Volume 41, Number 2 • March/April 2019

ViewPoint

The Official Publication of the
American Academy of Ambulatory Care Nursing

From Nurse to Nurse Manager

Historically, staff nurses have been promoted to nurse manager positions based on excellent clinical skills and knowledge, but have needed to rely on 'on the job training' in order to develop the competencies necessary for effective management. In today's complex, rapidly changing, and unpredictable health care environment, the nurse manager must also possess business acumen, emotional intelligence, an ability to communicate effectively across disciplines, and a drive to fully participate in the process to improve efficiency and outcomes – thereby increasing the value of health care. Vitale (2018) acknowledges "there is evidence that nurse leaders are ill equipped in terms of knowledge and may lack support and guidance to manage the challenges inherent in the role, such as productivity, job satisfaction, and retention concerns" (p. 8). This lack of preparedness, coupled with a lack of organizational support, leads to decreased job satisfaction, increased job stress, and an increased nurse manager turn-over rate which can lead to unit/department and organizational instability. The nurse manager who is ill-prepared and overwhelmed by the scope of responsibility inherent in the role also presents a less than favorable image of the role which could, in turn, discourage staff nurses to pursue opportunities in nursing leadership (Warshawsky & Havens, 2014). With a surge of nurses, including nurse managers reaching retirement age, our profession must rethink the way in which we prepare the next generation of nurse managers and leaders.

Nurse managers, in both acute and outpatient settings, are responsible for communicating and implementing organizational mission, vision, and values, to nursing non-licensed and ancillary personnel at the point of care. In some cases, nurse managers in ambulatory care settings have the added responsibility of developing new staffing models to accommodate the influx of patients with increasingly complex health care needs. As more organizations move to a value-based reimbursement system, it is imperative that the nurse manager has the skill set to lead high performing, interprofessional teams to achieve expected clinical outcomes and organizational goals. Nurse manager competencies identified by the American Organization of Nurse Executives (AONE) include, but are not limited to, financial and

continued on page 13

aacn American Academy of Ambulatory Care Nursing
Many settings. Multiple roles. One unifying specialty.

Ambulatory Care Nursing Voice and Value

Kathy Mertens

> "Without a community, it is nearly impossible to achieve voice: it takes a village…" – *Parker J. Palmer*

For the 17th consecutive year, nurses – including those in ambulatory care – rank as most trusted of all professions (Brenan, 2018). This trust, along with sheer numbers, yields boundless opportunities for nurses to influence and lead. Ambulatory care nurses, at all levels, demonstrate leadership as they navigate and act to improve the health of individuals and populations. They speak to the value of AAACN and ambulatory care nursing. As my year as your AAACN President comes to a close, I'm proud to present some of our key accomplishments that exhibit the exceptional work of ambulatory care nurses – both formal and informal leaders – who validate the excellence of our specialty.

- In May 2018, AAACN convened 41 leaders from across organizations for a Care Coordination and Transition Management (CCTM®) Invitational Summit. Under the expert guidance of Drs. Beth Ann Swan and Sheila Haas, participants discussed education, policy, research, and practice opportunities to facilitate adoption of the CCTM registered nurse (RN) role. Published articles in *Nursing Economic$* on the Summit process and recommendations are forthcoming. A CCTM Toolkit launched on our website in summer 2018. This visibility and action will thrust CCTM forward.
- In January 2019, a revision to our *Core Curriculum for Ambulatory Care Nursing, 4th Edition*, was released and it contains expanded content on telehealth, health promotion, emerging clinical issues, and other topics.
- An update to our *Scope and Standards of Practice for Professional Telehealth Nursing, 6th Edition,* was completed in May 2018.
- As I write this message, a revision to our *Care Coordination and Transition Management Core Curriculum* is also near publication.
- AAACN task forces are working to identify telehealth education resources and develop a Telephone Triage Course. Thanks to the enormous generosity of longtime member Carol Rutenberg in donating her course content to AAACN, we hope to launch AAACN's own course by 2020.
- Our Nurse Executive Task Force is developing resources to guide, expand, and influence the ambulatory care nurse executive role.

Over the year, *ViewPoint* routinely gave voice to expert authors on leadership, clinical best practices, and evidence from the field. Thanks to the dedication and expertise of our many outstanding volunteers, these resources deliver essential content to advance ambulatory care nursing practice.

Ensuring a pipeline of ambulatory care nurses continues to be paramount. AAACN proactively contacted 42 universities and

continued on page 10

Reader Services

AAACN ViewPoint is a peer-reviewed, bi-monthly publication that is owned and published by the American Academy of Ambulatory Care Nursing (AAACN). It is distributed to members as a direct benefit of membership. Postage paid at Bellmawr, NJ, and additional mailing offices.

Publication Management is provided by Anthony J. Jannetti, Inc., which is accredited by the Association Management Company Institute.

Volume 41, Number 2 • **March/April 2019**

ViewPoint is published by the American Academy of Ambulatory Care Nursing

Advertising
Contact Tom Greene, tom.greene@aaacn.org

Write for *ViewPoint*
For manuscript submissions, deadlines, and tips for authors, go to www.aaacn.org/ViewPoint. Submit manuscripts to Managing Editor Kaytlyn Mroz at kaytlyn.mroz@ajj.com.

Indexing
AAACN ViewPoint is indexed in the Cumulative Index to Nursing and Allied Health Literature (CINAHL).

Additional Reader Services are available at www.aaacn.org

aacn American Academy of Ambulatory Care Nursing
Many settings. Multiple roles. One unifying specialty.

AAACN members receive
FREECNE
continuing nursing education

Instructions for Continuing Nursing Education Contact Hours

Continuing nursing education credit can be earned for completing the learning activity associated with this article. Instructions can be found at aaacn.org/ViewPointCNE

Deadline for Submission: April 30, 2021
1.3 contact hour(s)

Factors Influencing HPV Vaccination Recommendations Among Nurses in the Ambulatory Care Setting

Shannon Richard Chopp

Introduction

Human papillomavirus (HPV) is believed to be the causative agent in most cases of cervical, anal, oropharynx, penile, vaginal, and vulvar cancers (Centers for Disease Control and Prevention [CDC], 2018; Hopkins & Wood, 2013). With approximately 79 million people in the United States infected with HPV (CDC, 2017), and almost half of new HPV infections occurring among adolescents and young adults aged 15-24 (Markowitz et al., 2014), it is the most common sexually transmitted infection and has – or will – infected most sexually active men and women at some point in time (National Cancer Institute, 2019). Van Dyne and colleagues (2018) recently reported that oropharyngeal squamous cell carcinoma increased in both men and women from 1999-2015 and is currently the most common HPV-associated cancer. Cervical and vaginal cancer rates showed a decrease in trends, penile cancer remained stable, and increases were noted for vulvar and anal cancers (Van Dyne et al., 2018).

There is no known cure for HPV infection, but vaccines have been developed as a method of primary prevention to help avoid transmission and, ultimately, cancers caused by HPV. To be most effective, the vaccines should be administered before sexual initiation occurs and during the recommended age of administration, which is when antibody responses are the highest (American Academy of Pediatrics, 2012). For preteens aged 11-12, the vaccines recommended by the Advisory Committee on Immunization Practices (ACIP) include the tetanus-diphtheria-acellular pertussis (Tdap) vaccine, meningococcal conjugate vaccine, and HPV vaccine (Reagan-Steiner et al., 2015). However, the HPV vaccination coverage levels continue to be lower for males and females than the coverage levels for both Tdap and meningococcal vaccines (Reagan-Steiner et al., 2015). Recently, the HPV vaccination recommendation decreased from a three-dose schedule to a two-dose schedule for males and females ages 9-14 (Meites, Kempe, & Markowitz, 2016).

Healthy People 2020 goals include having 80% of females and males between the ages of 13-15 receive the HPV vaccines (Office of Disease Prevention and Health Promotion, 2019). This goal is in alignment with the United Nations Sustainable Development Goal 3, which is focused on improving health status and promoting wellbeing (United Nations, 2015). Although there is variation in HPV vaccination rates among sources, it is evident that the HPV vaccination rates remain below the Healthy People 2020 goals. To improve vaccination rates, recommended strategies include promoting clinician educational sessions to underscore the importance of strong recommendations for the HPV vaccine for preteens aged 11-12, proposing methods to improve HPV vaccine recommendations, and preventing missed opportunities to educate both clinicians and parents about the importance of timely HPV vaccination (Reagan-Steiner et al., 2015). Other developed countries, such as Australia, the United Kingdom, and Canada, have launched effective HPV vaccination programs to increase uptake (President's Cancer Panel, n. d.) based solely on the recommendation of a health care clinician for vaccines (Haverkate et al., 2012). Likewise, in the United States, parents and adolescents have reported that the most common facilitator to receiving the HPV vaccine has been counseling and recommendation for the HPV vaccine (Staras, Vadaparampil, Patel, & Shenkman, 2014).

Considering the large number of people affected by HPV, it was proposed by the President's Cancer Panel (n. d.) that widespread HPV vaccination could dramatically reduce the incidences of HPV-related cancers such as oropharyngeal cancers, which could occur in males. Likewise, estimates from the CDC (2014) indicated that if missed clinical opportunities to provide HPV vaccination were eliminated, then 91% of adolescent females would have protection against HPV-related cancers.

Nurses in Ambulatory Care and Preventing Missed Opportunities

Within ambulatory care, the advanced practice registered nurses supplement the physician role by improving access to primary care while simultaneously emphasizing health promotion and disease prevention (American Association of Nurse Practitioners, n.d.). Registered nurses perform many roles related to patient care (American Academy of Ambulatory

Care Nursing [AAACN], 2017). When providing comprehensive care to individuals, the registered nurse consistently emphasizes patient safety, health promotion, health education, and disease prevention. The licensed vocational/practical nurses function under the purview of advanced practice registered nurses, registered nurses, and physicians to provide safe and effective care for individuals, which includes activities such as communicating and collaborating with health care professionals to ensure optimal patient outcomes, and providing patient education (National Council of State Boards of Nursing, 2012).

Briss and colleagues (2004) developed the Informed Decision-Making (IDM) framework to describe the components that affected patient outcomes. Shared-decision making (SDM) is a component of IDM that involves face-to-face, time-intensive, and individualized patient encounters which occurs between the individual and provider. However, the perception of time constraints during the provider encounter may lead to the belief that efforts for SDM should be devoted to treatment decisions that are more complex (Rimer, Briss, Zeller, Chan, & Woolf, 2004). Thus, routine preventive care measures may not receive appropriate attention during the face-to-face encounter, leading to missed opportunities for preventative services. Farmar and colleagues (2016) concurred, stating that missed opportunities for the HPV vaccine occur when health care clinicians do not treat every acute or preventive encounter as an occasion for vaccination. To counteract this challenge, it was proposed that providers must engage other health care clinicians who are trained to promote SDM (Rimer et al., 2004). Nurses can apply the SDM process to help individuals reach decisions regarding their health, including the use of preventive measures.

According to Briss and colleagues (2004), the knowledge, attitudes, self-efficacy, and intentions of the health care clinician influence the implementation of SDM during patient encounters. Acknowledging this influence, a modified version of Briss and colleagues' framework was conceptualized by Bartlett (2012) to aid in the development of an instrument to measure the latent variables of knowledge, attitudes, self-efficacy, and intentions regarding the HPV vaccine.

Methods

An analysis of the relationships between knowledge, attitudes, self-efficacy, and intentions of ambulatory care nurses to recommend the HPV vaccine to preteen males and females was the topic of this study. The research questions guiding the study were:

1) Among ambulatory care nursing staff, what is the effect of knowledge about the HPV disease and vaccine and the education level on clinician attitude toward recommending the vaccine to preteen males and females?
2) Among ambulatory care nursing staff, does attitude and self-efficacy about the HPV vaccine affect the clinician's intent to offer the vaccine to preteen males and females?

Following approval from the Texas Woman's University Institutional Review Board, and agreement from website administrators, data collection began. The setting was an anonymous, secure, online survey delivered via PsychData®. This method enabled the respondents to complete the questionnaire via any device with Internet access. For the purposes of this study, 'clinician' referred to ambulatory care nurses of any educational level.

There were 208 participants in the study. The sample was drawn from a population of registered nurses, advanced practice registered nurses, and licensed vocational/practical nurses that are employed in the ambulatory care setting and care for the preteen population. The participants were nurses employed in the United States; males and females; had the ability to read and understand English; and were 18 years of age or older (see Table 1). Participants were recruited via placement of the recruitment letter with an embedded link onto discussion boards of nursing organizations such as the American Nurses Association and the AAACN. In addition, snowball sampling was utilized by encouraging participants to forward the recruitment letter with the embedded link to other potential participants.

The Shared Decision-Making Inventory-Revised (SDMI-R) developed by Bartlett (2012) was used for data collection. The instrument includes 38 items divided into four subscales which measured the latent variables of HPV disease and HPV vaccine knowledge (20 items), attitude (six items), self-efficacy (10 items), and intent (two items) to recommend the HPV vaccine to female preteens. Knowledge is conceptually defined as possessing accurate information on a topic and was determined by counting the number of correct responses as measured by an objective standard (Ajzen, Joyce, Sheikh, & Cote, 2011). Attitude, a latent variable, has been conceptually defined as a consistent, learned predisposition to respond to a situation or object in a certain way (Kothandapani, 1971) and is a reaction to a preexisting stimulus that includes the components of affect, behavior, and cognition (Breckler, 1984). Self-efficacy is another latent variable that is not determined by proficiency, but rather by one's beliefs of their ability to perform using the skills they possess (de Vries, Dijkstra, & Kuhlman, 1988). Intent, the behavior one expects to achieve, is believed to be extremely predictive of behavior (Kothandapani, 1971). Eleven items were added to specifically address the nurses' HPV vaccine knowledge, attitude, self-efficacy, and intent regarding male preteens, increasing the total number of items on the survey to 47. For the additional items, the stem of items from the original SDMI-R was

Table 1.
Description of Sample

Variable	n (%)
Gender	
Male	7 (3.4)
Female	193 (92.8)
Age	
25-35 years	47 (22.6)
36-50 years	65 (31.3)
51-69 years	86 (41.3)
70 or older	2 (1)
Race	
Caucasian	138 (66.4)
Black	44 (21.2)
Hispanic	9 (4.3)
Asian	5 (2.4)
American Indian	4 (1.9)
Other	3 (1.4)
Years of Experience	
Less than 1 year	1 (0.5%)
1-5 years	27 (13%)
6-10 years	22 (10.6%)
11-15 years	25 (12%)
16-20 years	25 (12%)
21-25 years	29 (13.9%)
26-30 years	21 (10.1%)
31 or more	48 (23.1)
Education Level	
LVN/LPN	11 (5.3)
RN	121 (58.2)
APRN	52 (25)
DNP/PhD	9 (4.3)
Other	5 (2.4)

retained, and the word 'female' was changed to 'male.' Bartlett and Peterson (2013) reported on the psychometric properties of the instrument. Reliability for the total instrument was satisfactory (α=0.874) along with attitude, self-efficacy, and intent subscales 0.828, 0.917, and 0.891, respectively.

Results

Following completion of the study, the data was uploaded into the Statistical Package for the Social Sciences Version 23.0. Descriptive statistics were used to analyze the demographic data of the participants. Multiple linear regressions were used for the analysis for both research questions.

Research Question One

HPV disease and vaccine knowledge related to females (t = 5.169, p < 0.0001) was a significant predictor of the clinician's attitude toward the HPV vaccine, while the clinician's education level was not found to be significant (t = -1.649, p = 0.101). Likewise, HPV disease and vaccine knowledge related to male preteens (t = 2.207, p =0.028) was a significant predictor of the clinician's attitude toward the HPV vaccine related to preteen males, while the clinician's education level was not significant (t = 0.870, p = 0.385). There was partial support for research question one since HPV disease and vaccine knowledge related to females and males was a significant predictor of clinician's attitude toward the HPV vaccine related to preteen females. However, the clinician's education level was not significant.

Research Question Two

Analysis indicated that the clinician's attitude toward the HPV vaccine related to preteen females (t = 4.690, p < 0.0001) and self-efficacy related to the HPV vaccine and preteen females (t = 9.630, p < 0.0001) were both significant predictors of the clinician's intent to offer the HPV vaccine to preteen females. For preteen males, the clinician's self-efficacy related to the HPV vaccine in regards to preteen males was a significant predictor (t = 8.316, p < 0.0001) of intent to offer the HPV vaccine; conversely, the clinician's attitude toward the HPV vaccine in regards to preteen males (t = 1.950, p = 0.053) was not a significant predictor of clinician's intent to offer the HPV vaccine to preteen males. There was full support for research question two related to female preteens, as self-efficacy related to the HPV vaccine and the clinician's attitude toward the HPV vaccine in regard to preteen females were both significant predictors of the clinician's intent to offer the HPV vaccine to preteen females. However, there was only partial support related to preteen males, since self-efficacy toward the HPV vaccine in relation to preteen males was a significant predictor of clinician's intent to offer the HPV vaccine to preteen males, but the clinician's attitude toward the HPV vaccine related to preteen males was not significant.

Discussion

Effect of Knowledge and Education Level on Attitude

The effect of HPV disease and vaccine knowledge on clinician attitude toward recommending the HPV vaccine to preteen females and males was significant, but education level did not have a significant effect on clinician attitude. In addition, the findings suggest that other variables that were not measured in the study may account for a proportion of clinician attitude. For example, personal variables, such as intention to vaccinate one's own children or religious beliefs, could potentially affect the clinician's attitude toward recommending the HPV vaccine (Reynolds, 2014).

The differences in the results of the regression equations between males and females suggest that overall clinician knowledge of HPV disease and vaccines for male preteens may be lower than HPV disease and vaccine knowledge for females, which may in turn influence clinician attitude. A contributing factor may be that the HPV vaccine was not recommended by ACIP for male preteens

until 2011 (Dunne et al., 2011), 5 years after being introduced and recommended for female preteens.

The findings also suggested that nurses' knowledge about the HPV vaccine may significantly impact their attitudes toward recommending the HPV vaccine ($p < 0.05$). Rosen, Goodson, Thompson, and Wilson (2015) assessed the knowledge of nurses and the effect on clinician attitude toward recommending the HPV vaccine. This study reported that knowledge about the HPV vaccine significantly impacted nurses' attitudes toward recommending the HPV vaccine ($p < 0.05$). The findings from this study lend support to the findings from Rosen and colleagues' (2015) study, demonstrating a significant relationship between knowledge levels and attitude toward recommending the HPV vaccination to preteen females ($p < 0.0001$) and males ($p = 0.028$). These results suggest that interventions to increase clinician knowledge regarding HPV disease and the available HPV vaccines will result in positive attitudes toward recommending the HPV vaccine to preteen females and males.

The demographic distribution of the sample may have impacted the lack of a significant relationship between the nurses' educational level and recommending the HPV vaccination. The majority of participants reported an educational level of Associate Degree in Nursing or higher. All licensed nurses performing patient care are responsible for implementing health promotion interventions, including patient education and counseling regarding vaccinations (AAACN, 2017). For nurses to competently educate and counsel individuals, the assumption is that nurses of all education levels who work with the pediatric population have knowledge of the ACIP-recommended vaccines, including the HPV vaccine. Therefore, the findings from this study suggest that the clinician's attitude toward recommending the HPV vaccine is more likely affected by HPV knowledge level than educational level.

Effect of Attitude and Self-Efficacy on Intent

Kahn and colleagues (2009) found attitude significantly affected intention to recommend the HPV vaccine among nurses. Similarly, the findings from this study indicate that clinicians' attitude toward recommending the HPV vaccine to preteen females was a significant predictor of intent to recommend the HPV vaccine ($p < 0.0001$). In contrast, for preteen males, attitude was not a significant predictor of intent to recommend the HPV vaccine ($p = 0.053$). As HPV disease and vaccine knowledge level affects attitude toward recommending the HPV vaccine, the differences in clinicians' attitudes toward intent to recommend the HPV vaccine that were found between female and male preteens could possibly be attributed to clinicians' having lower HPV disease and vaccine knowledge levels related to preteen males.

McRee, Gilkey, and Dempsey (2014) discovered that providers who reported higher self-efficacy were more likely to recommend the HPV vaccine. Likewise, analysis of the data from this study also found that self-efficacy toward recommending the HPV vaccine to preteen females and males was a significant predictor ($p < 0.0001$) of clinician intent to recommend the HPV vaccine to preteen females and males.

Limitations

This study had several limitations. The sampling method employed included placement of the invitation and reminder letters on the discussion boards of nursing organizations and encouraged snowball sampling. Although the vast majority of respondents were from the United States, there is a possibility that a small percentage of respondents may reside outside of the country. Second, the use of a web-based survey limits the number of participants in that the respondents must have access to the Internet in order to participate. There may be other eligible nurses without ready access to the Internet who may have different responses that could affect the data analysis.

In addition, the sample size was small and the measurement tool chosen to assess the variables had limited testing to determine the psychometric properties. These limitations result in limited generalizability of the findings. Considerations for future research include the use of more rigorous methods for gathering data, a larger and more diverse sample size, and continued analysis of the psychometric properties of the tool.

Conclusion

The findings from this study propose that clinician HPV disease and

level of vaccine knowledge significantly affects their attitudes toward recommending the HPV vaccine. Additionally, clinician attitudes and self-efficacy related to recommending the HPV vaccine have a significant effect on intent to recommend the HPV vaccine. These findings suggest that improvement in clinician knowledge levels will likely increase intent to recommend the HPV vaccine. In addition, there are notable differences between clinician knowledge level of HPV disease and vaccines related to preteen females and males, which may possibly explain the differences in clinician attitude toward recommending the HPV vaccine between preteen females and males. The findings also imply that the education level of the nurse is not a significant predictor of attitude toward recommending the HPV vaccine and may not be relevant to implementation of the SDM process during client encounters.

The implications of the findings from this study are important in considering the role of the nurse working in ambulatory care settings. The use of targeted and specific education strategies tailored to improving HPV disease and vaccine knowledge levels of nurses, may result in more positive attitudes toward recommending the HPV vaccine and increased intent to recommend the HPV vaccine. Additionally, nurses, as an integral part of the health care team in all pediatric health care visits, can effectively participate in and lead SDM encounters regarding the HPV vaccine resulting in fewer missed opportunities for vaccination.

Shannon Richard Chopp, PhD, MSN, BS, RNC-OB, is an Assistant Professor, Chamberlain College of Nursing, Pearland, TX. She may be contacted at shannon.chopp@hotmail.com

References

American Academy of Ambulatory Care Nursing (AAACN). (2017). The role of the registered nurse in ambulatory care [position paper]. *Nursing Economic$, 35*(1), 39-47.

Ajzen, I., Joyce, N., Sheikh, S., & Cote, N.G. (2011). Knowledge and the prediction of behavior: The role of information accuracy in the theory of planned behavior. *Basic and Applied Social Psychology, 33*(2), 101-117. doi:10.1080/01973533.2011.568834

American Association of Nurse Practitioners. (n. d.). *Nurse practitioners in primary care*. Retrieved from https://www.aanp.org/images/documents/publications/primarycare.pdf

American Academy of Pediatrics. (2012). HPV vaccine recommendations [policy statement]. *Pediatrics, 129*(3), 602-605. doi:10.1542/peds.2011-3865

Bartlett, J.A. (2012). *The development and psychometric testing of the Shared Decision-Making Inventory instrument* [Doctoral dissertation]. Retrieved from https://mospace.umsystem.edu/xmlui/bitstream/handle/10355/14221/BartlettDevPsyTes.pdf?sequence=1

Bartlett, J.A., & Peterson, J.A. (2013). Psychometric evaluation of the Shared Decision-Making Instrument-Revised. *Western Journal of Nursing Research, 35*(2), 193-213. doi:10.1177/0193945912463267

Breckler, S.J. (1984). Empirical validation of affect, behavior, and cognition as distinct components of attitude. *Journal of Personality and Social Psychology, 47*(6), 1191-1205.

Briss, P., Rimer, B., Reilley, B., Coates, R.C., Lee, N.C., Mullen, P., … Lawrence, R. (2004). Promoting informed decisions about cancer screening in communities and healthcare systems. *American Journal of Preventive Medicine, 26*(1), 67-80. doi:10.1016/j.amepre.2003.09.012

Centers for Disease Control and Prevention (CDC). (2014). *Safe and effective vaccine that prevents cancer continues to be underutilized*. Retrieved from http://www.cdc.gov/media/releases/2014/p0724-nisteen.html

Centers for Disease Control and Prevention (CDC). (2017). Genital HPV infection – fact sheet. Retrieved from http://www.cdc.gov/std/hpv/stdfact-hpv.htm

Centers for Disease Control and Prevention (CDC). (2018). *How many cancers are linked with HPV each year?* Retrieved from http://www.cdc.gov/cancer/hpv/statistics/cases.htm

de Vries, H., Dijkstra, M., & Kuhlman, P. (1988). Self-efficacy: The third factor besides attitude and subjective norm as a predictor of behavioural intentions. *Health Education Research, 3*(3), 273-282. doi:10.1093/her/3.3.273

Dunne, E.F., Markowitz, L.E., Chesson, H., Curtis, C.R., Saraiya, M., Gee, J., & Unger, E.R. (2011). Recommendations on the use of quadrivalent human papillomavirus vaccine in males – Advisory Committee on Immunization Practices (ACIP), 2011. *Morbidity and Mortality Weekly Report, 60*(50), 1705-1708. Retrieved from https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6050a3.htm

Farmar, A.M., Love-Osborne, K., Chichester, K., Breslin, K., Bronkan, K., & Hambidge, S.J. (2016). Achieving high adolescent HPV vaccination coverage. *Pediatrics 138*(5), e1-e8. http://www.dx.doi.org/10.1542/peds.2015-2653

Haverkate, M., D'Ancona, F., Giambi, C., Johansen, K., Lopalco, P.L., Cozza, V., & Appelgren, E. (2012). Mandatory and recommended vaccination in the EU, Iceland and Norway: Results of the VENICE 2010 survey on the ways of implementing national vaccination programmes. *Eurosurveillance, 17*(22). doi:10.2807/ese.17.22.20183-en

Hopkins, T.G., & Wood, N. (2013). Female human papillomavirus (HPV) vaccination: Global uptake and the impact of attitudes. *Vaccine, 31*(13), 1673-1679. doi:10.1016/j.vaccine.2013.01.028

Kahn, J.A., Ding, L., Huang, B., Zimet, G.D., Rosenthal, S.L., & Frazier, A.L. (2009). Mothers' intention for their daughters and themselves to receive the human papillomavirus vaccine: A national study of nurses. *Pediatrics, 123*(6), 1439-1445. doi:10.1542/peds.2008-1536

Kothandapani, V. (1971). Validation of feeling, belief, and intention to act as three components of attitude and their contribution to prediction of contraceptive behavior. *Journal of Personality and Social Psychology, 19*(3), 321-333. doi:10.1037/h0031448

Markowitz, L.E., Dunne, E.F., Saraiya, M., Chesson, H.W, Curtis, C.R., Gee, J., … Unger, E.R. (2014). Human papillomavirus vaccination: Recommendations of the Advisory Committee on Immunization Practices (ACIP). *Morbidity and Mortality Weekly Report, 63*(RR05), 1-30. Retrieved from https://www.cdc.gov/mmwr/preview/mmwrhtml/rr6305a1.htm

McRee, A., Gilkey, M.B., & Dempsey, A.F. (2014). HPV vaccine hesitancy: Findings from a statewide survey of health care providers. *Journal of Pediatric Health Care, 28*(6), 541-549. doi:10.1016/j.pedhc.2014.05.003_

Meites, E., Kempe, A., & Markowitz, L.E. (2016). Use of a 2-dose schedule for human papillomavirus vaccination – Updated recommendations of the Advisory Committee on Immunization Practices. *Morbidity and Mortality Weekly Report, 65*(49), 1405-1408. Retrieved from https://www.cdc.gov/mmwr/volumes/65/wr/mm6549a5.htm

National Cancer Institute. (2019). HPV and cancer. Retrieved from https://www.cancer.gov/about-cancer/causes-prevention/risk/infectious-agents/hpv-fact-sheet

National Council of State Boards of Nursing. (2012). *NCSBN model act*. Retrieved from https://www.ncsbn.org/14_Model_Act_0914.pdf

Office of Disease Prevention and Health Promotion. (2019). *Immunization and infectious diseases*. Retrieved from https://www.healthypeople.gov/2020/topics-objectives/topic/immunization-and-infectious-diseases

President's Cancer Panel. (n. d.). *Accelerating HPV vaccine uptake: Urgency for action to prevent cancer*. Retrieved from https://deainfo.nci.nih.gov/advisory/pcp/annualReports/HPV/index.htm

Reagan-Steiner, S., Yankey, D., Jeyarajah, J., Elam-Evans, L.D., Singleton, J.A., Curtis, C.R., … Stokley, S. (2015). National, regional, state, and selected local area vaccination coverage among adolescents aged 13-17 years – United States, 2014. *Morbidity and Mortality Weekly Report, 64*(29), 784-792. Retrieved from http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6429a3.htm

Reynolds, D. (2014). Religiosity and parental acceptance of human papillomavirus (HPV) vaccine in 9-18 year-old girls. *Journal of Christian Nursing, 31*(3), 172-177.

Rimer, B.K., Briss, P.A., Zeller, P.K., Chan, E.C.Y., & Woolf, S.H. (2004). Informed decision making: What is its role in cancer screening? *Cancer Supplement, 101*(5), 1214-1228. doi:10.1002/cncr.20512

Rosen, B.L., Goodson, P., Thompson, B., & Wilson, K.L. (2015). School nurses' knowledge, attitudes, perceptions of role as opinion leader, and professional practice regarding human papillomavirus vaccine for youth. *Journal of School Health, 85*(2), 73-81. doi:10.1111/josh.12229

Staras, S.A.S., Vadaparampil, S.T., Patel, R.P., & Shenkman, E.A. (2014). Parent perceptions important for HPV vaccine initiation among low income adolescent girls. *Vaccine, 32*(46), 6163-6169. doi:10.1016/j.vaccine.2014.08.054

United Nations. (2015). *Transforming our world: The 2030 agenda for sustainable development*. Retrieved from https://sustainabledevelopment.un.org/post2015/transformingourworld_

Van Dyne, E.A., Henley, S.J., Saraiya, M., Thomas, C.C., Markowitz, L.E., & Benard, V.B. (2018). Trends in human papillomavirus – Associated cancers – United States, 1999-2015. *Morbidity and Mortality Weekly Report, 67*(33), 918-924. Retrieved from https://www.cdc.gov/mmwr/volumes/67/wr/mm6733a2.htm?s_cid=mm6733a2_w

Resolution for Improvement

Kathryn Koehne

Due to publishing deadlines, I am writing this column on New Year's Eve. At the beginning of a new year, it is traditional to reflect on the past year and contemplate new opportunities, ponder possibilities, and create resolutions as a new year unfolds. There is a palpable sense of optimism as many people consider overcoming past limitations and assuming healthier habits. Top resolutions include saving money, losing weight, getting in shape, traveling more, and quitting smoking (McCarthy, 2019). However, resolutions may also be applied to not only personal improvement but also professional development. According to the Oxford Dictionary (2019), a resolution is "a firm decision to do or not to do something" (para. 1). Nurses may seek to improve practice by assessing their strengths and limitations, developing goals, and determining an action plan.

A person identifies a resolution based on a desire for self-improvement that is intrinsically inspired. The inspiration is then supported by accessing external resources. When there is a goal to save more money, a person may seek the help of a financial advisor. If there is a need to lose weight or adopt an exercise program, there are countless resources such as apps, websites, books, weight loss programs, and wellness coaches available for the resolution maker. There are also deals on cruises and airfare for those who seek more travel adventures. For nurses who desire to expand knowledge and enhance skill in telehealth practice, there are resources that can be accessed for information and support.

During my seminars and consultations, I dialogue with nurses throughout the country who provide care to patients using telehealth technology. Although their practice settings may differ, they have a shared priority as they desire to practice safely, effectively, and within scope. Oftentimes, they express concerns about quality of care and professional risk. Nurses feel vulnerable since few academic programs offer a dedicated ambulatory care clinical rotation and many employers do not offer a formalized orientation program including care of patients via telehealth technology. Nurses seek educational sessions or wait for organizational initiatives to include topics such as telephone triage training. However, these opportunities are infrequent or non-existent as there is competition with other priorities. With this reality, it is crucial for nurses to take the initiative by reflecting on their knowledge, skills, and attitudes; identifying strengths and limitations; and making an action plan.

> "Were there none who were discontented with what they have, the world would never reach anything better."
>
> – *Florence Nightingale*

Standards for Practice

The American Academy of Ambulatory Care Nursing (AAACN) 2018 *Scope and Standards of Practice for Professional Telehealth Nursing, 6th Edition,* is a valuable resource that allows for nurses to identify strengths and gaps in practice. The Standards allow nurses to perform a self-assessment for competency in the areas of Clinical Practice, Nursing Organizational and Professional Performance. Several years ago, I led a 16-month long activity with our organization's Outpatient Nursing Council members. Each member received a copy of the AAACN *Scope and Standards of Practice for Professional Telehealth Nursing, 6th Edition.* Every month we reviewed the list of competencies for each standard and noted whether the competency was met or not met in their department, respectively. Next step was developing an action plan of how the competency could be met. Although this evaluation was done with a group, an individual nurse could use the same process.

Table 1.
Standard 11 Communication

The RN practicing in the telehealth setting communicates effectively using a variety of formats, tools, and technologies to build professional relationships and to deliver care across the continuum (AAACN, 2018).

Competency	Meets	Needs Improvement	Does Not Meet	Comments/Action Plan
1) Promote active communication using techniques that enhance learning and sharing information.	X			Formalized orientation focuses on communication techniques. New nurses attend "live" education session on effective communication and health literacy.
2) Identify and evaluate personal skills and styles of communication to enhance effectiveness.			X	Plan: • Department will obtain a digital voice recorder. • Education Committee will develop a Q&A form focusing on effective communication. • Staff will review five self-recorded calls (no identifying information) quarterly. • Staff will identify areas of strength and opportunity.
3) Share telehealth nursing best practices with peers, requesting feedback and evaluation.	X			Peer review in place. Best practices are shared at staff meetings.

This council-led project followed the nursing process:

Assessment Each council member along with the other nurses in their respective department completed an analysis of each competency with the telehealth standard by asking, 'Are we meeting the standard, is improvement needed, or is the standard not met at all?'

Nursing Diagnosis: Conversations were facilitated by the council member. The groups discussed strengths and weaknesses in their practice environments. Then, based on a critical analysis and collaborative problem identification, the nursing groups categorized and prioritized the areas of opportunities in order of significance, simplicity, and urgency.

Planning: The nurses in each department then collectively developed an action plan with specific and realistic interventions that would facilitate meeting the competency. The department manager was included in the discussions to offer support and guidance as needed. During the planning phase, the council member would complete a summary report at the council meeting and receive feedback from peers from the other departments. The council member would then return to their department with a more robust plan and be ready to move into the action phase.

Implementation: The collective effort of the nurses was necessary for the plan to be carried out in the department. Despite the identified need and shared vision for improvement, engagement waned. Day-to-day tasks in care delivery and competing priorities often led to sidestepping the implementation of the strategy. However, vigilance of the council member influenced peer commitment.

Evaluation: Nurses and management in each department evaluated the effectiveness of the improvement plans. There were many adjustments made in response to the effectiveness of the strategy. Table 1 is an example of this process using Standard 11 from the AAACN *Scope and Standards of Practice for Professional Telehealth Nursing, 6th Edition*.

This council-generated project lasted over 2 years as each standard assessment and improvement plan spanned 2 months. Overall, the project was successful as it brought the standards to life and led to notable improvement in telehealth nursing practice in the health system. However, sustainment has been a struggle in a few practice settings. Like resolutions, there may be initial excitement and effectiveness but without continual encouragement and engagement, there may be some regression to former practices or behaviors.

Change is Challenging

Despite the synergy from intrinsic motivation and extrinsic reinforcement, change is difficult. Although there is initial excitement and commitment, many resolutions fail. Norcross, Mrykalo, and Blagys (2002) followed participants who made resolutions for 6 months and discovered less than 50% of individuals maintained their resolutions at the 6-month mark. Unlike changing a habit, increasing knowledge or enhancing skills is inherent in professional nursing. According to the American Nurses Association *Code of Ethics for Nurses*

with Interpretive Statements (2015), performance standards include the "ongoing acquisition and development of the knowledge, skills, dispositions, practice, experiences, commitment, relational maturity, and personal integrity essential for professional practice" (p. 10). It is an expectation that nurses welcome opportunities for performance improvement and growth.

There is nothing magical about January 1st to begin anew. Resolutions to make improvements may be made at any time. According to the 10th Standard of Practice for Professional Telehealth, nurses should "continuously evaluate telehealth nursing practice to identify opportunities for improving clinical outcomes, safety, and patient experience" (AAACN, 2018, p. 37). As Florence Nightingale (1859) once said, "Were there none who were discontented with what they have, the world would never reach anything better" (p. 29). It is important that nurses never grow complacent in their practice. The quest for improvement needs to be continuous and not be limited by an annual resolution. Whether the education is at the department, system, or national level, professional practice will advance when nurses embrace learning and share best practices. ●

Kathryn Koehne, DNP, RN-BC, C-TNP, is a Clinical Manager - Ambulatory Care, Gundersen Health System; an Adjunct Faculty, Viterbo University; and a Professional Educator, Telehealth Triage Consulting, Inc. She may be contacted at krkoehne@gundersenhealth.org

References

American Academy of Ambulatory Care Nursing (AAACN). (2018). Scope and standards of practice for professional telehealth nursing (6th ed.). Pitman, NJ: Author.

American Nurses Association. (2015). Code of ethics for nurses with interpretive statements. Silver Spring, MD: American Nurses Association.

McCarthy, N. (2019). The top new year's resolutions for 2019. Retrieved from https://www.statista.com/chart/16500/top-us-new-years-resolutions/

Nightingale, F. (1859). Notes on nursing: What it is, and what it is not. London: Harrison.

Norcross, J.C., Mrykalo, M.S., & Blagys, M.D. (2002). Auld lang syne: Success predictors, change processes, and self-reported outcomes of New Year's resolvers and nonresolvers. Journal of Clinical Psychology, 58(4), 397-405.

Oxford Dictionary. (2019). Resolution. Retrieved from https://en.oxforddictionaries.com/definition/resolution

From the President

continued from page 2

organizations that received U.S. Health Resources and Services Administration (HRSA) funding to increase baccalaureate nurse education in primary care. AAACN informed grantees of the many resources within our organization and greater numbers are requesting our expertise and collaboration as they develop education programs. We've launched the Academic-Practice Partnerships Task Force to develop guidelines to boost collaboration in ambulatory care education for nursing students and increase clinical placements.

The revised Ambulatory Care Nursing Conceptual Framework was published in *Nursing Economic$* (Mastal, 2018). Drs. Margaret Mastal and Stephanie Witwer were selected to present the model at the Sigma Theta Tau International Conference in November 2019, providing an opportunity for future global impact. Model modifications depict the growth in the profession and care delivery changes over time. Additions include the *continuum of care* and *social determinants of health*. The key role of nurses in impacting population health, behavioral health interventions, and addressing social determinants is recognized. These topics also will be discussed at the AAACN Annual Conference Town Hall in May – don't miss it!

The strategic Nurse-Sensitive Indicator (NSI) work is expanding exponentially. AAACN's partnership with the Collaborative Alliance for Nursing Outcomes (CALNOC) continued, including publication (Stuart, Matlock, Brown, Aronow, & Soban, 2018), and just this month, Press Ganey acquired CALNOC. Our NSI Team is publishing NSI details in ViewPoint for greater use and understanding by our members. Our NSI experts are sought out and greater numbers of ambulatory care nurses are collecting structure, process, and outcome data. The increased focus on ambulatory care nursing as part of the Magnet Recognition Program® brought new collaboration with the American Nurses Credentialing Center. We look forward to what lies ahead with NSIs will share more information as it becomes available.Finally, AAACN has looked internally to strengthen structures and processes toward greater effectiveness and transparency. Our website is undergoing revision to better serve members. Our Special Interest Group leaders worked to synchronize structures and processes. Our Connected Communities were abuzz with vital dialogue and point of care expertise.

What can more than 4,300 AAACN members accomplish? As I started my presidency, I committed to working with your Board of Directors and members toward a greater AAACN voice and value. Over the year, we've witnessed the power of volunteerism, collaboration, networking, new member engagement, publication, and presentation that yielded outstanding results. This energy will continue at our Annual Conference in Palm Springs and will catalyze voice and value through the coming year.

It's been an honor and privilege to serve as your President. Thank you for the incredible opportunity. ●

Kathy Mertens, DNP, MPH, RN, is Associate Chief Nurse, Assistant Administrator, Harborview Medical Center, Seattle, WA. She may be contacted at aaacn_president@aaacn.org

References

Brenan, M. (2018). *Nurses again outpace other professions for honesty, ethics.* Retrieved from https://news.gallup.com/poll/245597/nurses-again-outpace-professions-honesty-ethics.aspx?g_source=link_NEWSV9&g_medium=NEWSFEED&g_campaign=item_&g_content=Nurses%2520Again%2520Outpace%2520Other%2520Professions%2520for%2520Honesty,%2520Ethics

Mastal, M. (2018). Evolution of a conceptual model: Ambulatory care nursing. *Nursing Economic$, 36*(6), 296-300, 303.

Palmer, P.J. (2011). Fifth habit of the heart. Center for Courage & Renewal. Retrieved from http://www.couragerenewal.org/habitsoftheheart/five/

Start, R., Matlock, A.M., Brown, D. Aronow, H., & Soban, L. (2018). Realizing momentum and synergy: Benchmarking meaningful ambulatory care nurse-sensitive indicators. *Nursing Economic$, 36*(5),246-251.

Are You Taking Advantage of the New Behavioral Health Billing Codes for Integrated Care?

Lois Stauffer

Behavioral health (BH) has received increased focus within care delivery models such as the patient-centered medical home and comprehensive primary care. Depression and anxiety disorders frequently go unrecognized within the primary care setting (Kroenke, Spitzer, Williams, Monahan, & Löwe, 2007). Many primary care offices are implementing global screening for these disorders. However, with increased identification of individuals with BH diagnosis, limited access to psychiatry or BH counseling services often prevents individuals from getting the care they need.

As organizations look at new models to increase access to BH services, integration of BH teams and providers into primary care can help individuals get the services they need. Behavioral health integration (BHI), within primary care settings, enhances typical primary care models by using a health care team of physicians, non-physicians, and trained clinical staff to support individuals' BH needs. Not only does integration of BH services into primary care represent a significant investment in work and role redesign, it will require a viable payment model to support and maintain these services – especially within fee-for-service environments. Traditionally, BH billing codes were designed for face-to-face psychiatric or counseling services. However, providers have not been able to collect reimbursement for work such as recommendations from an informal consult, virtual care, electronic chart reviews, or other non-face-to-face services. Payment reform models have prompted Medicare to provide alternative payment strategies for BH services that can capture work value for those types of services. These payment models encompass services provided to individuals with a BH diagnosis by physicians and non-physicians. The new CPT® codes that can be used for monthly billing are an approach to finance and sustain BHI (Medicare Learning Network Fact Sheet, 2018).

The general BHI model uses billing code CPT 99494 and is used to bill monthly services provided by a clinical staff member overseen by a physician or qualified health care professional. These services include assessment, monitoring, and development of a BH care plan for individuals with a BH condition being treated by the billing practitioner. Requirements for this time-based billing code include:

- Use of a validated rating scale for initial assessment and ongoing monitoring.
- Individual's involvement in care planning with care plan revision for individual not progressing toward improvement.
- Facilitation and coordination of BH treatment including psychotherapy, pharmacotherapy, or counseling.
- Continuous relationship with a designated care team member.

This code may be used to report services provided within a model of care that does not involve a psychiatric consultant or designated behavioral health care manager (Medicare Learning Network Fact Sheet, 2018).

The collaborative care model (CoCM) adds additional services for individuals with a BH diagnosis within the typical primary care model and has additional time-based billing codes for key services. The components of the collaborative care model are administered by a BH care manager, a primary billing practitioner, and a psychiatric consultant. Additional requirements for billing collaborative care model codes CPT 9992 and 99493 beyond general BHI include:

Figure 1.
BHI Coding Summary

BHI CODING SUMMARY

BHI CODE	BEHAVIORAL HEALTH CARE MANAGER OR CLINICAL STAFF THRESHOLD TIME	ASSUMED BILLING PRACTITIONER TIME
CoCM First Month (99492)	70 minutes per calendar month	30 min
CoCM Subsequent Months** (99493)	60 minutes per calendar month	26 min
Add-On CoCM (Any month) (99494)	Each additional 30 minutes per calendar month	13 min
General BHI (99484)	At least 20 minutes per calendar month	15 min
BHI Initiating Visit (AWV, IPPE, TCM or other qualifying E/M)	N/A	Usual work for the visit code

*Medicare Physician Fee Schedule (MPFS) payment is available under the MPFS regardless of whether the beneficiary spends part or all of the month in a facility stay or institutional setting. Report the place-of-service (POS) where the billing practitioner would ordinarily provide face-to-face care to the beneficiary. Separate Part B payment can be made to hospitals (including critical access hospitals) when the billing practitioner reports a hospital outpatient POS.
**CoCM is furnished monthly for an episode of care that ends when targeted treatment goals are met or there is failure to attain targeted treatment goals culminating in referral for direct psychiatric care, or there is a break in episode (no CoCM for 6 consecutive months).
†Annual Wellness Visit (AWV), Initial Preventive Physical Examination (IPPE), Transitional Care Management services (TCM).

Source: Medicare Learning Network Fact Sheet, 2018

- Use of a patient registry for tracking individual follow-up and progress.
- Regular review and weekly caseload consultation with a psychiatric consultant for care plan progress, medication review, and treatment modifications as needed.
- Provision of brief, focused interventions and use of evidence-based interventions such as motivational interviewing or other treatment strategies for behavioral activation.
- Monitoring of outcomes using validated tools and implementation of relapse prevention planning for individuals achieving remission or meeting treatment goals (Medicare Learning Network Fact Sheet, 2018).

Figure 1 shows billing time requirements for each of the BHI codes.

Obtaining and documenting individuals' consent for services and billing is a requirement for submitting the BHI codes. Services provided by the BH care manager (both face-to-face and non-face-to-face) must be under the oversight and direction of the billing practitioner (who is typically the primary care provider). Qualifications of a BH care manager may include formal education or specialized training in BH and may include a range of disciplines such as social work, nursing, or counseling. Medicare, however, does not specify a minimum educational requirement for a BH care manager and they are not required to be independently licensed as they would be if billing traditional psychotherapy codes. Psychiatric consultant services may be provided remotely through telehealth services, as well as services provided by other members of the care team (Centers for Medicare & Medicaid Services [CMS], 2018)

Providers billing BHI codes must be able to demonstrate through documentation the core components of measurement-based care. An accurate inventory of time that care managers, psychiatry, and other providers spend on each individual for face-to-face and non-face-to-face services is also a key component of billing. In addition, documentation of the individual's verbal consent for these services is necessary for billing. These documentation requirements can involve significant workflow and medical record challenges. Additional electronic medical record build may be required for flowsheets, documentation templates, BH registry components, and reporting capabilities.

Acceptance of these billing codes by commercial insurance varies among payers. Both Medicare and commercial insurances require a copay for these services. Individuals with commercial insurance may find it difficult to determine their cost for BHI services and often prevent individuals from giving consent to receive these services out of concern for out-of-pocket costs.

Long-term analysis of BHI indicates the positive impact on the total cost of care for individuals with co-occurring BH and chronic diseases such as diabetes. Studies show that initial implementation costs of BHI were offset in 2 to 3 years with decreased total cost of care for individual interventions compared with a usual-care cohort (Unutzer et al., 2008).

As health care transforms to a value-driven world, clinical delivery of care will need to reflect care of the whole person as in the BHI model. This will require payment models that incentivize new roles, decrease fragmentation of care, and promote access to needed services to provide better care at a lower cost. ●

Lois Stauffer, MSN, RN, CNL, is a retired Director of Care Management. She may be contacted at stauffer@redbird.net

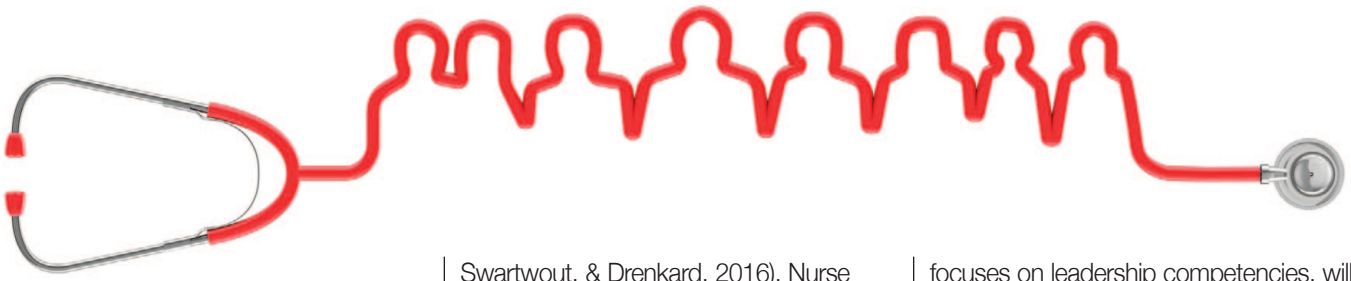
References

Centers for Medicare & Medicaid Services (CMS). (2018). Frequently asked questions about billing Medicare for behavioral *health integration (BHI) services.* Retrieved from https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/Behavioral-Health-Integration-FAQs.pdf

Kroenke, K., Spitzer, R.L., Williams, J.B., Monahan, P.O., & Löwe, B. (2007). Anxiety disorders in primary care: Prevalence, impairment, comorbidity, and detection. *Annals of Internal Medicine, 146*(5), *317-326.*

Medicare Learning Network Fact Sheet. (2018). *Behavioral health integration services*. Retrieved from https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/BehavioralHealthIntegration.pdf

Unutzer, J.K., Katon, W.J., Fan, M.Y., Schoenbaum, M.C., Lin, E.H., Della Penna, R.D., & Powers, D. (2008). Long-term cost effects of collaborative care for late-life depression. *The American Journal of Managed, 14*(2), 95-100.



From Nurse to Nurse Manager

continued from page 1

human resource management, performance improvement, foundational thinking, technology, strategic thinking, clinical knowledge, personal/professional accountability, career planning, relationship management, influencing behavior, and shared decision making (AONE, 2015).

It is no longer feasible to promote nurses to management positions based on clinical skills alone. Advanced nursing education – beyond the baccalaureate level – is the first step in preparing the next generation of nurse managers and leaders. While many undergraduate nursing programs include course work in nursing leadership, the focus of undergraduate nursing education, by necessity, must emphasize basic clinical competency. The depth and breadth of undergraduate leadership course work is not adequate to prepare the next generation of nurse managers. It is interesting to note that while graduate nursing education is a prerequisite for both the Certified Registered Nurse Practitioner (CRNP) and the Clinical Nurse Specialist (CNS), it is not a prerequisite for the nurse manager. A review conducted by Thompson and Fairchild (2013) reported a positive correlation between advanced nursing education and nursing professionalism, which was found to have a direct impact on staff satisfaction and retention.

Nurse managers are tasked with the responsibility of creating and maintaining microsystems of care that promote patient and family engagement which in turn will lead to improved patient outcomes and population health (Deyo, Swartwout, & Drenkard, 2016). Nurse managers are expected to lead interprofessional teams and participate in quality improvement initiatives. They are also the frontline leaders who regularly identify, plan, and implement quality improvement programs. This work involves using evidence-based practice and data to continuously monitor care processes and outcomes to improve the quality and safety of health care delivery at the microsystem level (Djukic, Kovner, Brewer, Fatehi, & Jun, 2015). The Counsel on Graduate Education for Administration in Nursing advocates for Master of Science in Nursing preparation and board certification for NMs (Pawlak, Scott, & Murphy, 2013). Advanced nursing education – beyond the Baccalaureate level – coupled with continuing nursing education, which focuses on leadership competencies, will provide the nurse manager with the knowledge and skills that are necessary to successfully navigate and improve health care systems.

> “As the largest segment of health care professionals, nurses are poised to lead the way in transforming health care in the United States, and this transformation begins with the nurse manager.

Nurse managers are the face of nursing leadership at the point of care in all health care organizations. In addition to educational preparedness, the novice nurse manager requires ongoing support from executive nursing leadership and health care organizations. Developing and implementing strategies to support, recruit, and retain nurse managers can lead to organizational success and stability. Successful strategies include identifying nurses who demonstrate a willingness to learn and perform under challenging conditions (Glassman & Whithall, 2018), implementing a nurse manager residency program where prospective nurse managers participate in a year-long structured training (Watkins et al., 2014), and nurse leader mentorship. Mentorship is a proven strategy that has been utilized to provide support and guidance to new-to-practice registered nurses. Mentorship can also be utilized to promote leadership development in nurse managers. Leadership succession planning through mentorship has been identified as an evidence-based strategy in the identification and promotion of nurse managers (Vitale, 2018).

Nursing leadership is an evolving discipline which requires an advanced skill set. This skill set includes advanced planning and education among nursing professionals who aspire to nurse management positions. Effective nurse managers develop their skills through a combination of experience and formal education. Current research suggests graduate-level preparation is an essential

foundation for nursing leadership positions, with specific training and certification in health care leadership preferred (Pawlak, Scott, & Murphy, 2013). As the largest segment of health care professionals, nurses are poised to lead the way in transforming health care in the United States, and this transformation begins with the nurse manager. ●

Mary Ellen Schlaak, MSN, RN, is Director of Ambulatory Nursing, Department of Obstetrics and Gynecology, Thomas Jefferson University Hospital, Philadelphia, PA. She may be contacted at Mary.Schlaak@jefferson.edu

References

American Organization of Nurse Executives (AONE). (2015). Nurse manager competencies. Retrieved from http://www.aone.org/resources/nurse-manager-competencies.pdf

Deyo, P., Swartwout, E., & Drenkard, K. (2016). Nurse manager competencies supporting patient engagement [Special section]. *The Journal of Nursing Administration*, *46*(3S), S19-S26. doi:10.1097/NNA.0000000000000318

Djukic, M., Kovner, C.T., Brewer, C.S., Fatehi, F., & Jun, J. (2015). Educational gaps and solutions for early-career nurse managers' education and participation in quality improvement. *The Journal of Nursing Administration*, *45*(4), 206-211. doi:10.1097/NNA.0000000000000186

Glassman, K.S., & Whithall, J. (2018). Nurse manager learning agility and observed leadership ability: A case study. *Nursing Economic$*, *36*(2), 74-82.

Pawlak, R.P., Scott, E.S., & Murphy, L.S. (2013). Crossing our quality chasm: Continuing the case for graduate preparation for nurse managers and leaders. *The Journal of Nursing Administration*, *43*(12), 627-629. doi:10.1097/NNA.0000000000000003

Thompson, J.A., & Fairchild, R. (2013). Does nurse manager education really matter? *Nursing Management, 44*(9), 10-14. doi.org/10.1097/01.NUMA.0000433382.65013.ba

Vitale, T.R. (2018). Nurse leader mentorship. *Nursing Management, 49*(2) 8-10. doi:10.1097/01.NUMA.0000529932.89246.ab

Warshawsky, N.E., & Havens, D.S. (2014). Nurse manager job satisfaction and intent to leave. *Nursing Economic$*, *32*(1), 32-39. Retrieved from https://www.ncbi.nlm.nih.gov/pubmed/24689156

Watkins, A., Wagner, J., Martin, C., Grant, B., Maule, K., Resh, K., ... Thompson, E.J. (2014). Nurse manager residency program: An innovative leadership succession plan. *Dimensions of Critical Care Nursing*, *33*(3), 121-128. doi:10.1097/DCC.0000000000000036

Member-Get-a-Member Campaign is Underway

The best way to recruit new members is by encouraging existing members to share the benefits they receive from their AAACN membership with their colleagues. One of the biggest benefits AAACN members frequently emphasize is the opportunity to network with other ambulatory care nurses. Other benefits include AAACN's official publication, *ViewPoint,* your choice of a complimentary journal subscription, awards/scholarship opportunities, and discounts on AAACN conference registration, publications, and certification exams, to name a few.

A total of 147 AAACN members recruited 180 new members in 2018, which helped increase the AAACN membership to 4,365! We continue to grow with the dedication of satisfied members recruiting their colleagues and friends.

2018 Winners

- Kirsten Hastings is the Grand Prize winner of a complimentary 3-day registration to the Annual Conference for recruiting 14 new members.
- Robin Steaban won $100 in AAACN credits for recruiting more than three new members.
- Brian Wildman received a 2-year membership extension for his recruiting efforts.

Care Coordination and Transition Management Review/Certification Prep

When: Monday, July 1, 2019 through Wednesday, Sept. 4, 2019

In collaboration with Nurse.com, AAACN is pleased to offer another option to nurses preparing for the Medical-Surgical Nursing Certification Board (MSNCB) Certified in Care Coordination and Transition Management (CCCTM®) exam.

This program includes 13 individual online modules from the AAACN CCTM course (a total of 26.4 contact hours), three live webinars including sample questions (a total of 3 contact hours), and a practice test with 65 additional sample questions (a total of 1.1 contact hours).

TOTAL CONTACT HOURS = 30.5

AAACN Special Membership Rate: $370 per attendee

To obtain your special rate, sign into AAACN-savings-area and you'll find details for your savings.

We also offer a discount for the Ambulatory Care Nursing Certification Review Focused CE Series. Sign into AAACN-savings-area and you'll find upcoming dates and discounts.

ANPD Clinical Education Matrix Now Available to AAACN members

The AAACN Clinical Education Matrix Task Force worked with the Association for Nursing Professional Development (ANPD) to develop new ambulatory care tabs for the ANPD Clinical Education Matrix, which serves as a guide to education required by regulatory and accrediting bodies. The new ambulatory care tabs are a collaboration between AAACN and ANPD and include accrediting, onboarding, and regulatory requirements for ambulatory care clinical education. This education matrix is considered a living document and will be updated annually.

The ambulatory care tabs from the Matrix are available to AAACN members to download in spreadsheet format, allowing nursing professional development practitioners to filter by column title (i.e., Topic, Standard, etc.) to easily research information, in the following tabs:

- Ambulatory – TJC
- Ambulatory – AAAHC, NPSG, CMS, ACHD

The complete Clinical Education Matrix is available exclusively to ANPD members and includes information on Centers for Medicare & Medicaid Services, Det Norske Veritas (DNV), DNV Ventricular Assist Devices, The Joint Commission, and more.

Disclaimer: The Clinical Education Matrix is a guideline for required education, not an official document. Requirements for education vary based on many factors, and some states may have requirements in addition to those portrayed on the Matrix. Each organization is responsible for ascertaining the education required for its staff.

Thank you to AAACN's Clinical Education Matrix Task Force for their hard work in developing the tabs:

Chair:

Staci Redding, MSN, RN-BC

Members:

Elizabeth Anderson, MSN, RN-BC
Calli Davis, MSN-ED, RN
Kim Giles, DNP, RN
Leslie Morris, RN, BN

American Academy of Ambulatory Care Nursing
Many settings. Multiple roles. One unifying specialty.

East Holly Avenue, Box 56 • Pitman, NJ 08071-0056

CHANGE SERVICE REQUESTED

PRSTD STD
U.S. POSTAGE PAID
HANOVER, PA 17331
PERMIT NO 4

Volume 41, Number 2
March/April 2019

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.

connect with us

Save the Date for the 2020 Annual Conference

We Can't Wait to See You April 15-18, 2020 at the Hilton Chicago!

Call for Speakers and Poster Presenters

You're invited to submit an oral or poster abstract for AAACN's 2020 Annual Conference. Share your knowledge, best practices, and research with your colleagues in the Windy City! Presenters receive $100 off their registration fee and speakers also receive an honorarium. Oral presentations must be received by May 15, 2019, and the deadline for poster abstracts is Dec. 15, 2019. Submission criteria is available on our website at aaacn.org

Would You Like to Attend the Annual Conference for Free? Apply For a Conference Scholarship!

AAACN supports the advancement of its members and ambulatory care nursing practice by offering conference, excellence, scholarship, and research awards to qualified applicants. If you've been a AAACN member for 2 or more continuous years you may be eligible to apply.

Conference scholarship provides financial assistance for a member, a new nurse (practicing less than 2 years), and a student nurse to attend the conference.

Visit the AAACN website for more information and to apply by Nov.15, 2019: aaacn.org/membership/scholarships-and-awards