

aaacn ViewPoint

The Voice of Ambulatory Care Nursing

Fostering Patient Loyalty In Urgent Care Settings



Patients will return to a facility if they have received good customer service in addition to quality care.

Penny J. Miceli, PhD
Dave Van Remortel, RN

Of all the changes within the health care industry, one thing is unmistakable – the people you treat are not just your patients, they are also your customers (Mayer & Cates, 1998).

Clinically skilled care is a necessary but not sufficient basis for engendering patient satisfaction. In today's consumer-oriented health care environment, clinically skilled care is expected as a given, and therefore won't be the sole reason for patients to return to you in the future. To earn patients' loyalty, care must be delivered with a strong customer service focus. These two qualities – clinical skill and customer service – define high quality health care from the patient's perspective (Kenagy, Berwick, & Shore, 1999).

Increasingly, consumers looking for convenient, immediately accessible, affordable care for their episodic health needs are turning to Urgent Care (UC) centers. Perhaps the greatest asset of UC centers is their ability to provide access to care at times when a primary care physician may not be available, without the high cost and lengthy wait times of a typical emergency department. UC centers typically do not require an appointment, making it easy to see their appeal to today's highly selective health care consumers.

But how satisfied are patients who visit UC centers? And importantly, how can UC centers increase patient satisfaction, and by extension, *loyalty*? To answer these questions, Press Ganey Associates, a South Bend, IN, corporation that provides satisfaction measurement and improvement services to

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Looking Inward To Keep Up With The Times

Dear Colleagues,

We have focused our work this year on achieving the objectives necessary to meet our four primary goals: Be 'The Voice of Ambulatory Care Nursing'; Promote Professional Practice; Strengthen AAACN Resource Base; and Develop AAACN Leadership Ability and Capacity.

The third goal, to strengthen the AAACN resource base, is one of the most challenging. The objectives for this goal include broadening our membership base and retaining existing AAACN members. To achieve these objectives we must look inward and raise questions that may be difficult or even controversial. However, answers to difficult questions are what we need to move the organization to a new level of responsiveness.

There are a number of questions we can and are raising. However, there are two particular issues I would like to review with you.

First, why do we exist? Why was AAACN organized in the very beginning? When the association began, we were an organization for ambulatory care nurse leaders. The focus at that time was on developing nursing leadership skills, increasing the visibility of ambulatory care in the health care arena, and advocating for advances in the practice of ambulatory care nursing.

As time went by, we recognized the need to expand the AAACN membership to include not only nursing leaders but also practicing ambulatory care nurses, case managers, educators, researchers, and others interested in ambulatory care. Our structure began to change as we sought to involve this diverse membership in a variety of ways. In particular we evolved Special Interest Groups (SIGs) and Local Networking Groups (LNGs). The intent was to provide an interest niche for each of the different segments of our membership and to provide opportunities at the local level for AAACN members to organize and meet at regular intervals.

As we look to the future, do the SIGs and the LNGs provide meaningful opportunities for our members to meet, network, learn, and expand their involvement with the organization? When well defined and focused on a topic of significant interest, it would appear that the SIGs are meeting the needs of specific elements of our membership. Should we have more SIGs (for example a leadership SIG)? Should we find ways to more strongly link the SIGs to the AAACN strategic plan? Do they need more or less structure? We would find great value in hearing your answers to these questions, so please send an e-mail to aaacn@ajj.com and share your thoughts.

The LNGs, however, appear to be struggling and in some cases disappearing. Why? Are they being effectively supported by AAACN? Are we at a point in time when having more meetings is not necessarily a valued thing? Would we be better positioned if we offered regional educational activities? Is it OK for non-AAACN members to participate in the local networks? The real issue is that of evolving a variety of options to better meet the needs of our members at the



Catherine J. Futch

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DEPLOYED in Iraq

Tammy M Dunham, Capt, USAF, NC

FEATURE

Air Force nurse recounts service in the first expeditionary medical group stationed near the frontlines.

"Lt Dunham, you need to pack your bags and be ready to leave by this afternoon. You are being sent to Iraq."

I had been at a U.S. Air Force base in Saudi Arabia since February 2003, my work time alternating between a ward and a clinic. Now it was May, and I was going to Iraq. In the space of one phone call I went from being at a supporting base to joining one in the front. So I packed my bags and readied myself to go to this new place, scared and excited at what lie ahead.

With a group of nurses and technicians, I arrived at our destination 2 days later, uncertain of what to expect. It was late at night and was dark, hot, and dusty. As we rode in the bus to our camp we could see lights from various tent encampments. We met the hospital commander at the medical tents, where he told us we were now a part of the first expeditionary medical group in Iraq, the most forward deployed of any combat medical group in Air Force history. The commander said we would be working hard, but he would not keep us there a day more than was needed. I was assigned to work the ward.

Conditions a Challenge

The only place with heat and dust comparable to Iraq in July is Death Valley, CA. The average daily temperature was 125 degrees Fahrenheit, and intense winds occurred daily with dust blowing everywhere, even into the pores of your skin. There was some rain, however it dried as soon as it hit the ground.

We did not receive any direct enemy fire and our camp was considered safe and secure for the area. Our water was nonpotable, so we were able



At left, Air Force technicians transport a trauma patient who will be taken by ambulance to the hospital ER. Shown below, soldiers wait to be treated in the 'hallway' of the medical clinic.

(Photos courtesy of the United States Air Force, 2003.)



to use it to wash ourselves and our clothes, but not for brushing our teeth, drinking, or cooking. Wild rabid dogs ran through the camp, bats flew around the lights at night, and a

plethora of insect life surrounded us. I don't recall one shower that I did not share with a cricket. It was necessary to watch for signs and symptoms of malaria and leishmaniasis, a parasitic

“Our commander told us...
...we had done things most military
hospitals may manage only once a year.”



The 407th Expeditionary Medical Squadron in front of the Air Force hospital in Iraq on July 4, 2003. (Photo courtesy of the United States Air Force, 2003.)

disease transmitted to humans by the bite of infected sandflies.

These were the conditions in which we received our patients; they arrived dirty along with being sick or hurt. We pooled together our care packages to make sure the soldiers could have toothbrushes, toothpaste, combs, feminine products, soap, and deodorant during their stay with us. One patient told me after he washed that it was the first bath with water he'd had in 3 weeks.

Infection control is an interesting concept in these conditions and required a lot of creativity. We had three wards – two medical/surgical and one ICU. The toilet facilities were comprised of two portajohns, one female and one male. At one point we had one ward dedicated as an acute gastroenteritis ward. We curtained off an area of this tent and put a bedside commode in it for these patients to use to try and avoid spread of the disease to others.

While our tents had environmental control units, the hotter it got during the day, the warmer the tents became in spite of these wonderful units. Patients with temperatures or heat-related injuries definitely tested the

resourcefulness of the staff. Patients arrived to the emergency room with core body temperatures of 101 degrees Fahrenheit and greater. Patients would be stripped of their clothing, sprayed with water, fanned, covered with wet towels, packed with ice, and treated symptomatically. Also, patients were given acetaminophen. Some had such high core temperatures and low Glasgow scales (which determines neurologic function and possible brain injury), that they had to be intubated. Stable patients were moved to the ward. The intubated and unstable, such as those with potassium imbalances, were moved to the ICU.

The medical group I worked with did not provide care for refugees or nationals, however we did care for government contracted people who were from the region. Through the translator we heard that most were appreciative of their care and did not have a problem receiving care from female nurses.

According to the Geneva Convention, loaded weapons are not permitted inside medical facilities. Making sure all visitors and patients at our facility did not have such weapons was of great concern.

Supplies: Creative Solutions

Supplies seemed to be either over or under stocked. At one time we had boxes of thermometer probes for the thermometers we did not have, but no probes for the thermometers we did have. Eventually we acquired the needed supplies.

We used boxes covered with blankets for elevating extremities and also for elevating the head of the cots that were broken. We received supplies from bases that were closing in the region, so we did surprisingly well on supplies. Unfortunately, we had more boxes than staff to unpack and stock (and no room for stock), so if you wanted something specific that was not used every day and unpacked, you had to look through the boxes. For a dressing change that needed a 3" Kerlix® gauze, I would take the 6" wrap and cut it. We had boxes and boxes of 6" Kerlix, and we didn't find the 3" until the next day.

Another challenge regarding supplies sitting in boxes was the effects of the heat on the contents. The Iraq temperatures were so high that many of the supplies were ruined, especially the temperature-sensitive drugs. As time

went on, we did receive a couple of refrigerators with freezers; we stocked them with the patients' drinking water and IV fluid bags. We used the frozen IV bags for ice packs, but did not reuse those for actual IVs.

Nutritional medicine proved a challenge and specialized diets were limited. The easiest special diet was clear liquid, so again we got creative, pooling our care packages for tea bags, soup, and whatever we could find that would be appropriate for the patients. The most difficult diet was a 2,200-calorie diet for a patient who had been newly diagnosed with diabetes. We had "unit grade rations," which are basically the military prepackaged meals put in larger containers so they could be fixed for a group instead of an individual. The patients ate, to their ability, these meals with us. The ambulatory patients without IV fluids running were given a meal pass to eat at the dining tent. The nursing assistants arranged through dining services take out meals for the non-ambulatory patients.

Returning patients to their units upon discharge was like treasure hunting at times. Not all units had phones. Some units were in convoys. Some units were days away. Patients would sometimes get rides from visitors going their way. Others waited overnight. Those who were stationed nearby would even walk to get back to their units.

Honoring Accomplishments, Returning Home

Our work in Iraq called for us to tackle many challenges daily. Our commander told us that we had done things that most military hospitals may manage only once a year. I focused on taking care of patients the best I could

I focused on taking care of patients the best I could. I tried to stay positive and not dwell on the conditions, especially since many had it much worse than we did.

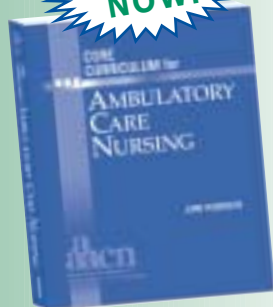
with what I was given. I tried to stay positive and not dwell on the difficult conditions, especially since many had it much worse than we did.

When it came time to leave, I knew that others were coming to take my place so the work could continue. Now that I am home, I listen for news about what is happening in the region where I was stationed and word of how my patients are doing. I am also working through my feelings now about what I saw and how my colleagues and I lived and worked.

I am glad for the opportunity to serve my country with my service to these soldiers. I gave some, but others gave all so we can enjoy our lives today with the freedoms we embrace.

Tammy M Dunham, Capt, USAF, NC, is *Clinical Nurse, FHC, Offutt AFB, Nebraska*. She can be reached at (402) 294-9282 (w); tammy.dunham@offutt.af.mil; or johnny6973@cox.net.

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The Legislative Process

The ABCs of Lobbying

Regina C. Phillips, MSN, RN



Part Three

Who are lobbyists? Have you ever called, written, e-mailed, or visited your congressman or woman? If you answered yes to either of these questions, you are a lobbyist.

While you may have lobbied on your own time without monetary compensation, there are professional lobbyists who are paid for their

activities on behalf of a client, a special interest group, or an employer. These lobbyists are required by the Lobbying Disclosure Act of 1995 to be registered with the federal government (Maskell, 2001).

The focus of this article, however, is not on the professional lobbyist but on you, the private citizen. In fact, the most effective lobbyists are regular citizens who come to Washington simply to tell their stories (www.your-congress.com, 2003). It is the constituents who have more influence with legislators because they voted them into office.

What is Lobbying?

Lobbying is simply communicating your views on local, state, or national policy issues to your elected officials in a timely and effective manner. By doing so, you are making your voice heard and your concerns addressed (www.aorn.org, 2000). The purpose is to get a member of Congress to vote for you, your goal, or your cause (Ross, 1993).

Why Lobby?

If you don't look out for your interests and those of your patients, who will? If you are not involved in the political decision-making process, you may not like the decisions that are made without your input (www.aorn.org, 2000). Lobbying members of Congress to persuade them to pass specific legislation, make changes in proposed legislation, or undo legislation already on the books is central to our form of government (Ross, 2003).

How Do I Lobby?

For the private citizen, there are several methods of lobbying. These include face-to-face meetings, telephone calls, letters, or e-mails. Generally, the more personal the contact, the more effective. If you cannot meet with a legislator, a meeting with his/her legislative assistant is almost as good.

You can meet legislators either in Washington, DC, or in their local office by contacting the scheduler through the U.S. Capitol Switchboard at (202) 224-3121 and asking for the senator's and/or representative's office.

You may have many issues to discuss, but it is best to limit your agenda to no more than three separate topics. It is also a good idea to have a printed fact sheet per issue that you can leave with the legislator. Make sure to have copies for the legislative assistants and other staff members who often attend such meetings.

When telephoning your representative in Congress, be aware that staff members often take the calls. Ask to speak to the legislative assistant who handles the issue you want to discuss. After identifying yourself, it is helpful to have a script prepared that states the bill number as well as a list of the details you want to talk about. For example: "Please tell Senator/Representative [Name] that I support/oppose (S. ___/H.R. ___)." It is also beneficial to state reasons for your support or opposition to the bill (www.nursingworld.org, 2001).

When writing to a member of Congress, remember a personal letter is more effective than a form letter. However, if you are short on time a form letter is certainly better than no correspondence at all. If you decide to write a letter, your purpose for writing should be stated in the first paragraph of the letter and you should identify the specific bill or piece of legislation up-front. Be courteous and to the point, and include key information using examples to support your position. Address only one issue per letter and if possible keep the letter to one page. Include your full name and address which identifies you as a constituent, along with your telephone number (www.nursingworld.org, 2001). When e-mailing, the same general guidelines apply as with writing a letter.

Tips on Lobbying Congress

1. Keep it short and to the point.
2. Don't forget to say "Thank you."
3. Get to know the legislator's staff. It is frequently more productive to speak to a staff member than the law-makers themselves.
4. Tell the whole story by acknowledging when something is difficult and when there is opposition.
5. Timing is everything. It is important to know Congress' procedures, so mention proper deadlines and don't ask for requests at the last minute.

Get to know the
legislator's staff members.
They are usually more
accessible than the
lawmaker and may be
able to expedite
your request.



6. Have a 1-page written draft of what you want available to leave or send to the legislator.
7. Be professional even when the answer is "No." Regroup and wait for another chance.
(www.yourcongress.com, 2003).

Sources of Lobbying Information

If you have a burning interest in lobbying, there are resources available to provide additional information including a book written by veteran lobbyists Bruce C. Wolpe and Bertram L. Levine, *Lobbying Congress, How the System Works, 2nd Edition*. There are Web sites that offer e-mail alert systems that inform activists about federal bills that need action; they also suggest ways that make it easier to e-mail or contact your representatives. One such Web site is the National NOW Action Center, www.now.org. The Web site "Thomas" (named after Thomas Jefferson) located at <http://thomas.loc.gov> is an excellent source for research on current and recent bills (Stapleton-Gray, 2003).

The Power of Your Voice

Never underestimate the importance of what you have to say. As a professional, you bring a unique perspective to health care issues and often have intricate knowledge that helps provide insight for our country's lawmakers. It is also important that you lobby those members of Congress who may support your views as well as those who may not. Lobbying can change votes so it is important that you lobby the people who disagree with you. Lobbying supporters provides them with evidence that there are people out there backing their position and allows them to be more active in championing that position (<http://archive.aclu.org>, 2003).

As a professional nurse, your tools are your voice, power, knowledge, and vote. These tools are crucial to future health care legislation and they are most effective when used to influence policymaking. The best way to do this is by lobbying. Let's get busy.

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Nursing Care at the End of Life

Sally Russell, MN, CMSRN

Second in a series of reports on the End of Life Nursing Education Consortium (ELNEC). The ELNEC curriculum is supported by a grant from the Robert Wood Johnson Foundation to the American Association of Colleges of Nursing and City of Hope National Medical Center (Geraldine Bednash, PhD, FAAN and Betty R. Ferrell, PhD, FAAN, Principal Investigators.)

At the End of Life Nursing Education Consortium (ELNEC) I attended in January, nine modules were presented, each encompassing a different aspect of care for patients in the end of life. The first module creates the foundation for the entire curriculum and is an overview of the need to improve end-of-life care. It also addresses the role of the nurse as a member of an interdisciplinary team in providing quality care.

The key messages shared in this module included the following:

1. There are major deficiencies in current systems of care for patients and families at the end of life.
2. Social and economic forces influence care provided at the end of life.
3. Nurses should not work in isolation but rather as partners in collaboration with physicians and other disciplines.
4. Caring for the dying means not only "doing for" but also "being with." Palliative nursing care combines caring, communication, knowledge, and skill.

Following is a summary of the information that would be included in training sessions provided by ELNEC trainers.

Change is Needed

During the last century, there has been improvement in the care of those experiencing end-of-life concerns, but a great need exists to quicken the pace of these changes.

In the late 1800s there was not much that health care professionals could do as most people died within days. Most deaths occurred at home, with family members providing the care.

In the early to mid-1900s there were improvements to living and working conditions and antibiotics were developed, which positively affected life expectancy. As the focus of health care shifted from easing suffering to curing dis-

ease, there was a change in the way people looked at health care, causing most people – lay as well as health professionals – to see death as a failure of the medical system. Even more positive changes have occurred to life expectancy rates since the mid-1900s leading to an increasingly aged population, and institutions have replaced the home as the most common place for death to occur.

Studies, such as the massive "Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatment" (SUPPORT, 1995), have been conducted to determine needs as perceived by those experiencing the end of life. Each study has demonstrated that today patients are dying in pain and that many people don't realize they have the right to have that pain controlled. In 1999 only 29% of people in the end of life received hospice care.

Choice Matters

It is also more widely understood today that people don't die the way they would prefer. Most adults prefer to be cared for at home, and when asked, the majority say they would be interested in programs such as hospice but that they were unaware such a program existed.

The two greatest fears people express are being a burden to their families and dying in pain, yet a system that would alleviate those concerns is not being used to its fullest extent.

Patients and families also share a concern that when they are told "nothing more can be done" they will no longer be cared for by physicians or hospitals. What this leads them to believe is that nothing can be done in any of the arenas of care, when what they may have actually been told was there was nothing else curatively that could be attempted.

Challenges

There are a number of barriers to quality of care at the end of life. The disease process can present a barrier as both the patient/family and the health care professionals may have difficulty admitting that medical knowledge isn't advanced enough to eventually work, which may then lead to even more aggressive treatments with no great outcome.

Lack of adequate training of professionals caring for these persons leads to ineffective means to control not just the pain but many of the other symptoms as well. Delayed access to hospice and palliative care services sometimes occurs because health care professionals may not understand what those services are.



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In addition, regulatory measures can also create a barrier, which is unfortunate because they were actually designed to protect patients. Institutional rules that may restrict visiting hours were meant to provide rest and privacy but in the end of life are seen as difficult at best and inhumane at worst. Regulation of the use of controlled substances, while meant to protect from substance abuse or misuse may actually prolong pain in those with end-stage cancer. Denial of death is a large barrier to quality care by families who won't or can't admit that it will happen, or even by health care professionals who can't deal with the psychological care that requires them to converse with all involved.

Hospice

Hospice is a program of care provided anywhere and is based on the fact that dying is a normal part of living. Hospice promotes the idea of "living until you die," and medical and supportive services are provided wherever the patient is. There is a Medicare Hospice Benefit designed to provide support to families caring for dying patients with predictable illness/death trajectories, and is limited to those

expected to be in the last 6 months of life. With the increase in the number of people suffering from chronic illnesses, the desire has been expressed to expand the provision of services so that patients and families can receive palliative care before that 6 month period. Length of care is still limited under the current Medicare benefit, however, although work continues.

Palliative Care

Palliative care can be defined as "an approach that improves the quality of life of patients and their families, facing the problems associated with life-threatening illness, through the prevention and relief from suffering, by means of early identification, impeccable assessment, treatment of pain and other problems physical, psychosocial, and spiritual" (World Health Organization, 2002).

The goals of palliative care are comfort and quality end-of-life closure (allowing the patients and their families to find meaning and reach personal goals prior to and after death).

The general principles of palliative care are:

- The patient and family are the unit of care.
- Attention to the physical, psychological, social, and spiritual needs must be included.
- An interdisciplinary team is involved including the physician, nurse, social worker, chaplain, physical and occupational therapists, pharmacist, dietician, aides, along with any other complimentary therapist that is appropriate.
- Education and support is given to patient and family
- All patients and families, no matter the setting, are afforded access.
- Bereavement support is provided.

Assessment of end-of-life care should be based on a model for quality of life which encompasses all dimensions of a person's life. The assessment must include determining what quality of life means to the individual and recognizing that this will be different for each person, and may even be different for the same person at different stages of their end-of-life experience. Thus, the assessment should be a continual one, not a one-time "job."

Nursing Implications

The nurse's role in extending palliative care principles to improve end-of-life care is multifaceted. The importance of nursing presence cannot be overestimated as care can be frustrating for those involved based on the fact that not everything can be "fixed," as much as that might be desired by all. The use of nursing presence is a way to express compassionate caring.

Nurses are also a constant across all of the settings the patient and the family may have traversed on this journey. Nurses are the health care providers who typically spend the most time with patients and families, thus their role cannot be minimized.

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AAACN, Nursing Organizations, Continue Work on End-of-Life Care at National Summit

E. Mary Johnson, RN, BSN, C, CNA

This past fall, 44 professional nursing organizations participated in a follow-up 3-day conference designed to assess each of the organization's efforts to educate nurses around the country about palliative/end-of-life care (P/EOLC) during the past year.

This ongoing project is entitled "The Nursing Leadership Academy for End-of-Life Care," and is coordinated by the Institute for Johns Hopkins Nursing (IJHN) in Baltimore, MD. Funding is provided by the Open Society Institute's Project on Death in America. This follow-up meeting was held September 25-27 in Baltimore, MD.

Last year, Johns Hopkins called on professional nursing organizations to participate in this project because they have ready access to nurses as well as a variety of communications tools. In addition, nurses see themselves as advocates and educators for patients and families and are highly trusted by the public.

Work Continues

As with all diverse organizations, progress and accomplishments varied greatly. However, the groups were in unanimous agreement on their common goal of creating "One Vision and One Voice" to educate nurses about P/EOLC issues.

End-of-Life Care

continued from page 9

Quality end-of-life care encompasses physical, psychological, social, and spiritual aspects and includes the family as the unit of care. These are certainly part of the nursing role; they also demonstrate the quality of life model that typifies the palliative care movement.

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Linda Brixey, RN, and E. Mary Johnson, RN, BSN, C, CNA, have represented AAACN at the Academy since 2002. AAACN's progress in the past year has been steady and impressive. Both Linda and E. Mary have written several articles in *Viewpoint* and AAACN Education Director Sally Russell is involved in the "End-of-Life Nursing Education Consortium" funded by the Robert Wood Johnson Foundation. Sally has been sharing the teaching modules and critical aspects of end-of-life care in an ongoing series in *Viewpoint* (see pages 8-10, this issue; also May/June 2003 issue, pp. 5-6).

In addition, AAACN is collaborating on other end-of-life efforts with four other nursing organizations managed by Anthony J. Jannetti, Inc., AAACN's management firm.

Finally, AAACN is including end-of-life sessions at future conferences, including a preconference in Phoenix, AZ, during the 29th Annual Conference, March 18-22, 2004.

Looking Ahead

During the Nursing Leadership Academy meeting this fall, we reviewed the past year's work, renewed our commitment to our shared goal, and restored our energy in continuing this very important work. The added benefit of networking, sharing a few laughs, and holding spirited discussions promoted our sense of hope for the nursing profession overall.

The future of this project will take on a different form by becoming a "Virtual Community of Practice" as we continue discussions and measure our progress via some high-tech electronic communication methods. This virtual community will be made possible through generous grants from both Dell and Microsoft who are providing special software that will allow the work to continue in a focused format with access only by the participants. Johns Hopkins will continue to coordinate the Academy's efforts, which we all realize is vital to the continued success.

As the P/EOLC nursing community continues to refine its charter, collaboration and communication among the nursing representatives toward the goal of "One Vision and One Voice" become increasing important.

As always, AAACN encourages your involvement, ideas, and support. Help us understand what you need to educate patients and families on the critical issues facing the health care delivery system. One need only to reflect on the current controversy involving Terri Schiavo, the brain damaged woman on life support in Florida, as a painful reminder of how much is left to do when it comes to providing compassionate and optimum end of life care.

E. Mary Johnson, RN, BSN, C, CNA, is *Credentialing Consultant, Cleveland Clinic Foundation for Advanced Practice Nurses, Cleveland, OH*; and a AAACN past president. She can be reached at (330) 467-6214 or emjrn@adelphia.net.

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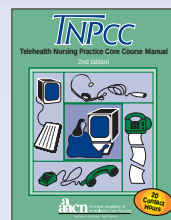
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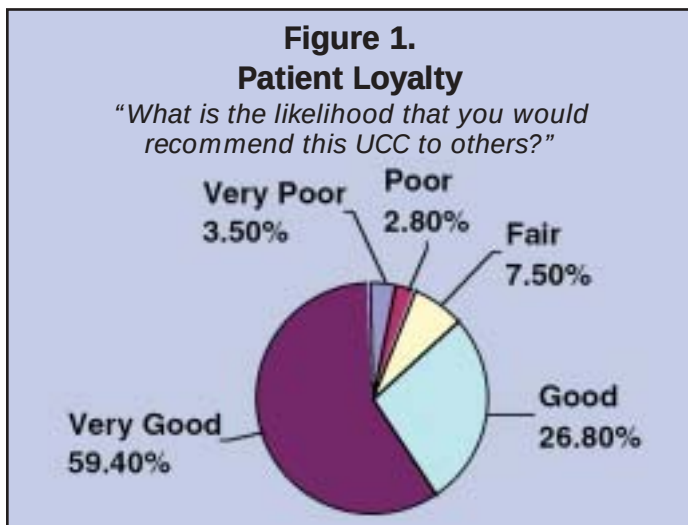
Patient Loyalty and Urgent Care Settings

continued from page 1

the health care industry, examined 64,389 patient satisfaction survey responses in 2002. Collectively, the patient responses represented 107 UC centers across the United States. The good news for the UC industry is that the average overall satisfaction rating (a composite measure on a 100-point scale) was 83.0, suggesting fairly high satisfaction levels among UC center patients.

However, when looking more closely at the issue of patient loyalty, there is perhaps less cause for celebration. As Jones and Sasser (1995, p. 91) point out, "the only truly loyal customers are totally satisfied customers." In the context of a patient satisfaction survey, a rating of anything other than the highest rating possible, even if it is a generally positive rating such as "good," indicates the potential for defection to another source of care in the future.

As shown in Figure 1 below, our survey results showed that only 59% of patients indicated that the likelihood of their recommending the UC center to others (a leading indicator of patient loyalty) was "very good," the highest rating on the scale. Thus, a large portion of the UC patient base may be likely to seek care elsewhere in the future if an opportunity they perceive as better should arise.



Effective Strategies

What can UC centers do to improve the experiences of the patients they treat and by extension increase patient loyalty and positive word of mouth? The best approach is to focus on those issues with which patients are currently least satisfied *and* view as integral to their satisfaction with the care experience.

Our national analysis prioritized each item on the Press Ganey Urgent Care Survey according to the probable impact the item's improvement would have on patient likelihood to recommend the UC center (see Table 1). Focusing quality improvement efforts first on the items at the top of the list will generate the largest gains in terms of positive word of mouth and loyalty.

The #1 priority in our analysis was to find out from the patient "How well you were kept informed about delays."

Table 1.

Top 10 Priorities for Improving UC Patient Satisfaction Nationally

1. How well you were kept informed about delays
 2. How well your pain was controlled
 3. Degree to which staff cared about you as a person
 4. Doctor's concern to keep you informed about your treatment
 5. Waiting time in the treatment area before you were seen by a doctor
 - 5.* Information you were given about caring for yourself at home
 7. Doctor's concern for your comfort while treating you
 - 7.* Staff concern to keep family or friends informed about your status during the course of your treatment
 9. Waiting time before you were brought to the treatment area
 10. Degree to which the doctor took time to listen to you
- *Duplicate numbers indicate items of equal priority.

When one considers that much of the appeal of UC centers is their perceived convenience when compared to other health care options, it is not surprising that the issue of delays emerges as a central concern. As shown in Figure 2 (next page), there is a clear relationship between how long a patient spent in the UC center and their stated likelihood to recommend the center.

These data suggest that patients expect UC centers to deliver care promptly, and their loyalty may wane if that expectation is not met. Therefore, streamlining processes so as to effectively manage patient flow is essential. This can be challenging, given the "no appointment necessary" nature of most UC centers.

A key factor in managing visit times and thus increasing patient loyalty is creating an environment that supports expedient care. Having a system in place for tracking length of stay and communicating this to staff is critical. The more challenging task, however, is developing a group consciousness that strives to meet the expectations that have been set. This is a delicate task that requires constant nurturing through hiring practices (finding the right staff), empowerment of staff members, routine discussion of length of stay goals, and acknowledgment of staff successes (see sidebar, next page, "Five Things Managers Can Do").

Example: UC Center in Indiana

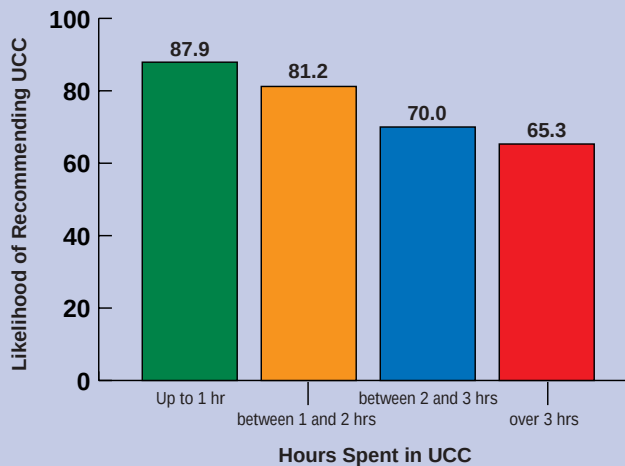
The goal at the Immediate Care and Occupational Health Clinic (ICC/OH) of Johnson Memorial Hospital (JMH) in Franklin, IN, is to average 40 minutes from door to discharge, and any deviation from that average is examined and shared with the staff.

To achieve those results, back office staff are empowered to use their judgment in performing tests that one could easily assume the physician will order. For example, if symptoms of a urinary tract infection (UTI) or strep

Figure 2.

Lengthy Waits Decrease Patient Loyalty

The longer it takes patients to receive care, the less likely they are to recommend your Urgent Care Center to others.



throat are the primary complaint, staff are encouraged to go ahead and do a urinalysis or a rapid strep. If the primary complaint is an ankle injury (with the possibility of a fracture), the radiology technician may proceed with an X-ray. Most often, they will run it past the physician quickly to see if that is reasonable. These measures all serve to expedite the patient's visit, thus reducing wait times.

At Johnson Memorial Hospital, all departments use Press Ganey surveys to evaluate customer satisfaction. The ICC/OH has won JMH's Eagle Award for highest patient satisfaction in 4 of the last 6 quarters. The JMH ICC/OH also ranks very high in the Press Ganey Urgent Care database. These accomplishments are shared with the staff and serve to further motivate them to continue to maintain this high standard.

Getting Over the Bumps

Let's suppose that you have done your best to streamline your processes and your staff take the initiative to order more routine sorts of tests promptly when indicated, but your patients still occasionally encounter delays. Must the drop in patient satisfaction associated with lengthy delays simply be accepted as inevitable?

Figure 3 (next page) suggests that the answer is "no," not if you have excellent customer service processes in place such as providing patients information and updates regarding delays.

Patient likelihood to recommend the UC center remains high *as long as patients are given very good information about the delay*. Even patients who experience very lengthy delays of 3 hours or more tend to remain loyal if they are provided with very good information about what is going on. As the patient's evaluation of the quality of information about delays becomes more negative, patient loyalty to the UC center becomes increasingly tenuous.

The bottom line? Patients view their time as valuable, want to be informed of the expected wait time, and want to be provided with periodic updates regarding delays

Five Things Managers Can Do To Decrease Visit Times In Urgent Care Centers

1. Hiring

Carefully screen prospective staff for their customer service orientation. It is challenging to evaluate a person's skill, personality, and work ethic within the context of one or two interviews. Remind yourself that many clinical skills can be taught...but it is often very difficult to shape personal dispositions.

One advantage urgent care centers have is that the core staff is usually small and therefore easier to monitor. If a manager is able to motivate and empower one or two staff members with regard to length of stay issues, they may be able to pull in the others over time to form a set of shared goals.

2. Tracking

Develop a system to track visit times and make certain all staff understand the goal regarding length of visits. This could be done by posting the length of stay goal and your clinic's results on a regular basis.

3. Discussing

Make the length of stay issue a regular agenda item at all staff meetings, allowing ample time for staff discussion of what works well and what seems to interfere with the delivery of expedient care.

4. Empowering

Allow your office staff to use their judgment in ordering tests. If patient symptoms logically suggest the physician would want a certain test ordered, don't wait. Getting a jump on these sorts of issues can expedite the visit.

5. Acknowledging

Small incentives can be put in place to reward the group when steps have been made to meet the goal. This is where the creativity of the manager is important. These incentives could be very small, such as a pitch-in for lunch or acknowledgment in the hospital newsletter if affiliated with a larger facility. A manager might be surprised how much mileage can be gained by presenting each staff member with a ribbon or card. What is necessary is acknowledgment, in whatever form.

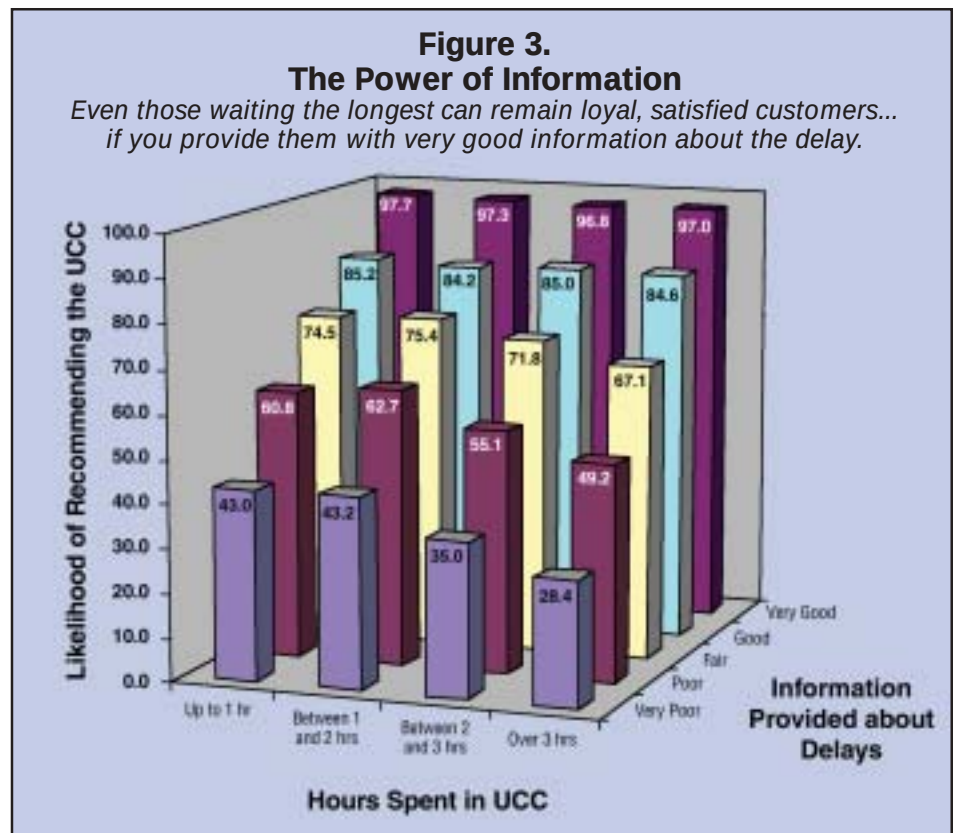
(Baker, 1997; Mayer & Cates, 2002).

On occasion, situations arise that prevent the delivery of 'urgent' care. When such situations occur, it is our responsibility to inform patients of delays.

Another aspect that is often overlooked is what happens in the back office during extended waits. Staff must be conscious of their behavior and interactions within the clinic. Many patients especially those who have waited for a period of time are extremely vigilant of activity within the clinic. If they hear laughter or see staff idle, their perception of the wait will definitely be affected.

Patients come to urgent care facilities to receive quick medical care and even if the staff that they observe cannot immediately expedite their visit, patients are left feeling that not everything is being done to meet their needs. For instance, if a medical assistant or nurse performed their necessary data collection and the chart is prepared for the doctor who is currently with another patient, there is very little that the staff can do except wait for the doctor. However, the reality of the situation may be lost to a patient who may not understand the roles of each particular staff member.

Generally, patients will tolerate waits if a trauma case arrives during their stay. Most can appreciate the need to attend to a more critical patient and they would want that for themselves or for a family member. Patients will also tolerate waits if they have arrived at a busy time and the waiting room is busy. At that point, if they choose to be seen regardless of the number of people present, they will be



more patient. However, if there is any sense that not all staff are involved or active, that patience may be short lived.

Conclusion

In today's health care environment, UC centers are attractive to patients because of their convenience. If the centers cease to be perceived by patients as more convenient than other care settings (emergency departments or primary care offices), then they risk losing the source of their appeal. Thus, keeping patients well-informed about delays and creating an environment where staff are ever-mindful of how those in their waiting area perceive the situation is essential.

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Time is running out! **AAACN Member-Get-A-Member Campaign**

The Member-Get-A-Member Campaign ends December 31, 2003. You still have time to recruit new members and earn a chance to win a free trip to the 2004 conference in Phoenix or a \$100 certificate toward AAACN programs or products! Take a few minutes to inform your associates of the benefits you enjoy as an AAACN member. You might also consider giving a membership as a holiday gift to a colleague.

Membership applications may be filled out on-line at the AAACN Web site, www.aaacn.org. You may also call the National Office at 1-800-262-6877 to obtain applications. Make sure the colleagues you recruit fill in your name as the "Recruiter" on their membership applications so you qualify.

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AAACN 2003 Financial Profile

On July 29, 2003, the accounting firm Gold, Meltzer, Plasky and Wise provided the accountant's review report to the AAACN Board of Directors.

A review consists principally of inquiries of company personnel and analytical procedures applied to financial data, and is substantially less in scope than an audit. The review was made for the purpose of expressing limited assurance that there are no material modifications that should be made to the financial statements in order for them to be in conformity with the modified cash basis of accounting.

The report concluded with the following: "We have reviewed the accompanying statements of assets, liabilities, and fund balance – modified cash basis of the American Academy of Ambulatory Care Nursing, as of June 30, 2003 and the related statements of cash flows for the years then ended in accordance with Statements on Standards for Accounting and Review Services issued by the American Institute of Certified Public Accountants. Based on our review, we are not aware of any material modifications that should be made to the accompanying financial statements in order for them to be in conformity with the basis of accounting."

Compared with Fiscal Year (FY) 2002, there was less than 1% decrease in total revenues. Membership dues revenue decreased 3% and annual conference registration decreased 4%. Given the impending Middle East conflict, this decrease was less than anticipated.

The 32% increase in annual conference exhibit and grant income and the 55% increase for Telehealth Nursing Practice Core Course (TNPCC) products offset the decreases in revenues. The decrease in standards publication sales is due to aging of the material. The Board anticipates an increase in this category with the availability of revised standards for the 2004 conference.

There was a 6% decrease in total expenses, driven by a 7% decrease in administrative expenses, as well as decreases in all other expenses with the exception of membership expenses. Total expenses exceeded revenues by \$5,575 or 1% in FY 2003, which was less of a deficit than anticipated.

Discussion and efforts by the AAACN Executive Director and Board were focused on increasing revenue sources, including sale of revised standards and additional education products.

FY 2003 was closed with a fund balance of \$274,496. The Board approved converting from a July-1-June 30 FY to a calendar year in 2005.

Regina C. Phillips, MSN, RN
AAACN Treasurer

Cynthia R. Nowicki, EdD, RN
AAACN Executive Director

Statements of Assets, Liabilities, and Fund Balances - Modified Cash Basis

June 30	2003	2002 (Audited)
Assets		
Current assets		
Cash	\$193,077	\$98,024
Accounts receivable	50	2,032
Accrued interest receivable	476	1,018
Prepaid expenses and exchanges	131	1,485
Total current assets	193,734	102,559
Other assets		
Investments	208,125	323,201
	<u>\$401,859</u>	<u>\$425,760</u>
Liabilities and fund balance		
Liabilities		
Accounts payable	\$33,662	\$38,728
Deferred revenues	93,701	106,961
Total liabilities	127,363	145,689
Fund balance		
	<u>274,496</u>	<u>280,071</u>
	<u>\$401,859</u>	<u>\$425,760</u>

Statements of Revenues and Expenses – Modified Cash Basis

June 30	2003	2002 (Audited)
Revenues		
Membership dues	\$163,511	\$168,810
Annual conference registration	189,872	199,382
Annual conference exhibits/grants	42,214	32,000
Certification review course	11,850	15,514
Standards publication sales	5,648	7,952
Telephone standards	6,104	6,682
TNP resource directory	237	335
Interest and dividend income	10,248	10,152
Grants/contributions	9,815	3,002
VP advertising and subscriptions	2,895	6,293
Miscellaneous income	2,856	3,361
Certification Products	7,116	7,164
Royalties	2,079	6,472
ANA/AAACN monograph	95	358
TNPC course	35,005	22,618
Total revenues	489,545	490,095
Expenses		
Administration expenses	169,160	181,568
Membership expenses	128,817	127,851
Committee expenses	4,011	5,681
Educational programming	187,240	198,725
Educational materials	1,288	2,026
Loss on sale of investments	4,604	13,514
Total expenses	495,120	529,365
(Expenses) in excess of revenues	(5,575)	(39,270)
Fund balance, July 1	280,071	319,341
Fund balance, June 30	\$274,496	\$280,071

AAACN Launches 'Virtual University'

AAACN has partnered with *360 Training*, a provider of compliance and workforce e-learning courseware based in Austin, TX, to provide our members and other nursing professionals with media rich, interactive courses.

These courses have been created to help advance careers, comply with regulatory requirements, and foster safer working conditions. The courses are fully narrated, cost effective, and easy to use without requiring high-speed Internet connections.

Through this addition to our on-line education, AAACN is working to meet the growing demand for innovative, self-service training products that allow our members to comply with regulatory demands while increasing abilities to care for clients safely and effectively.

Visit <http://aaacn.360training.com> to view a sample of the following courses:

- Bloodborne Pathogens
- HIPAA Compliance Toolkit for Physician Practices
- HIPAA Compliance Training Course

New Member Benefit: Searchable On-line Membership Directory

The redesigned AAACN Web site, www.aaacn.org, now features a searchable on-line membership directory.

This *new* member benefit further expands AAACN networking options by making members' contact information easily (and quickly) accessible.

Because the directory is on the Web site, you can access it anywhere...home, work, or from a remote location. All you need is a computer with an Internet connection and your username and password. The directory is especially handy if, for example, you met another member at the AAACN Annual Conference and misplaced his/her contact information.

How to Use the Membership Directory:

- Log in at the top of the home page.
- Click on "Find a Member" at the left under "Complete a Task."
- Enter the member information you know: last name, state, region, or member type.
- Click on "Search." The member names, cities, and states appear for those members who match the search data you entered.
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The AAACN Career Center is a member of the *HEALTHeCAREERS™* Network, a nationwide on-line recruiting network of professional health care associations.

For more information, visit our Web site at www.aaacn.org and click "jobs," or contact the Customer Care Center at 888-884-8242. You may also send an e-mail to info@healthcareers.com.

Conference Features Wide Range of Innovative Sessions

Concurrent sessions that will educate, energize, and engage participants during the AAACN 29th Annual Conference are many and diverse. The planning committee has carefully considered the varying work places of our members and attendees, as well as the needs of the patients they serve.

For those interested in politics and health care, Leonard Kirschner, MD, MPH, will provide an invaluable session on that topic. Dr. Kirschner, who is a member of the Executive Council of AARP Arizona and on the Boards of several Arizona Health care organizations, will provide a short history of America's health care system, describe the current state of health care politics, and discuss the importance of the nurse's role as patient advocate.

Linda L. D'Angelo, RN, MSN, MBA, CMPE, will take a different look as she discusses the country's health care economics and how health care delivery systems thrive as free market businesses and the associated challenges in today's political climate. Ms. D'Angelo teaches Health Care Finance at the University of Illinois and serves as acting CEO of DBMS, INC., a care and disease management software company in Indiana.

Deloras Jones, RN, MS, is Executive Director of the California Institute for Nursing & Health Care (CINHC). She will discuss how CINHC, a non-profit organization established by nurses alarmed by the lack of coordinated planning for the state's nursing shortage, was developed. CINHC also provides a non-partisan forum to address statewide nursing concerns. Ms. Jones will describe how CINHC can be used as a model for statewide planning regarding nursing workforce issues.

Patient safety has received a great deal of media attention in recent years, sparking health care professionals to identify problems and find solutions. Emily J. Sandelin, RN, MS, will lead a session entitled "Creating a Culture of Patient Safety: Vision, Structure, Tools, and the Impact on Nursing Practice." Ms. Sandelin will examine philosophies about responses to error and how these philosophies affect patient safety. She will also discuss tools that can be used to develop a patient safety culture in the practice arena. Emily is the Patient Safety Manager, Kaiser Permanente, Denver, CO.

Moderators Needed

AAACN program planners are currently seeking moderators for the 2004 Annual Conference in Phoenix.

A moderator introduces the speaker, distributes handouts, keeps the session on time, facilitates discussions, and trouble-shoots room or AV problems.

If you are going to the conference and would like to volunteer to be a moderator, please contact Pat Reichart at reichartp@ajj.com. When you receive your registration brochure, contact Pat to let her know which sessions you would like to moderate.

Your help in making the annual conference a success is greatly appreciated!

Maureen T. Power, RN, MPH, will also explore patient safety issues in her session "Addressing Risk Identification and Reduction in the Ambulatory Care Setting." She will examine the regulatory and public response to reducing risk in ambulatory care settings. Ms. Power is the Owner/Senior Consultant of Strategic Health Systems, Inc., Elmhurst, IL.

Along with these concurrent sessions, AAACN program planners have also included a wide range of clinical sessions. These include the following:

- "Aggravating Factors that Impact Heart Failure and Ambulatory Nurses' Role." Presenter Nancy M. Albert, MSN, RN, CCNS, CCRN, CNA, is the Manager, Clinical Investigations Thoracic and Cardiovascular Surgery, Kaufman Center for Heart Failure, Cleveland, OH.
- "Prevention of Obesity and Weight Management in Children and Adults." Presenters Betsey Haren, RN, MN, and Evelyn Eckberg, MSN, RN, PHN, are both Senior Clinical Strategy Consultants at Kaiser Permanente, Pasadena, CA.
- "SARS – The Toronto Experience & Setting Up a SARS Clinic in 24 Hours" (2 sessions). The presenters are Elizabeth Fornasier, RN, MED, BScN, and Judith Manson, RN, BScN. Ms. Fornasier is a Clinical Nurse Educator for Medicine, Trillium Health Centre, Etobicoke, Ontario; and Ms. Manson is the Patient Care Manager, Family Practice Division, Sunnybrook Hospital, University of Toronto Clinics, Toronto, Ontario.
- "Pain Management: Forging Ahead with Acupuncture." Sandy Petersen, MBA, RN, Senior Clinical Strategy Consultant, Kaiser Permanente, Pasadena, CA, will present.
- "How Can it Hurt Me? – It's Natural." Ina Hardesty, RN, MA, APN, and Kathleen McWeeny, RN, BSN, will present this session on the use of complementary and alternative therapies. Ms. Hardesty is an Advanced Practice Nurse, Clinical Nurse Specialist, Cleveland Clinic Foundation, Cleveland, OH. Ms. McWeeny is Clinical Coordinator, Cleveland Clinic Foundation, Cleveland, OH.

Look for more information about the conference in future issues of *Viewpoint*, in AAACN e-mail updates, and on the AAACN Web site, www.aaacn.org. If you have any questions about the conference, contact the AAACN National Office at (800) AMB-NURS or (856) 256-2350; or e-mail aaacn@ajj.com.

Sally Russell, MN, CMSRN, AAACN Education Director. She can be reached at (856) 256-2427; russells@ajj.com.

See back cover for more
**CONFERENCE
NEWS!!!**

AAACN Board Meets in Atlanta

*Key business items approved,
party crasher welcomed*

The AAACN Board of Directors held their fall meeting October 3-5, 2003 in Atlanta, GA, hometown of President Catherine Futch. Catherine hosted the meeting at the Kaiser Permanente Offices where she is Regional Compliance Officer.

Joining Catherine were AAACN President-Elect Kathleen Krone; Immediate Past President Candia Baker Laughlin; Secretary Beth Ann Swan; Treasurer Regina Phillips, Directors Deborah Brigadier, Carole Becker, and Karen Griffin; Executive Director Cynthia Nowicki; and Association Services Manager Pat Reichart.

The Board approved the following business items:

- Expanded partnership with HMS Northwest, a AAACN Corporate Member, including renewal of AAACN's endorsement of their benchmarking survey.
- Renewal of Web site contract with Anthony J. Jannetti, Inc., AAACN's management firm.
- AAACN's first audioconference on "Linking Performance and Staffing."
- Audio recording of the 2004 Annual Conference to be held in Phoenix in March.
- Change in Fiscal Year to a calendar year effective January, 2005.
- Change to Chair, Chair-Elect, Past Chair structure for committees.
- Conduct focus groups at AAACN Annual Conference.
- Special Interest Group (SIG) "interest" meetings at Annual Conference to discuss forming Geriatric, Nursing Management, and Patient Education SIGs.
- Corporate Affiliate Membership Category.

Although the Board worked from dawn to dusk for 2 full days, they were able to enjoy some southern hospitality including a traditional meal at Catherine's home, cooked by her cousin, Annie Winfield, with assistance from good friends



Attending the dinner in Atlanta are (from left) E. Mary Johnson, Regina Phillips, Beth Ann Swan, Candia Laughlin, Debbie Brigadier, Carole Becker, Cynthia Nowicki, Pat Reichart, Kathleen Krone, Karen Griffin, and Catherine Futch.

Lin Barker, Peggy Crawford, and Melanie Johnson. The highlight of the evening was an unexpected visit from AAACN Past President E. Mary Johnson who jumped out of a back room. Naturally, the board welcomed E. Mary's valuable input and unique sense of humor as they enjoyed a special evening.

Attend a Board Meeting

AAACN's Board of Directors meetings are open to all members. If you would like to attend the next meeting and offer input, please come to the Wednesday, March 17, 2004 Board meeting that will be held during the 29th Annual Conference in Phoenix, AZ. Stop in anytime that day between 8:00 am and 5:00 pm.

E-mail Pat Reichart at the AAACN National Office at reichartp@ajj.com and let her know if you plan on attending.

From the President

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grassroots level. AAACN's Immediate Past President Candy Laughlin is currently leading the effort to address this critical question.

The second issue I want to raise is that of membership. If AAACN is really an "Association of professional nurses and associates who recognize ambulatory care practice as essential to the continuum of high quality, cost-effective health care" (AAACN Identity Statement) then it would seem there is critical value in having and even expanding the diversity of our membership.

To be a vital and responsive organization, we need leaders to advance the organization and to mentor emerging leaders as well as to expand their own knowledge base and skill set. We need researchers who will examine the vital questions related to ambulatory care: staffing predictors, outcomes of care, effectiveness of disease state management, and issues surrounding end of life, pain management, and culturally competent care. We need practicing ambulatory care nurses who will know and understand the

changing practice environment, nurses who will benefit from a variety of opportunities to expand their knowledge and skill set. We need diversity in order to better understand and value the critical elements of culturally competent care.

This much is clear: Having a broad membership base seems to be the right thing for us to do. However, it also means finding new and different ways to engage various groups in a meaningful and effective way. This often translates to meeting the needs of each group on their terms. For some it means networking and national meetings, for others it means regional meetings, on-line training opportunities, or chat rooms. What does it mean for you?

These are very important questions for the organization. It isn't OK to be silent. We need your voice... we need your brain... we need your suggestions. So please e-mail or call us and let us know what you want so we can find solutions that will provide more value for you (see back cover for AAACN contact information).

Catherine Futch, MN, RN, CNA, CHE, CHC, is AAACN President and Regional Compliance Officer, Kaiser Permanente, Smyrna, GA. She can be reached at catherine.futch@kp.org.

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MISSION STATEMENT

Advance the art and science of ambulatory care nursing

AAACN Conference News

Silent Auction Returns!

AAACN's ever-popular Silent Auction will again take place as part of the Opening Reception of the 29th Annual Conference, March 18-22, 2004, in Phoenix, AZ.

It is not too early to begin thinking about participating in the Silent Auction, either as a donor, bidder, or both. Items included in previous auctions were gift baskets, nursing memorabilia, cookbooks, and vintage nursing books, pictures, crafts, gift certificates, and jewelry. Items should be portable and easy to carry in a suitcase.

The money raised from the auction goes to the AAACN Scholarship Program, which provides funding for academic and professional activities. For more information on the scholarship program call or e-mail the AAACN National Office (phone: 800-AMB-NURS; e-mail: aaacn@ajj.com).

For more information about the Silent Auction, please contact Pam Del Monte at pameladelmonte@med.va.gov; or Sana Savage at lcdr-sana.savage@cnet.navy.mil.

Share Your Nursing Stories

If you plan on attending the AAACN Annual Conference, March 18-22, 2004, in Phoenix, AZ, and have a funny or inspirational nursing story to share with your colleagues, please e-mail a brief synopsis to Pat Reichart, reichartp@ajj.com, at the

AAACN National Office by December 31, 2003.

Nurses will tell their stories during the Closing Session of the conference. The format is intended to be fun and informal, and will be an enjoyable way to connect with others as they share their nursing experiences.

You don't need to be a polished speaker, simply tell your story from the heart. Story presentations should take no longer than 5 minutes. We look forward to hearing from you.

Tri-Service Military SIG to Hold Preconference

The annual meeting of the AAACN Tri-Service Military Special Interest Group (SIG) will be on March 17, 2004, in Phoenix, AZ, from 8:00 am - 5:00 pm.

Each of the U.S. Army, Navy, and Air Force Nurse Corps Chiefs will brief attendees on the current status of the nurse corps and the vision for the future. Additional briefings will provide insight into strategies and programs supporting the future of military medicine.

Registration is open to all AAACN members. Contact CDR Sara Marks, NC, USN at marks@nwdc.navy.mil, Col Monica Secula, USA, NC, at monica.secula@amedd.army.mil, or Lt Col Carol Andrews, USAF, NC at Carol.Andrews@lakenheath.af.mil.

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