According to the National Center for Health Statistics (NCHS, 2009), the prevalence of hypertension in the United States is estimated at 31.3%, or about one out of every three adults. Women and men are equally affected over their lifetime. However, for people under the age of 45, it affects more men than women. After age 65, more women are affected than men. Ethnicity is also a factor with over 42% of African Americans affected by hypertension (NCHS, 2009). In 2006, high blood pressure was listed as a primary or contributing cause of death for 326,000 Americans. Currently, only about 46.6% of all hypertensive patients have their blood pressure controlled (Lloyd-Jones et al., 2010).

While many factors contribute to achieving acceptable control of hypertension, one of the main problems is patient compliance with the recommended treatment plan. Hypertension may progress silently and is often only detected during an annual exam or when the patient seeks care for another condition. Without any noticeable symptoms or distress, the patient may not understand the importance of treatment. If the side effects of treatment are worse than the perceived dangers of the disease, then compliance decreases (Kaplan, Bakris, & Sheridan, 2009).

The consequences of noncompliance are far-reaching in terms of morbidity and mortality. Surveys of older adults indicate that 55% do not follow their medication regimens (American Society on Aging and American Society of Consultant Pharmacists Foundation, 2006). Improving adherence with medication regimens can make a difference. One study found that for a number of chronic medical conditions, one of which was hypertension, higher rates of medication adherence were associated with lower rates of hospitalization and a...
The Power of Nursing and Nurse Leadership

Greetings, ambulatory care nurses! It is with great pleasure that I am writing my first President’s Message in our award-winning newsletter, ViewPoint. The release of this issue comes shortly after the time we, as nurses, celebrated our profession – National Nurses Week (May 6-12). As I reflect on nursing’s past, I look forward to our future and being a member of such a dynamic organization. We face enormous issues in the health care environment. We will need a strong organization with committed members and leaders to provide guidance, be our voice, and help shape the future of health care. I believe AAACN is that organization.

In celebration of National Nurses Week, AAACN, along with other professional nursing organizations, embraced this year’s theme, “Nurses: Caring Today for a Healthier Tomorrow.” As leaders, we must be forward-thinking and collaborate with others to articulate our role in directing the ever-evolving changes before us. Drafted by the American Nurses Association (ANA), the following talking points will be published by many nursing organizations in an effort to communicate a unified message about the power of nursing and nurse leadership.

1. Coming Together to Build Power, Lead Change

Common to all organizations is the desire to build a more powerful profession that will take charge and address the complexities in patient care, reshape our work environment, and influence health policy to benefit both our patients and the public.

2. Preparing to Take On the Complexity of Patient Care

Patient care is changing largely due to the rapid advances in technology, research, and practice. Nursing thrives on obtaining new knowledge of evidence-based care and is forever striving to achieve clinical best practices in the delivery of care. Clinical excellence emphasizes critical thinking and treating the patient as a whole.

3. A New Level of Nursing Leadership

Nursing has always been the conduit in facilitating, directing, and managing efficient and effective care. We are role models for building collaborative behaviors and forming partnerships that will lead health care systems to create better delivery models, ensuring good outcomes for both patients and their families.

4. Leadership is an Inherent Part of the Nursing Role

We, as leaders, need to mentor, educate, and inspire both informal and formal leadership skills among new graduates and experienced nurses alike. Nurse faculty, preceptors, and mentors can help shape future leaders by instilling in them the value of consensus building, partnership, and collaboration, as well as the importance of respect for those with whom we work and provide care.

5. Driving the Health Care System for the Future

Nurse leaders play an integral role in directing and reshaping the health care environment. It requires our knowledge and expertise to make recommendations and educate key stakeholders on new approaches, models of preventive and acute care, use of scarce resources, and outcome measures. Nurses have contributed meaningful solutions for health system reform, workplace standards, and environmental issues. On the health policy front, nurses have shown their prominence, power, and strength.

continued on page 15
Conference Highlights

May 4-7, 2010 • Las Vegas, NV

AAACN Descends on Las Vegas for One of Its Highest-Attended Conferences

What a meeting! This year’s conference drew more than 700 attendees to exciting Las Vegas, a 30% increase over last year and one of the highest attendance records in AAACN history! The conference kicked off with a sensational Opening Reception and Silent Auction on the Penthouse floor at the Riviera Hotel. Attendees enjoyed fantastic views of Las Vegas, delicious hors d’ouevres, and bid on jewelry, purses, nursing memorabilia, and more at the Silent Auction, raising more than $4,000 for AAACN’s scholarship and research grant program.

Michael Grossman, DM, MSN, RN, NEA-BC, presented an outstanding Keynote Address, How to Get Things Done When You’re Not in Charge. Attendees were empowered to develop their own leadership styles. The rest of the conference was filled with exceptional education sessions and outstanding networking opportunities. Based on feedback from previous years, the Planning Committee embraced a new conference pattern (Tuesday-Thursday), which was well-received. Attendees left Las Vegas feeling refreshed, rejuvenated, and raring to go!

The Passing of the AAACN Torch

2009-2010 AAACN President Kitty Shulman, MSN, RN,C, handed over her presidential duties to incoming President Traci Haynes, MSN, RN, BA, CEN, at Closing Ceremonies. Haynes, who hails from Scottsdale, AZ, is regional director of clinical services, National Healing Corporation. In her President’s address, Haynes talked about her journey from staff nurse to trauma nurse to tele-health nurse as well as her priorities this coming year, including a focus on continuing to provide value-added benefits to members and engaging members to help lead AAACN into the future.

Elvis “shook up” Opening Ceremony with several of his hits. He also sang an a cappella version of the national anthem. Attendees hesitated to join in singing the anthem because they wanted to hear his beautiful voice.

Attendees crowd the Silent Auction tables during the Opening Reception.

Traci Haynes (left) was inducted as AAACN President, and outgoing president Kitty Shulman (right) received a lifetime AAACN membership.

Keynote speaker Michael Grossman believes all nurses are leaders, and told attendees how to get things done, even when they’re not in charge.
President Kitty Shulman announced this year’s winner of the 2009 ViewPoint Writer’s Award. Mary Beth Modic, MSN, RN, CDE, from Cleveland Clinic in Ohio, was recognized for her article, “A Primer on Insulin Therapy,” which was published in the July/August 2009 issue of ViewPoint. ViewPoint articles published in 2009 were judged by Editorial Board members and the winner was selected based on the article’s value to ambulatory care nursing, timeliness, and writing style.

Town Hall

In the interactive Town Hall, members reviewed the draft position statement on “The Role of the Registered Nurse in Ambulatory Care.” Facilitator Marianne Sherman, with assistance from Carol Rutenberg and Peg Mastal, documented comments from participants and will incorporate those comments into the final statement. Members who were not at the conference will also be invited to review and comment on the statement, prior to final approval.

Attendees gave their opinions on the role of the RN in ambulatory care during the Town Hall meeting.

2009 ViewPoint Writer’s Award

2009 ViewPoint Writer’s Award. Mary Beth Modic, MSN, RN, CDE, from Cleveland Clinic in Ohio, was recognized for her article, “A Primer on Insulin Therapy,” which was published in the July/August 2009 issue of ViewPoint.

Administrator and Clinical Excellence Awards Presented

AAACN recognized two members for excellence in ambulatory care during the Awards Ceremony on Tuesday morning. The Administrator and Clinical Excellence awards, sponsored by the Anthony J. Jannetti, Inc. Nursing Economics Foundation, are presented annually and recognize excellence in administrative leadership or clinical nursing practice in an ambulatory setting.

Nancy May, RN-BC, BSN, MSN, ambulatory nursing director at Cleveland Clinic in Ohio, received the 2009 Administrator Excellence Award. Nancy was nominated by her colleagues for being a positive role model to those she leads and mentors. She has a wonderful capacity to see the big picture from multiple perspectives, ensures her managers have a voice in decision making, and thinks innovatively to make sure her team provides evidence-based best practices.

Wanda Mayo, RN, BSN, CPN, clinical educator at Children’s Medical Center in Dallas, received the 2009 Clinical Excellence Award. Wanda was described by her colleagues as a positive role model, one whom staff “seek out” for her expertise in nursing. She is passionate about nursing and always reflects compassion, respect, and professionalism in her work. She develops and maintains competencies, creates and offers ongoing educational programs, and provides support to new employees.

Education and Conference Scholarships

Thanks to AAACN’s annual Silent Auction and other private donations to the AAACN scholarship and research grant program, AAACN was able to present scholarships to several members. Donna Heim Paul, BSN, RN, Aurora, CO, received an education scholarship for $750. Donna is pursuing her master’s degree at the University of Phoenix.

AAACN also presented conference scholarships to three members to provide financial assistance for them to attend the conference. The winners were Mary E. Farning, MS, RN-BC (Medford, WI), Donna Heim Paul, BSN, RN (Aurora, CO), and Gwen Riggins, MSN, RN (Portland, OR).

The deadline to apply for conference scholarships is December 1, 2010. The deadline to apply for all other awards and scholarships is January 15 annually. Applications can be downloaded at www.aaacn.org.
Online Library Boasts Big Benefits for Attendees

AAACN has gone (almost) paperless with the Online Library, and all conference session audio recordings, PowerPoint slides, and handouts are just a few mouse clicks away. Attendees can also complete their conference evaluations and print CNE certificates in the Online Library. New this year: Attendees received FREE, indefinite access to all 2010 conference sessions (on the days they were registered) in the Online Library! Another bonus: Attendees may share their Online Library access with two colleagues for free!

Nurses who were unable to attend the conference can purchase access to the full conference in the Online Library or they can purchase individual sessions. For more information and to access this convenient way to earn contact hours, visit www.prolibraries.com/aaacn.

Poster Presenters Recognized

Conference attendees earned 2.0 extra contact hours by viewing the 36 posters prepared by colleagues. For the first time, participants were asked to vote for the best poster. Winners were:

1st place: Virginia A. Forbes, MSN, RN, NE-C, BC, Director, Ambulatory Care Services, Hospital for Special Surgery, New York, NY. Poster: An Ambulatory Care Nursing Photo Essay: A Reflection on Nursing

2nd place: Karen Bocchicchio, BSN, RN, CPN, Staff Nurse, and Michelle Kahn, MSEd, BSN, RN, Staff Nurse, The Children's Hospital of Philadelphia, Philadelphia, PA. Poster: I've Answered the Phone, Now What?: Strategies for "Best Practices" in Telephone Triage

3rd place: Anne Hansen, BScN, RN, Nurse Educator, Urology, and Margaret Coburn, RN, Nurse, Urology Clinic, The Ottawa Hospital, Ottawa, ON. Poster: Men's Health: The Nurse's Role in the Erectile Dysfunction Clinic

New Board Inducted

The 2010-2011 Board of Directors took office at Closing Ceremonies. Pictured (l-r): Director/Secretary Carol Andrews, Executive Director Cynthia Nowicki Hastiuk, Director Susan Paschke, President Traci Haynes, President-Elect Linda Bixey, Director/Treasurer Suzi Wells, Director Mary Vinson, Immediate Past President Kitty Shulman, and Director Judy Dawson-Jones.
Implementing a Patient-Centered Medical Home Model in a Primary Care Clinic

Assanatu (Sana) I. Savage

The patient-centered medical home model facilitates partnerships between individual patients, their families, and the health care team. The American Academy of Pediatrics (AAP) conceptualized this model in 1967. As part of the Patient-Centered Primary Care Collaborative (PCPCC), the American Academy of Family Physicians, the American College of Physicians, and the American Osteopathic Association, along with the AAP, developed joint principles of the patient-centered medical home.

These principles define the following characteristics: personal physician, physician-directed medical practice, whole person orientation, coordinated/integrated care, quality and safety, enhanced access, and payment (PCPCC, 2007). Care takes place in multiple organizational and community settings and requires care/case management. Health care providers assess, plan, implement, coordinate, monitor, and evaluate options and services to meet the person’s health and human service needs across the continuum of services (AAACN, 2010).

In February 2009, the Primary Care Clinic, Naval Training Center, Branch Medical Clinic of the Naval Medical Center San Diego launched a full-fledged medical home model. Nursing was front and center in the project, with a focus on enhancing and facilitating the care of over 12,000 beneficiaries in TRICARE, the Department of Defense’s worldwide health care program for active duty and retired uniformed service members and their families.

A talented nursing manager who had previously initiated the patient-centered medical home concept in various forms took charge of the initiative, launching the project within three weeks of receiving a verbal order. Consequently, the staff understood the concept and was ready to act. Using the principle characteristics of a medical home, the nurse manager and nursing staff played a key role in redesigning primary care practices to keep the patient at the center of care. During this evolution of care, nursing staff ensured the following:

1. **Primary care manager (PCM) enrollment**: Nurses collaborated with the Business and Enrollment Office to ensure patients were aligned with appropriate primary care teams within the clinic.

2. **Team assignment**: Each team consisted of three to four providers, along with assigned support staff and a registered nurse as team leader/care manager. Home teams were in physical proximity of each other. Teams sometimes formed and reformed, based on staff turnover, while an integrated/whole person (family) care system was maintained.

3. **Identification of additional roles for support staff**: Both providers and support staff identified added responsibilities and competencies to enhance this model. A monthly evaluation process was created for support staff. Providers were responsible for training and ensured that support staff had the necessary requirements to perform new responsibilities.

4. **Development of policies for support staff assignments and team composition changes**: The senior nurse officer/clinic manager was in charge of this change. Teams were adapted based on several factors, including availability of manpower (provider and support staff) and irreconcilable team relationships. Team building, conflict management, and re-affirming the mission at hand immediately resolved these issues.

5. **Template management**: This was a fluid process based on such data as access, continuity of care, and evidence-based decision making. Using templates in four patient booking categories (“Established,” “Routine,” “Well,” “Acute”) ensured appropriate booking and availability of appointments.

6. **Development of Patient Advisory Board**: This was a joint venture with the TRICARE population served. Five candidates from the patient pool volunteered to form the board and acted as liaisons between the Primary Care Clinic and the population served.

7. **Communication**: Communication was public (written as well as verbal) and facilitated at all levels. A brochure regarding the patient-centered home model was made available, welcoming patients to their “Medical Home” and orienting them to their “Home Team.”

In addition, nursing staff provided and facilitated the following (although not all-inclusive) key roles and functions:

- Shared mission and vision
- Presented effective communication
- Served as team leaders
- Coordinated schedule management
- Supported management of team dynamics and patient flow
- Fostered health literacy initiatives
- Conducted health promotion assessments
- Directed population health management
- Served as gatekeeper for access
- Facilitated telephone and walk-in triage
- Facilitated role of case manager/care coordinator for referral services
- Ensured quality and safety
- Incorporated continuous process improvement
- Handled customer service
- Optimized coding
- Utilized evidence-based decision support

Implementing the patient-centered medical home model met the Command mission of delivering quality
health services and adhered to the following Command guiding principles:

- Quality health care is centered on families and communities.
- Communication, coordination, and cooperation are critical to success.
- Continuous improvement is essential to quality health care and patient safety (Naval Medical Center San Diego, n.d.).

Additionally, the patient-centered medical home model at the Primary Care Clinic, Naval Training Center met the following Joint Commission functions:

- **Rights and Ethics:** Clinic staff provided confidentiality, involved patients in care decisions, and made patients aware of complaint/compliment processes in place and their right to have complaints heard.
- **Assessment:** All staff members were equally trained to initiate assessment at their level and scope of practice, for both physical and psychosocial aspects.
- **Care, Treatment, and Services:** Patients were welcomed to their Medical Home, introduced to their primary care manager (PCM) and team, and educated on other services.
- **Patient Education:** Patient education was a priority at the clinic, and education occurred throughout the process. Education on medication and reconciliation was foremost. A health literacy program was used to facilitate patient education, while a group health promotion program addressed cholesterol, weight management, and tobacco cessation.
- **Continuity of Care:** The patient-centered medical home model improved access to care, and enhanced communication for patients and providers (Joint Commission, 2009).

**After Implementation**

Within two months after implementing the patient-centered medical home model, PCM continuity of care for all four major appointment categories (“Established,” “Routine,” “Well,” “Acute”) increased from 36.5% to 61.5%. In addition, access to care increased to 96%, exceeding the 90% target, with appointment availability increasing from 3,371 to 4,056 appointments available within two months.

Evidence-based health care was given greater focus, while each team worked together to meet the monthly performance-based “Get to Goal” objectives for eight Healthcare Effectiveness Data and Information Set (HEDIS) metrics. Benchmarks either met or exceeded metrics in all categories.

The patient-centered medical home model bridged the gap between providers and support staff, creating a partnership that provided a comprehensive approach to medical care to all patients. Staff members at all levels got to know patients more intimately and were able to better provide for their needs in a more timely manner. Patients appreciated PCM continuity of care and showed pride in knowing their PCM and “home team.”

Staff also received an abundance of positive verbal testimonies and written compliments, and received an unprecedented three consecutive wins of the “Admiral’s Cup” award for excellence in customer service. The clinic also received the Special Team Achievement Recognition (STAR) honoring more than 60 staff members for their extraordinary contribution to the successful launching and implementation of this program. See Figure 1 for results of a patient satisfaction survey.

**Dealing with Challenges**

When implementing an operation of this size, many challenges arise. A review of the literature revealed major obstacles are involved when developing processes and systems (including information technology [IT]) to support access, communications, and coordination of care within and outside the practice; capture and use data for care of patients and populations; evaluate performance; and provide support for evidence-based decision making (Berenson et al., 2008).

The major challenges faced when implementing the patient-centered medical home model at the primary care clinic were IT-related. The teams, which are now recognized as stand-alone clinics, had to be created in comprehensive software programs (the Armed Forces Healthcare Longitudinal Technological Application [AHLTA] and the Composite Healthcare System [CHCS]). These electronic programs were typically used for all types of patient care, from enrollment to booking appointments and creating patient records and encounters. The clinic and provider pro-

![Figure 1. Primary Care Clinic, Naval Training Center Response to Medical Home Survey](image-url)

*May 18–June 18, 2009*

*Number of patients seen = 753, n=441*
files had to be determined to facilitate appointments, and data had to be mined for each team as a separate clinic.

Telephone triage was also a major hurdle. Telephone consults (T-Cons) for all providers were diverted to the RNs, which increased their workload substantially.

Conclusion

The patient-centered medical home model at the Primary Care Clinic, Naval Training Center is indeed providing world-class care. With the model in place, the primary care clinic is equipped to foster greater cost savings, improved access to care, better health outcomes, reduced health disparities, increased quality, and safe patient care.

Assanatu (Sana) I. Savage, CDR, NC, USN, is a Senior Nurse Officer, Department of Primary Care Clinic, Naval Training Center, Naval Medical Center San Diego, CA. She can be reached at iyatutu_1@yahoo.com

Disclaimer: The views expressed in this article are those of the author and do not reflect the official policy or position of the Department of the Navy, Department of Defense, or the United States Government.

Acknowledgment: I would hereby like to acknowledge the entire staff of the Primary Care Clinic, Naval Training Center for their roles in making the patient-centered medical home model a success.

References


Forum on the Future of Nursing: Community Health, Public Health, Primary Care, and Long-Term Care

In 2009, the Institute of Medicine and the Robert Wood Johnson Foundation launched a joint effort to address the challenges facing the nursing profession, the “Initiative on the Future of Nursing.” This two-year project aims to seek solutions to the continuing challenges faced by the nursing profession, culminating in a transformational report on the future of nursing. This project will ensure that nursing is a major contributor in the national endeavor to improve the quality of care in a transformed health care delivery system.

Dr. Donna E. Shalala, former Secretary of Health and Human Services under the Clinton administration, is directing the Initiative on the Future of Nursing. As part of the initiative, a series of town hall meetings have been held across the country. Invited panels of nursing experts and stakeholders in education, health care, community, and business have spoken about their respective programs, challenges, and accomplishments.

One of these meetings was held in Philadelphia in December, and I was honored to attend on behalf of AAACN. This Forum on the Future of Nursing addressed regional and national issues related to community health, public health, primary care, and long-term care. (Other forums covered the topics of acute care and education.) The invited panelists and individuals from the community provided information on services provided and the current status of programs, as well as insights and concerns regarding the delivery of health care services.

Pennsylvania Governor Edward G. Rendell shared his perceptions of how new models of care that include nurse practitioners could increase health care access for the public. He emphasized the need for a more comprehensive and efficient health care delivery system.

An underlying and recurring question permeated the discussions: As the health care delivery system becomes more complex and difficult to navigate, how will newly minted nursing models collaborate with health care service organizations to fulfill their roles and responsibilities to the communities they serve? These service organizations include the Department of Health, the Visiting Nurses Association, and other community-based, population-driven health services, as well as long-term health care services. More simply stated... How will these agencies communicate with one another?

The Initiative on the Future of Nursing will be an essential factor in forecasting nursing’s future, with a goal of producing a document that can be a roadmap for our future planning. As Dr. Shalala stated so eloquently at the conclusion of the meeting, “We need to anticipate the future and not focus on the past.”

For more information on the Initiative on the Future of Nursing and to listen to the sessions, visit the Robert Wood Johnson Foundation Web site at www.rwjf.org

Judy Dawson-Jones, BSN, RN, MPH, is Director of Ambulatory Care Nursing, Children’s Hospital of Philadelphia, Philadelphia, PA. She can be reached at dawsonjones@email.chop.edu
2009 AAACN Financial Report

Have you noticed your finances are a bit tighter than in years past? AAACN, too, has watched the ups and downs of its finances, and we are providing this annual report for fiscal year 2009, ending December 31. The state of health care and the economy has created concerns for individuals, businesses, organizations, and communities. Ambulatory care nurses have felt the effects of downsizing as organizations look for cost-saving opportunities. The instability of the market has flattened this past year, and economists fear that it will continue to be erratic as it begins to improve. The AAACN Board of Directors understands its responsibility to the membership and works to manage resources appropriately and ensure financial viability.

As part of its fiduciary responsibility, the AAACN Board of Directors employs many safeguards to ensure that it is managing the association’s financial resources appropriately. AAACN benefits from the combined financial expertise of the following individuals and companies:

- The treasurer participates in the budget process; reviews revenue, expense, and investment reports on at least a monthly basis; asks pertinent questions on any variances or concerns; and prepares reports that are presented to the Board for discussion.
- The association management company, Anthony J. Jannetti, Inc., manages the day-to-day finances with an executive director leading the fiscal management and operations along with accounting staff.
- An accounting firm, Gold Social Gerstein LLC, conducts an annual accountant’s review, which is then reviewed and approved by the Board.
- An investment company, RBC Wealth Management, advises and manages AAACN’s investment portfolio based on an investment policy established by the Board. In January 2010, the above accounting firm provided the accountant’s review report for fiscal year 2009 to the AAACN Board of Directors. A review consists principally of inquiries of company personnel and analytical procedures applied to financial data. Although it is substantially less in scope than an audit, it is done in accordance with generally accepted auditing standards.

AAACN ended the 2009 fiscal year with a deficit. Total revenues for fiscal year 2009 were $791,902, expenses totaled $858,249, and this translated into a $66,347 deficit. The deficit was primarily attributed to the economic downturn which resulted in a 16% decrease in conference attendance, our primary revenue source.

In a survey of other nursing organization members of the Nursing Organizations Alliance, 60% reported an average decrease of 18.5% in their 2009 annual meeting attendance. In addition to a decrease in conference attendance, AAACN experienced a 15% decrease in membership. We expect a turnaround in both of these areas as the economy stabilizes. The deficit was managed through our financial reserves.

Our reserve account has helped us weather the economic storm. It is difficult to predict the future economic impact on AAACN, but the board and staff will continue to focus on increasing revenue streams and decreasing expenses guided by the strategic plan. We are committed to our mission of advancing the art and science of ambulatory care nursing and to providing our members with opportunities to collaboratively influence and enhance the quality of care for patients in the ambulatory setting.

Linda Brixe, RN, was AAACN Treasurer for 2009-2010. She is currently President-Elect. She can be reached at Linda.Brixe@kelsey-seibold.com

Cynthia Nowicki Hnatiuk, EdD, RN, CAE, is AAACN Executive Director. She can be reached at cyndee@ajj.com
reduction in total medical costs (Sokol, McGuigan, Verbrugge, & Epstein, 2005).

There are many variables that make it difficult to determine the best approach to designing and implementing an improvement plan. Issues related to the patient, physician, and financial considerations are among the many interwoven factors that influence adherence to therapy.

It is important to identify whether the hypertension is resistant to drug treatment or due to noncompliance of the patient. This is often difficult to ascertain because some patients are eager to please their physicians and/or are reluctant to share why they may have stopped taking their medication. Patients may report compliance with taking their medications or claim they understand the dosing instructions when they do not, simply to provide their doctor with what they think he or she wants to hear. Communication with medical providers has been identified as a key element to improved blood pressure self-management (Schmid et al., 2009).

To help improve adherence, many interventions focus on providing education for patients and clinical staff, establishing mutually agreed-upon treatment plans, simplifying therapy, providing telephone reminders, and making routine compliance/pill checks (Haynes, Ackloo, Sahota, McDonald, & Yao, 2008; Kaplan et al., 2009). Patients need to understand the rationale for therapy, as well as all therapy-related directions/instructions and the consequences of non-compliance. In order to have a positive impact on patient compliance and improved outcomes, a treatment plan should promote patient education and increased communication between the patient and health care provider. Nurses can play a key role in medication management and health education to enhance blood pressure self-management practices (Schmid et al., 2009).

Quality Improvement

Tampa General Hospital’s Family Care Medical Centers (FCMC) are hospital-based ambulatory clinics that serve an urban, low-income population at two sites separate from the hospital campus. Approximately half of the patients in these clinics are funded by a county sales tax for indigent health care. The majority of the remainder are Medicaid and/or Medicare beneficiaries. Board-certified internists, nurse practitioners, and registered nurses staff the clinics along with medical assistants and clerical staff. Quality reviews related to patient care outcomes are completed quarterly in both clinics.

During a routine quality review of indicators at FCMC in 2004, the blood pressure findings were higher than recommended guidelines. A focus review of hypertensive patients was conducted and compared to Healthcare Effectiveness Data and Information Set (HEDIS) guidelines. The results of both reviews indicated the need for improvement in the hypertensive and diabetic patient populations. The next year, all patients with a hypertension diagnosis were monitored for blood pressures as a part of the 2005 Quality Plan for FCMC. This was the beginning of a three-year quality improvement project.

The 2005 and 2006 Quality Improvement plans included several interventions for providers and nursing staff including:

- Developing and implementing an adult blood pressure measurement competency for all clinical staff
- Evaluating the manual cuffs located in each exam room and replacing more than half of the equipment
- Recalibrating the automatic blood pressure machines to ensure accuracy
- In addition, the Medical Director reviewed 10 charts for each provider to identify opportunities for prescribing different medications/combo therapy and also to determine if patients were taking their medications regularly.

Unfortunately, the results showed little improvement and indicated there were other factors affecting blood pressure outcomes.

Hypertension Compliance Action Plan

The FCMC team embarked on an extensive literature search to see what evidence-based practices were being utilized nationally to improve compliance with hypertensive treatments. Literature estimated real-world compliance rates at around 50-60%. Even when doctors and nurses were
patients, the team found compliance rates were 77% for short-term prescriptions and 84% for long-term prescriptions (Dezii, 2000). According to the American Heart Association, the most promising strategies to improve compliance were: patient education, self-monitoring, social support, discussing adverse effects/barriers to taking medications at each patient visit, and realizing non-compliance is a reality for most patients (Miller, Hill, Kottke, & Ockene, 1997; Krueger, Berger, & Felkey, 2005).

After considering some of the characteristics common to the FCMC indigent patient population (low education levels, extreme financial barriers, little social support, chaotic lifestyles that do not lend to routines, and seeking care only for sick episodes), the team developed an action plan to improve compliance levels.

A patient information packet and patient questionnaire were developed to show patients the importance of being diagnosed with hypertension and the role they would play in achieving control of their blood pressures. Each packet included eating tips adapted from the National Heart Lung and Blood Institute (NHLBI) Dietary Approaches to Stop Hypertension (NHLBI, 2006), a blood pressure medication information sheet, a magnet reminding them to take their blood pressure medication, and a pillbox to help organize their medications. It was hoped that presenting the information in this format would reiterate to patients that hypertension is a serious disease and requires their participation in the treatment.

A patient questionnaire was developed (in English and Spanish) and given out at each visit to determine if patients had been taking their blood pressure medication. The questionnaire addressed issues that patients are sometimes reluctant to ask health care providers but that may impact treatment compliance, such as embarrassing side effects like impotence, social issues such as amount of alcohol consumed, or inability to pay for medications (See Figure 1).

Sick and well patients with a hypertension diagnosis completed the questionnaire at every visit. The questionnaire served as a reminder to staff and the provider to check or review blood pressure results that were outside the target range of less than 140/90. In addition, providers used the answers provided as a communication tool to address compliance issues with the prescribed treatment and as a starting point for the hard-to-discuss issues between patient and provider. The action plan was implemented in May 2007, and in fall 2007, FCMC achieved a hypertension treatment compliance rate of 77%, the first improvement in the team’s results since issues were originally identified in 2004.

Overall, clinical staff felt that the questionnaire prompted them to be aware of blood pressure in general, regardless of reason for the visit. Since many patients only visited Family Care Medical Centers when they were sick, the questionnaire gave staff a system to track how patient blood pressure was being controlled. This gave providers the opportunity to make changes in the treatment plan that otherwise may have been missed in only dealing with the presenting problem. The next question was, would compliance be sustained and improved over time?

The FCMC team continued to monitor patient blood pressure levels and treatment compliance in 2008. That year, compliance rose to 82% (See Figure 2).

Many factors play a role in improving hypertension. The action plan implemented at FCMC may not have been the sole reason for compliance improvement, however, the team plans to maintain this practice. Quality improvement is continuous. The quality journey sometimes takes longer than expected and the outcomes sometimes do not occur as anticipated. Commitment to providing quality patient care is the key to being consistent and persistent in this pursuit. As providers of care, the FCMC team was willing to accept the fact that there was room for improvement. Changing beliefs and practices in order to accomplish a pursuit of quality is not an easy road. However, by implementing a few low-cost actions, the FCMC team improved outcomes and demonstrated that meaningful quality improvement plans do not always require complex or expensive actions.

Jana Gardner, BSN, MS, RN, NE-BC, is Director Ambulatory Services, Tampa General Hospital, Tampa, FL. She can be reached at jgardner@tgh.org

Patricia Ogden, BSN, MPH, RN, CDE, is Clinical Education Specialist, Ambulatory Services, Tampa General Hospital, Tampa, FL. She can be reached at pogden@tgh.org

References


Susan Paschke is ViewPoint Issue Editor

Susan Paschke, MSN, RN-BC, NEA-BC, is serving as ViewPoint Issue Editor for the third time with this issue. She is the Chief Clinical and Quality Officer for Visiting Nurse Association of Ohio, a position she accepted in 2009 after 23 years at Cleveland Clinic in Ohio. During her tenure at Cleveland Clinic, Susan worked in many positions, first as Quality Coordinator and Ambulatory Nursing Manager, and later, as an Administrator in the Division of Nursing and Associate Chief Nursing Officer.

Susan has been a member of AAACN since 1994. She received the President’s Above and Beyond Award in 2009, along with E. Mary Johnson and Candia Baker Laughlin, for their willingness to teach AAACN’s Ambulatory Care Nursing Certification Review Course on the road. Susan also received the AAACN Administrative Excellence Award in 2008. She was elected as a Director on the AAACN Board of Directors for 2010-11.

Thank you, Susan, for all you do for ViewPoint and AAACN!
The Comfort of Tone

My last column focused on the power of words. The words you select are critically important and are the foundational units of communication. This month I will focus on an equally important topic – tone.

Tone is the manner of speaking; it reveals a person’s attitude or feeling. Tone is the pitch, cadence, and inflection in your voice. As nurses, when you practice over the phone, you have to fully rely on your voice to share your feelings with a patient or family member. You cannot express empathy with your eyes, understanding with a smile, or openness with your posture. When you are on the phone, the only instrument through which you can relay your attitude is the tone of your voice.

Can you remember calling a business and knowing within seconds that the employee was distracted or rushed, condescending or rude, or just really didn’t seem to care? Did you want to continue the conversation? Did you trust the information that was relayed? Did you want to pursue or continue a consumer relationship? Most of us have had at least one if not many of these types of encounters. They leave us feeling unsettled; we may feel frustrated, irritated, or even confused.

The person answering your call may be unaware how he/she sounds to you, the caller. There are several factors that influence tone over the phone:
1. The environment is noisy or distracting.
2. The person answering the phone is multi-tasking.
3. The person answering the phone is tired, stressed, or ill.
4. The person does not like conversing over the phone.
5. The business undervalues their “phone” customer.

As nurses who practice patient care over the phone, we are aware of the importance of professional tone. So, how can we deal with these factors that exist in all businesses, including health care?

Noisy or Distracting Environment

When you attempt to manage patient calls in a noisy or distracting environment, you may have difficulty concentrating. As a result, your tone will change. You may talk louder than necessary because you cannot hear what is being said. Your tone may come across as frustrated because of the distraction. As a result, the patient may inaccurately perceive that your frustrated tone is directed toward them.

According to the American Academy of Ambulatory Care Nursing (AAACN) Telehealth Standard VII - Environment (2007), nurses should manage patient calls in an environment that is “safe, hazard-free, ergonomically correct and efficient” (pg. 14). If you are placing and receiving patient calls in a noisy or distracting setting, this standard is not met. It is the responsibility of leadership and frontline nurses to maintain an environment that is consistently confidential and free of distractions. This requires evaluating the surrounding areas where patient calls occur. It may be necessary to relocate a phone or have a separate room for managing phone calls.

Multi-Tasking

When you attempt to perform other tasks while managing a patient phone call, quality and safety are compromised. For example, you may listen to a patient who is reporting symptoms of illness while you complete documentation from the previous call. This is easy to consider doing because the patient does not see you. If you are doing multiple things, patients don’t know….or do they? Your tone of voice will reflect lack of concentration by sounding unnecessarily tentative. Diminished focus can lead to errors.

Multi-tasking while managing patients over the phone requires your full attention. Your voice will reflect your attentiveness. If you need to access a decision support tool while talking with a patient, be sure to tell them. Then they will understand why your voice may sound like it is drifting.

Tired, Stressed, or Ill

Be sure to care for yourself as well as your patients. Awareness is the key here. You need to be aware of how fatigue, stress, and illness can have an impact on your voice tone. If you are tired, your tone will be flat and slow. When stressed, you may be rushed or rude. When you are ill, you may sound apathetic or congested.

Even with your best efforts to be well-rested and stress-free, you cannot always prevent these situations. You will need to make extra effort to sound engaged in the phone conversation. If you are tired, try to get more sleep, drink...
The Comfort of Tone
continued from page 13
water, or take a walk during your break. If you are stressed, taking a deep breath in between calls may be helpful. If stress is chronic, consult your health care provider to incorporate healthy coping mechanisms. When you are ill, consider staying home. Managing care over the phone requires full presence, and when you are managing your own symptoms, this may be impossible. If you have mild symptoms, it may be appropriate to let the caller know you have a cold. This will help them understand your throat clearing or hoarseness. It makes you human! However, do not change your voice. This will help them understand your throat clearing or hoarseness. It makes you human! However, do not change your voice. This will help them understand your throat clearing or hoarseness. It makes you human! However, do not change your voice. This will help them understand your throat clearing or hoarseness. It makes you human! However, do not change your voice.

Telephone Work is Dissatisfying
As a profession, nursing offers many specialties and sub-specialties, and you can select areas that fit your strengths and passions. Managing patient care by phone can be challenging, and while some nurses find this type of patient care rewarding, others find it doesn’t suit them. When you are required to practice in an area you find difficult, it affects your attitude and your tone will reflect this. Your voice may sound dull or flat, and patients will hear the dissatisfaction in your tone. The quality of your patient encounters will be compromised.

According to AAACN Telehealth Standard IV - Telehealth Nursing Practice (2007), “telehealth nurses establish a relationship with the patient” through the encounter (pg. 10). Nurses who are assigned to manage patient calls must be competent and have interest in this area of patient care delivery. If you determine that this area of nursing is not for you, explore many of the other opportunities.

“Phone” Patients are Not a Priority
In some settings, there is a belief that managing patients over the phone interferes with work flow. There is a misconception that patients who are on the phone are not as important as patients who are present in exam rooms or hospital beds. This is a myth that must change. The patient who is in the hospital or clinic today will be at home tomorrow. You have a responsibility to serve patients who call from their homes.

Patients are being discharged more quickly than ever, and sometimes they are too ill or sedated to absorb vital homecare information. They have questions when they get home and after the ‘fog’ clears. The patient at home will pick up the phone and ask for necessary clarification from the nurse via the telephone or computer. Health care is shifting and the continuum of care must lengthen to include the patient who is trying to manage self-care outside of the hospital and clinic. Nurses are in the position to meet their needs.

In accordance with AAACN Telehealth Standard II - Staffing (2007), “an adequate number of competent telehealth nursing staff is available to meet the patient care needs of the telehealth practice setting. Staffing models address the complexity of the telehealth encounter care needs while maintaining a safe and caring work encounter” (pg. 7). Nursing leadership has a responsibility to recognize the importance of patient encounters over the phone. When the patient on the phone is not considered a priority patient by an organization, it will be reflected in the voices of all employees.

Awareness is Key
To ensure that your tone is professional, you need to be aware of how you sound to your patients. Be sure to listen to patient cues and evaluate your tone.

Patient cues. If a patient says, “I am sorry to bother you” or “You must be busy,” immediately evaluate and adjust your tone. The patient is subtly letting you know that you sound rushed, preoccupied, or harsh.

Evaluation. Many call centers and clinics have the capability to record calls and provide employees with feedback while still maintaining confidentiality. If you do not have this feature built into your call system, you can still monitor and evaluate your voice. Place a tape recorder beside yourself as you take phone calls. The recorder will not pick up the patient’s voice or personal information, but it will pick up your voice. Tape 5-10 calls and then listen to the recordings to evaluate your tone. Analyze your inflection, cadence, and pitch. What you hear will be very close to what your patients hear. This self-evaluation* can be built into an annual performance review.

In summary, your voice is crucial in practicing care over the phone. The way you use your voice is what makes telehealth nursing an art. You need to use your voice to reflect compassion and confidence. Your patients will be listening.

Kathryn Koehne, RNC, is a Nursing Systems Specialist, Department of Nursing, Gunderson Lutheran Health Systems, La Crosse, WI.

*Note: Gunderson Lutheran has developed a tool for this self-evaluation. Contact krkoehne@gundluth.org for more information.

Reference
President’s Message

continued from page 2

Nurse leaders will drive the paradigm shift that will represent the health care systems of the future.

6. Managing the System

The increasing complexity of care and the yet to be determined health care policies cast a shadow on managing the system. I ask you though, who is more adept than nurses in building strength and unity to manage their practice settings, find solutions, and cut through the red tape? To bring out the best in innovative thinking, nurses will rely on the engagement and support of nursing colleagues to enhance leadership skills, which will result in greater power to manage the systems of the future.

7. Leading the Charge for Quality, Patient-Centered Care

Nurses have unequivocally led the way as early adopters of quality improvement initiatives, recognizing the validity and setting examples for other disciplines. We are responsible for the development, implementation, and evaluation of key measures. Nursing has and will continue to collaborate and shape the health care quality platform by promoting coordinated, patient-centered care and engaging patients and their families in that care. These are the goals of the National Priorities Partnership, and nursing will have a key role in its implementation and evaluation.

8. Taking a Page from the High-Tech Industry to Harness Even More Nursing Power

Nursing has contributed innovative ideas for cutting-edge technology to promote and provide better care and greater outcomes. We all must become familiar with virtual communities of interest and professional social media to enhance our knowledge and skills.

Now, more than ever, we need to unite so that we may continue to influence and have an impact on health care. We must build strength and unity to better manage our practice settings and recognize the unique contributions we bring to health care and outcomes. Through our passion, communication, collaboration, and leadership, we will advocate for our patients’ needs and for our profession. This is the power of nursing.

Traci Haynes, MSN, RN, CEN, is Regional Director of Clinical Services, National Healing Corporation, Boca Raton, FL. She can be reached at traci.haynes@nationalhealing.com
The Scope and Standards of Practice for Professional Ambulatory Care Nursing explicitly identifies and defines ambulatory nursing practice in outpatient settings. The first formal Scope of Practice statement contains a definition of ambulatory care practice, an expanded conceptual framework, practice characteristics, roles of professional ambulatory care nurses, and trends and issues in ambulatory care settings and nursing practice.

Sixteen standards are categorized into two major classifications: the nursing process and professional performance. Each standard contains distinct measurement criteria to clarify the domains of clinical and administrative practice.

The Scope and Standards provides an invaluable guide for ambulatory care settings to guide nursing competencies; improve or create policies, procedures and standards; train and orient staff; create clinical, telehealth, and administrative job descriptions; and plan for regulatory agency surveys. Nurses will also find this 48-page resource helpful in preparing for the ambulatory care nursing certification exam.

Two New Resources Will Help Boost Your Practice

Scope and Standards of Practice for Professional Ambulatory Care Nursing, 8th Edition

The Scope and Standards of Practice for Professional Ambulatory Care Nursing explicitly identifies and defines ambulatory nursing practice in outpatient settings. The first formal Scope of Practice statement contains a definition of ambulatory care practice, an expanded conceptual framework, practice characteristics, roles of professional ambulatory care nurses, and trends and issues in ambulatory care settings and nursing practice.

Sixteen standards are categorized into two major classifications: the nursing process and professional performance. Each standard contains distinct measurement criteria to clarify the domains of clinical and administrative practice.

The Scope and Standards provides an invaluable guide for ambulatory care settings to guide nursing competencies; improve or create policies, procedures and standards; train and orient staff; create clinical, telehealth, and administrative job descriptions; and plan for regulatory agency surveys. Nurses will also find this 48-page resource helpful in preparing for the ambulatory care nursing certification exam.

Ambulatory Care Nursing Orientation and Competency Assessment Guide, 2nd Edition

The Ambulatory Care Nursing Orientation and Competency Assessment Guide serves as a valuable resource for orienting nurses new to ambulatory care as well as developing comprehensive competency assessment programs. A wide selection of age-specific and specialty care topics are covered, including telehealth. The updated, 260-page guide contains many enhancements:

- Updated content plus definitions, key tips, and examples
- Chapters on nurse educator competencies, defining the educator's role in ambulatory care, and providing guidance and tools for developing competencies
- Tool kit for transitioning to ambulatory care with many helpful links and resources
- Appendix containing sample orientation and competency tools

Order your copies at www.aaacn.org