In late spring 2013, the AAACN Board of Directors chartered a task force to “develop and identify nurse sensitive processes and outcomes indicators related to the role of the registered nurse in ambulatory care.” This important work supports the AAACN strategic plan. The task force began its work by examining what measurements already exist, brainstormed about what measurements were necessary but missing, and how to identify measures that capture the ambulatory nurse’s increasingly crucial role in health care redesign and transformation.

The task force identified the need to build upon the strong body of work of Care Coordination and Transition Management led by Drs. Beth Ann Swan and Sheila Haas and Traci Haynes (2013). Additionally, the task force gleaned knowledge from Dr. Nancy Dunton, ANA’s representative on the task force, for an overview of the development and implementation of nurse sensitive indicators (NSIs) by the National Database of Nursing Quality Indicators (NDNQI). Further conversations looked at the Centers for Medicare and Medicaid Services, Physician Quality Reporting System (PQRS) indicators and other important entity measurements such as those from National Quality Forum (NQF) regarding care coordination measures. The task force selected the Donabedian (1966) framework of structure, process, and outcomes to organize future ambulatory indicators.

Part of the task force’s work was to develop critical filter questions to assist in the selection of the strongest indicator(s) for ultimate success and recommendation to the AAACN Board. Task force members articulated selecting indicators that are:

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Greetings from your Board of Directors!

After what has seemed to be a very long and cold winter, spring is finally on the horizon and we look forward to the colors and sounds that announce the change of season. Spring is always an exciting time for AAACN as we continue to work on our strategic plan and initiatives to serve our members, expand our influence, and strengthen our core, as we anticipate coming together for the annual conference. And there are more of us than ever! AAACN reached a milestone at the end of 2013. More than 1,800 members renewed in December and we had the most new members ever at 1,201! Today we are 3,031 members strong and growing!! What a great testament to our organization and our members! Ambulatory nurses join AAACN to connect with others in similar roles and to network about common problems and solutions, to advance their practice and leadership skills through opportunities to collaborate with other leaders and mentors, and to advocate for the specialty of ambulatory care nursing locally and nationally.

Retention of current members and recruitment of new members, especially those of the more recent generations, is and has been one of our strategic objectives for the organization. The board has been discussing leadership development of the new and emerging leaders of AAACN and succession planning for the future. This will be a theme of our board meeting in New Orleans. If you want to be part of the leadership of the future, find a way to get involved with the organization. Join a committee, SIG, or a task force. Prepare a poster or podium presentation for the annual conference. Become involved in a local networking group or start one in your area. You may not desire to be a board member or the president, but there are plenty of leadership opportunities outside of those roles. Remember, as ambulatory care nurses, we are all leaders!

I had the pleasure of participating in a first for the nursing organizations that are managed by Anthony J. Jannetti, Inc. The leaders of six nursing organizations participated: AAACN, Academy of Medical-Surgical Nurses (AMSN), American Nephrology Nurses’ Association (ANNA), American Nursing Informatics Association (ANIA), Gerontology Advanced Practice Nurses Association (GAPNA), and the Society of Urology Nurses and Associates (SUNA). Each organization provided information about their members and the major issues they are concerned about: low membership, engaging younger members, and developing new leaders. Opportunities for collaboration were discussed with the following suggestions brought forward: consider sharing speakers, making our Online Libraries available to each other, sharing technology best practices, and pursuing joint marketing of programs and products through our e-newsletters. Leveraging our resources and sharing the expertise of colleagues is a great first step. Further conference calls and discussions about future collaboration are planned.

Collaboration is an important concept for AAACN this year. The first Ambulatory Care Certification Intensive CE Series in partnership with Gannett Education was offered in January and February. Approximately 60 participants engaged in five webinars and completed four reading modules in preparation to take the Ambulatory Care Certification exam. The series was so successful that four more series are planned for 2014. In addition to the Ambulatory Care Certification review course offered at the annual conference and at various sites

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Meeting the Needs of the Newly Insured: A Look at the Numbers

The title of a recent article from Kaiser Health News (KHN) (Ollove, 2014) posed the question, “Are There Enough Doctors for the Newly Insured?” A news article with such a title is misleading. The article was stimulated by a story in Stateline, the daily news service of The Pew Charitable Trusts. Unfortunately, this headline and the article content create a false impression that we will continue with Medical Model health care where the pivotal provider is a medical doctor. However, the Affordable Care Act (ACA, 2010) provisions are designed to foster wellness, health promotion, and disease prevention through interprofessional provider teams working collaboratively in Patient-Centered Medical Homes (PCMH) and Accountable Care Organizations (ACOs), whereas the Medical Model focuses on physician diagnosis and treatment of acute and chronic illnesses. Missing in the headline as well is the acknowledgement that health care also involves other primary care providers such as nurse practitioners, physician assistants, pharmacists, social workers, dieticians, dental specialists, and mental health care providers who focus on prevention of disease and promotion of wellness. Such providers are also members of interprofessional teams providing care for the newly insured.

The KHN article (Ollove, 2014) also provides statistics derived from the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA, 2014) regarding the numbers of providers needed to improve access to health care. These numbers demonstrate that there will be access issues for the newly insured.

“Nearly 20% of Americans live in areas with an insufficient number of primary care doctors. Sixteen percent live in areas with too few dentists and a whopping 30% are in areas that are short of mental health providers. Under federal guidelines, there should be no more than 3,500 people for each primary care provider, no more than 5,000 people for each dental provider; and no more than 30,000 people for each mental health provider” (Ollove, 2013, 2014, p. 1; HRSA, 2014).

Again, this information does not view providers through a broad lens; instead, the focus is on the traditional view of doctors, dentists, and psychiatrists and how shortages of these providers will hamper access for the newly insured. The following reinforces this view: “Many primary care doctors and dentists do not accept Medicaid patients because of low reimbursement rates...and many psychiatrists refuse to accept insurance at all” (Ollove, 2014, p. 1). It is not until page 3 of the article that advanced nurse practitioners (APNs), physician assistants (PAs), and pharmacists are mentioned as potential primary care providers, even though the ACA (2010) provisions list them as primary care provider members of the interprofessional team. The lead-in to a discussion of alternative primary care providers begins with, “A more controversial idea is to allow nurse practitioners, physician assistants, pharmacists, and dental aides to do some of the work usually reserved for doctors and dentists. Many states have passed such legislation while other are eyeing similar measures” (Ollove, 2014, p. 3). The KHN article also states that the American Dental Association opposes use of mid-level dental workers, even for routine preventive and restorative work, and some groups representing physicians are resisting allowing APNs to write prescriptions and admit patients to the hospital. Polly Bednash, Executive Director of the American Association of Colleges of Nursing, responded to such resistance with, “Health care is not a zero-sum game where there is a limited amount of care to be given. If there’s more care needed than we can deliver in the world, we have to decide who else can provide quality care” (Ollove, 2014, p. 3).

What is needed in health care today to meet the needs of the newly insured is visionary thinking and innovation. We cannot afford to deliver Medical Model health care using fee-for-service methods. Rather, we need to consider outcomes that need to be achieved; methods to deliver disease prevention, wellness, and health promotion; as well as acute and chronic disease care and valid and reliable measures of processes and outcomes.

The Institute of Medicine’s (IOM) report, The Future of Nursing (2010), demonstrated such visionary thinking with its recommendations. It speaks directly to the topics in this column.

* Nurses should practice to the full extent of their education and training.
* Nurses should achieve higher levels of education and training through an improved education system that promotes seamless academic progression.
* Nurses should be full partners, with physicians and other health care professionals, in redesigning health care in the United States.
* Effective workforce planning and policy-making require better data collection and an improved information infrastructure.

As you know, AAACN has been working over the past 18 months to develop the dimensions, competencies, and a model of Care Coordination and Transition Management (CCTM) (Haas, Swan, & Haynes, 2013). This work on the
Pneumococcal Vaccination: Identifying Barriers and Strategies to Improve Administration Rates

Melly Turner  Cherie Parks  Felicia Murphy
Laura Dick  Cherie Chaney  Kathryn Ward  Suzanne M. Burns

Streptococcus pneumonia results in more deaths than any other vaccine preventable disease in the United States. Most deaths related to pneumococcal disease occur among older adults with underlying chronic conditions (Szilagyi et al., 2005). Case fatality rates are high, especially when the disease results in meningitis or bacteremia (Atkinson & Kroger, 2011). The advent of an increased number of aging “baby boomers,” people living longer with chronic disease and the emerging problem of antibiotic resistance have added to the population at risk for pneumococcal infection.

Streptococcus Pneumoniae bacteria is a major cause of the 900,000 cases of community-acquired pneumonia in the US each year and approximately 175,000 people are hospitalized annually with the infection. In addition, concurrent cardiac events are common among patients hospitalized with pneumococcal pneumonia. It is also a major cause of milder common illnesses such as sinusitis and otitis media (Nuorti, 2011). The bacterium is transmitted directly from person to person by respiratory droplets and can cause life-threatening illnesses such as meningitis, bacteremia, and pneumonia (Nuorti, 2011). Symptoms can suddenly develop and vary by clinical presentation. Pneumonia symptoms include fever, shaking, chills, cough, shortness of breath, and chest pain. In the elderly, symptoms may be atypical and might include weakness or confusion without the presence of a fever or other more common symptoms (Facts about pneumococcal disease and prevention in adults, 2011).

Prevention of pneumococcal pneumonia begins with vaccination. The Immunization Action Coalition (Atkinson & Kroger, 2011) recognizes the following “at risk” populations for which the pneumococcal polysaccharide vaccine (PPSV) is indicated:

- Previously unvaccinated adults age 65 years of age and older
- Age 2-64 with any of the following conditions:
  a. cigarette smokers age 19 and older
  b. functional or anatomic asplenia (e.g., sickle cell disease, splenectomy)
  c. immunocompromising conditions (e.g., HIV infection, leukemia, congenital immunodeficiency, Hodgkin’s disease, lymphoma, multiple myeloma, generalized malignancy) or on immunosuppressive therapy
  d. organ or bone marrow transplantation
  e. chronic renal failure or nephrotic syndrome
  f. chronic cardiovascular disease (e.g., congestive heart failure, cardiomyopathies)
  g. chronic pulmonary disease (including asthma in people age 19 and older)
  h. cerebrospinal fluid leak
  i. diabetes mellitus
  j. alcoholism or chronic liver disease (cirrhosis)
  k. candidate for or recipient of cochlear implant

Pneumococcal Vaccination

The PPSV is a sterile liquid vaccine that may be given either by intramuscular (IM) or subcutaneous (SC) injection. When administration is IM, the nurse chooses needle length as appropriate to the person’s age and body mass. In adults, the standard needle is 1–1½” long. A ½” needle may be used for adult patients weighing less than 130 lbs (60 kg) for IM injection in the deltoid muscle only if the subcuta-
neous tissue is not bunched and the injection is made at a 90-degree angle. When administration of PPSV is SC, a 5/8” needle is recommended. The timing of vaccine administration is also important. The vaccine should be given at least two weeks before elective splenectomy and the initiation of immunosuppressive therapy, and avoided during chemotherapy or radiation therapy. The vaccine may be administered at the same time as the influenza vaccine but by separate injection in the opposite arm. The most common adverse reactions reported are local reactions at the injection site including soreness, warmth, swelling and induration as well as a fever less than 102 degrees Fahrenheit. It is contraindicated for anyone who has a hypersensitivity to any component of the vaccine. Epinephrine injection (1:1000) must be available should an acute anaphylactic reaction occur due to any component of the vaccine. All significant adverse events that occur after vaccination of adults, even if there is uncertainty about whether the vaccine caused the adverse event or not, should be reported to the Vaccine Adverse Event Reporting System (VAERS).

The vaccine for pneumonia is safe and cost effective. According to CDC records, in 2011 VAERS received 2,071 reports of adverse events in persons vaccinated with the pneumococcal vaccine (G. Redmond, personal communication, May 17, 2013). The VAERS report indicates that the adverse events occurred after the administration of the vaccine and were not necessarily caused by the vaccine itself. Although the vaccination is considered safe and only a small minority of patients experience an adverse drug reaction, it is essential that precautions are noted. For example, it is important to note that there is a higher incidence of systemic adverse reactions, following revaccination in patients 65 years or older. Furthermore routine revaccination of immunocompetent persons previously vaccinated with a 23-valent vaccine is not recommended (Merck and Company, 2013). Despite the potential risk, in most cases, the vaccine is much less costly than the disease itself. The average cost of pneumonia care for Medicare beneficiary patients from 2005-2007 was $10,266 with a range of $3,341 to $17,192 (Thomas et al., 2012) as compared to the cost of the vaccine, which is $64.22 per dose (Merck Global Health Division, 2013).

The vaccine and administration costs are typically covered by Medicare and most major insurance companies. The Centers for Disease Control indicate that PPSV vaccine is 60%-80% effective against invasive pneumococcal disease when it is given to people age 65 years and older or people with chronic illnesses. The vaccine is less effective in those patients who are immunosuppressed (Atkinson & Kroger, 2011). However, the number of older adults (age 65 and older) who received the vaccine was 61% in 2008, which is below the 90% target for 2020 Healthy People goals (U.S. Department of Health and Human Services, 2010). Despite the fact that the vaccine is universally available, patients who are seen by health care providers are not requesting the vaccine and clinicians who interact with them do not appear to be recommending it (Gooden, 2010).

### Barriers to Vaccination

The barriers to adult immunization commonly fall into three categories: lack of knowledge about

<table>
<thead>
<tr>
<th>Consumer Reasons for Not Getting Immunized</th>
<th>Health Care Provider Perceptions of Why Patients Don’t Get Immunized</th>
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<tbody>
<tr>
<td>“Was healthy so don’t need it.”</td>
<td>“Lack of knowledge about illness prevention.”</td>
</tr>
<tr>
<td>“Doctor didn’t tell me I needed it.”</td>
<td>“Not receiving physician’s recommendation.”</td>
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<tr>
<td>“The vaccine may have side effects.”</td>
<td>“Concern about side effects.”</td>
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<tr>
<td>“Could interact with medication.”</td>
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<tr>
<td>“Don’t know when to get it.”</td>
<td>“Unaware of the schedule.”</td>
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<tr>
<td>“May not work well.”</td>
<td>“It will cause illness.”</td>
</tr>
<tr>
<td>“Dislike needles or shots.”</td>
<td>“Fear of needles.”</td>
</tr>
<tr>
<td>“Might get the disease.”</td>
<td>“Confused about recommended vaccination schedule.”</td>
</tr>
<tr>
<td>“Could worsen current conditions.”</td>
<td>“Lack of knowledge about illness prevention.”</td>
</tr>
<tr>
<td>“Insurance doesn’t cover it.”</td>
<td>“No effective reminder system.”</td>
</tr>
<tr>
<td>“Don’t visit a doctor regularly.”</td>
<td>“Patient does not make regular well visits.”</td>
</tr>
<tr>
<td>“Don’t visit a doctor regularly.”</td>
<td>“Not going to the same physician regularly.”</td>
</tr>
<tr>
<td>“Costs too much.”</td>
<td>“The vaccine is too expensive.”</td>
</tr>
</tbody>
</table>

Source: Adapted from Johnson et al., 2008.
immunizations, fears about vaccine safety, and logistical problems that limit access to immunization (Burns & Zimmerman, 2005). Similarly, health care providers also encounter barriers such as: lack of knowledge regarding indications and contraindications to immunizations, costs of immunizations, difficulties in vaccine storage or availability, lack of access to a patient's prior immunization records, and missed opportunities to administer a needed immunization during a clinic visit (Burns & Zimmerman, 2005). Although the evidence shows that most patients will receive vaccinations if recommended by their health care provider, such recommendations are not routinely made (Gooden, 2010).

Lack of awareness also plays a role in missed vaccinations. In a study of Medicare beneficiaries, lack of awareness was the most common response cited for not receiving the pneumococcal vaccine (Gooden, 2010). Rangel and colleagues (2005) showed that lack of awareness, as well as personal beliefs, were significant barriers to vaccination. It is also possible that socioeconomic and educational levels play an indirect role as barriers to vaccination (Gooden, 2010).

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Johnson, Nichol, and Lipczynski (2008) conducted a survey focused on determining barriers to pneumococcal vaccinations as reported by 2002 consumers and 200 health care providers. The reasons cited by both groups for not receiving the pneumococcal immunization are listed in Table 1. Interestingly, the health care providers perceptions of why individuals do not get immunized closely mirrors the reasons provided by the consumers (Johnson et al., 2008).

Methods
Combining knowledge learned from the Johnson survey with a goal of preventing pneumonia in their high-risk patient population, a cardiology clinic in an academic center focused on discovering in their own practice setting, potential or real vaccination rate barriers. Furthermore, the Johnson study provided a tool to assess knowledge base; therefore it was an appropriate survey to replicate. In an effort to assure that pneumococcal vaccines are appropriately provided to patients in a heart and vascular outpatient clinic, a derivative of the Johnson survey was distributed to determine the perceptions of registered nurses and nurse practitioners regarding barriers to patient pneumococcal vaccination and nurses' knowledge about the existing vaccine guidelines.

The study survey focused on current practice norms and perceived barriers and beliefs. The questionnaire had two sections: Practice and Knowledge. A variety of questions were used such as multiple choice, True-False, Yes-No, and some used a five-point Likert scale with the points of strongly agree and disagree. The practice section consisted of thirteen questions that were adapted from the Barriers to Adult Immunization Survey with permission of Johnson and co-authors (2008). The Knowledge section included an additional ten questions, developed by the research team, to assess the nurses’ knowledge of the following pneumococcal vaccine topics: indications, administration, revaccination, immunity timeline, adverse experiences, and treatment of anaphylactic reaction. The study was conducted by providing a confidential, electronic questionnaire to all nurses and nurse practitioners who worked in the heart and vascular clinic using no identifiers. Twenty-two nurses were sent the questionnaire and the response rate was 100%.

Survey Findings
The survey findings of the clinic nurses’ perceptions regarding the barriers to immunization that patients experience were consistent with those found in the literature. The top seven responses (listed below) regarding these barriers fit into the categories of lack of knowledge, fears about vaccine safety, and logistical problems that limit access.

1. Patients may not be aware of, or are confused by, the vaccination schedule.
2. Some patients may believe the vaccine has side effects or will make them sick.
3. Patients may not understand the seriousness of pneumococcal pneumonia.
4. No effective reminder system for the patients was in place.
5. Patients may believe that healthy people do not need the vaccine.
6. Not receiving a physician’s recommendation.
7. Not going to the same physician regularly and thus follow-up was not present.

In the same survey, respondents estimated that during routine office visits approximately 33% of patients received the vaccine as a result of a recommendation. Seventy-two percent of the nurses reported “sometimes” discussing the possible conse-
In eight out of thirteen interventions to address knowledge deficits, staff ranked 50% or greater that they “somewhat/strongly agree the intervention had a positive effect on their knowledge and/or practice (see Figure 2).

All strategies of the intervention program are now embedded in the cardiology clinic practice. The success of this program is determined by following, on a monthly basis, the vaccination compliance rates.

**Organizational Response**

The health care system established a vaccination task force to explore strategies to increase Influenza and Pneumococcal vaccine administration compliance. The task force administered a survey to nursing staff throughout the ambulatory care clinics that focused on current practice norms, perceived barriers and beliefs. The survey results were similar to the heart and vascular clinic survey results regarding knowledge deficits and perceived versus actual administration compliance rates. To reduce the knowledge deficit and better inform all nursing staff, an article on Pneumococcal vaccination indications and clinic results was published in the health system’s nursing practice newsletter. Two actionable items derived from the survey results were incorporated into the electronic medical record. A hyperlink was established from the electronic medical record to the CDC’s Vaccine Information Sheet website. This assures the most current patient information is easily available. Additionally, a pathway was created to support a standardized process for documenting patient refusals of vaccinations. Additional action plans are also underway. A computer-based learning module focusing on Influenza and Pneumococcal vaccinations is being developed. An electronic medical record vaccination reminder is in production. The reminder will alert clinicians when indications for the Pneumococcal vaccine are met. Furthermore, additional refrigerators are being stationed directly in the clinics to facilitate Influenza and Pneumococcal vaccine storage and ease of obtaining these necessary vaccines.

![Figure 2.](image_url)

**Interventions and Results**

As a follow up to the survey responses, the authors developed a nurse led, multifaceted intervention program to address knowledge deficits and determine if the interventions would increase vaccination rates. These interventions consisted of incorporating standing protocol vaccine orders, educating nurses on the current ACIP guidelines through weekly in-services, providing a pocket guide with related pneumococcal vaccine information, and creating a script for nurses to use with each patient encounter, which comprehensively covered the importance and benefits of immunizations. Involving patients in the process was also important as was providing Vaccine Information Sheets (VIS) to patients during rooming in and displaying informational flyers in each clinic room. Informational posters were also displayed in additional prominent clinic locations to increase patient interest in vaccination and prompt them to ask about the vaccine. Additionally, a reminder system that included vaccine-specific information with mailed appointment notices, as well as adding a reminder to the office or nurse(s) voicemail greeting assisted in increasing this awareness of and demand for immunization.

To determine the effectiveness of our intervention program, the initial survey was re-administered with the addition of a six-point Likert scale having the end points of strongly disagree, somewhat disagree, neither agree nor disagree, somewhat agree, strongly agree, and don’t know. Nurses were asked to use this scale to evaluate the effect of each intervention on their knowledge and practice.

**New Knowledge Results**

In eight out of ten knowledge categories, there was marked improvement. The most dramatic was familiarity with the ACIP guidelines rising from 32% pre intervention to 65% post intervention. The second largest knowledge gain was related to the importance of vaccinating patients 19-64 years of age who are smokers or have asthma (see Figure 1).
What Can Nurses Do

The Community Guide, developed in 2000 as an evidence-based Guide to Community Preventive Services, outlined recommendations regarding interventions to improve vaccination in children, adolescents and adults (Ndiaye et al., 2005). These interventions are categorized as those that are provider- or system-based, enhance access, or increase demand for vaccinations. This guide serves as a valuable tool for health care providers as they strategize to improve their vaccination practices.

In addition to The Community Guide tools, cultural changes are required. Nurses in any setting are in an ideal role in advocating for and assuring vaccines are available to all patients for whom they are indicated cannot be understated. Nurses should work collaboratively to establish plans to assure that with every patient encounter: vaccination status is addressed, the vaccine is administered appropriately, patients are informed of the associated cost and insurance coverage, and of the potential consequences of not receiving the vaccination.

Conclusion

Pneumococcal polysaccharide vaccine is safe and cost effective. Barriers, such as patients not being aware of, or confused by, the vaccination schedule and/or the lack of recommendation by a health care provider, may contribute to the current low adherence to national health goals. However, identifying barriers in your organization and formulating strategies to address them in clinic settings may minimize their impact. Nurses must be knowledgeable about the vaccine. Activities such as enrolling to receive weekly newsletters from the Immunization Action Coalition, reviewing the ACIP guidelines, and staying abreast of local health department announcements of health trends can increase this knowledge base. Nurses should also incorporate assessing, advising and administering the vaccine into daily routine care. Clear communication of the vaccine risk and benefits by nurses is key to improving patient knowledge and acceptance of the pneumococcal vaccine. Furthermore, system changes that encourage the consistent monitoring of vaccination schedules and timely provision of vaccines would also enhance the rate of vaccination against streptococcus pneumonia. A robust immunization program is a regulatory and patient safety priority.

References


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Did you ever experience a dilemma while on a phone with a patient? Has a question been posed that makes you feel trapped? You may suddenly feel inept, tongue-tied, or deficient. You may feel at a loss for the right response and silence is not an option. You may find yourself between a rock and a hard place.

This column will discuss three common questions callers pose to nurses on telephones across the country in all settings. The callers believe they are asking a reasonable question, but experienced telephone nurses know that these questions are riddled with risk. When answered appropriately, the nurse will confidently maintain comfort and feel competent and the patient or family member will perceive that the question was expertly handled.

**What will they do if I come in for an appointment?**

A patient requests to know what will be done during an appointment or emergency room visit. This situation occurs when you have completed your assessment and have recommended that the patient be evaluated by a care provider. The level of care may be emergent, urgent, or routine. The conversation with the patient may have been focused and straightforward. The disposition is evident. Then when you are validating that patient’s follow-through, the following question is expressed: “What will they do if I come in for an appointment?”

When I was an inexperienced triage nurse, this question made me feel cornered. I considered responding in one of two ways and neither seemed appropriate.

**Option 1: Speculate.** I could make an educated guess about the various possibilities that could occur in an emergency or exam room. I knew hypothesizing about diagnostic testing or medications was not appropriate. I would be setting both the patient and provider up.

**Option 2: Respond to the caller by saying, “I don’t know.”** This is similar to the first scenario. If you say you don’t know, your caller may lose confidence in your skill and competence. Additionally, you may actually know what he or she is experiencing.

**Best Option.** Choose your words carefully. Relaying any hint of a medical diagnosis can jeopardize your license and mislead the patient. The consequences may not be able to be rescinded. This response promotes patient satisfaction and keeps the nurse safely within scope:

I am a nurse and I cannot make medical diagnosis. However, from what you have shared with me, your symptoms are serious and you need to have an appointment for the provider to examine you and diagnose your condition. The benefit of a face-to-face visit allows for a visual assessment, which is vital in making a diagnosis.

**Will I make it through the night?**

I would get this response mainly at the end of the day when I worked in a clinic or during an evening or night shift when I worked in a call center. My assessment was completed and the symptoms indicated home care or a continued on page 12
Cystoscopy Reprocessing Safety: One Practice’s Experience

Our medical group performs more than 700 cystoscopies a year in the urology office. Because invasive procedures such as cystoscopies involve contact of a medical instrument with a patient’s sterile tissue, one major concern is the risk for infection. According to the Center for Disease Control and Prevention’s (CDC) Healthcare Infection Control Practices Advisory Committee (Rutala, Weber, & HICPAC, 2008), cystoscopes are considered semi-critical medical devices and therefore, high-level disinfection (HLD) with chemicals is the minimal reprocessing method recommended for killing microorganisms that may be present on the cystoscope. Unfortunately, studies cited in this same report show that compliance with established guidelines for disinfection and sterilization is poor and most infections associated with reprocessing involve HLD of semi-critical items. In fact, according to the CDC, semi-critical items cause more health care-associated infections than critical or non-critical items (Rutala, Weber, & HICPAC, 2008). Additionally, a study by Alfa and Howie (2009) showed that the progressive accumulation of biofilm through repeated rounds of inadequate reprocessing decreased the effectiveness of HDL. Following anecdotal reports of an increased incidence of UTIs by the urology nurse, the medical group knew we had to investigate further. This article describes how our organization worked to improved cystoscopy reprocessing to enhance patient safety.

The issue was brought to the attention of the Medical Director of Quality and Patient Safety, the urologists and the nursing staff. Several major areas of concern were identified: 1) lack of standardized processes for instrument reprocessing; 2) lack of competency-based training and validation on flexible cystoscope reprocessing; 3) inefficient workflow around reprocessing; 4) reprocessing logs that were not kept up to date; 5) inappropriate storage of clean flexible cystoscopes; and 6) inappropriate handling, disposal and storage of the high-level disinfectant.

Next, we developed a plan to address the gaps. A process map was developed to understand the workflow around reprocessing. Our workflow analysis showed a need to set up separate clean and dirty utility rooms, and to create an auditory reminder to tell the staff when the soaking phase was complete (over soaking can damage the instrument) since staff do not stay in the reprocessing room during the soak phase. Our low-tech solution to the auditory reminder was a kitchen timer. The reprocessing room is centrally located and within earshot of all the exam rooms and the front desk. We also had safety concerns for the staff, as the chemicals used in reprocessing are dangerous to humans. The utility room was already equipped with a ventilation hood; therefore, staff education sessions were focused on the safety risks to health care providers in handling, disposal, and storage of the chemical disinfectants, correct use of the ventilation hood, and personal protective equipment as well as relevant Material Safety Data Sheets. Proper maintenance of reprocessing logs was also emphasized.

As a first step, a literature review was conducted to establish best practices (Clemens et al., 2009; Rutala, Weber & HICPAC, 2008) in flexible cystoscope reprocessing. The product manufacturer’s user manual (Karl Storz Endoskope, 2011) and the chemical disinfectant brochure (Advanced Sterilization Products, 2011) were reviewed for information specific to the flexible cystoscopes used in our practice. Next we examined our current practice. Clinical staff were shadowed for two days and the entire process documented beginning with patient intake through patient exiting. Staff were interviewed to understand the training they received to assist with cystoscopy procedures and cleaning equipment. Findings were documented in detail, a gap analysis was performed comparing our current practice against best practices to identify problematic areas, and the findings shared with the Medical Director of Quality and Patient Safety, the urologists and the nursing staff.

Having recognized the skills gaps of the nursing staff, we developed competencies that have become an essential part of staff education. The competencies cover the entire process from start to finish, including identifying which instruments we use, best practice recommendations for initial cleaning and HDL, steps to protect our workforce...
from exposure to chemical and potentially hazardous materials, and safe disposal of HDL chemicals. Instrument reprocessing via HDL is a multi-step process and it is important that each step occur in a specific order. To support this step-by-step approach, we created and placed a laminated poster of the steps in the reprocessing room. Completed competency validation is kept on file for all staff involved in instrument reprocessing documenting their skills to ensure consistent evidence-based practice. We plan to do annual staff competency validation and this will be done in mid-2014.

Lastly, we developed a PI monitor tool to measure compliance with completing the reprocessing logs. The nurse manager completed the tool and evaluated the results. Based on the results, remediation was needed to ensure that the log was filled in completely and up-to-date. Compliance with completing reprocessing logs is monitored periodically and the results are shared with the staff. There is also a plan to develop a form in our electronic medical record to improve nursing documentation.

Feedback from the physicians and nursing staff has been very positive. As a result of this project, the nursing staff report improved confidence in their ability to reprocess the equipment and feel good that they are taking steps to ensure patient safety. Additionally, the cystoscopy PI project became the launch pad for additional quality improvement work in our urology and GYN practices. We used the newly developed cystoscopy competencies to cross train other staff in cystoscope reprocessing and as the basis for the development of competencies for hysteroscope reprocessing. Obstetric and gynecological (OB-GYN) physicians perform hysteroscopies in the urology procedure rooms. Our urology and OB-GYN nurses are now cross-trained to assist with both cystoscopies and hysteroscopies. In the very near future, we will begin a PI project looking at patient safety and staff competency for urodynamics testing, another procedure performed by both urology and GYN practices.

References


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Health Care Reform
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CCTM model and competencies is now the basis for the CCTM Core Curriculum text (Haas, Swan, & Haynes, in press) and a series of modules that began in February 2014 to educate registered nurses working in ambulatory care. The Core Curriculum text and CCTM course are designed to assist ambulatory care nurses to develop the knowledge, skills, and attitudes needed to successfully assume the role of the RN working in CCTM.

The Core Curriculum is evidence-based and provides cutting-edge methods to be used by the registered nurse delivering care coordination. Alternatives to face-to-face office visits are presented. For example, telehealth methods are discussed in depth, such as the use of Skype® and tele-monitoring. There is discussion of methods for interprofessional communication, interagency communication, and measurement of outcomes.

True to the recommendations of the IOM report, The Future of Nursing (2010), AAACN has provided a visionary new role for registered nurses that will enhance access for the newly insured and provide high quality care for all patients served. For further information on the CCTM Core Curriculum text and course, visit www.aaacn.org/cctm.

References

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Trials and Triumphs
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visit within 24 hours. Although the triage went smoothly and I was confident in the direction, this question would halt closing the call. What did the caller withhold? Was I missing something? What did he or she not report?

**Option 1: Stay the course.** With a thorough assessment, you could reassure the caller that the level of care is appropriate. However, this option could lead to a disastrous outcome if this was your caller’s way of letting you that he/she did not report everything. Are you overlooking his or her gut feeling?

**Option 2: Panic.** Assume that the patient needs 911 after they utter a question that hints at a premonition of death. If you assume impending doom, you may be executing an unnecessary emergent response plan.

**Best Option.** This question is really quite easy to react to. You may need to triage the symptoms again to ensure that you have heard everything accurately. It is important to be direct with the caller and ask the following open-ended questions, What is concerning you about nighttime? What are you experiencing that makes you uneasy about homecare/waiting until tomorrow? Summarize what the patient has reported to you and then say, You seem worried about tonight, is there anything you or I have missed from what you are experiencing?

Although the telephone triage process typically flows smoothly, there will be occasions when the caller poses a question that makes you feel cornered. Most of the times, these show-stopping questions occur as you are wrapping up. It is important that there is good connectivity during the call, but also at the end of the call. Do not mentally disconnect before the call ends. Stay focused and allow for those end-of-the-call inquiries. Be prepared for these types of questions and be proactive in preparing responses that relay not only direction, but confidence, safety, and quality of care. This is the art of telephone triage nursing.

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Sensitive Indicators Task Force
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important to patients and their families; impact organizational effectiveness and reimbursement; relevant to AAACN member practice, available in standardized or endorsed metrics; adequate in volume and repeated over time; and readily accessible or already available in electronic databases.

“The transition of health care from the inpatient to the outpatient setting has led to challenges with access to care and coordination of services, and has increased the complexity of care delivered outside the hospital walls. This shift has dramatically increased the need for professional nursing services.... Ambulatory RNs facili-
Researching the Scope of Practice for Medical Assistants

In our current health care system, ambulatory care nursing must focus work efforts on delivering safe, effective, and efficient patient care while utilizing cost effective measures within staffing models. This drives ambulatory care to place the right person, with the right skill set in the right position. Adding medical assistants to the staffing mix assists with cost containment but opens many questions as to what the medical assistant can legally perform in the ambulatory care setting. This column will review how to research scope of practice, appropriate delegation, state legislation, rules and regulation that are needed to guide our decisions related to the utilization of medical assistants.

Before determining what tasks the medical assistant can perform, one must first understand what encompasses a scope of practice. The American Academy of Ambulatory Care Nursing (AAACN) defines Scope of Practice as the “procedures, actions and processes permitted for a licensed individual and is limited to that which the law allows for specific education and experience, and specific demonstrated competency” (Paschke, 2013, p. 38). The definition refers to the “licensed individual.” Currently medical assistants are not licensed in the United States and there is not a uniform, standard, or national definition of a medical assistant’s scope of practice. Medical assistants work under the direct supervision of a licensed physician who has the authority within their state to delegate certain medical tasks and procedures. Maryland’s definition of physician to medical assistant delegation is typical of most states, whereby the delegating individual is a “physician possessing an active license to practice medicine in the State who directs an assistant to perform technical acts” (Code of Maryland Regulations, 2013). This leaves each state to determine scope of practice laws along with any educational requirements they deem necessary for the medical assistant. These laws and scopes vary greatly across the country from state to state.

In California, medical assistants are not licensed, certified or registered by the State (Medical Board of California, 2010). However, the physicians’ malpractice insurance carriers may require medical assistants to be certified by a private or national organization. The legislature recognizes a core scope of practice for medical assistants and the Medical Board has set forth minimal training requirements for procedures that include: intradermal, intramuscular, and subcutaneous injections, skin testing and venipuncture for withdrawing blood (Medical Board of California, 2010). “In every instance, prior to administration of medicine by a medical assistant, a licensed person such as a supervising physician, podiatrist or another appropriate licensed person, must verify the correct medication and dosage” (Medical Board of California, 2010). For additional tasks, the medical assistant shall receive training, as necessary, in the judgment of the supervising physician, podiatrist or instructor, to assure competence in performing that service at the appropriate standard of care (Medical Board of California, 2010). These tasks include: performing EKGs, administering and removing bandages and dressings, applying orthopedic devices, removing sutures or staples from superficial incisions or lacerations, ear lavages, providing patients with information and instructions as authorized by the physician, performing and recording vital signs, performing simple lab and screening test, and cutting the nails of healthy patients (McCarty, 2012).

In South Dakota, the regulations states, “No person may practice as a medical assistant unless that person is registered with the Board of Medical and Osteopathic Examiners” (South Dakota Board of Nursing, 2012). To register with the Board, the applicant must have “graduated from an accredited school or a school which meets standards similar to an accredited school and has met other qualifications established by the Board of Medical and Osteopathic Examiners and the Board of Nursing” (South Dakota Board of Nursing, 2012). Once the standard is met, the medical assistant may administer medications by unit dose, which means “medication prepared in the exact amount, in an individual packet, for a specific patient” (South Dakota Board of Nursing, 2012). They may also report diagnostic lab findings to patients only after appropriate interpretation by the physician, provide education information to the patient, perform EKG’s, glucose testing, distribute pre-printed information to the patient on medications and inhalers, apply ace bandages and splints to extremities, may only perform suprapubic catheterizations involving an established fistula, skin testing performed by intradermal or scratch techniques, telephone prescriptions to a pharmacy pursuant to their supervising physician’s written or verbal order, administer medications via inhalation route as long as the supervising physician assures appropriate training, competence, and assumes ultimate responsibility for administration of such drugs (South Dakota Board of Nursing, 2012). Medical assistants in South Dakota may not inject insulin, perform arterial withdrawal of blood, provide patient education, health teaching or counseling, administer medication which requires calculations, or perform irrigation for ostomy/stoma care (South Dakota Board of Nursing, 2012).

Under Florida statutes, medical assistants are not required to be certified to be employed but may be certified by the American Association of Medical Assistants or as a Registered Medical Assistant by the American Medical Technologists. Some of the duties they may perform under the direct supervision of a licensed physician include: performing aseptic technique, taking vital signs, performing venipuncture and non-intravenous injections, observing and reporting signs and symptoms, administering basic first aid, assisting with examinations or treatments, collecting routine lab specimens as directed by the physician and performing basic laboratory procedures, administering
medications as directed by the physician, performing office procedures and general administrative duties, and performing dialysis procedures, including home dialysis (The Florida Senate, 2013).

In Texas, physician written delegation allows for medical assistants to administer immunizations and designated medications to patients by written physician orders. The Texas Medical Association requires physicians to assure education and competency for designated tasks have been met. Licensed nurses provide education, skill validation, and supervision. The Texas Board of Nursing Rule 224.10 Supervising Unlicensed Personnel Performing Tasks Delegated by Other Practitioners states “the RN (a) (1) verifies the training of the unlicensed person; (2) verifies that the person can properly and adequately perform the delegated task without jeopardizing the client’s welfare; and (3) adequately supervises the unlicensed person. (b) If the RN cannot verify the unlicensed person’s capability to perform the delegated task, the RN must communicate this fact to the licensee who delegated the task” (Texas Board of Nursing, 2013, p. 160). For example, Kelsey-Seybold Clinic in Houston was able to utilize the physician delegation rules, combined with the registered nurses rules and regulations for supervising unlicensed personnel to create a program to ensure competency. This program provided the opportunity to reshape the staffing model within the clinic system. This program was implemented in primary care in 2009 and has proven to be very successful. Moving forward, the program has expanded to some specialty areas and there are plans to expand in the near future.

To discover the scope of practice for each individual state, one must research state laws, health codes, statutes, nursing boards, medical boards, and relevant practice acts. Delegation rules are important to review and consider, as well as, the type of supervision required by each state. Utilizing search engines with your state’s name, physician delegation or state’s name and scope of practice will yield a vast amount of information. For example, the American Association of Medical Assistants (AAMA) currently has links posted on their web-site for medical assistant tasks in the following States: Arizona, California, Florida, Illinois, Maryland, New Jersey, Ohio, South Dakota, and Virginia (American Association of Medical Assistants, 2013). Also on the AAMA site there is an area to enter questions you may have and they will provide a response. The Medical Assistant Training site will provide links to all of the state’s Medical Boards in the United States.

What tasks can be delegated to the Medical Assistant rest with state regulations, the employing organization, and the licensed providers supervising their work. The state rules and regulations provide a framework as to what can be delegated; however, if an organization wants to further limit these tasks, it is their right to do so. Providers can also decide to limit what tasks they are comfortable with delegating. In all cases, competency of that individual Medical Assistant is the responsibility of the provider and the employing organization.

References
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Virtually Attend the 39th Annual Conference
By the time you read this copy of ViewPoint, it is probably too late for you to attend the New Orleans conference. But don’t worry! The audio recordings and handouts from all sessions offered at the conference will be available about six weeks after the conference in the AAACN Online Library (www.aacn.org/library). You may purchase individual sessions or a package of all sessions. Prices include continuing education credit. Once you make a purchase, you have permanent access to those sessions. Past conferences, ViewPoint articles, and webinars are also in the Library. We encourage you to browse the Online Library for topics of interest to you. If you know someone who attended the conference, ask if he or she will share content with you. Conference attendees can each offer two colleagues access to the conference sessions for free.
Poison control is not just for children who search in medicine cabinets. The American Association of Poison Control Centers report that adults account for 92% of poison-related deaths. For more information and poison prevention tips for adults, visit http://www.aapcc.org/prevention/adults/.

Health disparity issues that are different among groups of people such as women, the elderly, children, and the like are important for nurses to be familiar with in ambulatory care practice. To review health disparities and research on diverse groups, refer to MedlinePlus at http://www.nlm.nih.gov/medlineplus/healthdisparities.html.

Peripheral neuropathy can be a painful, chronic condition for those undergoing chemotherapy or with diabetes and other neurological conditions. For more information, visit the National Institute for Neurological Disease and Strokes (http://www.ninds.nih.gov/disorders/peripheral_neuropathy/detail_peripheralneuropathy.htm).

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2014 Challenge Underway

The AAACN annual Member-Get-A-Member recruitment program kicked off April 1. The program invites members to recruit new members to the association by explaining the value they’ll get from membership, as well as by sharing all the benefits of membership.

Recruiting is easy. Download and print the membership application from the website (www.aaacn.org), enter your name in the “referred by” section, make a few copies, and then talk to your colleagues about joining and give them the application. You can also direct your colleagues to the website and ask them to place your name in the “referred by” section of the online application.

You could be the winner of the monthly prize of a $50 AAACN certificate. When the program closes at the end of 2014, you are also eligible to win a $100 certificate for recruiting 3 or more members. One member will receive FREE registration to the 2015 Orlando conference for recruiting the most members (at least 5 or more).

President’s Message
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around the country, or the recorded course offered in the Online Library, the series provides other options for those interested in becoming certified in ambulatory care.

AAACN continues to collaborate with the American Nurses Association (ANA) on the development of Nurse Sensitive Indicators (NSI) for ambulatory care. The AAACN NSI Task Force, begun last year, has had an ANA staff member participating since its inception. Seven representatives from AAACN attended a national Summit in January and served as subject matter experts in the discussion and identification of a preliminary set of indicators that are meaningful in ambulatory care. See the cover article to learn how this important work is developing.

Care Coordination and Transition Management (CCTM) has been a major focus of AAACN’s efforts and resources for the past few years. Four separate expert panels consisting of members and non-members collaborated on this project. One group reviewed the existing literature on care coordination, a second group identified nine core dimensions and created a table of evidence, and the third group defined core competencies for each of the dimensions. The work continued by a fourth panel with the development of a core curriculum for CCTM with expected publication in June and the CCTM course, which debuted with the Introductory module in February. Because Care Coordination has been a topic of discussion in all health care environments, especially since the inception of the Patient Protection and Affordable Care Act, resources to assist nurses and organizations in preparing for and creating these roles for registered nurses have been sporadic. The availability of the CCTM core curriculum and course to all nurses and health care organizations will help to define the roles and skills required to serve in this important position now and in the future.

As my presidency is winding down and I reflect on all that has happened this past year, I am grateful for the members of this organization who have given of their time and talent to accomplish all of the things mentioned above. It is an honor to represent such a dedicated and committed group of individuals who find or make time in their busy work and personal lives to impact the lives of patients and colleagues through their work on these projects and initiatives. The word is out...we ARE ambulatory care!

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AAACN is a welcoming, unifying community for registered nurses in all ambulatory care settings. Our mission is to advance the art and science of ambulatory care nursing.

Call for Abstracts for the 2015 Orlando Conference

You are invited to submit an oral or 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. Oral presenters also receive an honorarium. The deadline for oral presentations is May 30, 2014, and the poster deadline is December 15, 2014. Obtain the abstract submission criteria from the Events section of our website at www.aaacn.org.