-free, and ergonomically correct environment” for telehealth nursing staff (AAACN, 2011, p. 37). The Scope and Standards of Practice of Professional Telehealth Nursing (Standard 16 – Environment) has defined criteria which include proper ergonomic seating and equipment, and proper lighting and sound. AAACN is advocating for the health of telephone triage nurses through this standard.
Conclusion

As discussed throughout this series, telephone triage nurses are highly valued and in great demand. It takes experienced nurses with excellent communication skills, critical thinking ability, confidence in decision-making, and common sense to manage patient care via telephone. Even with life and professional experience, telephone triage nursing is highly sophisticated and takes time to develop and refine itself. However, the longer we spend on the phones in a physically static state, the more we risk our chance to remain healthy. But by engaging in workstation wellness activities, we can maintain and improve our health and well-being. If we implement ergonomic principles, we will be able to help patients for years to come!

References


Suggested Readings


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

● Yes, even older Americans can exercise to maintain body mass, strengthen muscles, and promote cardiovascular health. Check many resources at the National Institute of Health, National Institute on Aging, for free brochures that you can share with your elderly patients: http://www.nia.nih.gov/health/publication

● Love your heart this Valentine’s Day! Check out various ethnic options for eating more healthfully, including the Asian, Latin American, and Mediterranean food pyramids from Mayo Clinic: http://www.mayoclinic.com/health/healthy-diet/NR00190

● Ever consider becoming an organ donor? Check out information on live organ donations from the United Network for Organ Sharing: http://www.unos.org/docs/Living_Donation.pdf

● Did you forget about adult immunizations and what should be updated at each visit? Print and share this poster on what is required and when from the Centers for Disease Control and Prevention: http://www.cdc.gov/vaccines/recs/schedules/downloads/adult/adult-schedule-11x17.pdf

Carol Ann Attwood, MLS, AHIP, MPH, RN,C, is a Medical Librarian, Patient Health and Education Library, Mayo Clinic Arizona, Scottsdale, AZ, and a ViewPoint Editorial Board member. She can be contacted at attwood.carol@mayo.edu

We took everything you need for your job search and put it all in one place.

Welcome to the AAACN Career Center—your leading resource for an ideal position or effective recruitment. Job seekers can:

- Find the right nursing jobs. Quicker.
- Get job alerts.
- Receive targeted e-mails, e-newsletter, and career advice.

And if you’re hiring, there’s something for you too. Because we’re connected to other disciplines, your career centers job posting is seen by more people every day.

Connect today!

www.healthecareers.com/AAACN

(888) 884-8242 • info@healthecareers.com
President’s Message

continued from page 2

- The third recommendation is to implement nurse residency programs. These programs would help transition new nurses into practice, support advanced practice degree programs, or facilitate nurses transitioning into a new clinical area of practice. The goal of the programs would be to promote retention of nurses, expanded competencies, and improved patient outcomes.

- The fourth recommendation is to increase the proportion of nurses with a baccalaureate degree to 80% by 2020. Fifty percent of RNs currently have a baccalaureate degree. This recommendation also seeks funding for education and encourages nurses with associate or diploma degrees to enter baccalaureate nursing programs within 5 years of graduation.

- The fifth recommendation of the IOM is to double the number of nurses with a doctorate by 2020. This requires an increase in accredited programs to support student enrollment. The goal is that 10% of baccalaureate graduates will enter a master’s or doctorate program within 5 years of graduation.

- The sixth recommendation is to ensure that nurses engage in lifelong learning. Nurses must continually participate in learning to gain and maintain competencies needed to provide care for diverse patient populations. Educational programs should be adaptable, flexible, accessible, and have a positive impact on clinical outcomes.

AAACN and many employers offer scholarships or financial assistance for the continuing education of their members or staff.

The third key message is that nursing must be a full partner with physicians and other health care professionals in redesigning health care systems.

- In their seventh recommendation, the IOM states nurses need to be prepared and enabled to lead change to advance health initiatives. Nurses should be educationally prepared to assume leadership positions. There needs to be a grassroots nursing involvement to effect this change.

- We need nursing representation at every level of health care decision-making to advocate for our patients and define the impact of nursing on improving outcomes.

The fourth key message relates to the eighth recommendation. There needs to be effective workforce planning and policy-making.

- The IOM recommends an infrastructure be built that supports the collection and analysis of inter-professional health care workforce data. The Workforce Commission and Health Resources and Service Administration should lead collaborative efforts to improve research, collection, and analysis of data on effective workforce planning and policy-making.

- Political activism for nursing has been around since the Crimean War in 1853 when Florence Nightingale began collecting data on the high death rate of soldiers. When the military surgeons did not embrace her suggestion for improvements in environmental conditions, she used her connection with a reporter to alert the British people of the conditions. This sparked public outrage, and she received the needed supplies, equipment, and support to implement the changes (Mason, 2011).

As ambulatory care nurses, we can advocate for National Compact Licensure. This initiative allows nurses to practice in any compact state, the goal being all states become part of the compact. Licensure impacts us all because of the telehealth connection to our patients.

The Future of Nursing report provides us with more opportunities to stand as equals at the ‘table’ to devise a stronger and better health care system through collaboration.

Ambulatory care nurses need to arm themselves with the knowledge and tools to articulate our value in improving patient outcomes. We continue to expand our independent and collaborative practice using our broad knowledge base of nursing and health sciences, clinical judgment, and critical thinking skills to manage the complex problems of our patients. We work with our patients to promote optimal wellness, provide leadership, and coordinate care through the continuum of life in a variety of settings and methods of communication.

References


Linda Brixey, RN, is Program Manager, Clinical Education, Kelsey-Seybold Clinic, Houston, TX. She can be contacted at linda.brixey@kelsey-seybold.com
Members to Serve on The Joint Commission Professional and Technical Advisory Committee

Two AAACN members were recently appointed to serve on the Joint Commission Ambulatory Care Professional and Technical Advisory Committee (PTAC). Margarita Gore, RN-BC, BSN, MBA, from the Mayo Clinic in Scottsdale, AZ, had served as the alternate to this committee and will now serve as the official representative to the PTAC. Stephen E. Anderson, MBA, RN, FACHE, from VHA Pacific Northwest, in Seattle, WA, was appointed to serve as the alternate to this committee. Both members will serve 2-year terms.

PTAC representatives assist The Joint Commission in the development and refinement of standards and elements of performance. They also provide observations regarding environmental trends, educational needs, and other important issues facing each of the fields in which The Joint Commission offers accreditation services. PTAC representatives are expected to be proponents of their respective bodies of knowledge to The Joint Commission, and proponents of The Joint Commission to their constituents.

ViewPoint Article “Wish List”

ViewPoint features articles on a variety of topics of interest to ambulatory care and telehealth nurses. The following “wish list” includes topics members have told us they’d like to read more about, and now we’re hoping you can share your experience and knowledge with other members!

- Ambulatory care staffing ratios
- Ambulatory pediatrics
- Bariatrics
- Case management
- Disease management
- Immunizations
- Leadership in nursing education
- Legal nurse consulting
- Magnet® process for ambulatory care
- Medical home model
- Metrics for ambulatory care nursing
- Patient safety
- RN leadership
- Staff education
- Staffing/competencies in specialty clinics
- Travel medicine

If you or someone you know might be able to write an article on a “wish list” topic, complete the Author Interest Form at www.aaacn.org (click Publications > ViewPoint).

AAACN Marketing Opportunities

Advertise with AAACN and reach more than 2,000 nurse managers and supervisors, nurse administrators and directors, staff nurses, educators, consultants, NPs, and researchers – the ideal audience for your sales and marketing message!

Marketing opportunities include:
- Exhibiting at the AAACN Annual Conference
- Corporate sponsorships
- Premium advertising
  - ViewPoint, the AAACN official newsletter
  - AAACN Web site
  - AAACN monthly Enewsletter
  - Online Library
  - Conference program book

For more information, contact Marketing Director Tom Greene at greenet@ajj.com or 856-256-2367.

Online Library Tip

An easy way to check if you are logged in as a member in the Online Library (www.prolibraries.com/aaacn) is to look in the upper left corner of the screen (below the PROLibraries Home text) for this image:

Because members receive discounted pricing on all Online Library education, and you can only access any free CNE offerings by logging in as a member, this is an important thing to check. Also, an easy way to access the Online Library is to login to the AAACN Web site (www.aaacn.org) first, then click on the Online Library button on the left side of the home page. When you do this, the Online Library will recognize you as a member and will automatically show you member pricing.

New Webinars Added to Online Library

These November and December webinars have been added to the Online Library (www.prolibraries.com/aaacn):
- Medical Home Model and Review of the NCQA Certification presented by M. Colette Carver, APRN-BC, ADM, FNP
- The Transitional Care Model presented by Christine Bradway, PhD, CRNP, FAAN

These webinars each offer 1.0 contact hour and will enhance your knowledge on these current topics in ambulatory care.

Member Price: $29
National Office Election Results

Results of the 2012 AAACN National Office election are in. A record-breaking number of members took a few minutes to cast their votes online for the future leaders of the association and approve Bylaws changes. Newly elected officers will begin their terms at the close of the 37th Annual Conference. The Nominating Committee will also begin its work recruiting candidates for the next election during the conference. Congratulations to these members who have volunteered to serve AAACN and you, our members:

- **President-Elect**
  Susan M. Paschke, MSN, RN-BC, NEA-BC

- **Director**
  Col. Carol Andrews, RN-BC, NE-BC, CCP (second 3-year term)

- **Director**
  Judy Dawson-Jones, MPH, BSN, RN (second 3-year term)

- **Nominating Committee**
  Carol Zeek, BSN, MSBA, RNC

Put on Your Mouse Ears and Meet us at Lake Buena Vista!

Nurses across the country may not all put on mouse ears, but they will gather at the Hilton Walt Disney World® to network, learn, and squeeze in a little fun at the 37th Annual Conference, May 2-5, 2012, in Lake Buena Vista, FL. The weather in May will be between 62 and 85 degrees. We encourage you to consider coming a few days early or staying a few extra days to make the most of your trip to the Sunshine State. The hotel is located across the street from Downtown Disney, which offers an array of restaurants, shopping, and attractions.

The conference will offer cutting-edge sessions on ambulatory care and telehealth nursing. A Pre-Conference workshop will help you “Guard your Ambulatory Practice” by reducing your liability and practicing safely. Military nurses will network and learn at the new, 2-day Tri-Service Military Pre-Conference. Once the conference gets started, you’ll enjoy Opening Ceremonies and Barbee Bancroft, MSN, RN, PNP, as the Keynote. Barb will take you on a hilarious trip down memory lane through the last 30 years of nursing and medicine. An array of groundbreaking sessions, an Opening Reception, Networking Luncheon, Exhibit Hall/Poster Display, interactive Town Hall, and more will offer you educational opportunities you will not forget.

Visit www.aaacn.org/conference for more information and to register online.

HOT OFF THE PRESS

*Scope and Standards of Practice for Professional Telehealth Nursing, 5th Edition*

A team of our telehealth experts has updated this valuable resource for current practice. This expanded fifth edition defines clear responsibilities and accountabilities for clinical practitioners and administrators in the multitude of practice settings delivering telehealth nursing care. Each standard contains a statement and competencies. The 16 standards define:

- Assessment
- Nursing Diagnoses
- Outcomes Identification
- Planning
- Implementation/Coordination of Care/Health Teaching and Health Promotion, Consultation
- Evaluation
- Ethics
- Education
- Research and Evidence-Based Practice
- Performance Improvement
- Communication
- Leadership
- Collaboration
- Professional Practice Evaluation
- Resource Utilization
- Environment

The publication also contains our new Scope of Practice that includes the Definition of Professional Ambulatory Care Nursing, describes the Conceptual Framework, analyzes the Evolution of Modern Ambulatory Care and Nursing Practice, defines the Practice Environment, and explains Ambulatory Care Nursing Roles.

**Member Price:** $29  **Non-Member Price:** $44

Order this must-have resource online at www.aaacn.org/store today!
New Year Resolutions for 2012

Here are some resolutions we hope you will consider adding to your list:

- Get certified in ambulatory care nursing to validate your knowledge;
- Attend the annual conference to learn the latest in ambulatory care practice;
- Encourage a colleague to join AAACN;
- Purchase the NEW *Scope and Standards of Practice for Professional Telehealth Nursing*;
- Join one of the 7 Special Interest Group email discussion lists to network with other members;
- Get involved in AAACN – volunteer to serve on a task force, write an article for *ViewPoint*, or serve on a committee;
- Contact the National Office if you have any questions about your membership or our products and services; and most importantly
- Take care of yourself. Your family and patients need you!

AAACN wishes all of our members a happy, healthy, and prosperous New Year.