The number of cases of Lyme disease is increasing. Lyme disease impacts quality of life, as well as health care resources and costs because of missed or inaccurate diagnosis and ineffective or inadequate treatment. Ambulatory care nurses can identify and educate others about this silent stalker.

Lyme disease (LD) is the most commonly reported vector-borne disease in the United States. Ninety-five percent of cases are reported by 12 states, mostly along the Eastern coast as well as Minnesota and Wisconsin, although cases have been reported in almost every state (Centers for Disease Control and Prevention [CDC], 2012; Mayo Clinic, n.d.). Over 35,000 confirmed or probable cases were reported in 2008 (Matteucci & Schub, 2010). Figure 1 displays the geographical location of LD in the United States.

Have you cared for any patients with LD? Do you know any friends or family members that have LD or a cluster of seemingly unrelated symptoms searching for appropriate treatment? Chances are that the answer to these questions is yes! Let’s delve into this illness.

LD is a multi-system, multi-stage inflammatory disease (Matteucci & Schub, 2010), and recognizing LD early and providing prompt treatment are keys to promoting better outcomes (Seybold, Reiser, & Schlenk, 2008). Lyme disease is caused by the spirochete bacterium Borrelia burgdorferi, which is transmitted through the bites of deer ticks. This tick is no bigger than a poppy seed (Seybold et al., 2008). Ticks that carry the bacteria live on dogs, horses, sheep, deer, squirrels, and mice. Humans can be bitten in tick-infested areas such as grassy, wooded areas, or during close contact with animals carrying the tick. A tick must be embedded in the skin for at least 24-36 hours in order to transmit infection (Harvard Women’s Health Watch, 2009).

LD was first recognized in 1975 in the town of Old Lyme, Connecticut (PubMed Health, 2011) and is most common in adults between 40-60 years of age and children ages 5-15, although it can be present at any age (Matteucci & Schub, 2010). LD is contracted more frequently between the months of May and November. Although the incidence of LD is 4.4:100,000 in the U.S., the incidence increases to 29.2:100,000 in states where it is endemic (Matteucci & Schub, 2010).

continued on page 10
Advancing Leadership and Building Friendships Through AAACN

It is an absolute honor for me to serve as the 38th President of the American Academy of Ambulatory Care Nursing during the same year I also celebrate 38 years as a registered nurse. I am humbled by the opportunity to lead our unified community for nurses working in ambulatory care, where the energy comes from the engagement of our members and volunteer leaders.

As your new president, I’d like to share a little information about myself to help you get to know me better. I would also like to take this opportunity to update you about the exciting priorities the association will be working on in the coming year.

My first clinical experience in ambulatory care came in 1987. It wasn’t until the spring of 2000, however, when I took my position with St. Louis Children’s Hospital managing the pediatric clinical services in the BJC Call Center that I became aware of AAACN. Soon after I started, my director, a non-nurse, strongly encouraged me to become a member of AAACN. She had become aware of AAACN through her professional relationship with a past AAACN president. Her strong encouragement ties back to our strategic message and is a perfect example of helping someone “connect with others in similar roles.”

I became actively involved in AAACN as a volunteer leader after our San Diego Conference in 2005. It was the warm, welcoming interaction with two AAACN members on two separate conference occasions that influenced my decision to become involved in the important work of the association. Over the years, I have served as co-chair and chair of the Telehealth Nursing Practice Special Interest Group. I have presented on telephone triage topics at two AAACN conferences and have also had the privilege to serve as AAACN’s liaison to the American Academy of Pediatric Nursing’s Section on Telehealth Care for several years.

My involvement in AAACN has led me to work that has been valuable to my leadership role at St. Louis Children’s Hospital, the telehealth industry, and AAACN. My volunteer activities have not only given me the opportunity to advance my leadership skills, but have also led me to many life-long friendships.

It is impossible to know how someone you have never met before can change your life, but for me, two brief personal interactions influenced my life in ways that were unimaginable. As you interact with other members, think of how you, too, could impact their personal and professional trajectory.

AAACN’s 37th Annual Conference in Orlando, Florida, was a huge success! As your new president, I am very pleased to inform you that our attendance of 756 was the highest conference attendance in the history of the association. The annual conference provided attendees with many opportunities to connect with other nurses in similar roles, enhance leadership skills, and advance their practice.
I would like to be sure you notice the new format for the ViewPoint President’s Message. We recently received feedback from a member that having a sidebar identifying current initiatives discussed in the President’s Message would provide the reader with this valuable information “at a glance.” We responded by incorporating this enhancement into this issue and also future issues of ViewPoint.

**Strategic Goals**

There is much to be accomplished by the association in the coming year to advance the practice of our members and advocate for our specialty of ambulatory care nursing. With three strategic goals to guide our future work, I would like to share our initiatives for each of them.

**Strategic Goal #1 – “Serve our Members”**

AAACN plans to advance Web site functionality. This functionality will help us better serve our Special Interest Groups (SIGs). One example of enhanced functionality relates to our listserves, or discussion lists. The outstanding dialogue that exists on our SIG discussion lists today would be archived. Archiving would allow discussion list conversations to be categorized. SIG leaders would be able to define categories under which their discussions would fall, such as clinical, policy, and staffing, to keep the conversations from running together. Members can then read through topics that are of particular interest to them. If you haven’t signed up for a SIG email discussion list, you are missing a valuable benefit of your membership. You may sign up through your online account on the AAACN Web site.

In the coming year, we also hope to improve our process to identify, develop, mentor, and support new authors in writing for ViewPoint and Nursing Economics. New authors will be supported as they develop writing skills, and our publications will contain quality articles relevant to ambulatory care. Through the initiatives of Health Care Reform alone, we know our members are making great contributions in the areas of accountable care organizations (ACOs), patient-centered medical homes, and preventing readmissions, to name just a few. Just think of all the other clinical practice initiatives in which our members are involved. Our professional stories need to be told. This is our opportunity to advocate for ambulatory care, to tell our stories, and contribute to the body of knowledge on ambulatory care nursing.

**Strategic Goal #2 – “Expand our Influence”**

Over the past year, our opportunity to recruit qualified and enthusiastic volunteer leaders for specific volunteer opportunities has greatly increased. At a national level, AAACN has stronger visibility than ever before. AAACN is a member of the Nursing Organizations Alliance and an Organizational Affiliate of the American Nurses Association (ANA). We are also represented on the Joint Commission’s Professional and Technical Advisory Committee, and the National Council of the State Boards of Nursing Licensure Compact Coalition, to name just a few.

There are also several ongoing initiatives within the organization that remain strategies under Goal #2.

- The work group is moving closer to completing the RN Role Position Paper to support the RN Role Position Statement.
- Our Health Care Reform Advisory Team is in place to advise us on issues of Health Care Reform.
- The Legislative Team continues to monitor several key Web sites for changes being proposed by the legislature that could impact ambulatory care practice. They will inform us if action is needed on our part.
- Under the leadership of Past-Presidents Traci Haynes, Beth Ann Swan, and Sheila Haas, along with the contributions of many members, AAACN will complete our work in the development of care coordination competencies for the registered nurse. This project will promote the value of the registered nurse as a key member of the health care team in providing patient-centered care across the continuum.
- AAACN is working with the Centers for Disease Control and Prevention (CDC) in their nurse triage line pandemic project. In collaboration with the CDC to move to a state of “readiness” in preparation for the next pandemic, AAACN is investigating the feasibility of a registry of nurse triage call centers. In the event of a high-level pandemic, these call centers will utilize guidelines consistent with the CDC for the initiation of antivirals. Through the coordinated efforts of the CDC, AAACN, nurse triage call centers, and other national health-related associations, we would promote social distancing, decrease the surge in our emergency departments and primary practice settings, and decrease the spread of illness.
- In the coming year, we will develop a plan of action to address important implications of the Institute of Medicine’s Report on the Future of Nursing pertinent to ambulatory care. The report provides great opportunity for the nursing profession and allows registered nurses a place at the table to determine our future.
- Lastly, First Lady Michelle Obama has mobilized all sectors of the community through a comprehensive national initiative, Joining Forces, that will give service members, veterans, and their families the support they so deserve, specifically in the areas of wellness, education, and employment. Through AAACN’s support and future involvement in Joining Forces, we, along with others in the profession of nursing, will be prepared to recognize the unique health and wellness concerns of this population to improve the lives of those who have sacrificed in their service to our country.

**Strategic Goal #3 – “Strengthen Our Core”**

A critical objective under this goal is to promote the leadership development of volunteer leaders. As president of AAACN, a nurse leader, and a 2012 MSN graduate, leadership development is particularly meaningful to me. Spending over 23 years as a manager and the past three years working toward my graduate degree has raised my awareness of the value of continuing education and the development of our current and future leaders.
With so many new volunteer leaders serving in roles both within AAACN and representing the association externally, it is our responsibility to maintain a healthy organization by assuring the professional development of our volunteers. During the coming year, we have charged the Volunteer Management Task Force, formed last year, with the development of learning activities that address the different skills or competencies of association volunteer leadership. We hope to see these learning activities available to our volunteers on the Web site in the near future.

**AAACN – Our Passion and Professional Fuel**

This will be a very exciting year! AAACN is involved in so many relevant initiatives driven by a time in history when nurses are defining their role in the health care environment. Today provides us with a tremendous opportunity to connect with others in similar roles, advance our practice and leadership skills, and advocate for our specialty of ambulatory care nursing.

I can’t imagine my life not being a nurse, not working in the autonomous clinical environments of ambulatory care, and not being part of AAACN, our dynamic and visionary ambulatory care nursing association! AAACN is my passion and professional “fuel.” I know it is yours, too!

Over the coming year, I will keep you informed regarding the progress of AAACN’s strategic goal initiatives, as I have done in this first President’s Message. I encourage each of you to consider active volunteerism in AAACN, as I did many years ago. It is a marvelous opportunity to advance your clinical practice, advance your leadership skills, advocate for our specialty of ambulatory care nursing, and develop friendships that will last a lifetime!

Again, I am honored and humbled to serve as your professional association’s president over the next year.

Suzanne N. Wells, MSN, RN, is Manager, Answer Line, St. Louis Children’s Hospital, St. Louis, MO. She can be contacted at snw4713@bjc.org

**Congratulations to Suzi Wells on recently obtaining her MSN from Webster University!**

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**How Did You Celebrate Nurses Week?**

Nurses Week is May 6-12 annually, celebrating the most trusted profession. We asked how you celebrated, and some of you told us your stories.

Robert Wood Johnson Medical School honored its nurses on May 8 with a presentation for Excellence in Nursing Practice. Three nurses were nominated by their colleagues for the Excellence in Licensed Practical Nursing: Lydia Seguine, LPN; Diane Seich, LPN; and Ebony Felix, LPN, who was presented with the award. Five nurses were nominated for Excellence in Professional Nursing: Deborah McCluskey, RN, BSN; Carol Perret, BSN, MS, COHN-S; Kristine Peterson, RNC, CCCE; Joyce Plaza, RN, BSN, OCN; and award recipient Orlando Gopez, MS, CRNA.

Robert Wood Johnson Medical School kicked off Nurses Day with a special live broadcast by Chris McCoy of the Magic 98.3 Morning Show on WMGQ-FM. Chris interviewed five teams of nurses and physicians from throughout the medical school and discussed nursing careers, teaching, and patient care that nurses provide to adults and children through the school’s clinical practice, The Robert Wood Johnson Medical Group.

Jennifer Forbes
Robert Wood Johnson Medical School
New Brunswick, NJ

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Chris McCoy (left), Magic 98.3 WMGQ-FM Morning Show host, interviews Roseann Marone, RN, BSN, MPH, (center) Assistant Professor of Pediatrics and Patricia Whitley-Williams, MD, (right) Chair of Pediatrics.
At The Villages VA Outpatient Clinic in Florida, nurses are celebrated and respected. Staff members are empowered and encouraged to work at the top of their scope of practice. This translates into a very happy nursing staff that provides deeply personal care for each of the many veterans they proudly serve.

One of the unique and enterprising ways staff celebrated Nurses Week was in dressing a metal dressmaker’s mannequin in a white nursing uniform, complete with a stethoscope around its neck, and a sash that stated “Nursing’s Finest 2012.” The Chief Nursing Officer and Supervisor then asked nurses to write down some of the admirable qualities and characteristics of their co-workers, and a snapshot was taken of each nurse. Each picture was placed on a cutout star, and each nurse’s individual attributes were written beneath his or her picture. At a celebratory Tea Party, the attributes of all individuals were read aloud, after which the nurse being recognized was called up and asked to place his or her star onto the uniform of the mannequin. It was an extraordinary day that was enjoyed by all!

Donna M. Carroll BSN, RN-BC
The Villages VA Outpatient Clinic
The Villages, FL

Lakeland Community Based Outpatient Clinic (CBOC) is a Primary Care Clinic located in Lakeland, FL, under James A. Haley Veterans’ Hospital (JAHVH), the first VA Magnet hospital in Tampa, FL. Through shared governance, the nurses at CBOC conducted activities for each day of Nurses Week. Monday was Military Day, honoring veterans by wearing clothing from the branches of service. Tuesday was Red, White, and Blue Day, with a Fajita luncheon and a gift bag (privately funded). Wednesday was favorite Team Jersey Day. Thursday was Aloha Day, and cake was provided. Friday was Fun/Casual Day, with teambuilding games and a hula-hoop contest; breakfast was included. The staff at CBOC received a visit from their Nurse Manager Leticia Rivera, Chief Nurse/Ambulatory Care William Messina, Associate Director Patient Care/Nursing Service Laureen Doloresco, and Associate Chief of Staff Ambulatory Care Dr. Angie Denietolis. They were kind enough to bring cakes from JAHVH!

Carolyn King, MSN, RN-BC
Lakeland Community Based Outpatient Clinic
Lakeland, FL

In honor of Nurses Week, staff members at Quincy Medical Group in Quincy, IL, were invited to enjoy dessert and paraffin hand treatments on May 9. Fresh fruit, pretzels, cookies, and marshmallows were set out along with a chocolate fountain for dipping. This was a relaxing treat for a hardworking team!

Sheila Brocksieck, RN-BC
Quincy Medical Group
Quincy, IL


First row (l-r): Jessica Perez, Charity Shields, Alesha Kelley, Paula Rivers, Lynne Shenk (Case Manager), and Carolyn King. Second row (l-r): Liliana Cintron, Monica Brown, Damaris Perez, Marcelle Nehring, Eva Bonilla, Jovoni Hamilton, Cesar Cintron, Marlena Knight, Beth Vamos, and Kevin Vamos HT. Not pictured: Cari Greb.
More Attributes of an Excellent Telephone Triage Nurse

In the last issue of AAACN ViewPoint (March/April 2012), I wrote an article about the essential attributes of nurses who practice telephone triage nursing (Koehne, 2012). As I completed the article, I was sharing the content with some nursing colleagues. I had told them it was slightly ironic that the essential attributes all began with the letter “c.” They found this intriguing and were determined to try to guess all eleven. They rattled off a litany of “c” attributes. The discussion was lively as they listed additional important characteristics that I now feel compelled to add to the original list, which included caring, compassionate, critical thinking, common sense, competent, confident, courteous, excellent communicating skills, curious, cautious, and current.

Additional Attributes

In this article, I will present the additional attributes that my astute nursing colleagues believed carry the same importance as the original 11 attributes. Read on, and you will hear their voices within this article.

Concern

Concern is minimally an interest in a caller and his or her situation. At a maximum, our concern is expressed as worry. At an extreme, our concern may even result in personal anxiety about a caller’s dilemma. This is the spectrum of concern. As we assess our patients’ expressed symptoms, our concern will vary in response to our patients’ expressions. Our concern will reach a high if we determine their situation is life-threatening and they cannot carry out the safest plan (see Figure 1).

Clinical Expertise

A question arises frequently among clinic and call center managers. It is the same question that circulates on a consistent basis among AAACN Telephone Triage Special Interest Group (SIG) participants. What is the recommended minimum amount of experience required for the role of a telephone triage nurse?

The response I consistently hear/read is that nurses need a minimum of five years of clinical experience before performing telephone triage. I agree and would also recommend the experience should include ambulatory care. It is important that the telephone triage nurse should have seen what they now hear the patient describing. The nurses “blind” assessment increases in accuracy if she or he has vast and varied clinical experience.

Courageous

My nursing colleague who shared that courage is an essential attribute views telephone triage nursing as highly sophisticated and adventurous, yet a little bit “scary.” She shared that delivering care while not seeing your patient takes courage.

Coordinator

The National Quality Forum (NQF) defines care coordination as a “function that helps ensure that the patient’s needs and preferences for health services and information sharing across people, functions, and sites are met over time” (National Quality Forum Homepage, 2006). Telephone nurses perform this function in every encounter. They provide care coordination when they triage symptoms, provide preventative care information, discuss disease management, or place a post-hospitalization follow-up call.

Centered

Centered is being “emotionally stable and secure” (Merriam-Webster, 2011). These personality traits will serve a telephone triage nurse very well. The nurse who suggested this attribute said it takes an “extremely together human being” to engage in telephone triage. The nurse has to have a level of maturity that relays reassurance and support to the patient, resulting in trust.

Charismatic

What is charisma? Most people describe it as “personal magic.” When I think about charisma in reference to telephone triage, I would describe it as warmth, charm, and authenticity relayed over the phone. This trait is what compels patients and families to call back.

Charisma is a highly developed attribute for a telephone nurse to possess. When we can relay charisma over the phone, our callers will like us and trust us even though they may have never seen us.

Collaborative

Collaborating is working together to achieve a goal. To determine the correct disposition or level of care, we must collaborate with the patient. In a telephone discussion, we collaborate with our caller to determine a mutually agreed-upon and appropriate level of care. Additionally, collaboration with a physician, mid-level provider, pharmacist, or other health care team members may also be necessary to provide accurate advice to the patient. In the American Academy of Ambulatory Care Nursing (AAACN) Scope and Standards of Practice for Professional Ambulatory Care Nursing, Standard 11 is Collaboration. This standard states that ambulatory care nurses “collaborate with patients, family members, caregivers, and other health care profes-

![Figure 1. “Concern” Attribute](image-url)
sionals in the conduct of ambulatory care nursing practice" (AAACN, 2010, p. 31).

**Connector**

When I describe the importance of telephone triage nursing, I often use a visual.

- Hospital stays and clinic visits = brick
- Contacts to the clinic or call centers = mortar

The mortar between the bricks is an adhesive that holds the whole structure together. These episodes of patient care are critically important to maintain wellness, promote healing, and prevent complications.

**Comfortable**

The telephone triage nurse must be comfortable mentally and physically. The nurse must possess enough training and education to be comfortable to practice by phone. There must be a comfort in your skill level. Your manager may say you are competent enough, but you have to have the inner comfort to work in this area.

The nurse must also have physical comfort. In the AAACN Scope and Standards of Practice for Professional Telehealth Nursing, Standard 16 is Environment (AAACN, 2011). This standard includes a requirement to ensure proper ergonomics, lighting, and space. If this standard is met, physical comfort is promoted.

**Conclusion**

When these new nine attributes are added to the original 11, there is a comprehensive list of 20 essential attributes for an effective telephone triage nurse. If you are currently practicing telephone triage, perform a self-assessment. Think about all of these attributes – What are your strengths? What are areas of opportunity? Search out mentors and resources to develop your opportunities into strengths. If you are a manager of a clinic or call center and you have an employee who possesses all 20 attributes, you have a treasure.

**References**


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**Member to Attend Overuse Summit and Serve on Panel**

Margaret Ross Kraft, PhD, RN, has been selected to serve as the AAACN representative at a national summit on overuse in September hosted by The Joint Commission and the American Medical Association-convened Physician Consortium for Performance Improvement. Overuse is defined as the use of a health service in circumstances where the likelihood of benefit is negligible or zero, and the patient is exposed to the risk of harm. Margaret will also serve on an Antibiotics Advisory Panel that will focus on antibiotics for uncomplicated viral upper respiratory infections. The panel will validate the evidence and data on overuse of the intervention, review guidelines and quality measures, and identify and/or develop strategies for organizations and key stakeholders to reduce overuse. Margaret is an Assistant Professor at Niehoff School of Nursing at Loyola University Chicago.
The Lake Buena Vista conference broke the all-time attendance record with 756 attendees!

Keynote speaker Barb Bancroft, MSN, RN, PNP, had everyone in “stitches” as she took attendees on a trip down memory lane through the last 30 years of nursing. Barb’s humor and experience in nursing left everyone with a new sense of professionalism and provided some very healthy laughter.

Before welcoming everyone to the conference, President Linda Brixey and the Board of Directors were welcomed to Orlando by Mickey Mouse!

Excellence Award Winners
Two distinguished members were recipients of the Nursing Economic$ Foundation Excellence Awards:

Janet Fuchs, MBA, MSN, RN, NEA-BC, was nominated by her colleagues for the Administrative Excellence Award for being compassionate, engaging, and a visionary. She brings individuals with divergent perspectives together. She helped obtain prescriptive authority to APNs in her state. Her leadership qualities are direct, gentle, compassionate, and focused. She assists nurses to understand the big picture and empowers nurses to challenge the status quo. She fosters confidence among her nursing staff that change is both possible and sustainable. Jan works at the Cleveland Clinic.

Janette Meier, RN, was nominated for the Clinical Excellence Award by her colleagues for being a positive role model who is a clinical leader committed to making a difference for her patients. Under her leadership, patient outcomes improved. She defines best practices; is committed to clinical excellence; mentors students, new staff, and residents; and is a wonderful example of what excellence in ambulatory clinical nursing can achieve. Janet works at the University of Colorado Hospital.

Tri-Service Military Holds First Two-Day Pre-Conference
Before the conference officially kicked off, 129 nurses traveled from across the country and overseas to attend the new, two-day Tri-Service Military Pre-Conference. The focus of the pre-conference was implementation of the Patient Centered Medical Home (PCMH) with an interdisciplinary approach for both the adult and pediatric population.

Scholarships & Research Grant
Dedria R. Tuck, BSN, RN, CPN, won a $1,500 education scholarship to pursue her master’s degree.

Pamela Sanford, MSN, RN-BC, CNS, received a $1,000 research grant for a research project titled “Medication Adherence in Chronically Ill Patients.”

Recipients of four conference scholarships to financially assist members in attending the annual conference were:
Deborah Byrne-Barta, BSN, RN-BC – Children’s Hospital, Philadelphia, PA
Kathleen Bozek, RN-BC – Northern Westchester Hospital, Yorktown, NY
Wanda Mayo, BSN, RN, CPN – Amerigroup, Arlington, TX
Dedria R. Tuck, BSN, RN, CPN – Carillion Clinic, Roanoke, VA

Silent Auction Raised over $6,000 For the Scholarship Fund
The 13th annual Silent Auction raised over $4,600 in support of our Awards and Scholarship Fund. Jewelry, electronics, nursing items, and baskets representing a variety of home states were donated and bid on vigorously by participants. We were able to raise this amazing amount of money through the generous donations and bids by the attendees. Thank you to everyone who participated in the auction.

Share your content! If you attended the AAACN Conference in Lake Buena Vista, you could be the most-liked colleague at your facility! Pinpoint two colleagues who can benefit from all of the education from the conference, then go to www.aaacn.org/library, login, and click Share my Content in the My Account area. Your colleagues will receive an automated email asking them to establish their own usernames and passwords in order to access the educational sessions.
2012 AAACN Poster Presentations
Everyone who presented a poster should be commended for his or her hard work. All registered attendees were invited to cast one ballot for the poster they felt best met the following criteria:
- Clarity in description of topic/issue
- Implication of topic/issue to ambulatory care nurses
- Presentation of clearly defined outcomes
- Appeal in visual portrayal of topic

All posters were excellent and it was wonderful that so many of our colleagues shared their expertise and experience with us. Ribbons were presented for first, second, and third place in total number of ballots cast. Congratulations to the winners! The 2012 Conference Program Planning Committee would like to thank all who participated.

1st Place – Elizabeth Barton and Pamela Sanford
Verifying Competency of the Charge Nurse in Ambulatory Care

2nd Place – Susan Brennan
Evaluation of Non-Urgent Emergency Department Visits in a Pediatric Primary Care Population

3rd Place – Gretchen Bodnar and Maureen Sims
Integrating Ambulatory Objectives into an Existing Inpatient Nursing Orientation Program

New Board of Directors Takes Office
The 2012-2013 Board of Directors took office during the Closing Ceremonies.

Networking Luncheon
Attendees made new acquaintances while discussing hot topics in ambulatory care nursing. Once a hot topic was identified, discussions ensued on determining a unique approach to the workplace challenge.

AAACN Inducts New President
2011-2012 President Linda Brixey passed responsibility for leading the association over to Suzanne Wells during the Closing Ceremonies. Suzi presented Linda with a gold membership card denoting lifetime membership in AAACN. Suzi said in her President’s Address, “I can’t imagine my life not being a nurse, not working in the autonomous clinical environments of ambulatory care, and not being part of AAACN, our dynamic and visionary ambulatory care nursing association! AAACN is my passion and professional ‘fuel.’ I know it is yours too!”

Town Hall
Dialogue was brisk at the Town Hall where participants shared how health care reform is affecting their practice. An Expert Panel responded to questions and commented on the topics presented by participants who spoke from the floor microphones.

If you were unable to attend the conference… You can virtually attend sessions by purchasing the ones of interest to you in the Online Library at www.aaacn.org/library. Sessions include audio recordings and handouts. Contact hours are included. Posters displayed at the conference will be posted on the AAACN Web site for members. Login as a member, then click on Poster Presentations in the left-hand box.
Lyme Disease
continued from page 1

Disease Progression

It is important to remember that the onset of complaints can be subtle and delayed for a year or more. Patients may say, “I’ve always had those problems,” signifying the intensity and duration of the disease. Symptoms can be exacerbated before or during menses, during pregnancy, or with the use of oral contraceptive hormones. Other conditions causing flare-ups include stress, sleep deprivation, alcohol consumption, fasting, and dehydration (Bleiweiss, n.d.).

Three phases of disease progression are recognized. Stage I is considered the early localized stage that lasts from 3-30 days after the tick bite. The infected person can present with erythema migrans, fever, chills, headache, myalgia, arthralgia or joint pain (often attributed to growing pains or aging), fatigue, and lymphedema (Matteucci & Schub, 2010; Meletis, Zabriskie, & Rountree, 2009; Seybold et al., 2008). Erythema migrans or a bull’s eye rash/lesion is considered the hallmark sign of LD, but more than 50% of patients report not noticing this rash (Burrascano, 2008; Seybold et al., 2008). The rash generally resolves within a month even without treatment.

Stage II, or early disseminated stage, lasts from a few days to 10 months after the tick bite. Patients complain of stiff neck, photophobia and sensory loss, asymmetric back pain, poor memory (foggy brain), difficulty concentrating, nerve palsies, dyspnea, light-headedness, syncope, conjunctivitis, anorexia, and nausea. Hyporeflexia, non-painful areflexia, nerve palsy, myocarditis, and cardiac conduction blocks may be found during the physical examination (Matteucci & Schub, 2010). The wide range of signs and symptoms contributes to an inaccurate diagnosis.

The last phase, Stage III, occurs months to years after the initial tick bite. In the late persistent phase, symptoms progress to chronic arthritis (most commonly in the knees), myalgias, severe fatigue, subacute encephalopathy, axonal neuropathy, mood and personality changes, sleep disturbances, paresis, and interstitial keratitis (Matteucci & Schub, 2010). Chronic arthritis will develop in 10-20% of untreated individuals (Meletis et al., 2009). Up to 5% of untreated patients may develop chronic neurological complications such as sensory and motor nerve damage (Meletis et al., 2009).

Diagnosis

Diagnosis is based on symptoms and the likelihood of possible exposure to ticks (Harvard Health Letter, 2010). Diagnosis is confirmed by serology, although the CDC reports that there is no reliable test for the diagnosis of LD (Seybold et al., 2008). The CDC recommends a two-step procedure starting with an enzyme-linked immunosorbent assay (ELISA) titer, which has 65% sensitivity for LD. If the ELISA is positive or indeterminate, the Western Blot, a more reliable test that detects antibody proteins for *B. burgdorferi*, can confirm diagnosis (Meletis et al., 2009). The polymerase chain reaction test (PCR) detects the *Borrelia* DNA in blood, skin biopsies, and cerebral spinal fluid. The PCR is a very sensitive test but not well standardized (Meletis et al., 2009).

Differential diagnoses include viral infections, joint disorders, fibromyalgia, chronic fatigue syndrome, multiple sclerosis, lupus, chronic mononucleosis, rheumatoid arthritis, and depression (Bleiweiss, n.d.; Mayo Clinic, n.d.; Meletis et al., 2009). Wormser and Shapiro (2009) concluded from their study that illnesses within a predominantly female population such as fibromyalgia, chronic fatigue syndrome, or depression might be diagnosed as chronic Lyme disease.

A retrospective study conducted by Aucott and colleagues (2009) concluded that the diagnosis of LD continues to remain a challenge. These researchers state that the inability to recognize erythema migrans or viral-like manifestations without a rash can lead to missed or delayed diagnosis, ineffective treatment, and the potential for later complications.

Treatment

If diagnosed early, oral antibiotics can often prevent complications from LD. The antibiotic of choice is doxycycline (Vibramycin®), but amoxicillin (Augmentin®) and cefuroxime (Zinacef®) are also effective (Mayo Clinic Health Letter, 2010). Current guidelines recommend a single dose of antibiotic if a tick from an area prone to LD has been attached for at least 36 hours (Harvard Health Letter, 2010). If the patient has erythema migrans, treatment should begin immediately (Seybold et al., 2008). Treatment for early stage disease typically lasts 4-8 weeks (Meletis et al., 2009). Late stage disease requires a minimum of 4-6 months of continuous treatment with intravenous antibiotics (Burrascano, 2008; Mayo Clinic, n.d.). Symptoms will often flare due to lysis of the spirochetes after several days of the appropriate antibiotic (Burrascano, 2008). Other symptoms may be treated with analgesics,
antipyretics, anti-inflammatory medications, and muscle relaxants (Matteucci & Schub, 2010; Seybold et al., 2008). There is limited research supporting the use of natural supplements for treating LD. Suggested supplements include Cat’s claw, ginger root, stinging nettles, licorice, garlic, Echinacea probiotics, and Ginkgo biloba (Meletis et al., 2009). A vaccine for LD was removed from the market in 2002 because of infrequent use and concerns of adverse events (Matteucci & Schub, 2010).

The diagnosis and treatment of LD is controversial within the medical community especially since there is no standard protocol that is effective for all patients. Insurance companies may be reluctant to pay for treatment.

Complications

Chronic LD is defined as: 1) disease present for at least one year; 2) persistent major neurologic involvement; and 3) active infection with B. burgdorferi, regardless of prior treatment. Some sources include patients classified as having post-Lyme disease syndrome as having chronic LD (Burrsacano, 2008; Meletis et al., 2009). Treatment requires a combination of antibiotics (Burrsacano, 2008) although there is no effective treatment for chronic LD (PubMed Health, 2011). The longer one is ill with LD, the greater the amount of neurotoxin in the body (Burrsacano, 2008). There may be no objective signs of previous or current infection with B. burgdorferi. Physicians and scientists disagree on whether or not chronic LD is a true medical condition thus making this a controversial diagnosis (Matteucci & Schub, 2010; Meletis et al., 2009). At the present time, the Infectious Disease Society of America and the CDC do not recognize chronic LD (Meletis et al., 2009). Post-Lyme disease syndrome is characterized by continuing or relapsing generalized symptoms (fatigue, musculoskeletal pain, and cognitive complaints) in patients previously treated for LD (Meletis et al., 2009).

Prevention

Lyme disease may not be totally preventable, but one can implement several actions during the months of high risk for acquiring LD (March through November). Table 1 lists ways to reduce your risk of Lyme disease.

Case Study

The following case study demonstrates the challenges experienced by one person who struggles to find answers for her symptoms. Mrs. K. is a 55-year-old woman who presented with pain in the occipital area of her head with some neck stiffness. Upon returning home from another state, she had nausea, vertigo, and dizziness that she contributed to “jet lag.” Her doctor diagnosed her with hypothyroidism and prescribed treatment with levothyroxine (Synthroid®) and nabumetone (Relefen®), which helped the head and neck pain. The jet lag symptoms stopped along with the pain.

Within a year, the occipital pain returned along with pain and stiffness in the neck and shoulders. A neurologist diagnosed her with fibromyalgia. For 20 years, Mrs. K. endured the diagnosis of fibromyalgia. She saw numerous physicians, received numerous treatment methodologies, but nothing worked. Treatments included various medications (e.g., nabumetone, clonazepam, amitriptyline, cyclobenzaprine, oxaprozin, prasterone, Pregnenalone®, triiodothyronine, thyroxine, hydrocortisone, human growth hormone, testosterone, acetaminophen and tramadol, valacyclovir, gabapentin, levetiracetam, duloxetine, pregabalin, lidocaine patch, tiagabine, hydrocodone, and various supplements, especially if they were indicated for the treatment of fibromyalgia). Mrs. K. also tried alternative remedies such as acupuncture, chiropractic treatment, massage therapy, transcutaneous electrical nerve stimulation (TENS), and osteopathic manipulation.

Nothing helped her symptoms, which gradually worsened over the years. The pain and stiffness spread to the majority of her body, and she constantly battled fatigue. Brain fog brought memory loss, decreased attention span and comprehension, irritability, and difficulty with elementary math. Mrs. K. experienced various other systemic symptoms that greatly impacted her life and functioning. Interestingly, she looked deceptively well but felt awful.

In her unending search for effective treatment, Mrs. K. made an appointment with an integrative medicine physician for a specialized thyroid treatment. After performing a history and physical, the doctor suspected more than thyroid dysfunction. After diagnostic testing and a review of her clinical presentation, Lyme disease was confirmed. She began a six-month treatment regime with oral antibiotics, herbs, and various supplements, such as probiotics, heavy metal detoxifiers, omega 3, and fish oil, to name a few. Mrs. K. began to feel worse during her treatment, which she believed could be a sign that treatments were working to eradicate the bacteria. Mrs. K. is now being treated by an integrative medicine physician who practices the

<table>
<thead>
<tr>
<th>Table 1. Tips to Prevent Lyme Disease</th>
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<tr>
<td>Avoid tick habitats.</td>
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<tr>
<td>Wear light colored clothes.</td>
</tr>
<tr>
<td>Wear long sleeved shirts and long pants.</td>
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<tr>
<td>Check yourself and your pets after walks.</td>
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<tr>
<td>Spray exposed skin with DEET-containing insect repellant.</td>
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<tr>
<td>Stay in the middle of the path.</td>
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<tr>
<td>Dry clothes in the dryer.</td>
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<tr>
<td>Remove ticks gently.</td>
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<td>Stay out of shady places.</td>
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Eastern medicine philosophy of guiding the body back into balance and health from within. She is undergoing acupuncture, herbal therapies, homeopathic remedies, and bio-energetic therapies. Along with her LD, she has several co-infections such as babesia, bartonella, and Chlamydia and is currently being treated with homeopathic remedies. Sadly, most of her treatments are not covered by insurance.

Mrs. K.’s quest to feel better continues, but she is relieved to have an authentic diagnosis. She is pleased to have found a “Lyme-literate MD,” the term given to physicians who are educated and knowledgeable about insect-borne illnesses such as LD. Because she has advanced stage LD, she knows it will take quite some time to feel better, assuming her treatments will work over time. She is amazed that none of the physicians and other health care providers she had seen in more than 20 years ever suspected LD.

A lesson to all of us: learn more about Lyme disease and spread the word about the incidence, symptoms, and treatments for a disease that is approaching epidemic proportions.

References

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Editor’s Notes: The month of May is recognized as Lyme Disease Awareness Month. Lyme Disease Association, Inc., has handouts available for patients, as well as prevention tips, medical photos, and statistical maps and graphs. Visit http://www.lymediseaseassociation.org/ to view and download these resources.

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Objectives
The purpose of this continuing nursing education article is to increase the awareness of Lyme disease in nurses and other health care professionals. After studying the information presented in this article, you will be able to:
1. Discuss the transmission and progression of Lyme disease.
2. Describe the diagnosis of Lyme disease and treatment options.
3. Identify complications related to advanced Lyme disease.
4. Explain Lyme disease prevention methods.

The author, editor, and education director reported no actual or potential conflict of interest in relation to this continuing nursing education article.

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This article was reviewed and formatted for contact hour credit by Rosemarie Marmion, MSN, RN-BC, NE-BC, Education Director.
AAACN and the Board of Directors strive to ensure a healthy organization by focusing on the three goals of the current strategic plan: serving our members, expanding our influence, and strengthening our core. Maintaining the financial stability of the organization is part of strengthening our core. This annual financial report for fiscal year 2011 will provide you with the details.

AAACN began the fiscal year in the black, experiencing a rebound in 2010 from the economic decline of the previous year. 2011 proved to be a tough year for the organization. Total revenues for 2011 were $847,659 while total expenses were $887,706 resulting in a deficit of $40,047. As a result, the net assets for fiscal year 2011 opened at $518,960 and closed at $478,913, an 8% decrease from 2010. Although we experienced a 4.2% increase in membership, conference attendance was not as robust as the previous year, fewer certification review courses were requested, and the Telehealth Standards published late in 2011 brought the cost of publication without the associated revenue from sales (revenue is expected to be realized in 2012).

There is good news, however! Nonprofit organizations benchmark financial stability as having at least 50% of their operating expenses in reserves. AAACN finished 2011 ahead of the benchmark at 54%.

As depicted in the pie charts shown here, the majority of our revenue comes from education and membership, which is consistent with our strategic plan. Education represents 52% of AAACN’s revenues stemming from the annual conference, other programs such as webinars, and certification review courses and educational products. Membership represents 34% of the revenues. AAACN ended 2011 with 2,347 members, the highest number in our history, with a member retention rate of 68% (a 9% increase over last year)!

Administrative operations (38%) and education (33%) represent the majority of expenses. As AAACN is committed to continued development of services and programs that bring value to ambulatory care nurses, management of the organization is a key component to that success. Several checks and balances are in place to help the Board of Directors assure that AAACN’s finances are appropriately managed.

- The treasurer participates in the budget review process and presents it to the board for approval, reviews monthly revenue, expense and investment reports, and investigates and questions variances that occur. Financial reports are presented to the board at regular intervals.
- Haefele, Flanagan & Co. serves as the external accounting firm for AAACN and provides a year-end review of all financial statements. This report is reviewed and approved by the Board of Directors annually.
- RBC Wealth Management advises and manages the investment portfolio for AAACN. Quarterly reports are provided to the board for review and approval.
- Anthony J. Jannetti, Inc., the association’s management company, is responsible for daily management of AAACN’s finances by the executive director, controller, and the accounting staff.

Overall, 2011 was a good year for AAACN! The organization finished the year in a great position to continue to implement the strategic plan and to seek new opportunities to serve our members, expand our influence, and strengthen our core.

Susan M. Paschke, MSN, RN-BC, NEA-BC, was AAACN Treasurer for 2011-2012. She is currently President-Elect. Susan can be reached at spaschke@vnahio.org

Cynthia Nowicki Hnatuk, EdD, RN, CAE, is AAACN Executive Director. She can be reached at cyndee@ajj.com
Implications for Ambulatory Care Nurses of the ACA ‘Individual Mandate’ Provision and Possible Supreme Court Decisions

The Individual Mandate provision of the Affordable Care Act (ACA), now a law since 2010, is an issue with the ACA that has been brought to the Supreme Court. The ACA Individual Mandate, simply stated, requires that all Americans have health insurance or pay a fine. It is one of the best-known and least popular components of the ACA (Henry J. Kaiser Family Foundation [HJKFF], 2012b). Arguments regarding the Mandate were presented to the Supreme Court in March, and a ruling is expected in June 2012. The Republican primaries and candidate rhetoric have added to the angst and confusion among the public regarding the Individual Mandate and have apparently slowed progression in the establishment of State Health Insurance Exchanges because 26 states are involved in lawsuits being brought to the Supreme Court. What do ambulatory care nurses need to know about these issues? What, if any, effect will the Supreme Court ruling have on coverage of patients, ambulatory care nurses and their families, and patients?

Unfortunately, although the public is aware of the Individual Mandate as an issue, they do not have sufficient facts to make an informed decision about the implications of the Individual Mandate. The Urban Institute did a study titled, The Individual Mandate in Perspective, using the Urban Institute’s Health Insurance Policy Simulation Model (HIPSM) to estimate the number and share of Americans potentially subject to the mandate, identify their insurance status absent the ACA, and simulate eligibility for Medicaid and exchange-based premium and cost-sharing subsidies (Blumberg, Buettgens, & Feder, 2012). They found if the ACA mandate were in effect today, “94 % of the total population would not face a requirement to newly purchase insurance or pay a fine” (Blumberg et al., 2012, p. 1). Bringing this 6% into the insurance market would have a positive effect on health care insurance throughout the United States because it would lower premiums and create a more stable insurance market. Only 3% of the 6% mandated to purchase insurance would not be eligible for financial assistance to purchase insurance (Blumberg et al., 2012).

The Kaiser Family Foundation found in the polling data that the opinions of the public with regard to the Individual Mandate were affected by how they perceived the mandate would affect them. They were unaware that if they have employer, private or government health care coverage, such as Medicare or Medicaid, it would not apply to them. Unfortunately, however, this is not the message they are hearing. They are currently subject to sound bites about “big government” controlling health care and health care decisions.

The other message not being heard by the public or health care professionals is what will happen to health care if the entire ACA law is struck down by the Supreme Court. The American Nurses Association (ANA) Analysis of the Supreme Court of the United States – Oral Arguments on the ACA Topic: The “Individual Mandate” (March 29, 2012) provides implications of decisions on constitutionality, severability, and the consequences of the ACA law being struck down. The very popular ACA consumer protections already enacted include coverage of children up to age 26 under a parent’s plan, tax breaks for small employers, prohibition of lifetime insurance limits, prohibition on pre-existing conditions exclusion for children, and the discount on prescriptions for seniors on Medicare (ANA, 2012). The focus and funding for primary care, wellness, health promotion, and disease prevention will presumably also fall by the wayside.

State-based health insurance exchanges are a key component of the ACA. They will help facilitate expanded access to private health insurance for individuals and employees of small businesses (HJKFF, 2012a). Exchanges are required to be fully operational in every state by January 1, 2014, and readiness will be evaluated by the U.S. Department of Health and Human Services (DHHS) one year prior to this date. However, we only have 13 states with established exchanges and three with plans to establish. The ACA provides states with options regarding the structure of their exchanges, how they contract with qualified health plans, and financing of the exchanges (HJKFF, 2012a). The ACA requires that states create seamless, user-friendly interface that allows for eligibility determinations and enrollment. For example, it can be established within an existing or new state agency, as an independent public entity, or as a non-profit (HJKFF, 2012a). Given requirements specified for State Health Insurance exchanges, significant work remains for the states that are moving slowly on this component, and the Supreme Court decisions in June play a large role in how their trajectory will play out.

This brief overview provides some clarification regarding the facts about the individual mandate required in the ACA, as well as the implications of a Supreme Court decision to strike it down. Knowing who could be impacted by the individual mandate and that it affects only a small percent of the population, ambulatory care nurses can provide reassurance to patients and their families when they fall in the 94% insured. Further, they can give direction to the
Health, Healing, and Harmony found at a Women Veterans Health Fair

The 5th Tri-County Women Veterans Health Fair sponsored by The Villages VA Outpatient, Ocala and Lecanto Community Based Outpatient Clinics was held on Saturday, February 4, 2012, at the Villages VA Outpatient Clinic. Based on the 281 veterans and participants, 67 vendors, 90 lecturers/presenters/entertainers, 90 volunteers, and staff who attended the health fair, this event was a complete success.

While the numbers are impressive, the real success in this event comes from the collaboration and collegiality found among the outpatient clinic staff, vendors, and community groups that resulted in the outstanding service that our women veteran population deserves and received at this event.

Veterans obtained health information on the holistic management of their complete health including their mind, body, and soul. The theme for this year’s event was “Health, Healing, and Harmony: Reducing Stress and Promoting Health.” With this theme in mind, vendors at the health fair offered complimentary massage therapy, reiki, guided mediation sessions, and acupuncture information.

In addition, various local community service groups and health care organizations attended and provided their support as well as health information. Additional services, such as bone density screening, balance testing, blood pressure screening, and “Ask the Doctor/Nurse” booths were provided. Self-defense and Zumba instruction were offered, and there was a full complement of entertainment. Numerous local musicians and artists performed patriotic music.

A gallery of pictures of female veterans lined the entranceway, setting the stage of honor and pride for our women veterans. Veterans and participants left the health fair enlightened and one step closer to better health, healing, and harmony.

Veteran outreach events such as these give back to our veterans by putting our appreciation and thanks into action. On all accounts, The 5th Tri-County Women Veterans Health Fair was truly a grand success.

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References

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Health Care Reform

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other 6% regarding possibilities of financial aid for purchase of insurance through state insurance exchanges.

This overview also discusses the impact that Individual Mandate has had on slowing the process of establishment of ACA Health Insurance Exchanges. Depending on state of residence, ambulatory nurses need to know the status of their state planning or enactment of insurance exchanges so they can answer patient questions and those of their family. They can use this understanding as we near January 1, 2014 to help patients know where to look for insurance coverage through state insurance exchanges.

References

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ViewPoint features articles on a variety of topics of interest to ambulatory care and telehealth nurses. The following abbreviated “wish list” includes topics members have told us they’d like to read more about, and now we’re hoping you can share your experience and knowledge with other members!

- Bariatrics
- Care coordination competencies
- Case management
- Collaboration across the continuum (e.g. hospital to clinic)
- Current practice issues
- Dermatology and skin topics
- Disease management
- Evidence-based practice
- Health care reform
- Immunizations
- Magnet process for ambulatory care
- Management (practice and system level)
- Medical home model
- Nurse leadership
- Patient safety
- Pediatrics
- RN role in primary care practices/clinics
- Staff education
- Staffing/competencies in specialty clinics
- Strategic direction of leadership
- Teletriage
- Travel medicine

If you or someone you know would like to write an article on a “wish list” topic, complete the Author Interest Form at www.aaacn.org (click Publications > ViewPoint).