The Centers for Medicare & Medicaid Services (CMS) has developed and implemented a number of quality improvement programs designed to improve quality and decrease cost associated with Medicare patients. These programs include the Medicaid Electronic Health Record (EHR) Incentive Program run by individual states, the Physician Quality Reporting System, and the Medicare Improvements for Patients and Providers Act e-Prescribing Program. The Medicare EHR Incentive (or Meaningful Use [MU]) Program is another of the CMS quality programs. This article will review the Meaningful Use program and Stage 2 core criteria. Future “Health Policy Update” columns will discuss the menu objectives and clinical quality measures (CQMs) of Stage 2 Meaningful Use. Ambulatory care nurses can be key in helping to assure compliance with these MU objectives and help facilitate and assure quality patient care as outlined in the MU program.

The Medicare EHR program is a CMS incentive program, which provides payments to eligible providers (EP) who use EHR technology to positively impact patient care in a meaningful way, hence the term Meaningful Use. The MU program began in 2011 and continued on page 10

Stage 2 Meaningful Use – Implications for Ambulatory Care Nursing

Janet Fuchs
Teams Achieve:
Our Members at Work

I recently saw a video online called “The Meaning of TEAM: Together Everyone Achieves More.” After viewing this, I stopped to reflect on this year’s conference. The energy and excitement was palpable at the 39th AAACN Annual Conference in New Orleans in May. Evident was the camaraderie of everyone to support and mentor others, and that by working together, we continue to advance the art and science of ambulatory care nursing.

There were many excellent speakers on best practices, caring for ourselves, and ways to improve our clinical practice. There were presentations on two important projects: the Ambulatory Nurse Sensitive Indicators and the need for a Nurse Residency Program in ambulatory care. During my President’s address I said, “It is your leadership, passion, and knowledge that can help empower ambulatory care nurses to lead the change.” The conference reinforced for me what the power of a group of nurse leaders can accomplish together as TEAM AAACN.

Working together to expand our influence is vital to our profession. It is your dedication and commitment that makes AAACN successful, and I want to thank those that help us meet our strategic goal of expanding our influence. Let me begin by thanking all the members who represent and are the voice for AAACN outside our organization.

• Joint Commission PTAC – Stephen Anderson
• NAQC and Expert Panel – Eileen Esposito
• HIMSS – Cynthia Whitfield
• Joining Forces – Bonnie Richter
• AAP Section on Telehealth Care – Kathy Koehne
• CDC Clinical Outreach and Communication Activity – Staff
• NCSSBN NLCC – Carol Rutenberg and Kathryn Scheidt

There are several projects for which the organization’s members have volunteered their time to help AAACN expand our influence and ambulatory care nurses to achieve a greater positive impact on the quality of ambulatory care. A BIG thank you to the RN Residency Program Task Force for their excellent work in developing a White Paper. The presentation at the conference was stimulating, and the White Paper is now located on the AAACN website (www.aacn.org). This group will continue to work on how to implement the recommendations in the White Paper.

Hillary Clinton wrote a book called It Takes A Village. That title reminded me of what it took to develop the Care Coordination and Transition Management Core Curriculum text and online course. This is an example of many expert leaders who dedicated hours of work to develop this important resource. The authors were on hand at conference to be honored for their work on this important resource. Many members stopped by their booth in the exhibit hall to learn more and meet these experts. The book will be released in the very near future and several modules of the course are active in the AAACN Online Library. I thank each of them for making this a reality.

The initial work on Ambulatory Care Nurse Sensitive Indicators is moving forward, and your feedback from the Town Hall at conference will be invaluable.

continued on page 13
Results of 2014 AAACN Telehealth Survey

In order to better serve our members, AAACN recently conducted a survey to determine the current state of telehealth nursing practice and to identify the anticipated challenges and the ways in which AAACN can meet telehealth nursing practice needs. The Telehealth Nursing Practice Survey was sent electronically to 2,298 members, of which 381 (17%) responded.

According to the survey response, the majority (79%) of telehealth nursing practice takes place in four settings: academic health systems, group practice/health centers, managed care/HMO/PPOs, and the VA. Other settings (21%) include public/community health, free-standing call centers, university, military, and ambulatory surgery centers. Responses suggest growth in the use of online patient portals and secure message exchange as 70.4% and 64.8% of organizations (respectively) are thinking about using these modalities.

Additional highlights of the survey are featured here. AAACN plans to use this information to support current practice and to help our members meet the challenges of the future. Thank you to those who participated by sharing your valuable expertise and experience with AAACN!

Liz Greenberg, PhD, RN-BC, C-TNP
Debra L. Cox, MS, RN
Suzi Wells, MSN, RN
AAACN Board of Directors

Most frequently used telehealth technology

75% respondents report spending 51-100% of their time using telehealth technology

Most used
1 - Telephone - 61.5%
2 - EMR - 31.8%
3 - Fax - 23.5%, Health/patient portal - 21.2%
4 - Secure messaging - 27.6%
Other - home monitoring, video, TTY & Language lines

Nursing services provided using technology

1 = Most frequently provided  8 = Least frequently provided
1 - Triage and advice - 67.7%
2 - Care coordination - 24.7
3 - Care management - 23.9
4 - Patient follow-up - 23.7
5 - Patient education/support - 24.7
6 - Referrals - 30.6%
7 - Interdisciplinary communication - 25.5%
Promoting Smoking Cessation in Ambulatory Care

Patricia Chandler Finn

The Centers for Disease Control and Prevention’s (CDC) current campaign message to smokers is “You can quit. Talk with your doctor for help” (2013d). Patients need to know, too, that they may “talk with your nurse for help.” The purpose of this article is to promote nurses, especially those in the ambulatory care setting, as champions to support patients and families in their efforts to quit smoking, and to leverage ways that social media and telehealth technologies may enhance those efforts.

Nearly one in five adults (45.3 million) in the United States smoke, and despite a slight decrease in the number of adults who smoke from 20.9% in 2005 to 19.3% in 2010, cigarette smoking and exposure to secondhand smoke result in 443,000 deaths every year (CDC, 2013a). The importance of helping patients quit smoking because of the health consequences cannot be overemphasized. The financial burden – to smokers, their families, communities, and the healthcare system overall – is also staggering; smoking-caused diseases result in $96 billion in health care costs annually (CDC, 2013b).

Financial Incentives

Talking to patients about smoking is not only the right thing to do, but potentially could provide financial incentives to physicians and institutions participating in the Meaningful Use program (HealthIT, n.d.). Meaningful Use describes a set of standards, defined by the Centers for Medicare and Medicaid Services (CMS), regarding the use of electronic health records (EHRs). Documentation of smoking status for patients 13 years and older is one of the many standards required to receive the financial incentive (CMS, 2013). The financial incentive provides an additional compelling reason for health care team members to talk with patients about their smoking status and to document it in the EHR.

Nurses as Smoking Cessation Champions

Nurses are uniquely positioned to talk with patients about their smoking status. In both inpatient and outpatient settings, nurses are in constant contact with patients in person and on the phone. Taking the time to learn if a patient smokes – to explore the reasons why a patient smokes and whether or not he or she wants to quit and is ready to discuss cessation intervention – is an important role for all nurses. As part of the health care team, nurses are positioned to become “champions” for smoking cessation. The American Academy of Family Physicians (AAFP) promotes the idea of the “office champion,” a staff member who “plays a critical role in providing overall leadership for tobacco cessation efforts” (Theobald et al., 2010, p. 3). In its 2012 position statement on the role of the registered nurse in ambulatory care, the American Academy of Ambulatory Care Nursing (AAACN), stated that “Registered nurses will partner with other health professionals to lead the transformation of American ambulatory care systems from a traditional medical model to a team-based system that advances a health care delivery model focused on preventing illness, disease, and unnecessary complications; promoting wellness; and eliminating unnecessary costs” (Mastal et al., 2012, p. 233). Educating nurses about evidence-based smoking cessation interventions is the first step to empower nurses to...
take on the role of educator and “champion” to support and promote patients’ smoking cessation efforts.

**Review of the Literature**

In 2003, the Tobacco Free Nurses (TFN) program, an initiative to foster and increase nurse involvement in smoking cessation efforts with nurse-focused resources, was launched with the recognition that nurses – the largest group of healthcare employees, almost three million strong – have the potential to make a significant and positive impact on the nation’s efforts to combat tobacco use (TFN, 2006). Sarna and colleagues (2009) found that nursing awareness of evidence-based resources promoted by TFN is positively associated with increased frequency of nurse-initiated smoking cessation interventions. Specifically, nurses with an awareness of the TFN program are significantly more likely to refer their patients to a telephone quit line service. Newhouse and colleagues (2011) studied the smoking cessation counseling practices of nurses in 23 acute care rural hospitals and found that nurses who feel most comfortable with providing smoking cessation counseling are more likely to use evidence-based interventions. The authors surmised that if nurses are provided with education about evidence-based smoking cessation interventions, they are more likely to implement interventions that are known to work, thus improving the success of patients’ quit attempts. The study concludes that health care institutions are able to improve patient access to smoking cessation resources by increasing nurses’ comfort with smoking cessation counseling skills (Newhouse et al., 2011). Despite some study limitations, the survey of 591 registered nurses highlights nurse self-efficacy and the importance of training nurses in evidence-based interventions for smoking cessation (Newhouse et al., 2011).

**Nurses Can Make a Difference**

In its 2013 position statement on nursing leadership in global and domestic tobacco control, the Oncology Nursing Society (ONS) promoted the role of the nurse in the treatment of patients with tobacco dependence with specific recommendations, including “at a minimum, all nurses assess tobacco use and willingness to quit, provide advice to quit, and refer tobacco users to existing resources, including telephone quit line” (ONS, 2013). Education about tobacco use and cessation methods is crucial at all levels of training and experience within the nursing practice. The ONS (2013) recommends that nursing education should include information about the health effects of tobacco use, including secondhand smoke exposure, dependence, prevention, and cessation interventions. Practicing nurses should be provided with ongoing educational workshops regarding tobacco and smoking cessation interventions (ONS, 2013). Education and training, as well as time allotted for patient teaching and counseling, allow for nursing interventions that may improve the rates of smoking cessation.

**Patient Readiness to Quit Smoking**

How does a nurse know when a patient is ready to discuss smoking cessation? Exploring a patient’s readiness for behavior change provides information that will help develop an individualized plan for smoking cessation. One tool available to nurses is Motivational Interviewing (MI), which is designed to facilitate patient exploration and resolution of ambivalence about behavior change (Miller & Rose, 2009). A review of 14 studies involving more than 10,000 smokers demonstrated modest success in the use of MI provided by primary care physicians, hospital clinicians, nurses, and counselors in the promotion of smoking cessation when compared to brief advice or usual care (Lai, 2011). Every patient encounter is an opportunity to assess current smoking status and readiness for behavior change.

**The 5 A’s: Ask, Advise, Assess, Assist, Arrange**

The 5 A’s, as outlined in the U.S. Department of Health and Humans Services “Helping Smokers Quit” guide for clinicians, and described in greater detail in the 2008 Public Health Services Treating Tobacco Use and Dependence Clinical Practice Guidelines (Fiore et al., 2008), is a prescriptive formula for engaging patients in an ongoing discussion regarding tobacco use:

**ASK** about smoking at every patient encounter
**ADVISE** smokers to quit
**ASSESS** readiness and willingness to quit
**ASSIST** with quitting
**ARRANGE** for follow-up to review progress

Interventions to assist with quitting may vary greatly depending on a patient’s insurance benefits, ability to pay for services, the health care system’s capacity for providing low or no-cost interventions, clinician use of the EHR, and awareness of and referral to quit lines and internet-based interventions, including social media. The more cessation interventions that a smoker uses, the better his or her chances are for a successful quit attempt (Fiore et al., 2008). Encouraging a patient who has been prescribed bupropion to take advantage of smoking cessation counseling, or educating a patient that it is safe and recommended to combine the nicotine patch with another form of nicotine replacement therapy (NRT) (e.g., gum or lozenges) (WebMD, 2011), are two ways of combining interventions.

**Approved Pharmatherapies**

Current U.S. Food and Drug Administration (FDA) recommended first-line treatments for smoking cessation include over-the-counter (OTC) NRT (e.g., nicotine patches, gum, and lozenges), prescribed nicotine nasal spray and inhalers, and prescription medications bupropion (Zyban®, Wellbutrin®) and varenicline (Chantix®). All therapies, both OTC and prescription, have risks and benefits, and no single recommendation is appropriate for every patient. There are many resources available that describe each treatment in greater detail. Three reliable websites supported by evidence-based research where nurses and patients may access:
more information about smoking cessation are:
- http://talktoyourpatients.org
- www.smokefree.gov

**Documentation of the Smoking Cessation Plan**

An EHR allows for the input and storing of patient health information. In order for health care providers and facilities to qualify for the financial incentives of Meaningful Use, the EHR must also enhance coordination of patient care and tracking of health status. The Meaningful Use criteria require the capture of data on smokers 13 years and older (CMS, 2013). One benefit of the Meaningful Use of the EHR is a medical record with more timely and accurate information. Another benefit is improved and efficient access to patient information, which may enhance empowerment, as patients may take a more active role in their own health management when they are able to view health information and securely exchange information with their health care teams (CMS, 2013). The EHR assists the clinician by providing electronic prompts, immediate access to previously gathered information regarding a patient’s smoking status, ready access to patient education handouts, and electronic referrals to quit lines and other smoking cessation interventions. In addition, e-visits, patient-initiated contacts via an electronic portal, allow patients to update their health care teams on quit attempt progress and to request further assistance, support, or intervention (Theobald et al., 2010).

**The Role of Telehealth and Social Media**

Funded by the CDC Office on Smoking and Health, telephone quit lines are available in all 50 states. The telephone quit line programs provide telephonic counseling and other resources to help patients with quit attempts. Quit lines provide evidence-based behavioral counseling by trained cessation specialists at no cost to patients. SmokeFree.gov provides information about how to access each state’s quit line service and 1-800-Quit-Now will connect you directly to your own state’s quit line program.

The abundance of smoking cessation information can be overwhelming, and accuracy of information can be an issue. Facebook, Twitter, chat rooms, blogs, smartphone apps, and YouTube videos are only as valid as the authenticity of the information provided. Credible resources for health care providers to supplement a patient’s medical plan for smoking cessation include the CDC’s Facebook page, Twitter feed, Pinterest boards, and YouTube videos, all of which are part of the CDC’s “Tobacco Free” initiative (CDC, 2013c). In addition, a search of “stop smoking” in smartphone applications provides more than 80 free applications available to assist smokers with staying focused and motivated. Three free smoking cessation smartphone applications that are evidence-based and supported by the National Cancer Institute (NCI) are available at http://smokefree.gov/apps-quitguide. The three apps for patients who are contemplating quitting are: NCI QuitPal, Smokefree Teen QuitSTART, and QuitGuide.

**Champions in Action**

A nurse-managed smoking cessation program in ambulatory care settings is an intervention that makes sense. For example, in a family practice clinic of more than 13,000 patients, an electronic “smoking cessation” referral “desktop” in the EHR was created as part of a family medicine resident’s research project involving a smoking cessation decision support system. The referral program was sustained after the conclusion of the research project. Any ambulatory staff member may refer a patient who expresses interest or curiosity in smoking cessation treatment. Within a week of the referral, an RN dedicated to the program calls the patient to discuss treatment and support options, which may include referral to the quit line, Nicotine Replacement Therapy (NRT) or medications prescribed by a clinic physician, and/or scheduling counseling with a trained smoking cessation counselor. Two attempts to reach each patient are made and, using the features of the EHR, the RN provides telephone support with full access to patient’s history, medications, and past smoking cessation efforts and interventions. In addition, the RN communicates electronically with the patient’s Primary Care Provider (PCP) directly through the patient’s EHR for information sharing, decision agreement, and orders, if indicated. Additionally, the RN is able to see patients in person when they arrive for scheduled appointments. The smoking cessation counselor provides one-on-one counseling for patients over a 5-6 week period and communicates regularly with the RN regarding a patient’s need for refills of prescribed medications or NRT. Anecdotal results have been overwhelmingly positive from patients, physicians, and staff. One patient, when asked how she was able to quit smoking, stated that it was “the right time, right tools, and right support.”

**Summary**

The impact of smoking nationally and globally cannot be ignored. As nurses, we are positioned and well prepared to support patients, families, and each other on this difficult, but surmountable journey out of tobacco addiction. The first step is to gain knowledge and proficiency so that we may say with confidence, “I’m a nurse, and you can talk with me about getting help to quit smoking.”

**References**


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**ViewPoint Article “Wish List”**

Consider sharing your ambulatory care or telehealth nursing expertise by writing an article for ViewPoint! The newsletter features articles on a variety of topics of interest to ambulatory care and telehealth nurses. The following abbreviated “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
- Bariatrics
- Best practice
- Budgeting
- Care coordination competencies
- Case management
- Chronic illness
- Dermatology and skin topics
- Disease management
- Electronic medical records
- Evidence-based practice
- Health care reform
- Hematology
- Hospice
- Leadership in nursing education
- Legal nurse consulting
- Legislative topics
- Magnet® process for ambulatory care
- Medical home model
- Metrics for ambulatory care nursing
- Military/veteran patients
- Nurse leadership
- Nurse residency
- Office-based practice
- Patient safety
- Pediatrics
- Reimbursement
- Report cards (creation and utilization)
- RN role in primary care practices/clinics
- Scope of practice for ambulatory care APRNs, NPs, RNs, LPNs, and MAs
- Staff education
- Strategic direction of leadership
- Teletriage
- Transition management
- Travel medicine

If you or someone you know would like to write an article on a “wish list” topic, complete the Author Interest Form at www.aaacn.org/viewpoint.

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**It’s Your Time To Shine!**

If you would like to be featured in the “member spotlight” in a future issue, please contact Deborah Smith at dsmith5@gru.edu to receive a brief set of introductory questions. These questions can also be found on the AAACN website (www.aaacn.org/viewpoint). Please include a high-resolution photo with your submission.
Education Hit a High Note in the BIG Easy!

Education combined with jazz music, Creole food, beignets, and an exciting city helped make the AAACN 39th Annual Conference in New Orleans a success. 688 nurses attended the conference, which kicked off with local jazz musicians and revelers entertaining at Opening Ceremonies. Keynote Donna Wright, MS, RN, launched the conference with a humorous look at what is needed to succeed in health care today. 119 nurses took the Ambulatory Care Nursing Certification Review Course to prepare to take the certification exam. 52 nurses from all branches of the military attended the Tri-Service Military evening forum, and 116 nurses attended the Pre-Conference Workshop “Best Practices in Nursing: Self Care for Better Patient Care.” Registrants discussed Nurse Sensitive Indicators at the Town Hall, met vendors in the exhibit hall, and also learned from colleagues through the 71 posters displayed. Feedback heard throughout the conference was it was the best ever! If you missed the conference, all sessions were recorded and are available in the Online Library (www.aaacn.org/library). Members pay $199 for the complete conference package or $15 for individual sessions. The Pre-Conference Workshop is $49. All prices include contact hours.

Kathy Mertens Receives the Above and Beyond Award

President Susan Paschke presented her President’s Above and Beyond Award to Kathy Mertens, RN, MN, MPH, for her 14 years of continued support of AAACN through her oversight of the Leadership Special Interest Group (SIG), many conference presentations, service as a member of the Care Coordination and Transition Management (CCTM) expert panel, authorship of a chapter in the CCTM Core Curriculum, and piloting the Communities of Practice concept. Susan indicated Kathy was not planning to come to the conference due to the launch of an EMR system at her workplace. However, when her employer, Harborview Medical Center in Seattle, Washington, heard she was the recipient of this award, they flew her in and agreed to live without her on the first day of their EMR launch!

Janice Mills Receives First Candia Baker Laughlin Scholarship

Janice Mills, MS, was recognized as the recipient of the first annual Candia Baker Laughlin Certification Scholarship, a new award that funds the costs for the certification exam and study materials. Janice met “Candy” at the New Orleans conference, and we are proud to report she passed the exam following the conference. She has thus added RN-BC to her credentials. Congratulations, Janice!

Excellence Award Winners

Two AAACN Excellence Awards were provided by the Nursing Economics$ Foundation. The recipients of the awards were:

Clinical Excellence
Kellie A. Johnson, Lt Col, USAF, NC
10th Medical Group, USAF Academy

Administrative Excellence
Cecilia G. Fowler, BSN, RN
Kelsey-Seybold Clinic, Houston, TX

Education Scholarship
Jeannette Richardson, MS RN CNS-BC, was awarded a $1,000 education scholarship to assist in obtaining her DNP.

Conference Scholarships
Dedere Tuck, MSN, RN-BC, CPN, from Roanoke, Virginia, and Patricia White, BSN, RN, CPN, from Springfield, Pennsylvania, received funding to help with expenses to attend the annual conference.

Research Grant
Susan M. Brennan, RN, CPN, was the recipient of a $500 research grant to support her study, “Outcomes of Cultural Change and Fever Teaching Intervention in a Pediatric Primary Care Setting.”

ViewPoint Writer’s Award

The recipients of the ViewPoint Writer’s Award were Barbara Weber, MS, RN-BC, and Anne Hammer, BA, BSN, RN, of Denver Health, for their article “From Chaos to Control: Implementation of Mass Influenza Immunization Clinics.” The article appeared in the September/October 2013 issue of ViewPoint.
Poster Winners

In order to accommodate 71 posters, two locations were used to display posters prepared by participants this year. Registrants were asked to vote for the best poster. Due to the high level of the posters, there was a tie for first and second place! Ribbons were awarded to:

1st Place (Tie)
Call Us for Care and We’ll Be There: Developing a Daytime Pediatric Nurse Triage Call Center
Rashidah Hasan, BSN, RN
Mary E. Sizer, MSN, RN, CPN
Daneen Smith, MSN, RN
The Children’s Hospital of Philadelphia, Pennsylvania

1st Place (Tie)
Improving Health Outcomes in the Pediatric Medical Home: 2014 & Beyond
Teresa Graves, BSN, RN
Regina Hartridge, MSN, RN, CPN
Claudette R. Nealy, MHA, BSN, RN, CPN
Patricia B. Powell, BSN, RN
Juanita Pryor, MSN, RN, CPN, CPHQ
Children’s National Health System, Washington, DC

2nd Place (Tie, photo at left)
Understanding the Purpose and Significance of Nursing Data Quality Indicator and the Nursing Criteria Required Measuring the Expected Standard: The Emphasis/Focus Will Be on Nursing Documentation, Quality of Care, and Patient Outcome
Maria Jessica Lourdes A. Catubig, MPH, BSN, RN, RM
Isah Mar Montallana, RN
King Faisal Specialist Hospital and Research Centre, Riyadh, Saudi Arabia

2nd Place (Tie)
Pre-Visit Planning Indirect Model of Care and Huddles Target Health Care Disparities through Disease Management and Health Promotion
Kathy Goodman, BBA, RN
Corey Henry, BSN, RN
Thomas Porter, MD
Donaji Stelzig, MPH, CHES, CHW
Harris Health System, Houston, Texas

3rd Place
Use of Nurse-Led Clinics in Treatment of Uncomplicated Hypertension in Adults
Noreen Bristow, MSN, PHN, RN
Jennifer Regnante, RN, AABA
Kaiser Permanente, La Mesa, California

New Orleans Basket Winners

The Children’s Hospital of New Orleans, Gifted Nurses, and Trinity Care Incorporated provided three fantastic baskets stuffed with food items and souvenirs from New Orleans. Basket winners were: Tracy Newman, Wen-Yin Chang, and Kathleen Martinez. Special thanks go to member Jackie Harrison and her colleagues for staffing a table to welcome attendees to New Orleans and offer the basket drawing.

Marianne Sherman Becomes AACN President

President Susan Paschke, MSN, RN-BC, NEA-BC, passed leadership of AACN to Marianne Sherman, MS, RN-BC, during the Closing Ceremonies. Marianne presented Susan with a gold membership card denoting lifetime membership in AACN. In her President’s Address, Marianne explained the road that led to her becoming a nurse – especially an ambulatory care nurse – how she discovered AACN, as well as her views of the future. Marianne is Director, Nursing and Professional Standards for Ambulatory, University of Colorado Hospital.

2014-2015 Board of Directors Takes Office

The 2014-2015 Board of Directors assumed their responsibilities at the close of the conference. Pictured (l-r): Judy Dawson Jones, Secretary; COL (Ret) Carol Andrews, Director; Cyndee Hnatiuk, Executive Director; Susan Paschke, Immediate Past President; Marianne Sherman, President; Nancy May, President-Elect; CAPT (Ret) Wanda Richards, Director; Debra Cox, Treasurer; and Liz Greenberg, Director.

Care Coordination Drawing

Activity was brisk at the Care Coordination and Transition Management (CCTM) booth, staffed by the editors and authors of the soon to be published CCTM Core Curriculum. Attendees had the opportunity to review draft copies of the publication and learn about the development of the Core text, as well as the online course. The winner of the full course prize was Char Patterson, MSN, RN, NE-BC, C-NE. The winner of a CCTM Core Curriculum was Joanne Adalin, RN.

AAACN members can view select posters online at www.aaacn.org/poster-presentations
Health Policy Update
*continued from page 1*

will continue through 2016. EPs may participate for up to five continuous years for the incentive payment. To qualify for incentive payments, EPs must successfully demonstrate Meaningful Use documentation for each year they participate in the program. EPs that have not enrolled by 2014 will not be eligible to receive incentive payments.

Beginning in 2015, there will be payment reductions for eligible providers who choose not to participate in the MU program. These penalties will start at 1% per year, up to a maximum of 5% per year. To receive an incentive payment, providers must: ensure they are using an EHR that has been certified for these incentive programs, register as an EP, and attest to CMS compliance with established standards or criteria (CMS, 2014a, 2014b).

There are three stages to the MU program. Stage 1 was focused on providers electronically capturing patient data that could then be shared with the patient or with other health care providers. Stage 2 is focused on the use of the EHR to capture clinical processes such as health information exchanges between providers, e-prescribing, transmission of patient care summaries across multiple settings, and increased patient and family involvement or engagement. Stage 3 will be focused on using the EHR data to improve patient care outcomes. A summary of the changes between Stage 1 and Stage 2 MU objectives may be found online (CMS, 2012).

**What are the Requirements for Stage 2 Meaningful Use?**

CMS has established objectives that providers must meet in order to demonstrate that they are using the EHR in a meaningful way. For Stage 2, providers must attest to the completion of 17 core objectives and their compliance with clinical quality measures. All EPs will be required to demonstrate MU compliance for a quarter of the year in 2014. Stage 2 MU objectives, along with summary requirements, can also be found online (CMS, 2013).

Ambulatory care nurses play a significant role in the completion of many of these Meaningful Use measures including the gathering of demographic information, the recording of vital signs, and identification of smoking status. Required demographic information includes preferred language, gender, race, ethnicity, and date of birth. Vital signs (height, weight, BMI, and blood pressure) are required to be measured and recorded in the EHR. Providers can be excluded from measuring blood pressure if they see patients under two years of age or if they feel that vital signs are not relevant to their scope of practice (CMS, 2013).

Identification and documentation of smoking status are also required if you see patients 13 years of age or older. Nurses can use this information to identify patients who might benefit from patient education related to hypertension, weight management, and smoking cessation. They can also use this information to help patients become more involved in the promotion and management of their own health.
Other MU objectives in which ambulatory care nurses may play a key role include the gathering of the clinical history, identification of preventive health care measures, patient-specific education, medication reconciliation, and immunization administration. Ambulatory care nurses may use data from the EHR to identify preventive health measures that are due. Reminders for preventive/follow-up care may then be sent to the patient. Medical assistants can review this information prior to the patient visit and contact the patient to remind him or her to assist with the scheduling of these preventive care measures. Meaningful Use requires that greater than 10% of patients receive patient-specific patient education. The EHR may be used to recommend educational resources to patients (CMS, 2013).

Medication reconciliation is required when a patient moves between care settings. In the case of medication reconciliation following a transfer or transition of care, it is the receiving provider’s responsibility to complete the medication reconciliation. Ambulatory care nurses are important in the gathering of a patient medication list and assessing the patient’s knowledge related to medications. Accurate medication reconciliation is crucial in promoting patient safety and preventing readmission to the hospital.

Another MU objective is that providers have a mechanism to transmit immunization data to an electronic registry, often a State Department of Health. These immunization registries can be helpful in compiling a unified list of current and completed immunizations for patients, providers, and schools. Ambulatory care nurses often administer immunizations per physician order or by protocol, which can then be transmitted to the immunization registry through the electronic health record system.

**How is MU Determined?**

To document compliance with the MU standards, providers are required to complete an attestation that declares their completion and compliance with the required objective measures of the MU program. The process of attestation occurs through an Internet-based CMS system. As part of the attestation process, providers enter data and answer yes/no questions related to the core measures, the menu objectives, and the CQMs.

**Implications of MU for Ambulatory Care Nursing**

The use of electronic health information to facilitate communication promotes quality and safe patient care. Computerized physician order entry promotes patient safety through improved legibility and more accurate ordering of medications, tests, and procedures. The use of after-visit summaries provides a written or printed summary document of medications and the plan of care, which can serve as a reference and reinforcement to the patient after the completion of the visit. Electronic reminders regarding upcoming visits can facilitate follow-up and promote wellness and engage the patient and family in care. The sharing and transmission of patient information between care settings and providers promotes care coordination; this increases safety, as well as communication and collaboration, related to patient care. Ambulatory care nurses can help promote the use of meaningful information through the EHR by being knowledgeable regarding its requirements, facilitating and assuring compliance with required documentation, as well as supporting and facilitating changes within the ambulatory care practice environment.

**Conclusion**

The implementation of MU standards utilizing EHR technology is an important step in the provision of safe and effective health care. Ambulatory care nurses can be instrumental in the development and support of systems to promote successful implementation of Meaningful Use standards.

**References**


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The Art of Listening: Mitra’s Story

A little over a year ago, I had the pleasure of meeting Mitra Abdullahpour at a telephone triage seminar. One of the topics I discussed in my presentation was best practices in communication over the telephone. During one of the breaks, I had an enlightening conversation with Mitra and her manager, Melissa Jameson. They shared an example of excellence in the art of listening.

By definition, to listen is “to pay attention to someone or something in order to hear what is being said” (Merriam-Webster, 2014). When you listen carefully, you not only hear words, but also sighs, breaths, pauses, background noises, and silence. In recent years, another term has been used that takes hearing another human being to a greater depth, and it is called deep listening.

According to the Centre of Innovation in Health Management (n.d.), deep listening occurs when the listener places himself or herself in the speaker’s place and tries to see things from the other’s point of view. It consists of reflecting, paraphrasing, and summarizing. Deep listening consists of more than listening to words; it captures the meaning and feelings behind the words.

Mitra is a certified oncology nurse who works in a call center for McKesson Specialty Health. Her focus is on managing and advocating for patients who are undergoing cancer treatment. She contacts patients prior to the initiation of chemotherapy to attain a baseline assessment, reinforce education, and inquire about questions and concerns. During treatment, Mitra contacts the patient after each cycle of chemotherapy and then follows up 30 days after the last treatment. According to Melissa, Mitra has an extraordinary ability to connect with patients over the telephone. She has a calming presence and establishes a trusting relationship through authentic conversation.

Over the years, Mitra has assisted many patients and families as they undergo treatment. There have been countless patients she helped from the beginning to the end of their journeys. She has deeply listened to their stories and captured her impression of them by drawing their image. These images allowed Mitra to immediately reconnect with her patients in a personal way with every call. This is her story.

In Mitra’s Words

The goal of the Innovent Oncology program is to reduce hospitalization and emergency room visits by preventing or decreasing the severity of the side effects caused by chemotherapy. This may ultimately improve quality of life for patients while reducing cost of care.

We have created a safe, informative, and trustworthy environment that reduces anxiety and stress for patients who are undergoing cancer treatment. We provide proactive symptom management, and patients can get answers to their questions while they are in the comfort of their home and away from the clinics, doctors, needles, or anything scary. This is what makes the Innovent Oncology program different from care in other clinics. Patients feel that their phone call is an informal conversation; it is more like talking to a friend or family member after each treatment.

We listen to what the patient wants to say and we serve as an advocate for them. Each call is only about him or her and is personalized. We have the chance to ask about their deepest fears or worries along with hearing their happiness and treasures in life. There is a difference in the level of connection; it is a heart to heart conversation. Because we are a voice from far away, patients feel more comfortable to ask direct questions and share feelings that they are not comfortable bringing up when there is a set of eyes staring at them.

When patients talk, I don’t see them, but I absorb the conversation with my heart. I can feel the highs and lows in their tones. It is amazing how you can feel the breakdown and vibration in their voices with asking a simple question at the right time. “Tell me more about you. How do you feel with all of this happening?”

I started drawing pictures as a way to capture my imagination about who the patient could be by listening to his or her voice. Voice tone, quality, and volume are important, but the patient is more than his or her voice. He or she is a human being who has hopes, dreams, feelings, relationships, and different life experiences. Soon after I began drawing pictures of my callers, I realized it helps me personalize my relationship with them. After chemotherapy, the patient may feel miserable. With just a glance at my drawings, I can instantly remember the whole story in detail about that specific person. I can talk to the patient about the things that are most important to the patient (e.g., children, pets, a hobby, etc.). Drawing pictures builds trust, helps connect, and keeps spirit in the conversation. It works like a charm.

In some cases, I have had the chance to see real pictures of some of my patients and was amazed at how similar they looked to my drawings. I could see the same body frame, facial expressions, furrows, and even the shape of the glasses they wore.

This position is a blessing. I have learned a lot and realized how I can have even a broader perspective with closed eyes.

References

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An evidence-based, patient-centered solution to the puzzle of fragmented care.

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Reference

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Strategic Planning: Initiatives to Consider and Conundrums to Ponder

There are four major challenges that are a part of the Affordable Care Act (ACA) (U.S. Department of Health and Human Services [HHS], 2010): a focus on wellness and health promotion, patient-centered care, use of evidence-based practice, and population health management. Each of these is a 180-degree change from the way that health care has been provided in the past. We now must think both in terms of care for acute and chronic disease, as well as provide wellness and disease prevention interventions for all. Instead of waiting the usual 17 years (Baumbusch et al., 2008; Westfall, Mold, & Fagnan, 2007) to use evidence to guide practice, we must now move from provider-preferred practices to implementing evidence-based guidelines as part of population health management while also providing patient-centered care. Although many health care providers like to think they are already doing patient-centered care, they must now elicit patient goals, preferences, and values, as well as engage patients in decision-making about their care.

There are incentives to do all of these required initiatives and also penalties if they are not embraced. We are seeing movement to risk stratification for patients with chronic illnesses, especially those with complex chronic illnesses and multiple co-morbidities, so that care can more appropriately be offered to those at highest risk. However, the fee-for-service providers are neophytes with risk stratification. They are not as aware of how social determinants or socioeconomic factors (health literacy, educational and income levels, presence of support of significant others, and community resources) markedly influence risk status and are mistakenly purchasing vendor tools that only use physical and mental status in stratification when these only account for about 50% of risk. Therefore, risk stratification using such computer programs is often flawed.

Organizations are becoming aware of the need for care coordination and transition management (CCTM), but they continue to think in terms of managing the individual patient. What they need to do is use evidence-based guidelines available for populations with complex chronic illnesses – such as congestive heart failure (CHF), chronic obstructive pulmonary disorder (COPD), and community-acquired pneumonia (CAP) – and make adaptations in such guidelines for individual patients based on patient values, goals, and preferences. Risk stratification has created a need to have providers who can focus on high-risk populations; however, organization senior management seems to be thinking in terms of traditional roles, such as individual case management and disease-focused educators. What is needed is an analysis of staffing within interprofessional teams in both acute and outpatient care that correlates with problems and needs of patient populations. It is likely that different populations will require different configurations of providers. For example, the high-risk COPD population will need pulmonologists, respiratory therapists, pharmacists, dieticians, and both inpatient and ambulatory care nurses in the CCTM role. Social workers would also be needed if there were significant socioeconomic issues in the population being served.

The traditional acute care mentality has made it challenging to put a focus on wellness and health promotion in this new age of health care, and this is exacerbated by traditional education for health care providers where wellness has not been a major focus. Nutrition, exercise, work/life balance, and mental health are not major topics in many health professional curricula and often not addressed in evidence-based guidelines. It was not surprising that the American Medical Association only designated obesity as a disease in 2013. Interprofessional collaboration and teamwork has not, until recently, been a focus in the education of health care providers.

So how can ambulatory care nurse leaders be responsive to incentives for the ACA (HHS, 2010) initiatives? Many wellness and health promotion initiatives can be completely nurse-driven. One requirement is that nurse leaders have accurate data on the demographics of patient populations served; their needs, values, and social determinants, such as education and income levels; as well as employment. Wellness programs can be planned and offered on nutrition, cooking, child wellness, exercise, and more, but they must be geared to education levels and times available given patients’ work schedules. Decision support programs should be considered to provide timely reminders of immunizations and routine testing needed so patients can have one-stop visits, where they receive these preventive health services when coming in for a visit with their health care team, no matter what the reason.

Implementation of evidence-based practice begins with strategic selection of evidence-based guidelines for major populations with chronic illnesses such as CHF, hypertension, diabetes, and COPD. The interprofessional team evaluates the strength of evidence-based assessments and interventions recommended and designs protocols for these populations. Individual providers work with their patients to make sure patient goals, values, and preferences are in alignment with these guidelines. The interprofessional team also selects process and outcome indicators for each evidence-based protocol that can be embedded in documentation using standardized coding in the electronic health record (EHR), so effectiveness of care can be...
tracked and evaluated. Appropriate staffing for each patient population can be tied to longitudinal data generated in the EHR.

References


Suggested Readings


Sheila 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

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**Call for Submissions: Safety Corner**

Please share your evidence-based strategies that can help us provide safer care in the ambulatory setting. Keep it simple as you address a topic you are passionate about sharing. For our official “Submission Tips,” visit www.aaacn.org/viewpoint. Share your questions, ideas, or submissions with Sarah Muegge at sarah.muegge@coxhealth.com.

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**Call for Poster Abstracts for the 2015 Conference**

You are invited to submit a poster abstract for the 40th AAACN Annual Conference, April 15-18, 2015, to take place at the Hilton Orlando. Share your knowledge, best practices, and research with your colleagues. Presenters receive $100 off their registration fee. The poster deadline is December 15, 2014. Obtain the abstract submission criteria from the *Events* section of our website at www.aaacn.org.
The Tri-Service Military Special Interest Group (SIG) held a pre-conference forum and networking sessions at the 2014 AAACN Annual Conference in New Orleans, which were a success. AAACN President Susan Paschke and the SIG’s Board Liaison Colonel (Ret) Carol Andrews gave a warm welcome and support for the SIG’s activities. The highlight of the evening forum was a dynamic informational presentation by Sara Bittiker, Capt, NC, USAF, on Standardization of a Nurse Telehealth Peer Review Program by the 56 Medical Group, Luke Air-Force Base. An impromptu presentation on the newly launched Nurse Advice Line was also invaluable. Additionally, attendees at the forum and networking sessions met experts and shared nursing initiatives, innovations, transformations, experiences, clinical issues of concern, and plans for implementing innovative solutions to identified clinical concerns affecting all military medical facilities. Attendees also had an opportunity to discuss conference funding and explored avenues for continued SIG activities and preparation for future conferences.

During the Tri-Service SIG networking session, Commander Sana Savage, Navy Lead Co-Chair, engaged the attendees in the SIG’s governance and aspects of volunteer leadership as she passed the baton to the Army Lead Co-Chair, Lieutenant Colonel Sonya Shaw for the 2015 AAACN Annual Conference. In addition, Major Dana Baker from the Air-Force will take on the role of Secretary. The webmaster position is currently available for a 3-year term. The SIG is also seeking a Navy Co-Chair for the 2015-2018 term. Interested volunteers can contact CDR Savage at iyatutu1@gmail.com or Lt Col Shaw at sonya.c.shaw.mil@mail.mil for more information.

The planning committee would like to move back to a full-day pre-conference in 2015, April 15-18, at the Hilton Orlando, Lake Buena Vista, Florida. They will be working to address funding and administrative requirements in order to make that happen.

Assanatu I. Savage, CDR, NC, USN
SIG Navy Co-Chair