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ViewPoint

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Needle Size Considerations

Leslie K. Morris

The COVID-19 pandemic has changed not only the landscape, but the lens through which many see the world – especially nurses. As caregivers, nurses pivot to various practice realities and lean into difficult situations. Knowledge and experience, along with compassion, guide the work of the ambulatory care nurse which is high quality, evidenced-based, and family-centered. What nurses have learned from their initial training and in the clinical setting informs their practice and promotes patient safety and positive patient outcomes. This column will examine current guidelines for the intramuscular (IM) injection as nurses continue to vaccinate the population to acquire herd immunity.

As lifelong learners, updating the skills necessary to enhance patient safety and provide a good patient experience and outcome are essential. That includes decreasing the variance in how nurses administer IM injections to their patients. The practice of administering an IM injection varies among nurses due to the educational program they attended and where they received their initial clinical procedures training. Nurses who do not practice giving IM medications in their current clinical setting may not recall the key steps necessary to perform this skill. Critical thinking is important when demonstrating this competency. The nurse must consider factors related to the patient and the vaccine, or other medication being administered when choosing the correct needle size and length. To that end, it is important for the nurse to examine the most current literature available on how to administer an IM injection. At the time of this writing, the COVID-19 vaccination was not currently indicated for children or teens younger than 16 years of age; therefore, this column will focus the appropriate injection practice of the older teen and adult.

An overall excellent resource for any nurse involved in vaccine administration is the Immunization Action Coalition (IAC) (2020) which was established in 1994. The IAC disseminates information about vaccines and the diseases they prevent. The Coalition works in partnership with the Centers for Disease Control and Prevention (CDC). The IAC (2020) plays an important role in both the community and health care arenas by creating and distributing education materials for both

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Many settings. Multiple roles. One unifying specialty.

The Resiliency of Ambulatory Care Nurses

Kathleen Martinez

We have seen pain and we have endured loss. We have been tested in ways never anticipated and have responded with courage and ingenuity never imagined. During the pandemic, ambulatory care nurses were always present, available, providing information, education, recommendations, and direction in a time of misinformation, anxiety, and fear.

As ambulatory care nurses, you are experts at care coordination and transition management® and telephone triage. These skills were paramount during the pandemic. While other specialties scrambled to redefine their profession within the limitations imposed by the quarantine and government regulations, ambulatory care nurses seamlessly navigated the chaos to ensure the health and safety of patients. The final numbers are not yet in, but the CDC estimates that the total number of COVID-19 cases may be close to 100 million. Using predictive models, they estimate approximately 5% of COVID-19 cases required hospitalization. Although all health care settings have been impacted during this pandemic, the number of infected compared to those hospitalized is dramatic. A significant burden of this disease has fallen on ambulatory care, including caring for those persons hospitalized with severe disease who are now facing the challenges of rehabilitation.

In the early days of the pandemic, many nurse-based telephone triage call centers saw their call volumes increase by thousands of calls per day. Nurses put in long hours and worked extra shifts while trying to sort out information and guidelines that were changing daily. Telephone triage is a complex skill where the nurse is required to assess a patient using only the phone. Strong nursing assessment skills are paramount. Determining when care can be safely delayed is challenging. In some patients, the line between urgent and non-urgent is very slim, and the impact from delay of care is a constant concern. High volume, high acuity, and long hours – combined with limited referral resources – increased the strain on nurses during this time. Ambulatory care professionals in schools, prisons, day cares, primary and specialty care clinics, federally qualified healthcare centers, and rural health care centers continually assessed risk versus benefit while navigating shortages of testing supplies and PPE.

Many ambulatory care nurse leaders were tapped to take on unprecedented projects. Nurses opened, staffed, and ran SARS-C0V-2 testing centers in empty storefronts and community centers. They were asked to find a way to keep homeless individuals safe under social distancing restrictions. When the vaccine became available at last, nurses were asked to organize mass vaccination campaigns in ball parks, stadiums, and parking lots. These are things you do not learn in nursing school! You are amazing!

Together, we are better. The American Academy of Ambulatory Care Nursing (AAACN) is a professional organization committed to supporting all nurses practicing in ambulatory care through advocacy, education, networking, and leadership growth opportunities. *ViewPoint* is a CINHAL-indexed professional publication that is committed to publishing research, QI, and EBP manuscripts from nurses working in ambulatory care. Special Interest Groups (SIGs) are available to promote net-

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Safety Corner

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those in health care and the public in general, thereby improving the safe and efficient delivery and use of vaccines and immunization services.

When preparing to administer the COVID-19 vaccine after reviewing the five rights of medication administration, there are several considerations that should be taken into account before the vaccine is given. These are:

- The weight of the patient including arm size and body mass index.
- The age and gender of the patient.
- the anatomical site of the injection. (CDC, 2020; Wexler, 2020)

As obesity has become more prevalent, a patient's arm size must be considered while preparing an injection. Several authors have similar views concerning the therapeutic delivery of the IM injection. Strohfus and colleagues (2017) note insufficient injection depth due to the choice of needle length is not a novel issue. The issue of the needle not reaching the muscle is recorded in the literature and especially impacts special populations such as women, overweight and obese children and adults, and those with asthma. Choosing the appropriate needle size is paramount as the vaccine needs to reach the preferred tissue site for the optimal immune response to take place. According to Ogston-Tuck (2014), medications given by the IM method are placed into the vascular muscle tissue and are rapidly absorbed into the circulation.

According to the CDC's recommendations, the site and size of the needle for teens receiving an IM injection are the deltoid muscle using ⅝- to 1-inch needle, 22-25 gauge. The deltoid muscle is also the preferred site for adults; however, the weight of the patient greatly influences needle length. Depending on the patient's weight, the needle length may need to be adjusted to a shorter or longer needle. The standard needle length for a normal body mass index is usually 1- to 1½-inch, 22-25 gauge (CDC, 2021). The following recommendations from the CDC (2021) about needle length and patient weight should be considered:

> *For men and women who weigh <130 lbs (<60 kg), a ⅝-inch needle is sufficient to ensure intramuscular injection in the deltoid muscle if the injection is made at a 90-degree angle and the tissue is not bunched. For men and women who weigh 130-152 lbs (60-70 kg), a 1-inch needle is sufficient. For women who weigh 152-200 lbs (70-90 kg) and men who weigh 152-260 lbs (70-118 kg), a 1- to 1.5-inch needle is recommended. For women who weigh >200 lbs (>90 kg) or men who weigh >260 lbs (>118 kg), a 1.5-inch needle is recommended.* (para. 19)

IM injection practices vary among nurses. Even though the evidence clearly provides sound recommendations, these procedures are not thoroughly documented or reinforced – including in nursing textbooks. It is important to remember that each nurse is responsible for their own practice. Having the honor of being one of the most trusted professions for many years running, nurses owe it to themselves and their patients to perform the most current and evidenced-based practice. ●

> "Capturing new understanding and exploring feelings and thoughts has allowed us to learn what we can accomplish by doing things differently having the faith to take steps when we can't see the whole staircase."

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From the President

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working and collaboration. Numerous awards and scholarships exist to honor and recognize excellence. I could not be prouder to serve as AAACN President for 2021-2022.

As we take a breath and prepare for our next adventures, know that you are part of a caring community who is here to encourage, support, and cheer on the outstanding work that occurs every day. What you do matters! ●

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Verifying the Effectiveness of Educational Communication Across Multi-Site Ambulatory Care Clinics

Susan B. Hamner and Linda S. Randazzo

Effective clinical education information flow is vital to ensure all clinical care team members receive and incorporate key information in their daily practice of providing safe and competent patient care. The rapid growth and increased volume of ambulatory care clinics in today's health care market presents new and unique challenges to this communication stream of essential information. If barriers to the rollout of clinical education are not addressed, patient care may be adversely affected. As Martin (2019) states, "the pace of change in healthcare policies, procedures, and clinical practices can impact patient care and safety" (p.17). The changing geographical landscape for providing patient health care services also presents additional complexities in the approach to education and learning. To remain viable and grow, many health systems have expanded their footprint to include opening clinics in numerous locations – near and far. In many health care organizations, the days of having ambulatory care clinics all in the same building or all within walking distance are disappearing.

As part of the evolving health care landscape, quality, cost, and innovation are driving the current shift in the industry from the inpatient to the outpatient setting. The constant changes in the health care environment include the expansion of many systems, with the greatest area of growth being the ambulatory care component. Outpatient service volumes are increasing as health systems are acquiring and building new facilities, as well as partnering with physician practices (Abrams et al., 2018). This expansion of ambulatory care services and locations in many health systems presents challenges in the orientation and education of health care clinicians serving in these locations. Strategies to develop a robust infrastructure that meets the educational needs of outpatient staff members are essential and must be established not only to ensure effective communication of important educational, quality and safety topics, but also to verify the information is both received and retained so practice change is accomplished when warranted. Patient safety may be jeopardized if clinical care team members have not received critical information, do not remember it, or do not know where to find it. The goal of this process improvement initiative was to improve care team members' knowledge by providing educational communication, then verifying its effectiveness across a health system's multi-site ambulatory care clinics.

Literature Review

It is well known that ineffective communication has a negative impact on patient safety (Joint Commission International, 2018). To provide safe, competent, and effective patient care, organizations must ensure staff not only receive information, but also understand and retain the essential components for clinical practice. This includes patient safety concerns such as changes in policy and procedures, new evidence-based practice initiatives or practice changes, new equipment training, and general education updates. A review of the literature for approaches that health care organizations use to communicate educational information to nursing and clinical staff yielded very few articles, highlighting the need for more published literature on this topic. Martin (2019) described an approach to communicating and reinforcing practice points with a weekly electronic flyer designed to educate the nursing staff by focusing on a topic each week. This proved successful based on monthly audits that tracked regulatory and safety requirements. Talbott and colleagues (2017) used a similar strategy with an online tool to standardize institutional communication to nurses on such topics as resources, professional development, recognition, and unit updates. Their results showed nurses found this to be a useful tool and emphasized the importance of a clear communication system to enhance patient care and outcomes.

Methods

In the ambulatory care setting at a Magnet®-designated academic medical center in the Southeast, the nursing professional development (NPD) practitioners, and the manager of integration for ambulatory services, faced the daunting task of verifying important educational information is received and retained. As of this writing, the ambulatory care clinical staff has grown to approximately 630 care team members serving in 140 locations. Most are located within five counties. Part of this

Table 1.
Building the Agenda

Standing Agenda Items	Additional Agenda Items
Organization-wide Education Rollout Committee: Pertinent topics for ambulatory care services	Clinical/Professional development topics selected by membership at annual planning meeting
Ambulatory care leadership: Strategic initiatives and other identified topics	Ambulatory care LEARNS presentations (**L**earning **E**mpathy, **A**cceptance, **R**espect, i**N**sight, and **S**ensitivity through reading)
Nursing excellence • Agenda items are identified with corresponding Magnet tenant • Periodic updates from professional excellence and Magnet program director	Evidence-based practice projects presented by committee members (e.g., clinical ladder projects)
Patient/Family Education Committee updates	Infection prevention and control updates
Regulatory compliance, safety, and policies	Information technology local governance update
Electronic medical record updates	Other topics as determined by the co-chairs and facilitator

growth was realized by the integration of three separate systems into one – each with its own diverse culture – requiring the creation of a new role: integration manager. A main goal of this role was developing a consistent approach to practice standards. While it was known some clinical functions were operationalized differently, this became more evident as the ambulatory care resource team members (float pool) reported differences in clinical practice and workflows at the various locations.

Since the organization delivers specialized care that is not offered everywhere in the state, some clinical services have added additional care locations in more distant areas of the state. The expanded geographic reach increases patient satisfaction as travel is not necessary to receive the needed highly specialized care. The clinical staff currently provide care for nearly 1 million patient visits per year, creating challenges to the effective flow of educational information and leaving limited time for activities other than direct patient care, such as classroom learning, hands-on simulations, and case study discussions.

With recent growth in the ambulatory care clinics, it was noted by the NPD practitioners, integration manager, and clinic managers that there were gaps in care team member knowledge related to certain policies, procedures, and other new or updated information. During clinic rounds, the NPD practitioners found this was especially evident with staff in clinics recently merged from other systems. It was found some care team members were unaware of basic resources such as how to access online policies or where to find continuing education information on the organization's intranet. Through discussions with ambulatory care leadership, it was determined there was a need to improve the effectiveness of communication flow. To meet this objective, the ambulatory care NPD team used the Education Resource Committee (ERC) – an ambulatory care committee focused on staff education – and worked with managers to ensure the new clinics had a representative on this committee.

The ERC is an interprofessional committee comprised of nurse representatives (registered nurses and licensed practical nurses) from the diverse ambulatory care services (adult, pediatric, primary care, and specialty care) as well as social work and dental hygiene representatives for a current total of 46 members. The ERC leadership team consists of two staff nurse co-chairs and an ambulatory care NPD practitioner. The leadership team fosters a learning environment which includes mutual trust and respect, collaboration, and acceptance of differences. These are integral to the learning environment. It has long been recognized that adult learning is based on experience and adults choose to pursue learning in response to a perceived need (Knowles et al., 2011). This is taken into consideration in the construction of the agenda, focusing on the learners' experiences in clinical practice and 'need to know' information. See Table 1 as an example of the agenda. The structure of the ERC provides a forum for discussion, questions, and clarification. This forum establishes the foundation for an integrated approach to consistent and safe practice for staff in the health system's outpatient clinics.

The journey to becoming a high reliability organization (HRO) includes deference to expertise (Godlock et al., 2017). Consequently, representing the nurse's work unit in ERC supports HRO principles by embracing the expertise of front-line staff. Selection for the ERC role is recognized as a professional development opportunity for high performing

clinical staff in each clinic. Representatives are evaluated annually by their managers for role effectiveness in communication, clinical expertise, and leadership. The ERC representatives have many responsibilities with the most important being to communicate clinic-specific information from the ERC meetings to clinical staff in their area. This is done by providing the handouts, minutes, and other ERC information during staff meetings, huddles, and one-on-one discussions, and by using the ERC website and the ERC communication notebook.

The ERC meets monthly. Many of the on-campus representatives attend in person, while off-site representatives attend remotely. The remote option implemented when more and more clinics were located at a distance from the central campus, improved participation of off-campus representatives, and has been essential for all during the current pandemic. The ERC has high meeting attendance because representatives take their roles seriously and are valued by both staff and leadership.

The ambulatory care ERC leadership team and NPD pratitioners attend the organization's monthly Education Roll Out Committee meeting. The information is filtered for what pertains to the ambulatory care clinics. This information, along with other important ambulatory care initiatives, is brought forward to the monthly ERC meeting to be disseminated to all clinical care team members by the ERC representatives. However, through environmental scanning, ambulatory care NPD rounding with staff, anecdotal information, and manager input, the question was raised as to whether the clinical staff in all locations were receiving and incorporating the educational information from their ERC representatives. Too often, comments such as 'I didn't know that,' or 'That's news to me,' were heard from care team members about information that had been distributed through ERC, leaving both ERC and ambulatory care leadership questioning whether educational information was being effectively relayed and retained.

To mitigate the potential for any process surprises, as described by Wheatcraft (2012), a review to validate the entire process was undertaken at the request of the ERC leadership. A rudimentary verification process was developed and implemented in 2008 to determine retention of information. The data was originally tracked manually after one-on-one question and answer discussions with staff. As the committee evolved, a more robust ERC post-test was developed using a standardized electronic survey tool. For time efficiency and to mitigate survey fatigue, post-tests were limited to no more than six questions. This is also consistent with recommendations by the American Society for Training and Development which advocates to design questionnaires for simplicity and to make every effort to keep the questionnaire as brief as possible (Phillips et al., 2013). The new post-test was implemented in 2010 and is sent three times per year to all clinical care team members throughout all ambulatory care clinics across the health care enterprise. To make the largest impact, post-test questions are chosen by the ERC leadership based on the most critical information that has been discussed in ERC in the preceding 4 months. Questions are created for educational topics that affect the majority of the roles and clinical specialties; however, there is an option for each question of 'not applicable to my role or clinic,' since not every topic applies everywhere. There is also a comment box for each question that allows staff to free type any additional information they may wish to share.

The post-test allows a drill-down analysis by clinic specialty, location, and role. Even though the committee strives for active participation to ensure reaching as many staff as possible to obtain a robust outcome, Morton and colleagues (2012) described from their review of recent studies "there is not a direct correlation between response rate and validity" (p.107). Therefore, based on average response rates from surveys within the organization, the NPD department at the organization considers a 30% response rate as standard or expected. To promote participation and accountability, the ambulatory care integration manager strongly encourages higher than expected participation rates by obtaining support from leadership and ERC representatives. Auto-reminders are sent via the survey system to the care team members and the post-test deadline is extended, especially when there have been competing organizational surveys or initiatives. The integration manager and ERC leadership team use many of the strategies outlined by the American Society for Training and Development to improve response rates (Phillips et al., 2013). Recent post-tests have averaged 50-60% response rates.

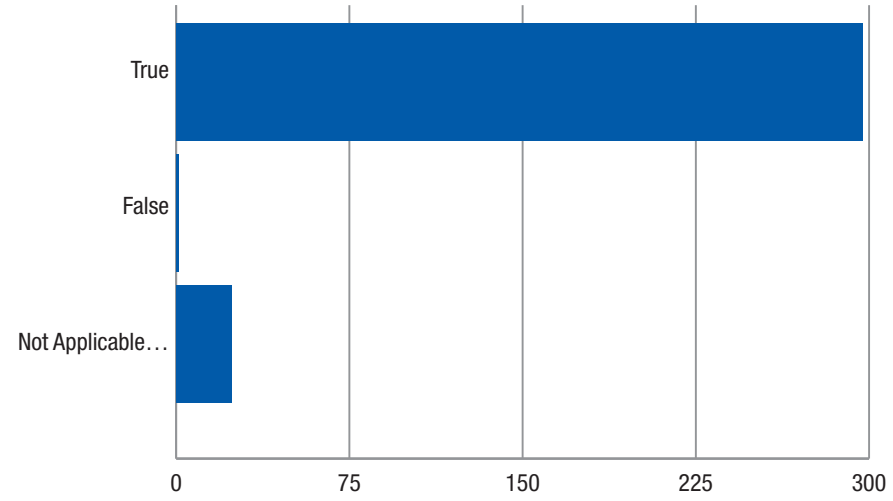
After the ERC leadership team reviews the post-test results, the information is shared during the next ERC meeting. Input is sought from the representatives on any unexpected results. Survey results are also shared at the leadership level. From these discussions, it is determined whether the survey question had validity and clarity and whether additional educational strategies are needed.

Results

Each ERC post-test result is reviewed and analyzed. Any items that have a significant number of incorrect responses trigger, at minimum, re-education of the topic in a subsequent ERC meeting. There may be other measures used for re-education as well. A follow-up question is added to a future ERC post-test. In addition, when incorrect responses are noted in specific areas, additional education can then be targeted by topic, location, or role as indicated. The post-tests are used as a barometer to ascertain if the information has been heard and retained and, if appropriate, a practice change has

Table 2.
Blood Pressure Measurement

Survey question: Abnormal blood pressure (BP) readings should be reported to the provider. If the BP is greater than 140/90 the BP should be taken again after the patient rests in the chair for 10 minutes or prior to the end of the visit. Specialty clinics are to refer patients with elevated BPs to their primary care provider.



Counts/Frequency
Total responses: 322; True (*n* = 297, 92.2%), False (*n* = 1, 0.3%); Not Applicable to my role or clinic (*n* = 24, 7.5%); (Post-test was sent to 629 clinical care team members. Participation rate was 51%).

occurred. Topics impacting patient safety may also have additional validation by partnering with managers for observation, auditing, and/or rounding with staff in the clinics by the ambulatory care NPD team. Outcome measures such as documentation of follow-up for elevated blood pressures (BPs) and completion of depression screenings are also used.

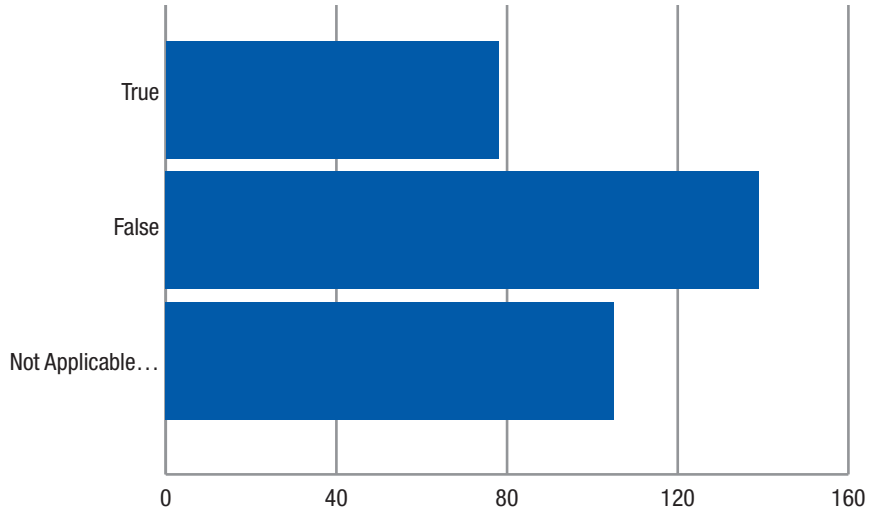
The following is a recent example of how the post-test process works. There has been an increased focus on BP measurements based on the Centers for Medicare & Medicaid Services (CMS) Accountable Care Organization quality measures, as well as patient safety concerns such as care team members not reporting high or low BP readings to the registered nurse or provider. Studies have documented that controlling hypertension reduces cardiovascular events and mortality (CMS, 2019). In addition, ambulatory care nurse screening for high blood pressure and follow-up care is one of the recommended nurse-sensitive indicator measures (American Academy of Ambulatory Care Nursing [AAACN], 2016; Start et al., 2018). In fact, a recent survey of members of AAACN revealed hypertension and follow-up care was one of the nurse-sensitive indicators that ambulatory care nurses were most interested in learning more about (Cantlin & Kronebusch, 2019). Consequently, this is a crucial area in which registered nurses and other clinical care team members can make a positive impact on the patient's health.

For this measure, the organization's primary care leadership team tracked data on the percentage of patients aged 18-85 years with a diagnosis of hypertension whose most recent BP was adequately controlled (less than 140/90 mmHg) in accordance with the CMS controlling high blood pressure measure (CMS, 2019). Data showed when a patient had an elevated BP reading of greater than 140/90, the BP was not consistently being retaken after a period of rest. In addition, there was inconsistency in clinic workflows such that some patients were having their BP measured as the first step of the intake process instead of at the end of the process. It is recommended patients sit in the exam room for at least 5 minutes prior to BP measurement (Whelton et al., 2018). Data also indicated some patients with elevated BPs were not referred to their primary care provider for hypertension management. In order to improve these clinical measures, an educational plan, called 'Blood Pressure Essentials,' was developed by the NPD practitioners and a small task force from primary care to ensure all staff were knowledgeable about hypertension, the steps of correct BP measurement, the requirements of the Accountable Care Organization measure on hypertension control, the workflow practices for documentation, and, if needed, referral to primary care for hypertension control.

After this education rollout, a question was added to the next ERC validation post-test to measure practice knowledge. As seen in Table 2, 99% of respondents (*n* = 297 of 298) who take BPs in the ambulatory care settings answered the question correctly. For those responding to the post-test, this

Table 3.
Charge Capture

Survey question: A patient presents for a nurse visit for a flu shot only. You should charge a medical visit with a modifier 25.



Counts/Frequency
Total responses: 322; True (*n* = 78, 24.2%); False (*n* = 139, 43.2%); Not Applicable for my role or clinic (*n* = 105, 32.6%); (Post-test was sent to 629 clinical care team members. Participation rate was 51%).

result indicated the educational initiative was successful. This information is helpful to managers because if the BP process is not completed correctly, they know it is not an educational barrier. They are then able to ascertain if it is a systems barrier; for example, the patient has left the clinic before a care team member had a chance to repeat the BP, or perhaps a behavioral barrier to completing the process correctly. The data for the BP measure is reviewed monthly by the primary care leadership team, which also includes directors of the specialty care clinics.

The second example centers on entering correct patient charges. It is required that clinical staff are knowledgeable about the revenue cycle and they take all appropriate steps to ensure accurate documentation of patient care and patient visit charges (Niedzwiecki, 2006). To meet these requirements, all care team members complete an annual compliance learning module. This includes billing and coding to ensure accuracy in billing, accurate and timely documentation, and appropriate code and/or charge selection. The revenue cycle team noted discrepancies in the way modifier 25 questions were being answered on the nursing documentation flowsheet. In deciding if a modifier 25 is needed, the staff member must consider whether or not the patient's condition required a service beyond the usual care associated with the procedure that was performed or if there was a significant, separately identifiable, evaluation/ management service that was above and beyond the other services provided (American Medical Association, 2018). To address this concern, the revenue cycle application trainer was invited to present at an ERC meeting. The trainer prepared and reviewed two educational tip sheets on this topic, one of which was specific to flu shots and modifier 25 questions on the nursing documentation flowsheet. An example given was that an established patient comes in for a routine follow-up appointment with medication reconciliation and vital signs. The patient receives a flu shot in clinic. Since the routine follow up is separate and distinct from the flu shot, a medical visit with a modifier 25 should be charged. The information was reviewed with the group and questions were answered. A question related to this information was asked on the subsequent ERC post-test. As seen in Table 3, 24% of participant responses were incorrect which triggered further investigation of the subject matter. The wording of the original question was reviewed for clarity and feedback from ERC members. The trainer was informed of the results and consulted. The content involved the complicated subject of patient billing and required further investigation to ensure that future education would be effective and documentation accurate. The plan is to communicate additional information to ERC and ambulatory care leadership as well as to include an online learning module. A different follow-up question will be used on a future post-test after the additional education plan is implemented.

Summary

Effective communication in health care environments continues to be an area of focus by many regulatory and accrediting bodies. Embracing strategies that enhance communication of essential information is an effective approach to improving patient safety and verifying outcomes. In ambulatory care services, ERC is recognized as a reliable education and communication resource providing a forum for sharing best practices and networking with others. Leadership involvement and support are imperative in making sure the ERC representatives can attend monthly meetings and are given time to share the information with their care team members. Despite continuing growth and logistical challenges, the ERC facilitates the transfer of educational information to clinics in many locations with the post-test serving as a valuable tool for assessing and confirming important educational information is communicated in a timely, effective manner, and knowledge is retained by staff in the ambulatory care clinics.

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AAACN News

Free Resources for Members

AAACN offers many resources that help define the specialty of ambulatory care nursing and the crucial role of the RN as care provider, care coordinator, care partner, and help you advocate for RNs in ambulatory care. The following are available for free on the AAACN website under Practice Resources, www.aaacn.org/practice-resources

- Ambulatory Care Nursing Conceptual Framework
- Role of the RN in Ambulatory Care Position Paper and Talking Points
- Nurse-Sensitive Indicator Industry Report
- CCTM Toolkit
- Telehealth Nursing Practice Resource Directory
- Ambulatory Care Tabs in the ANPD Clinical Education Matrix

Access AAACN Publications Digitally

Did you know digital access is available for many AAACN resources? Content licensing and ebook access to AAACN's *Core Curriculums*, *Scope and Standards*, *ViewPoint* and other publications is available through various services, including EBSCO, Ovid, ProQuest, Rittenhouse, and more.

Learn more at www.aaacn.org/publications-news/digital-publication-access

AAACN Open Forum Community is Live!

The Open Forum launched in the Connected Community in early May and members are already connecting! All members were automatically signed up. We encourage you to start a discussion thread or respond to an existing one.

- Log in to AAACN Connected Community
- Click on the "Open Forum" under "My Communities"
- Create or respond to a post

You may opt-out if you choose not to participate, however we hope you stay connected. We'll talk to you soon!

What is PCORI?

Anne T. Jessie

Traditional research, despite all the remarkable scientific advancements, has fallen short in guiding individuals, caregivers, and clinicians on how to approach informed, mutually shared decision-making in health care choices. Patient-Centered Outcomes Research Institute (PCORI), an independent nonprofit, nongovernmental organization in Washington, D.C., authorized by Congress in 2010 to fund research specifically around closing this gap. Since December 2012, PCORI has funded hundreds of comparative effectiveness research (CER) studies that compare health care options to determine which work best given patients' individual values, circumstances, preferences, and goals. Governed by a 21-member Board of Governors – representing the entire health care community – PCORI funds CER that engages patients and other stakeholders throughout the research process so resulting evidence will address individuals' most important health care concerns. In 2019, Congress reauthorized PCORI funding.

PCORI's (2021a) strategic plan includes the following three goals:

- Substantially increase the quantity, quality, and timeliness of useful, trustworthy information available to support health decisions.
- Speed the implementation and use of patient-centered outcomes research evidence.
- Influence clinical and health care research funded by others to be more patient-centered.

Supporting the goals are five imperatives:

- **"Engagement:** Engage patients, caregivers, and all other stakeholders in our entire research process, from topic generation to dissemination and implementation of results
- **Methods:** Develop and promote rigorous patient-centered outcomes research methods, standards, and best practices
- **Research:** Fund a comprehensive agenda of high-quality patient-centered outcomes research and evaluate its impact
- **Dissemination:** Disseminate patient-centered outcomes research to all stakeholders and support its uptake and implementation
- **Infrastructure:** Promote and facilitate the development of a sustainable infrastructure for conducting patient-centered outcomes research" (PCORI, 2021a, para. 10)

PCORI Clinician Roundtable

On January 27, 2021, AAACN was invited to attend the PCORI Clinician Roundtable of key clinical leaders and research stakeholders for the purpose of communicating PCORI's vision for their strategic framework for the future. Additional goals for the roundtable were to identify issues for consideration in setting the strategic framework, review current national health care priorities, and to solicit input on key priorities drawing on attendees' unique perspectives. Anne Jessie, AAACN President, represented AAACN and its interests.

Updating PCORI's National Priorities

Nakela Cook, MD, MPH; PCORI Executive Director, facilitated a discussion among participants to identify issues PCORI should consider as it shapes its future priorities and research agenda. The following themes from the Clinician Roundtable discussion were summarized and shared with participants by PCORI. Themes centered on opportunities learned from the current pandemic context and included new and innovative areas for focus:

- Addressing long-term symptoms and chronic conditions resulting from COVID-19.
- Furthering the evidence around prevention, recognizing delayed or foregone preventive and chronic care during the COVID-19 pandemic will have future implications for patients and health care systems.
- Emphasizing mental and behavioral health, including the effects of social isolation.
- Addressing workforce burnout and shortages across different specialties.
- Increasing attention on alternative care settings such as at-home care, long-term care facilities, and community-based settings.
- Expanding the evidence base around telehealth and translating evidence to patients and providers.
- Building more effective communication and partnerships with local communities to reflect what we are learning about vaccine hesitancy.

Proposed Areas for Research Expansion Reflecting Innovation Opportunities

The roundtable summary also included opportunity areas identified by participants that had not been historically funded through PCORI:

- Investing in young researchers to support diversity, equity, and inclusion among those who lead and participate in research.
- Supporting capacity for community-based research initiatives and priorities.

continued on page 13

Taking Action on Harmful Alcohol Use by Ambulatory Care Patients

Stephanie G. Witwer

Care coordination and transition management registered nurses (CCTM® RNs) work closely with patients, developing trusting relationships. As a result, patients sometimes share information that is sensitive and may not be known by other members of the care team – even their primary care provider. One CCTM RN shared this story of her work with a patient who was having challenges managing his diabetes. They regularly discussed diet, medication adherence, and activity level but, despite their efforts, blood sugars continued to fluctuate. One day during a routine call, the patient mentioned that he was feeling anxious and needed to get to the store as he had run out of vodka that he usually drinks to help calm his nerves. Surprised, the nurse responded with a few additional questions about his alcohol intake and discovered he was drinking over a liter per day. At that moment she knew a different approach was needed. Although the patient consented to work with her and the primary care provider on a plan to reduce his alcohol intake, the CCTM RN felt unprepared for the situation and the clinic did not have a standard approach.

This column will describe an evidence-based approach to screening, brief intervention, and referral to treatment (SBIRT) that has been successful in the management of alcohol and other substance use disorders (SUDs) in many settings (Agerwala & McCance-Katz, 2012).

Each year, the Substance Abuse and Mental Health Services Administration (SAMHSA) conducts a national survey on drug use and health. The 2019 study provides an important window into substance use and mental health issues in the United States (McCance-Katz, 2020). In 2019, 7.7% of adults aged 18 and older (19.3 million) had a SUD, with alcohol misuse accounting for 73% of those cases. The Centers for Disease Control and Prevention (2019) described outcomes of alcohol misuse in the United States. Excessive drinking alone kills 95,000 people each year and contributes to an annual cost of $249 billion in reduced productivity, health care expenses, criminal justice system expenses, and motor vehicle crashes. Quaye and colleagues (2020) add that when considering the burden of treatment for ensuing chronic conditions and lost quality of life, the cost is even higher. Despite the large number of people impacted, in 2019 only 1.5% of those with SUDs received any type of treatment (McCance-Katz, 2020).

SBIRT is a public health approach employed to identify and provide care for people with SUDs and those at risk for its development (Agerwala & McCance-Katz, 2012; Kerrins & Hemphill, 2020). This approach has its roots in the early 1980s as researchers identified large numbers of harmful drinkers who did not meet the clinical criteria for alcoholism and sought different treatment approaches. In 1982, the World Health Organization developed a screening tool and treatment approach for harmful and hazardous drinking that could be utilized in multiple settings (Babor et al., 2017). The SBIRT treatment approach has been tested in multiple countries, delivery settings, and provider types. Evidence of effectiveness is consistently strong with adult populations misusing alcohol. While it is used in assessment and treatment of patients misusing prescription or illicit drugs, efficacy is equivocal. To spur implementation in the United States, SAMHSA initiated a series of grants beginning in 2003 (Del Boca et al., 2017).

As with many public health approaches, SBIRT begins with standardized population screening to identify if an individual has a SUD or is at risk for its development. Although there are a variety of tools available, the Alcohol Disorders Identification Test (AUDIT) and the Alcohol Disorders Identification Test-C (AUDIT-C), tools developed by the World Health Organization are most widely used (Babor et. al., 2017; Bohn et al., 1995). The AUDIT-C is a three-item questionnaire. A positive result on the AUDIT-C triggers completion of a full AUDIT. Screening can be performed through a computerized questionnaire delivered through a patient portal, web-based device, or direct questioning by staff in the clinic or community setting. Specialized training for screening is not required. Some studies have suggested web-based tools may enhance self-reporting (Del Boca et al., 2017).

Under the SBIRT model, patients who screen positive are offered a brief

Table 1.
Select SBIRT Resources

SBIRT Training Videos: YouTube has many excellent examples of using MI principles and the SBIRT intervention. This example is from SBIRT Colorado.	https://www.youtube.com/watch?v=WFjFluUY8o4
Resources available from SAMHSA.gov for grants, training, implementation, and reimbursement for SBIRT.	https://www.samhsa.gov/sbirt/about
Planning and Implementing Screening and Brief Intervention for Risky Alcohol Use: A Step-by-Step Guide for Primary Care Practices (2014)	https://www.cdc.gov/ncbddd/fasd/documents/alcoholsbiimplementationguide.pdf
Substance Abuse and Mental Health Services Administration (SAMHSA) Motivational Interviewing Tip Sheet	https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP20-02-02-014.pdf

intervention lasting 5-15 minutes. Brief intervention uses a motivational interviewing approach to provide information and advice regarding current substance use, its potential adverse consequences, and to elicit willingness to change. Breif intervention should be performed by trained medical personnel or dedicated SBIRT providers. Computerized brief intervention approaches are also available and may include additional follow up contacts or booster sessions. For patients at higher risk, brief treatment may be employed. Brief treatment is a distinct level of care provided by licensed behavioral or substance abuse counselors and may be offered as part of primary care with integrated behavioral health or through referral.

If screening indicates a patient has a possible SUD, referral to more intensive treatment is necessary. To support patients and families needing this level of care and increase likelihood of participation, assistance with appointments and eliminating other barriers such as transportation, childcare, and insurance coverage is critical. This step benefits from an identified referral network with a range of available services.

Despite strong evidence of SBIRT effectiveness and prevalence of alcohol misuse, widespread implementation in the United States has not been realized. Reasons are multifactorial. Initial investment in SBIRT planning requires:

- Systematic distribution of screening questionnaires and follow up of positive screens.
- Education for medical personal in use of motivational interviewing techniques and the SBIRT intervention with ongoing quality monitoring.
- Development of provider referral pathways for brief and more intensive treatments.
- Program evaluation.

Although SAMHSA estimates the U.S. health care system saves $3.81 for each $1 spent on SBIRT (Rittle et al., 2019), sustainable funding is a barrier. Reimbursement is available to licensed independent practitioners and behavioral health providers; however, population screening and brief intervention performed by other medical personnel is not reimbursed. Overall reimbursement is low and often insufficient to sustain implementation.

Practice acceptability is another important consideration. Some providers believe discussions about alcohol misuse interfere with provider-patient relationships; others lack confidence in initiating these discussions. For successful implementation, staff and providers must embrace the importance of addressing alcohol misuse in their practice setting.

Despite barriers to implementation, SBIRT is an intervention proven to reduce harmful alcohol use in many settings. Opportunities exist to develop cost-effective population approaches. Helpful SBIRT resources and training are available (see Table 1) and motivational interviewing and SBIRT principles are beginning to be incorporated into curricula in nursing and other health disciplines (Rittle et al., 2019; Bremmer et al., 2020; Gonzalez et al., 2020).

Advocacy for reimbursement that supports primary and secondary prevention is essential to improve the health of our nation. If the CCTM RN in the earlier example had SBIRT training and her clinic established treatment pathways, she would have been able to immediately intervene and refer the patient to the appropriate level of care, preventing future health and social complications, and addressing his immediate issues of diabetes control. ●

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What is PCORI?

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- Building the evidence base around implementation of research findings to promote the uptake and impact of PCORI.
- Investing in infrastructure and initiatives to support efficient data capture and associated research (e.g., encouraging data sharing, leveraging registries and real-world data).
- Taking a holistic approach to population and behavioral health.
- Pursuing key areas of innovative research that go beyond addressing disparities and aim to advance health equity.
- The burden and affordability of treatments for patients.
- The interplay between innovative technology, clinical practice, population health, precision medicine, and health equity.
- Examining opportunities to combat workforce burnout and promote diversity in all levels of the health care workforce.

Next Steps for PCORI and AAACN

Included in the roundtable summary – shared with participants – were PCORI's next steps in finalizing its strategic plan including a timeline. Ongoing development of PCORI's strategic plan will continue through 2021, with many opportunities for clinicians and other stakeholders to provide input. The feedback from this meeting and other stakeholder convenings will inform PCORI's Board of Governors' approach to drafting its 'National Priorities' for the future. Draft priorities will be available for public comment in the spring and summer of 2021. The stakeholder-informed 'National Priorities' and research agenda will be finalized in PCORI's strategic plan in the fall of 2021.

Much of the research funded by PCORI aligns well with AAACN's (2020) strategic plan, especially as it relates to care coordination and transition management (CCTM®), telehealth and diversity, and equity and inclusion. AAACN members can seek out opportunities to provide input by visiting the PCORI (2021b) website. Additionally, members can view exemplars of previously funded research and how to apply for research funding by visiting https://www.pcori.org/about-us/pcoris-strategic-plan

As we continue to advance the art and science of ambulatory care nursing, this funding opportunity is foundational in demonstrating the value of our specialty. I encourage all to explore and seize the opportunity!

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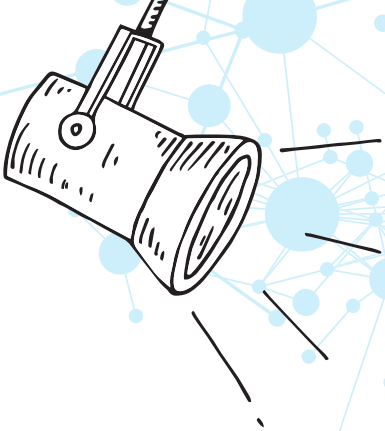


Spotlight:

The AAACN 46th Annual Virtual Conference

Collectively celebrating a year of resiliency and thoroughly embracing the virtual education experience, hundreds of nurses gathered in April for another successful AAACN Annual Conference.

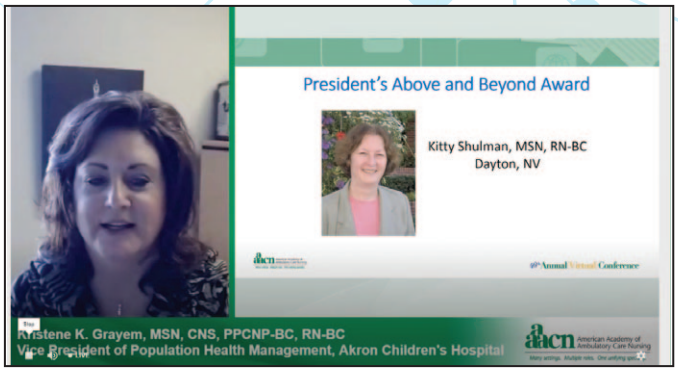
More than 750 nurses registered, with 300-400 nurses participating each day on April 8, 13, and 15, 2021. The impact of COVID-19, along with the practice innovations the pandemic has sparked, took center stage and dominated many of the discussions and presentations.

Nurses' extraordinary accomplishments and courage also got a well-deserved spotlight during the event, with many acknowledging that health care in the United States – as well as the way the public views nurses – has been forever changed.

"The past year has been as incredible as it was challenging. What was reflected throughout the conference – during the education sessions and personal interactions alike – was that we are taking what we've learned from COVID-19 and tackling the big issues now," new 2021-2022 AAACN President Kathleen Martinez, MSN, RN, CPN, said. "These include priorities like health care equity, better infection control, and intensified support and safety for all health care professionals."

Expert speakers presented 25 live education sessions during the 3 days, and there were also seven Zoom networking chat lobbies. Moving forward, attendees have unlimited and extended access via the Conference Event Page on AAACN's Online Library to view sessions they missed and continue their learning experience on their own schedules. In addition, those who missed the live sessions can purchase on-demand conference packages.

The education sessions span ambulatory care nursing practice and are organized in several major categories: clinical, management, leadership, Care Coordination and Transition Management (CCTM®), and telehealth.



Kristene Grayem, Immediate Past President, virtually presented the Above and Beyond Award to Kitty Shulman.

Conference Highlights

- During her "Welcome and President's Address" on April 8, 2020-2021 AAACN President Anne Jessie, DNP, RN, praised ambulatory care nurses for their courage during the pandemic and described some of the roles ambulatory care nurses took on during the COVID-19 emergencies like opening, staffing, and running SARS-C0V-2 testing centers in empty storefronts.
- On April 8, speaker and author Vicki Hess, MSN, RN, CTP, CVPC, delivered the Keynote Address, "Becoming a Champion of Change: Your Checklist for Success."
- Popular blogger, podcaster, and coach Keith Carlson, BSN, RN, NC-BC, (Nurse Keith) spoke later that day on "Catching Our Collective Breath."
- On April 13, American Nurses Association (ANA) President Ernest Grant, PhD, RN, FAAN, joined Jessie for the conference Town Hall, "No Turning Back Now: What's Next for Ambulatory Care Nursing." Their conversation highlighted the future of ambulatory care nursing and opportunities to enhance leadership, adapt to evolving roles, and conduct research, among other topics.
- On April 15, actor, educator, and emergency nurse Tim Cunningham, DrPH, RN, FAAN, presented the closing Keynote Address, "To Pivot, Pivot, and Then Pivot Some More: How We're Growing, Shifting, Suffering, and Surfing through the Pandemic."
- Additional featured speakers presented during the conference and included some of the country's most respected nurse leaders and experts.
- Along with the education sessions, AAACN's Special Interest Groups (SIGs) convened during virtual sessions so the nurses could share information relevant to specific practice areas.
- Attendees also enjoyed special events, viewed 50 poster presentations/recorded videos, and interacted with industry representatives in a virtual exhibit hall.
- AAACN's virtual Silent Auction raised more than $4,000, with the funds earmarked for scholarships, grants and awards.

Vowing to build a safer, stronger health care system for all patients, nurses learned and bonded during the annual event.

New Officers Inducted

Martinez, who is an Infection Prevention and Control Nurse, Children's Hospital Colorado, Aurora, CO, was inducted during the conference as AAACN 2021-2022 President. In this role, she will lead the AAACN Board of Directors (BOD) in fulfilling the association's strategic plan and steering the direction and vision of AAACN.

Also inducted to the BOD as directors were Capt. Andrea Petrovanie-Green, MSN, RN, AMB-BC; and Rachel Start, MSN, RN, NEA-BC, FAAN.

Scholarships and Awards

As in previous years, AAACN presented scholarships and awards to members during the conference. The 2021 award recipients are as follows:

- **President's Above and Beyond Award (highest award to AAACN members who exceeded the expectations of their volunteer roles):** Jessie Jones-Bell, MSN, Ed, RN, PHN; Laurel More, MS, RN, CPN; and Kitty Shulman, MSN, AMB-BC
- **Administrative Excellence Award:** Cynthia Murray, BN, RN, AMB-BC
- **Carol Rutenberg Telephone Triage EBP Project Award:** Kendra Sutton, DNP, AMB-BC
- **Education Scholarship:** Melissa Taylor, BSN, RN

You can learn more about AAACN scholarships and awards by visiting https://www.aaacn.org/career-education/scholarships-and-awards

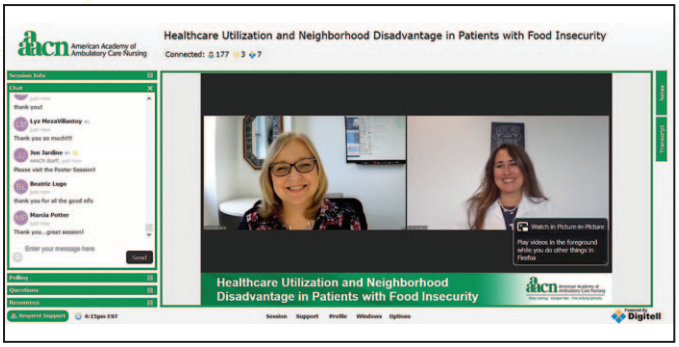
Continued Learning Available

Nurses who attended the conference have access to additional Nursing Continuing Professional Development (NCPD) contact hours in the AAACN Online Library, which can be used for certification and licensure requirements. They are also able to attend the sessions they may have missed during the live broadcasts.

Couldn't make it to this year's annual conference? You can now access on-demand packages from the AAACN 2021 Virtual Conference in the online Library. Choose the package that meet your budget and NCPD (formerly CNE) needs. Visit library.aaacn.org for more information.

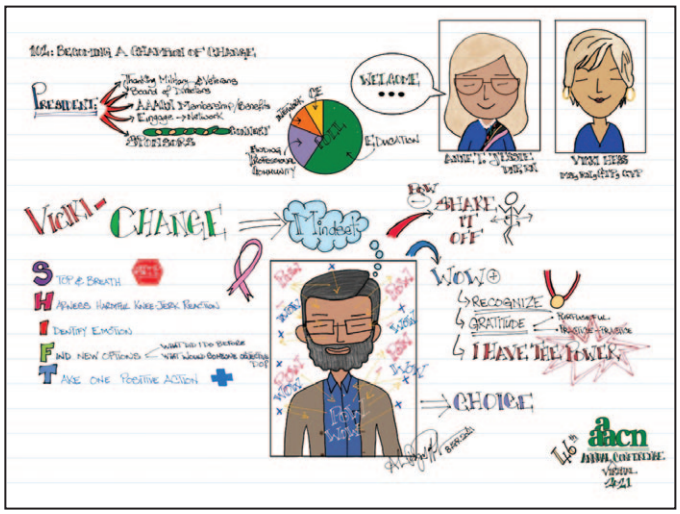
The AAACN 47th Annual Conference will be held Spring 2022, at Westgate Las Vegas, Las Vegas, NV. Oral abstracts are being accepted through July 15, 2021. Poster abstracts are being accepted through November 15, 2021.

Janet D'Alesandro is AAACN's Media and Communications Director. She may be contacted at janetd@ajj.com



A conference session discussed facilitating social care into CCTM practice to address food insecurity.

Tim Cunningham energized attendees during his closing session on April 15.



Visual Conference Notes: Ali R. Tayyeb, PhD, RN-BC, PHN, an assistant professor and U.S. navy Veteran who works at California State University in Los Angeles, created some amazing illustrations in real time during several sessions!

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Certification Review Course Live and On-Demand Bundle

Prepare for the Ambulatory Care Nursing Certification Exam with the Certification Review Course: Live & On-Demand Bundle, bringing you all of the content and expertise the in-person course offers, taught by instructors E. Mary Johnson, BSN, RN-BC, NE-BC; and Susan M. Paschke, MSN, RN-BC, NEA-BC.

The CRC: Live and On-Demand Bundle includes:

- Over 7 hours of recorded content from the Ambulatory Care Nursing Certification Review Course
- Three live webinars:
  - May 25, 2021, 3:00 – 4:00pm Eastern
    Let's Get Started (exam criteria and certification, ambulatory care overview)
  - June 8, 2021, 3:00 – 4:30pm Eastern
    Recap Part 1 (topics include plan of care and care management, clinical practice, telehealth and telephone triage, and more)
  - June 22, 2021, 3:00 – 4:30pm Eastern
    Recap Part 2 (topics include documentation and informatics, regulations and standards, legal and ethical issues, and more)
- Ambulatory Care Nursing Certification Review Course Syllabus
- Course PowerPoint slides
- Access to interactive forum to connect with the instructors and other attendees
- Discount on Core Curriculum for Ambulatory Care Nursing
- 12 contact hours*

Register in the AAACN Online Library
www.aaacn.org/CRCbundle21
AAACN Member Price $209
Regular Price $259

**This course does not grant certification in ambulatory care nursing.*
**Contact hours are earned in the Online Library by completing a session evaluation after reviewing the material.*