Telephone triage and advice programs originally began as demand management tools, ostensibly to decrease inappropriate access to health care. Cost reduction and improved customer satisfaction were cited as reasons for early program design. In some cases, however, efforts to reduce cost contributed to bad outcomes, and eventually lawsuits resulted. Occasionally, customer satisfaction was achieved but more often than not the “triage nurse” was perceived as a barrier to care. Opinions about triage, from inside and outside the health care industry, were mixed.

Eventually, the notion of triage as a strategy to keep patients out of the clinic/office came under attack. Empowered consumers began to rebel against programs that insisted on self-care, despite patients’ insistence that they wanted to be seen. The courts were not sympathetic to organizations that seemed to put conservation of the dollar ahead of the welfare of the patient. It became apparent that triage had to change or go away.

In many enlightened health care organizations, the decision was made to convert triage from a barrier to care to a strategy to assist patients in decision making.
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Publication Management by Anthony J. Jannetti, Inc.

President's Message

Dear Colleagues:

We in the nursing profession have had the benefit of some good press lately. National Nurses Week this year seemed much more of a media event, and the theme “Nurses Care for America” captured an important sentiment with which many can identify.

Many events on the legislative front, both nationally and among some states’ lawmakers, also have moved nurses into the public eye.

Add to that the Robert Wood Johnson Foundation report released May 8 on “Health Care’s Human Crisis: The American Nursing Shortage,” which challenges everyone to look at this nursing shortage in a different way than past shortages. On May 30, The New York Times reported the findings of Dr. Jack Needleman et al., Harvard School of Public Health, demonstrating that hospitals with low RN staffing have higher patient complication rates.

It seems that we have an urgent call to inform the public, our lawmakers, and each other about the difference that registered nurses make. It is also up to us to help improve the image of the profession, and to enhance career satisfaction.

People are legitimately anxious that the schools of nursing and the recruiters for health care employers will no longer be successful in providing the staffing necessary for an acceptable standard of care.

Nursing leaders from many specialty organizations have come together, and have developed a shared vision for the future and a strategic plan for addressing the many complex and interrelated factors contributing to the shortage of nursing. This plan is “Nursing’s Agenda for the Future,” as described in recent issues of Viewpoint. AAACN is participating in the implementation of the plan.

To be successful, however, nurses need to be joined by other health care providers, labor, and other industry stakeholders. The old strategies are not enough. Steven Shroeder, MD, president and CEO of the Robert Wood Johnson Foundation, states “We must re-examine some of our long-held assumptions about the nursing profession and its position within the health care system.”

Seeing What Can Be

In the landmark book, From Silence to Voice: What Nurses Know and Must Communicate to the Public, Bernice Buresh and Suzanne Gordon suggest the following exercise: “Envision how things would be if the voice and visibility of nursing were commensurate with the size and importance of nursing in health care.”

The authors go on to provide a practical and comprehensive “how-to” for nurses to get their messages to the media, and what we might do to enhance our image from “handmaiden” and “angel of mercy” to dedicated and professional scientists, applying research evidence, complex knowledge, and critical thinking to the care of patients and families.

AAACN’s power lies in its members, not just the activities of the Board of Directors. The Board wants to facilitate and support your “telling your story” locally, regionally, and nationally. Next year’s conference will include media training and other leadership development activities to help nurses learn effective ways to voice their important message.

continued on page 12
The Children’s Health System of Alabama has long enjoyed a mutually beneficial relationship with the University of Alabama Nursing School as well as several other universities in Alabama. These partnerships help the Children’s system to provide an exceptional clinical experience in pediatrics and also serve as a recruitment tool.

In 1995, responding to the continuing shift in care from inpatient to outpatient, I approached schools of nursing about a proposal for an improved clinical rotation in our ambulatory specialty clinics.

The University of Alabama in Birmingham wanted to change the traditional model of faculty supervision of a group of 8-10 nursing students to a “partnership” model. In the new model, the focus would shift from a typical preceptorship based on global leadership and management skills to one targeting direct patient care and management of multiple clients in the outpatient arena.

The new model was implemented in 1996. Currently, a collaborative partnership is implemented during the senior student’s basic course in pediatrics. Each term, names of licensed registered nurses with expertise in different pediatric specialty services are recommended by the managers of the outpatient areas to serve as a clinical partner to a nursing student for the entire term.

These names are coordinated through the Division Director of the Specialty Care Services, which maintains a consistent link to the faculty for the outpatient side. Typically the nurse partners assigned are from the advanced practice group but they can also be staff nurses.

At the beginning of the term, students identify their needs including days and shifts preferred. Students are then assigned by the faculty course coordinator to partners who best fit their needs. The student contacts their partner, and together they arrange the best clinical schedule for both of them.

Before beginning the partnership, the students review modifications needed to provide safe care to children. In addition, the students must pass a medication/dosage calculation exam. Before they begin the clinical rotation, the students also complete an orientation process with personnel from Children’s Nursing Education Department. The students are then oriented to the unit/clinic by their RN partner. Concurrent to the clinical schedule, the students also participate in the traditional didactic pediatric nursing classes.

A Win/Win Model

As a result of this program, several things have occurred that make this rotation a highly desired model:

- The benefits are mutual. The student and nurse partner form a working relationship which is geared to the student’s specific needs yet is fulfilling to the partner as well. A bond is formed between the two that creates for the student a unique, individualized learning experience with a recognized expert. At the same time, the more experienced nurses are able to share their knowledge in an environment that recognizes their contribution to patient care and fosters the opportunity to provide mentoring to “their” student. The model allows exposure to the Advanced Practice role and to the interdisciplinary component of
patient care – including exposure to the physicians – many of whom actively participate in the student’s learning experience.

- **Learning is individualized and targeted.** The traditional supervisory role of the faculty members is changed from that of being highly visible during the assignment to one in which they are able to focus on specific patients, specific diagnoses, treatment modalities, care interventions, and in general, the care of the patient across the continuum. The faculty can do this one-on-one with the student in a conference setting several times during the term. Also, faculty members and partners frequently review the student’s progress verbally. The partners complete midterm and final written clinical performance evaluations, which influence the final evaluative decision. The student evaluates the process as well, and this is shared with the managers and the partners.

- **The program is reality based.** This program has been consistently, positively evaluated by both the partners and the students as a method of teaching and learning that prepares the student for reality in the professional work arena. The program fosters progressive, individualized learning in a atmosphere in which autonomy is practiced by the partner and encouraged for the student. It also promotes development of decision-making abilities and critical thinking skills while helping the students build self-confidence in their nursing care and nursing abilities. The partners believe that the program stimulates them to keep their knowledge current, challenges them to develop new skills (such as performance evaluation), and assists them in career advancement. The exposure to the physicians has been extremely valuable in that the students gain more confidence in interacting with them and with the team approach to care.

- **The program boosts numbers of pediatric nurses, increases retention.** Last, but certainly not least, the positive experiences of this program have increased the number of graduates opting for employment in the pediatric setting, and the positive effects on the self-esteem of the nurse partners can only contribute to the retention of expert nurses for our hospital.

### Conclusion

This model has proven to be a highly successful teaching/learning tool that continues at the Children’s Hospital of Alabama and the University of Alabama in Birmingham Nursing Program.

### Bibliography


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In January 2002, the Naval Hospital in Guantanamo Bay, Cuba, embarked upon its new mission in support of Operation Enduring Freedom. Awaiting the arrival of Fleet Hospital 20 from Camp Lejeune, NC, a team of Navy nurses began preparing for duty at the now well-known Camp X-Ray. The team included LT Jeff Pool (NH GTMO), LT Harley Perry (NNMC Bethesda), LT Mark Marva (NH Camp Lejeune), LTJG Andrew Odea (NNMC Bethesda), and myself, LT Andrea Petrovanie (NH GTMO).

Before reporting to Camp X-Ray, the team received numerous briefings conducted by the Joint Task Force 160 Security Team. As one can imagine, ensuring a safe working environment was paramount to our new mission. The importance of Operations Security, also known as OPSEC, and the need to remain vigilant of our situation at all times was consistently emphasized.

The Preventive Medicine and Centers for Disease Control team discussed potential exposure to communicable diseases, including hepatitis, tuberculosis, and malaria. Training was provided on disease prevention, transmission, treatment, and management.

Working in close collaboration with our medical providers, a SPRINT team (Special Psychiatric Rapid Intervention Team) reported onboard from Jacksonville, FL. Team members conducted stress prevention and crisis management training and were available for mental health interventions as needed.

First Wave of Detainees

To prepare for the arrival of the initial group of Taliban and al Qaeda detainees, LT Pool and I reported to Camp X-Ray to familiarize ourselves with a prison environment and to ensure that necessary medical assets were readily available. We received additional briefings and also witnessed the security team conducting rigorous training exercises.

Although we harbored mixed emotions about delivering care to the detainees, the seamless, well-coordinated drills by the security team provided us with the confidence to function safely and efficiently in our new environment. Being a part of this unique experience made me proud to be a member of this elite organization. At that moment, I could not think of any other place I would rather be.

When the first detainees arrived, we worked 12-hour rotating shifts delivering care and assisting with medical screenings. We treated multiple conditions including wounds, amputations, and tuberculosis. Our team also established the foundation for a smooth transition with the Fleet Hospital 20 staff by setting up the operational and logistical framework necessary to deliver health care services.

Once Fleet Hospital 20 arrived and completed their training, they assumed the duties at Camp X-ray and we returned to Naval Hospital GTMO.

Although life in Guantanamo Bay is forever changed, my time there will remain one of the most memorable and unique experiences I have ever had. Navy nursing truly affords one the opportunity of a lifetime: “Let the journey begin.”

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Share Your Stories with Us
Nurses Telling Their Stories is featured periodically in Viewpoint.
If you have had a unique and exciting experience as an ambulatory care nurse, or if you know a nurse with an outstanding story to tell, please contact Editor Rebecca Linn Pyle at RLPyle@aol.com.
Telephone Triage
continued from page 1
The goal was to guide the patient in identifying the type of care most likely to adequately address his/her acute problem and to facilitate access to that level of care (get the right patient to the right place at the right time for the right level of care). Unlike the early days of telephone triage, the triage nurse became the much-needed patient advocate rather than primarily an advocate for the organization. While in most cases these positions should be parallel, it had become clear that was not always the case.

Other reasons telephone triage has survived include a renewed focus on patient safety and an emphasis on the need to move patients toward self-management. Additionally, pursuant to professional and regulatory developments, standards of practice now demand it. Finally, it must be recognized that not doing triage is no longer an option because as long as the phone keeps ringing, phone triage will continue to occur.

New Approaches
In making the transition to the role of patient advocate, triage nurses and their employers have been challenged to rethink conventional approaches to patient “management.” A number of misconceptions must be addressed in order for triage to successfully serve the population for which it exists.

The following is a summary of some of the misconceptions that have interfered with safe and effective patient-oriented nurse triage.

• A nurse is a nurse is a nurse.
Contrary to the beliefs of many, telephone triage is a nursing specialty. Significant experience is important to success, as is special training on how to perform an assessment over the phone. Expecting just any nurse to be able to do telephone triage, especially failure to differentiate the role of the RN and the LPN on the phone, is courting disaster. The following definition of telephone triage only scratches the surface on the complexity of the practice:
Telephone triage is an encounter with a patient/caller in which a specially trained, experienced nurse, utilizing clinical judgment and the nursing process, is guided by medically approved decision support tools (protocols) to determine the urgency of the patient’s problem and to direct the patient to the appropriate level of care. This plan of care is ideally developed in collaboration with the caller and includes patient education/advice as appropriate and necessary: ¹

• You need to go faster (and faster).
“How can I get on and off the phone faster?” is a common question posed by both experienced and inexperienced triage nurses. While productivity must be monitored and evaluated to determine staffing needs and identify best practices within an organization, it is important to remember that quality, (not speed) is our primary goal.

Admittedly, specialized training in interviewing techniques and use of documentation tools designed for telephone triage can certainly help nurses improve efficiency. However, the length of time a nurse is on a particular call is more dependent upon the nature of the patient’s problem and her/his ability to articulate that problem than upon the nurse’s skill in rushing the caller through the interview.

It is not unusual to see longer average call times for experienced telephone nurses than for the novice phone nurse. Experience helps the nurse identify the “irreducible minimums” that must routinely be asked of the caller, including distance from care, availability of transportation, and other important factors such as the presence/absence of comorbidities and other high-risk indicators.

• You’re getting too involved!
Triage nurses frequently hear, “You’re getting too involved! You’re not their mother; you’re not a social worker. You’re a nurse. You take care of their health care problems and let them take care of their social problems.”

It has been acknowledged that the triage nurse functions as a counselor, teacher, and facilitator of care, as well as other important roles. However, many of these functions require time. Frequently, patients call with agendas that supersede simple health care concerns. Ofen there are factors that unless adequately addressed, might prevent the patient from obtaining care. Occasionally, factors such as lack of child care or transportation interfere with a patient’s ability to access health care. It won’t matter how appropriate the recommended disposition is if the nurse fails to identify and address what is most important to the patient.

1 This definition has been adopted by the United States Air Force and was included in a 2001 survey of the regarding telephone triage.

Among other questions, the BONs were asked if they agreed with this definition. Responses could be “yes, absolutely,” “yes, somewhat,” “neutral,” “very little,” or “not at all.” The responses from the BONs were as follows:

<table>
<thead>
<tr>
<th>Response</th>
<th>RN Board</th>
<th>LVN/LPN Board</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes, absolutely</td>
<td>22</td>
<td>(+1 LVN)</td>
</tr>
<tr>
<td>Yes, somewhat*</td>
<td>16</td>
<td>(+1 LVN)</td>
</tr>
<tr>
<td>Neutral</td>
<td>5</td>
<td>(+1 LVN)</td>
</tr>
<tr>
<td>Very little</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Not at all</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>No response/silent</td>
<td>7</td>
<td>(+2 LPN)</td>
</tr>
</tbody>
</table>

* Those BONs that replied “agree somewhat” wanted reassurance that specialized training was adequate, protocols were used, only RNs were performing telephone triage, nurses weren’t diagnosing or prescribing, triage served to facilitate care rather than function as a barrier to care, the nursing process was used consistently, and in some cases that the recommendations were patient-specific rather than generalized to a population.
Compliance is achieved by putting the patient’s agenda ahead of our own.

- **Triage exists to keep patients out of the clinic.**
  
  An enlightened physician once said, “We’ve been practicing triage by obstruction too long!” Many of the problems associated with telephone triage are related to the fact that the triage nurse has been seen by many as a barrier to care. In actuality, the role of the nurse is to help the patient determine when, where, and how to best seek care and to facilitate that care when necessary. Although some patients do want appointments when the triage nurse feels that home care would be adequate, it is not prudent to deny an appointment to a patient who is expressing a desire to be seen. Not only is this a huge risk-management concern, but it does little to foster trust in the nurse or the system.

- **We need to get those nurses off the phone!**
  
  Interestingly, in doctors’ offices, clinics, and other health care facilities nationwide, unlicensed assistive personnel (UAPs) are often utilized to do telephone triage, even in offices that employ RNs. The frequently stated rationale is that “RNs are too expensive to be on the phone – we need them to provide direct patient care.”

  Unfortunately, this position overlooks the highly skilled form of professional nursing care that is being provided over the telephone. Even under the best of circumstances, patient triage and assessment require a level of sophistication that has been described by some boards of nursing as being “beyond the scope of practice” even for LPN/LVNs. The ability to perform an accurate and thorough patient assessment over the telephone requires an extensive knowledge base and ample experience to understand the implications of sometimes-subtle signs and symptoms.

  The emergency nursing literature argues that the triage nurse must be among the strongest nurses on staff. Likewise, telephone triage is appropriately the responsibility of the strongest, not the weakest, member of the nursing staff.

- **Downgrading a disposition is an open invitation for a lawsuit.**
  
  Telephone triage is ideally performed using protocols that standardize the approach to various complaints and decrease ambiguity in decision making. To do telephone triage without protocols does indeed increase the likelihood of an allegation that the “standard of care” wasn’t met. However, although use of protocols is important, it is essential that they be used by experienced, specially trained (preferably) RNs who understand that protocols exist to guide their decision making, not to make the decisions for them.

  Many programs insist on strict adherence to protocols. They overlook the reality of the patient situation at hand and ignore the importance of the clinical judgment of a trained, experienced professional in interacting with the patient. Strict adherence to protocol can provide a higher risk of legal ramifications if professional judgment is ignored.

  Although most will acknowledge that “upgrading” a protocol (that is, taking a more conservative approach) is acceptable, it is less common to find nurses who are willing to “downgrade” even if the nurse feels that there is a compelling reason to do so. The argument for this approach is stated as “If you deviate and have a bad outcome, you don’t have a leg to stand on in court.”

  Of course, as with deviation from any policy it is true that if a nurse decides to deviate from a protocol and has a bad outcome as a result of poor judgment, the likelihood of a judgment for the defense increases.

  However, failure to deviate when it’s indicated is a risk factor as well. Protocols do not represent artificial intelligence but serve as a checklist to guide the nurse in decision making.

  If a nurse isn’t willing and able to deviate from the protocol when it’s clearly indicated and in the best
interest of the patient, why do we have specially trained, experienced nurses on the telephone?

**Triage isn’t necessary with Open Access.**

The popularity of Open Access is growing as organizations experience success with this strategy. However, of significant concern is the frequency with which the question is asked, “If we’re going to see them anyway, why do we need telephone triage?”

In settings where this question arises, it is obvious that telephone triage is still being viewed as a barrier to care. Triage exists to assist patients in making informed decisions about what kind of care is appropriate for them, not to keep them out of the office.

An assumption is frequently made that all patients, given a choice, would rather be seen in the office than treated at home. In reality, most of our patients are as busy as we are and would be grateful to follow our recommendations for home treatment if they believe that we have their best interest at heart.

Traditional telephone triage (with the nurse being an obstacle to overcome in order to get an appointment) has put the nurse in the position of adversary rather than patient advocate. Many patients are convinced that our primary focus is saving money and that we are willing to go to almost any length to keep them out of the office.

Also, sometimes patients will request an appointment, when careful evaluation by an experienced telephone triage nurse would redirect them to the ED for a higher level of care. Patients such as those needing CTs, rehydration, or evaluation to rule out an MI, are clearly higher level of care. Patients such as those needing CTs, would be better served in the hospital presumably receive a more appropriate and expeditiously seen in the ED setting.

**They don’t know what’s best for them – I do.**

While it might be true that in an inpatient situation, some patients lack the level of understanding to make well-informed decisions about certain aspects of their care (how many fresh post-ops really look forward to turning, coughing, and deep breathing, let alone early ambulation?), that is less often true in an outpatient setting. Patients who have agreed to be admitted to the hospital presumably recognize that they are sick enough (at least for the time being) to allow their health care to take precedence over other facets of their lives. However, patients in an outpatient setting (or at home) are still juggling myriad responsibilities, only one of which is their health care. In the context of their life situation, it is conceivable that they might make a decision to delay treatment until what they view as a more pressing situation is resolved. While we might view their decision as “neglecting” their health, in the context of the “big picture,” the decision they make might indeed be in their best interest (see box, page 7).

These forced-choice decisions can usually only be made by the patients/callers who must live with the consequences of their decision. Our job is to inform patients and then let them make the final decision. Exceptions to this might be the patient who is incompe-
Inadequate in such situations. If we refuse to accommodate them, we are punishing the parent and the child! While a season of football or cheerleading might not seem important to us in the middle of our busy day, it might make a huge difference to the child. We’re there to facilitate care— not to serve as barriers or judges.

2. **They’re not there when I call them back (or their line is busy)**

It is customary in many settings for patients to leave a message for the nurse to return their call. Patients are also frequently told that the nurse will call them back “as soon as possible,” without any concrete indication of when that callback will happen. Although some patients might have the time (and temperament) to sit at home and wait for the return call, it is inevitable that some patients will place calls to their provider’s office on a day that they have many other pressing responsibilities. If we want patients to be available when their call is returned, would it not make better sense for us to advise them of the approximate time that would take place so that they could make arrangements to be near a phone?

3. **They LIE to get an appointment**

If a patient feels a need to exaggerate or misrepresent their symptoms in order to get an appointment, this might represent a creative way the patient has found to work their way through a broken system. Why should a patient have to lie to get an appointment? A simple request should be sufficient.

• **Demanding patients should be handled firmly, or they’ll continue to be a problem.**

We want our patients to assume responsibility for their own health care management, but when they do, we sometimes feel a loss of control and label them as “problems.” When patients are trying to navigate through broken systems, and they lose patience with us, they certainly may seem demanding. The responsibility of the triage nurse is to guide those motivated patients through the system, and hopefully bring their expectations into line with our capabilities. It might be best to view a demanding patient as an empowered patient and work to rechannel that energy.

**Nursing Process**

One final area that might require a slight shift in paradigm involves applying the nursing process over the phone. While the fundamental elements of the nursing process are the same in any practice area, a subtle shift in thinking has the potential to further enhance the quality of patient care. The following brief review highlights application of the nursing process by telephone.

• **Assessment (subjective, objective, conclusion)**

Traditionally, nurses have relied heavily upon objective data. For example, in years past, patients’ self-report of pain was not adequate. Student nurses were taught to look for objective evidence of the pain, including such signs as tachycardia, tachypnea, diaphoresis and elevated systolic pressure. We were also discouraged from drawing conclusions. In fact, many nurses remember having to document that the patient was “lying quietly in bed with his eyes closed, breathing deeply and regularly” rather than simply stating that the patient was (or appeared to be) asleep. Another example of the emphasis placed on purely objective data was found in the statement that the patient was “oozing serosanguinous fluid” instead of stating the obvious—that the patient was bleeding!

Greater reliance must be placed on subjective data when assessing a patient over the telephone, and we must learn to trust our patients to report accurate information. Objective data such as quality and rate of respirations, hoarseness, or slurred speech can be observed over the telephone once the nurse has been trained to listen for them. Other objective data must be self-reported by the patient, including such findings as swelling and/or discoloration of an extremity or fever (as measured by a thermometer).

We must also rely on our ability to interpret what we hear. In telephone triage, the conclusion (or “diagnosis”) must generally be stated in terms of a triage category (indication of urgency) rather than as a traditional nursing diagnosis.

• **Planning (collaboratively).**

Traditionally, nurses have recognized the importance of collaborative planning, but in the case of a
patient on the phone, unless the planning is truly collaborative (that is, unless the nurse identifies what is important to the patient and addresses that need), the patient is likely to hang up the phone and do precisely what he/she intended to do in the first place. Renewed respect for the patient is part of the paradigm shift that is necessary in order to meet the needs of the patient. Although we are “expert” nurses, our callers are there and are “experts” on their life situation. Their input is important.

• Implementation (think continuity/patient handoff).

In some cases, just telling the patient the appropriate action to take isn’t sufficient. In some cases (especially those in which there is a likelihood of a poor outcome), it is necessary for the nurse to go a step further and actually assist the patient in making an appointment or facilitating a referral. In other cases, follow-up calls to the patient or the referral source might be in order. While there are a variety of considerations (such as patient confidentiality, etc.), the ultimate goal is to get the patient to the right place at the right time for the right care to be delivered. Given the complexity of our current health care milieu, being a patient advocate sometimes necessitates going that extra mile to facilitate care and occasionally the nurse must assume a more active role than that of health care adviser. Continuity of care is essential to effective and safe patient care.

• Evaluation (how will you know if your patient doesn’t get better?).

While there are a number of ways to evaluate interactions with patients (not the least of which are patient satisfaction, cost-containment, staff satisfaction, clinical outcomes, and quality assurance/improvement measures), one of the most important ways to evaluate the effectiveness of the care delivered is simply for the nurse to know if the patient doesn’t get better. Since the ultimate goal is optimum health, and risk management must be a key element of telephone triage, it is critical for the nurse to be able to redirect patients to a different level of care if necessary. Occasionally, because of the high risk associated with a particular situation, the nurse must assume responsibility for following-up with patients. Other times, if the risk is relatively low, and the nurse assesses the caller as being reliable, the responsibility for PRN follow-up may be left in the hands of the patient/caller. If patients are to assume responsibility for seeking PRN follow-up, the nurse must educate them on what to expect and be certain that they know what to do if their symptoms persist, change, or worsen.

Conclusion

Telephone triage is here to stay. Performed properly, it can be an effective strategy for demand management, enhanced patient satisfaction, improved staff satisfaction, and above all, promotion of optimum health and wellness for our patients. However, if it is to meet these goals, it must cease to be regarded as a barrier to care. A significant paradigm shift must occur for all involved.

We, as nurses, must re-examine our approaches and be willing to openly challenge the misconceptions that interfere with quality patient care. We also must realize that the litigation we long feared is now a reality. We are at a crossroads in delivery of care by telephone.

Recognition of telephone triage as the practice of nursing is long overdue. And as with all nursing care, it must be patient centered and not used as a tool to manage the doctor’s schedule or to keep patients out of the office.

We must provide the patient advocacy our callers need to obtain health care on their terms and we must provide quality that assures our patients’ safety. A rushed, multitasked RN, let alone an underqualified UAP, is not in the best interest of safe patient care.

When it comes to who is manning the phones and under what circumstances, it is time that we identify the litigation we long feared is now a reality. We are at a crossroads in delivery of care by telephone.

Recognition of telephone triage as the practice of nursing is long overdue. And as with all nursing care, it must be patient centered and not used as a tool to manage the doctor’s schedule or to keep patients out of the office.

We must provide the patient advocacy our callers need to obtain health care on their terms and we must provide quality that assures our patients’ safety. A rushed, multitasked RN, let alone an underqualified UAP, is not in the best interest of safe patient care.

When it comes to who is manning the phones and under what circumstances, it is time that we identify the line is, draw it in the sand, and hold firm.

Because telephone triage is indeed the practice of nursing, we (with all due respect, not others) must define that practice and maintain standards of care that have our patients’ best interests at heart.

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AAACN Telehealth Nursing Practice

Definition

Telehealth nursing has been identified as one of the new and exciting areas of interest and specialty in ambulatory care nursing. Building upon the values of ambulatory care nursing and set within its broad parameters, Telehealth Nursing Practice has been defined as:

Nursing practice using the nursing process to provide care for individual patients or defined patient populations through telecommunications media.

Telehealth Nursing Practice occurs in many different health care settings. Defined criteria for Telehealth Nursing Practice include:

• Using protocols, algorithms, or guidelines to systematically assess and address patient needs.
• Prioritizing the urgency of patient needs.
• Developing a collaborative plan of care with the patient and his/her support systems. The plan of care may include: wellness promotion, prevention education, advice for care counseling, disease state management, and care coordination.
• Evaluating outcomes of practice and care.

Triage: Derived from the French, meaning “to sort out.” Triage is one of several activities used in telehealth nursing practice. It is often the first part of any telecommunication encounter to help order patient needs according to urgency and appropriate disposition.

AAACN Telehealth Nursing Practice Administration and Practice Standards © 2001
Telehealth Nursing Skills has arrived.

The American Academy of Ambulatory Care Nursing (AAACN) and DigiScript, Inc. have developed the FIRST and ONLY comprehensive course for telehealth nursing practice.

**Telehealth Nursing Practice Core Course (TNPCC)**

This course is available on-line and on CD-ROM. It covers everything from building patient trust, to legal issues, to high-risk calls.

- Taught by experts
- Supplemented by a 265-page manual
- Perfect for the nurse new to telehealth practice OR the experienced telehealth nurse seeking further education
- The ideal study tool for the TNP certification exam

**Course Options | Ordering Information**

| #1 ON-LINE: | http://aaacn.digiscript.com/index.cfm
  A subscription gives you on-line access to the course for 1 year. Cost: $99 (AAACN member), $119 (nonmember) |
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<td>#3 MANUAL:</td>
<td>Purchase the course manual with #1 or #2 above, and pay only $29 (member), or $49 (nonmember). That’s $30 off the regular manual prices of $69/$79.</td>
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No need to leave your home or office!!!

For just $30 more, the on-line course provides over 16 contact hours of continuing education credit!

To learn more about AAACN and other AAACN programs and products, visit www.aaacn.org, call 1.800.AMB.NURS, or e-mail aaacn@ajj.com
President's Message
continued from page 2

In addition, we are increasing our attention to legislative issues so that you might be aware and be facilitated in directly communicating your needs to lawmakers. We need to challenge ourselves to look at new models of nursing and health care provision across the spectrum of inpatient, outpatient, and other facilities.

We should each be advancing the study of nursing care and outcomes as well as applying research findings to our protocols and practice. We need to network at every opportunity, written, electronic, telephonic, and face-to-face to discuss effective strategies and advance change in our work cultures.

Operations Update

As before, the following update is aligned with AAACN’s six strategic goals.

Goal 1. Be the Voice of Ambulatory Care Nursing
- We are counting your votes and will be deciding on the tagline for AAACN during the Board’s August conference call. Our hope is that this will enhance our identity in marketing efforts.
- The Health Care Advisory Board, Nursing Executive Center, interviewed me regarding models of care in ambulatory care settings for research they are doing. The investigators felt that they needed to know what the issues were outside of the inpatient practice setting - BRAVO!

Goal 2. Promote Professional Practice
- The final deadline for registration for the Ambulatory Care Nursing Certification Examination on October 19, 2002 is August 9. Visit the Web site at www.nursingworld.org/ancc/certify/cert/catalogs/index.
- The initial registration deadline for the NCC Certification in Telephone Nursing Practice examination on December 6, 2002 is October 11. Information available at www.nccnet.org/Certification/examdesc.htm.

Goal 3. Stimulate Innovative Thinking
- We are enhancing our relationship with the American Nurses Credentialing Center (ANCC) related to ambulatory care certification. They will be seeking test item writers through Viewpoint and on our Web site www.aaacn.org. They are attempting to convene the Content Expert Panels (CEPs) for both the Ambulatory Care and Case Management certifications to look at potential modifications in the modular approach. AAACN's appointed representative on the CEP is Cynthia Marquardt, MS, RN. Additionally, AAACN member Charlene Williams, BSN, RNC, serves on the CEP. Hats off to both of these individuals for their work.

Goal 4. Build Collaborative Relationships
- We have accepted the invitation to endorse The Forum on Health Care Leadership’s conference August 17-20, 2002 “Back to Basics: The Elements of Success.” I will attend and exhibit our publications and benefits of AAACN membership.
- The American Nurses Credentialing Center (ANCC) has agreed to exhibit at next year’s AAACN Annual Conference to directly interact with our membership and to give away another free registration to the certification exam.

Goal 5. Strengthen AAACN Resource Base
The AAACN Board meeting in Philadelphia on June 28 focused on strategic thinking and planning, and the appropriate distribution of limited resources to priorities for the association. Please see Kathy Krone’s article on page 14, which describes the hard work the Board has undertaken. In the next issue of Viewpoint, we will describe the "mega issues" we identified as relevant to the future of AAACN and ambulatory care nursing, and ask for your feedback. In the Fall, the Board will continue the work of identifying our priorities and important strategies.

Goal 6. Develop AAACN Leadership Ability and Capacity
The Program Planning Committee for the 28th Annual Conference in Tampa, FL, has succeeded in confirming outstanding opening and closing speakers (see page 16). They are in the process of abstract review. They have also engaged a speaker for media training for a special session, as I mentioned earlier.

Looking Ahead

In closing, I will share a quote from Florence Nightingale (1893):

“...No system can endure that does not march. Are we walking to the future or to the past? For us who nurse, our nursing is a thing, which, unless in it we are walking to the future or to the past? For us who nurse, our nursing is a thing, which, unless in it we are making progress every year, every month, every week, take my word for it, we are going back.”

References


Candia Baker Laughlin, MS, RN, C
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The AAACN Grand Scan Plan

The AAACN Board of Directors recently sought information directly from members so they could better guide the association and tailor programs to members’ needs. This is the second installment describing feedback from those interviews.

As described in the May/June 2002 issue of Viewpoint (“The AAACN Grand Scan Plan,” p. 20, and “President’s Message,” p. 18), the AAACN Board of Directors recently contacted a random sample of members for feedback about AAACN. The reason for the interviews, which were conducted by telephone, was to help the Board identify the issues members feel are most critical for the future. These issues would then be incorporated by the Board into the association’s strategic plan.

Participants were asked the following five questions:
1. What are the three key issues you are dealing with in your ambulatory care work environment?
2. What are your expectations of AAACN as a professional organization? How can AAACN best meet your expectations?
3. What value are you getting for your AAACN membership/dues?
4. How can we make AAACN relevant to your concerns and interests?
5. How would you describe effective participation in a professional organization?

To share the results with AAACN members, the responses to these questions are being published in Viewpoint. Question #1 appeared in the May/June issue (p. 20) and we are continuing here with the responses to the second question.

Question #2 (a two-part question):

What are your expectations of AAACN as a professional organization?

- Networking: Provides networking opportunities, local networking groups.
- Knowledge about ambulatory care: Offers annual conference; provides timely information relative to changing practices, regulations, and inspections; publishes printed and electronic materials; sets standards for ambulatory care; highlights key activities and clinical trends.
- Education and professional development: Provides offerings at the national, regional, and local levels; opportunities provided on the Internet; offers Ambulatory Care Nursing Certification.
- Research: Informs members of recent studies pertinent to ambulatory care.
- Legislative updates: Is an advocate of health care issues.

How can AAACN best meet your expectations?

- Continue with excellent newsletter
- Expand offerings on Web site with contact hours
- Offer more competency assessment
- Provide tools to use for quality improvement
- Provide voice on legislative issues
- Make available a list of experts

The Board would like to thank each of the participants for taking time out of their busy schedules to provide valuable candid feedback, input, and suggestions. The responses to Question #3 will be provided in the September/October issue of Viewpoint.

Feel free to contact a member of the AAACN Board if you have questions or comments about our environmental scan (see contact information on back cover).

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The AAACN Board of Directors and the Anthony J. Jannetti, Inc. (AJJ) staff met in June at the National Office in Pitman, NJ, to engage in some thoughtful and creative discussions about future directions and strategies for AAACN. These discussions paved the way for a day and a half of strategic planning and resulted in a draft of a business plan for 2002-2003. This plan will be validated by other AAACN leaders and presented to the membership in a future issue of Viewpoint.

Starting with a presentation on leading during turbulent times Candia Baker Laughlin, AAACN president, and Cynthia Nowicki, Executive Director, provided leadership for the strategic planning process. This began with review of AAACN’s core ideology and validation that these still guide our direction and decision-making. The following continue to be our guideposts:

**Identity Statement**

The American Academy of Ambulatory Care Nursing is the association of professional nurses and associates who recognize ambulatory care practice as essential to the continuum of high quality, cost-effective health care.

**Values**

The following values guide member and organization vision, actions, and relationships:

- Excellent health care delivery for individuals and communities
- Visionary and accountable leadership
- Productive partnerships and alliances
- Proactive innovation and responsible risk-taking
- Responsive member services
- Diverse and committed membership
- Continual advancement of professional ambulatory care nursing practice

**Mission Statement**

Advance the art and science of ambulatory care nursing

**Vision**

AAACN is the premier nursing organization for ambulatory care.

The strategic thinking process began by reviewing data that had been obtained from the membership over the past year. This data included:

1. Board telephone interviews of a random sample of members
2. The results of the Staff Education SIG survey on usage of AAACN products
3. The summary of the roundtable discussions at the March 2002 Leadership Symposium
4. The 2002 conference evaluation summary

AAACN Board Drafts Strategic Plan

Kathleen P. Krone, MS, RN

The data provided by AAACN members provided a wealth of information for the Board to use during its strategic planning session. In addition, we met with Tony Jannetti, AJJ president, and Tom Greene, AAACN’s marketing manager, for dialogue about membership and marketing possibilities.

The board then used a structured process to identify the “mega issues” that will affect our society and the practice of ambulatory care nursing over the next 5-10 years. The mega issues identified are:

1. Expanded life expectancy
2. Ethics and integrity in business and clinical practices
3. War and bioterrorism vulnerability
4. Increased and expanded health care in alternative/ambulatory settings
5. Financial pressures in the health care industry
6. Workforce issues

A description of these issues and their impact on ambulatory care nursing will be published in the September/October 2002 issue of Viewpoint.

**Goals**

Using all of these data, the board proceeded to identify goals, objectives, and strategies for 2002-2003. The goals are:

**Goal 1:** Be the voice of ambulatory care nursing

**Goal 2:** Promote professional practice

**Goal 3:** Strengthen the AAACN resource base

**Goal 4:** Develop AAACN leadership ability and capacity

The business plan including objectives and specific strategies for each goal will be further refined and prioritized and published in its entirety, following review and validation by additional AAACN leaders.

Kathleen P. Krone, MS, RN

AAACN Director

kkrone@umich.edu
The AAACN Nominating Committee is pleased to present the 2003 slate of candidates for upcoming selection by the membership. These candidates are from varied and prestigious backgrounds and have agreed to devote their expertise to serving AAACN. The candidates are as follows:

### President elect: (1 position)
**Nancy R. Kowal, MS, RN, C, NP**  
Pain Consultant/Adjunct Professor  
University of Massachusetts Memorial Healthcare System  
Worcester, MA

**Kathleen P. Krone, MS, RN**  
Consultant  
Ann Arbor, MI

### Board of Directors (2 positions)
**Carole Becker, MS, RN**  
Director, Clinical Development  
McKesson HBOC  
Phoenix, AZ

**Pam Delmonte, MS, RN**  
Clinical Coordinator  
Kaiser Permanente  
Potomac Falls, VA

**Telia Emmanual, RN, MHA, CNAA**  
Administrator, Patient Care Services  
Florida Health Care Plans  
Holly Hill, FL

**Karen Griffin, MSN, RN, CNAA**  
Associate Chief, Nursing Service/Ambulatory Care  
South TX VA Health Care System  
San Antonio, TX

### Nominating Committee (2 positions)
**Linda Brixey, RN**  
Program Manager, Clinical Education  
Kelsey-Seybold Clinic  
Houston, TX

**Susan Paschke, MSN, RN, CM, CNA**  
Accreditation Coordinator  
Cleveland Clinic Foundation  
Strongsville, OH

**Christine Ruygrot, RN, MBA**  
Director, Clinical Strategy consulting Department  
Southern California Permanente Medical Group, Kaiser Permanente  
Pasadena, CA

The September/October 2002 issue of Viewpoint will include the candidates’ biographies and statements. A ballot will be mailed to all AAACN members in November 2002.

E. Mary Johnson, BSN, RN, C, CNA  
Nominating Committee Chair  
emjr@adelphia.net

### Staff Education SIG
The staff education SIG held a business meeting on March 9, 2001 in New Orleans, LA, during AAACN’s 27th annual conference. Marianne Sherman (outgoing chair) introduced the new chair, Cheryl Martin, from Bedford, NY. The group recommended no changes to the SIG’s mission and objectives:

**Mission:** This SIG will work to promote staff education by creating a sharing environment for members of AAACN. We will work to provide guidelines for educating and assessing nursing staff. We will work with the AAACN training coordinator to promote educational opportunities. We will also: support and provide input and recommendation to AAACN leadership in development of ambulatory core competencies; promote sharing of strategies to meet staff training needs; develop a network for staff educators to use as a resource; and work with AAACN with training initiatives.

**Projects**
The SIG identified two projects for 2002-2003: publishing information on how AAACN resources are used and identify core competencies for ambulatory nurses.

**AAACN resources:** A survey distributed at the conference and by quick poll will be used to gather information about how ambulatory care nurses use AAACN resources in their practice. A summary of the survey will discuss the results. Future articles will explain how individual resources are utilized. If you are using resources and would like to contribute, please e-mail Cheryl Martin at martinc@wcmc.com.

**Identification of core competencies for ambulatory care nurses:** The staff education committee will focus on identifying core ambulatory nursing competencies by telephone conference calls. If you would like to participate, please e-mail Cheryl Martin.

Communication of SIG activities will be done by:
- Posting of minutes from meetings and telephone conference calls to the Web site
- Welcome letters to interest new SIG members
- Telephone conference calls every other month

The Staff Education SIG is also encouraging members to submit abstracts for the AAACN Annual Conference in Tampa, FL, April 10-13, 2003.

This will be an exciting year for the SIG. Those who are interested in participating in projects that will support our mission and objectives are invited to contact Cheryl Martin at the e-mail address mentioned earlier.

Cheryl Martin, Chair  
Marianne Sherman, Past Chair
Connie Curran

The keynote speaker for AAACN’s 28th Annual Conference will be Connie Curran, EdD, RN, FAAN, a dynamic, nationally-known speaker, editor, and nurse consultant.

Dr. Curran's talk will address the theme of this conference, “Networking in Ambulatory Care: Advancing Innovative and Professional Practice.” As the editor of Nursing Economics$, the Journal for Health Care Leaders, she is involved in a daily basis in innovation and improvement of professional practice. Dr. Curran has timely and practical tips for her audiences on creative solutions while providing safe and effective care. She has been an invited speaker nationally and internationally on this topic, and will bring those experiences with her as she speaks to us in her keynote speech.

Dr. Curran earned her BSN from the University of Wisconsin and received the Distinguished Alumni Achievement Award from the school in 2000. She earned her MSN in medical-surgical nursing from De Paul University and her EdD from Northern Illinois University. She also attended the University of San Francisco School of Business, and Harvard Business School’s President’s Program. Dr. Curran has timely and practical tips for her audiences on creative solutions while providing safe and effective care. She has been an invited speaker nationally and internationally on this topic, and will bring those experiences with her as she speaks to us in her keynote speech.

Ms. Roberts has been a nurse for 29 years and is certified in rehabilitation nursing. She has been a manager in neonatal, obstetric, and rehabilitation settings, a psychiatric charge nurse, and a professional recruiter. She is a co-author of The Core Curriculum of Sub-Acute Care and has also published various articles on spirituality, parish nursing, prayer, and presence. She is currently the coordinator of the Community Parish Nurse Program at Carle Foundation Hospital in Urbana, IL.