There is an epidemic of obesity in America, which has lead to an epidemic of type II diabetes. According to the Centers for Disease Control and Prevention (2008), there are 24 million individuals in the U.S. with diabetes, and another 57 million with pre-diabetes, a condition that increases the risk of developing diabetes. Slowing or reversing this trend will depend on collaboration between patients and their health care teams.

This article focuses on the steps taken by staff in the Internal Medicine Clinic, Maine Medical Center (MMC), located in Portland, Maine, to “Target Diabetes.” The largest hospital north of Boston, MMC has 606-licensed beds, is a teaching hospital, and is JCAHO and Magnet® accredited.

In 2000, MaineHealth, the parent company of MMC, developed a workgroup with primary care physicians, diabetes nurse educators, nutritionists, and other health care professionals. This workgroup created a Target Diabetes Provider “toolkit” to be used by health care teams providing diabetes care (MaineHealth, 2006). Similar to efforts in other states, this program brought together the knowledge of multi-disciplinary teams from across the state to develop “best practices” for diabetes care. Two features of the toolkit are the Diabetes Self-Care Report (Self-Care Report) (see Figure 1) and the Diabetes Self-Care Action Plan (Action Plan) (see Figure 2).

The Self-Care Report is standards-based and intended to reflect actual patient achievement in meeting American Diabetes Association standards of care. To accommodate different learning styles, the Self-Care Report utilizes both visual and written formats. The “score card” tracks patient progress for 11 risk factors from controlling blood pressure and hemoglobin A1c (HbA1c) to kidney/urine protein and triglycerides. Data are posted for current and past results, how often measures should be taken, and actions the patient can take and why they are important. Patients become particularly excited about the “On Target” column, where successes or areas within the target range are easily identified by a red and blue check mark. A plotted graph in the lower left corner shows the current result and a long-term view of the HbA1c results, and a pyra-
As AAACN works toward becoming a remarkable association, we also want to assist our members to become remarkable individuals. We work toward this goal by providing educational programs and resources; encouraging members to participate in task forces, committees, and special interest groups; and offering opportunities to share best practices and innovations through Viewpoint and various journals, such as Nursing Economics. We want to build on basic professional and personal traits, and assist you to be remarkable.

I believe that the following list contains traits that ambulatory care nurses possess.

The ambulatory care nurse:

- Acts as a colleague to other staff and members of the team.
- Advocates for patients, families, significant others, peers, and others.
- Believes in self and has the courage to do the right thing.
- Builds relationships and fosters collaboration.
- Coaches others.
- Is committed to a goal related to the patient, staff, family, student, peer, or project.
- Communicates, communicates, communicates.
- Is competent.
- Participates in continuous learning.
- Empowers self and others.
- Demonstrates ethical behaviors.
- Acts as a facilitator.
- Listens.
- Mentors others.
- Problem solves.
- Puts others first.
- Possesses a positive attitude.
- Is responsible.
- Role models.
- Has a sense of purpose and knows what needs to be accomplished.
- Sees the whole.
- Takes the initiative.

These are also the traits of a leader. As nurses, we are all leaders. It does not matter the role – staff nurse, manager, executive, researcher, educator, or staff support. Leadership is about understanding people, and getting people pointing and acting in the same direction. One of the leadership processes described in the literature by Mike Yates (www.leadership-values.com) is called the 4 Es of Leadership: Envision, Enable, Empower, and Energize.

Envision

The first concept, “Envision,” starts with the leader having a clear view of the goal in mind. For example, a patient is newly diagnosed with diabetes and needs to learn how to measure his blood sugars at home. The goal is to ensure the patient has the knowledge needed to complete this task, how to interpret the readings, and what to do if the readings are over a certain level.

Enable

The second concept, “Enable,” is where leaders must decide what methods or tools will be used to meet the goal. We know that the patient will need to learn how to use the blood glucose monitoring machine, test strips, and control solu-
American Association of Colleges of Nursing (AACN) Clinical Nurse Leader (CNL) Staff Nurse Advisory Panel

It was my privilege to represent AACN at the Clinical Nurse Leader (CNL) Staff Nurse Advisory Panel meeting on August 13 and 14, 2008. The role of the panel was created to assist AACN and the CNL Steering Committee in the role of the CNL. Their role also includes implementation across all practice settings within the health care system, as well as standardizing the educational requirements and competencies necessary to fulfill this role.

Prior to attending the meeting, I gathered feedback from AACN leadership regarding the CNL role in ambulatory nursing practice. Their responses varied by perspective and depth of knowledge regarding the role. It is important to start with some basic information of the Clinical Nurse Leader Role: “The CNL provides and manages care at the point of care to individuals, clinical populations, and communities” (American Association of Colleges of Nursing [AACN], 2007, p. 11). The CNL works as part of an interdisciplinary health care team to identify ways we can better utilize our available resources in the health care system and to improve patient care outcomes. The CNL works with the staff nurse, the nurse manager, and the physician to achieve these goals. It is the first new master’s prepared role in nursing in 35 years. Several aspects of the CNL role have been identified as vital to its success. These include:

- Lateral integration of care – Facilitate, coordinate, and oversee the care provided by the health care team.
- Interdisciplinary care planning – Communicate and collaborate with other members of the health care team.
- Physician liaison – Collaborate with physicians regarding the patient’s plan of care by taking an active role in patient rounds.
- Resource person – Educate staff through mentoring, coaching, and clinical conferences.
- System analyst – Manage and coordinate care at the multidisciplinary level.

- Evidence-based practice (EBP) – Raise questions to challenge existing practices in an effort to promote EBP (Stanley et al., 2008).

The role of the CNL is being developed based on research begun in 2000 by AACN. “Two AACN task forces were convened to identify (1) how to improve the quality of patient care, and (2) how to best prepare nurses with the competencies needed to thrive in the current and future health care system” (Begun, Hamilton, Tornabeni, & White, 2006, p. 20). The core competencies listed above as necessary to the CNL role are the result of this research. A CNL position requires preparation at the master’s degree level, along with successful completion of the CNL certification examination. There are currently just over 90 CNL programs being offered by schools across the country. A list of these programs can be found at the AACN Web site.

The CNL is a role complementary to the roles of the unit nurse manager, clinical nurse specialist (CNS), and staff nurse. Most unit nurse managers are currently responsible primarily for the business aspect of managing a unit or clinic. The CNL is responsible for overseeing the clinical side of patient care delivery, at the point of care. The CNS is a clinical expert in a specialty or subspecialty of nursing practice, while the CNL functions as a generalist in nursing care delivery. The CNS works within his or her specialty to provide care to a specific population at the microsystem and across the systems levels. The CNL works primarily at the microsystem level of unit, clinic, or home health agency. While both the CNL and the CNS can serve to mentor nursing staff, the CNL is responsible for working directly with nursing staff to provide optimal care delivery. The CNS works from the perspective of his or her specialty or subspecialty.

The staff nurse advisory panel is a group of nurses from different geographic areas, varying backgrounds, and practice settings, and they represent several professional nursing organizations. Among the panel is one CNL, currently practicing, and his or her nurse manager. The current position and impact the CNL role has made in the facility was discussed. AACN is hoping for continued input over approximately 18 months to facilitate the development of the CNL initiative on a national level. The goals outlined for continued work are:

- Moving as quickly as possible to a national/regional evaluation phase.
- Reinforcing the need to educate nurses and other health care professionals about the CNL role in all settings prior to the implementation of the CNL in the care delivery model.

continued on page 17
In June 2007, the USNS Comfort (T-AH 20) began its travel of more than 11,680 nautical miles to complete a four-month humanitarian assistance and training deployment to 12 Latin American and Caribbean countries. The mission was in support of President Bush’s initiative, “Advancing the Cause of Social Justice in the Western Hemisphere.” Ambulatory care nurses were part of this mission – the first of its kind – and assisted with providing health care to more than 98,000 patients in Belize, Guatemala, Panama, Nicaragua, El Salvador, Peru, Ecuador, Colombia, Haiti, Trinidad and Tobago, Guyana, and Suriname. Services ranged from primary adult and pediatric care, pre-surgical screenings, optometry, and dentistry.

The deployment was a training and education opportunity for military medical personnel and civilians to enhance their skills in disaster relief and treating patients in real-life situations. A joint, interagency crew totaling more than 740 personnel manned the USNS Comfort. Of that number, more than 500 made up the medical crew composed of Sailors, Coast Guardsmen, Airmen, Soldiers, Canadian troops, and U.S. Public Health Service health care professionals, along with representatives from Non-Governmental Organizations (NGOs), including Project Hope and Operation Smile.

The ship was operated and navigated by a crew of 68 civilian mariners (CIVMARS) from the U.S. Navy’s Military Sealift Command (MSC). The USNS Comfort is one of two U.S. Navy hospital ships that is able to rapidly respond to a range of situations on short notice. The ship is uniquely capable of providing health services support as an element of humanitarian assistance and disaster relief, and has been configured to provide a range of services at sea and ashore.

This deployment offered unique opportunities for two ambulatory care colleagues and AAACN members, CAPT Wanda C. Richards, Pre-Deployment Site Survey (PDSS) Team Leader and Senior Nurse Executive (SNE) and LCDR Andrea C. Petrovanie, Medical Operations Liaison Officer (MEDOPS). CAPT Richards was one of two team leaders who served as an ambassador for the United States, establishing the blueprint for the ship’s diplomatic and medical-legal ties with 6 of the 12 countries. “Working and collaborating with the military groups and host nation governments prior to USNS Comfort arrival was an experience of a lifetime,” said CAPT Richards. “Our mission was to ensure safety and provide unrestricted access for patients and staff to and from the ship.”

LCDR Petrovanie was a member of the Advanced Coordination Element (ACE) team, which traveled ahead of the ship to coordinate the logistics for the U.S.N.S. Comfort’s arrival to the
host nation. The team consisted of a force protection officer, medical operations officer, and construction battalion (SEEBEES) military personnel. Her most memorable experience was returning to Trinidad and Tobago where she was born and raised. “It was very humbling to return to my country as an ambassador for the United States,” she stated. Her role included preparing for clinical missions ashore, shore-ship patient movement, host nation partnerships, and training schedules.

During the four months, there was very little down time and many long hours worked; a lasting “footprint” remained in the countries that were visited. The vast majority of the populations served consisted of women and children. In several countries, Richards and Petrovanie traveled to rural areas to provide care to many who were seeing a provider for the very first time. Major health concerns included diabetes, hypertension, skin lesions, and malnutrition. Pre-surgical screenings for cataracts, gynecological and urological complaints, hemicas, and cleft lip/cleft palate were common in all countries. As ambulatory care nurses, they utilized their knowledge, skills, and experiences to provide culturally competent patient care, participated in education and training opportunities, and assisted with patient transport, discharge planning, and coordination of follow-up care with the host nation. To ensure appropriate post-surgical and follow-up care, they collaborated with the Ministry of Health (MOH) in each country who played a pivotal role in coordinating patient referrals and follow-up.

For CAPT Richards and LCDR Petrovanie, this mission proved to be an extremely challenging yet truly rewarding experience that has changed their lives forever. They state, “It brought tears to our eyes knowing that we were doing some good for the people and their country. Their appreciation was expressed in many ways, from a big smile, to a warm hug, and words of appreciation, ‘thank you, thank you, and God bless America.’ Ambulatory care nursing is the way of the future, and this was an experience we will never forget.”

I have learned that people will forget what you said, people will forget what you did, but people will never forget how you made them feel. – Maya Angelou

Wanda C Richards, RN, MPA, MSM, is a Captain, NC, U.S. Navy, and Senior Nurse, Nursing Integration and Base Realignment and Closure, Bethesda, MD.

Andrea C. Petrovanie, MSN, RN, BC, is a Lieutenant Commander, NC, U.S. Navy, Junior Nurse Corps Assignment Officer, Navy Personnel Command (PERS 4415K), Millington, TN.
AAACN Supports the VA Let’s Get Certified Program

AAACN is supporting the Veterans Administration (VA) national Let’s Get Certified Campaign that runs through May 31, 2009. This initiative promotes nurses within the VA to get certified in a variety of specialties, including ambulatory care. AAACN is supporting this initiative with special discounts on study materials to prepare for the ambulatory certification examination. ANCC is also offering $100 off the full exam fee. If you are a VA nurse planning to become certified under this program, download the special AAACN VA Let’s Get Certified product flyer to order your study materials.

Consider sitting for the examination on March 29, 2009, during AAACN’s Annual Conference in Philadelphia, or when the exam is offered electronically at Pro-Metric Testing Centers across the country in April or May 2009. For complete details on this program, go to the VA’s Intranet site at your facility, then go to the Office of Nursing Services Web site and click on the Let’s Get Certified Campaign link. Once you do that, there is a tab to preview discounts and approved certification exams under this program.

AAACN encourages other facilities and groups to follow the VA’s lead in promoting certification.

AAACN Welcomes New Education Director

Valerie Leek, MSN, RNC-NIC, CMSRN, is AAACN’s new Education Director. Valerie has many years of education experience and is currently an assistant professor at a local college in New Jersey. Val is pursuing her PhD in education with a specialization in online learning. Val has worked in both the neonatal intensive care setting and in adult health. She maintains certification as a Neonatal Intensive Care Nurse from NCC since 1985 and a Certified Medical-Surgical Registered Nurse (CMSRN) through MSNCB since 2005.

Val will work closely with the Program Planning Committee to plan AAACN’s annual conferences. She will also be involved in all AAACN educational products and activities, our “going green” initiatives, our monthly audio seminars, CNE credit for articles in Viewpoint, and ensuring that AAACN’s continuing nursing education records are kept in accordance with ANCC requirements. We are excited to have Valerie on board and encourage anyone attending the 2009 conference to make sure you meet Val. Sally Russell, AAACN’s previous Education Director, is mentoring Val to AAACN and also to the Academy of Medical Surgical Nurses, another association managed by Anthony J. Jannetti, Inc. Sally remains on board at Anthony J. Jannetti, Inc. as Director of Education Services. AAACN thanks Sally for all of her guidance and support over the 7 1/2 years she was AAACN’s Education Director.

2009 Ballot to be Conducted Electronically!

One more step in “going green” will be to conduct the 2009 national office election electronically! This new process will eliminate the need for AAACN to print ballot booklets, ballot cards, two separate envelopes, and pay postage to mail ballots to voting members. This will definitely save a few trees!

AAACN has contracted with Survey and Ballot Systems to conduct its 2009 election electronically. Members who have provided e-mail addresses to AAACN will be notified regarding the upcoming election via e-mail in November. The e-mail will provide a convenient link to the electronic ballot that will contain information on each candidate, including statements on why each wants to serve AAACN. Openings in 2009 include President-Elect, two Directors, and two Nominating Committee positions.

Members who have not provided e-mail addresses will receive notification of the election by mail and will be asked to vote online. This notification will ask members to provide an e-mail address to AAACN for future ballots and other important member communications. AAACN recognizes each member’s privacy, and as such, wants to clarify to all members that member e-mail addresses are not rented to anyone.

It is our hope that members support AAACN’s efforts in making the planet a healthier place as well as find voting electronically quick and convenient. We ask that you take a few minutes of your time in November to vote for the individuals you feel will represent your nursing views and work toward meeting the goals of AAACN and advancing the specialty of ambulatory care nursing. Watch for an e-mail notifying you to vote electronically in November.

2008-2009 Nominating Committee

Order Your Holiday Gifts Early!

If you purchase gifts for your colleagues or staff, think about giving AAACN’s logo items and education resources as gifts. Fill a stainless steel coffee mug with candy, buy your staff tee shirts with the “Ambulatory Care Nurses are Everywhere Caring for You” logo on them, or give the world time calculator with alarm clock. A gift of a Core textbook or the standards, along with a nice note from you might also be appropriate. Any of these items may be ordered at www.aaacn.org. Gift certificates are also available. Call the AAACN National Office at 800-262-6877, press 3 to order your certificates.
Certification Review Course and Exam to be held at Philadelphia Conference

For the third consecutive year, AAACN is pleased to be able to offer our all-day Ambulatory Care Nursing Certification Review Course on Thursday, March 26, 2009, as a Pre-Conference Workshop prior to the Annual Conference, and the American Nurses Credentialing Center (ANCC) Ambulatory Care Nursing Certification Exam on Sunday, March 29, 2009, following Closing Ceremonies. Achieving certification has never been easier! Of the 41 nurses who passed the exam this year in Chicago, 38 took the review course!

If you plan to attend the Annual Conference in Philadelphia, consider getting certified while you are there! Begin studying by ordering the Core Curriculum for Ambulatory Care Nursing, 2nd Edition, that offers over 30 contact hours. Many nurses find the Ambulatory Care Nursing Review Questions, 2nd Edition, 2007, referenced to the Core, helps identify their weak areas. If you are unable to arrive at the conference early for the course, purchase the CD-ROM of the course online at www.aaacn.org, click on “Certification.”

AAACN Annual Scholarship, Grants, and Awards Program

Application deadline: January 15

AAACN’s scholarship, grants, and awards program offers members an opportunity to advance their education or conduct research, and be recognized for excellence in administrative, clinical, and ambulatory nursing through the following awards:

Research Grant*
Funded through Silent Auction fund raising, personal, and corporate donations.
Nurses who have been members for a minimum of 2 years, who submit a research abstract and proof of acceptance of the research study, and agree to present the research findings at the AAACN Annual Conference and/or publish an article in Viewpoint, may be awarded funding for a research project.

Excellence Awards
Sponsored by the Anthony J. Jannetti, Inc. Nursing Economic$ Foundation
Two nurse members will be recognized by AAACN as positive role models for mentoring, sharing expertise, effective management of rapidly changing situations, and improving patient care outcomes. Two awards of $500 will be given, one for Excellence in Administrative Ambulatory Nursing and one for Excellence in Clinical Ambulatory Nursing Practice.

Scholarships*
Funded through Silent Auction fund raising, personal, and corporate donations.
Nurses who have been members for a minimum of 2 years may receive an award for payment of tuition, books, or academic supplies. Eligibility includes current enrollment in an accredited school of nursing or a program to advance the profession of nursing.

All applications receive a blind review and are scored on an objective point system.
• You can download award applications from the AAACN Web site. Click on “About AAACN/Awards.”
• Candidates for the Excellence awards may be nominated by a colleague, supervisor, or may be self-nominated.
• Deadline date for all awards: January 15, 2009.
• All awards will be presented at the AAACN Annual Conference, March 26-30, 2009, in Philadelphia, PA. Please consider supporting the AAACN Scholarship/Awards program. Honor a colleague, family member, or support your specialty. Donations are tax deductible and may be sent to: AAACN Scholarship Fund, P.O. Box 56, Pitman, NJ 08071-0056.

Get Certified at the Philadelphia Conference

If certification in Ambulatory Care nursing is one of your goals, AAACN can help you achieve it! Plan to attend the annual conference, March 26-30, 2009. Start off by attending the Ambulatory Care Nursing Certification Review Course all-day on Thursday, March 26, for some last minute preparation before you take the ambulatory exam. This course is also an excellent overview of ambulatory care nursing if you are new to ambulatory care. Then attend the array of sessions offered during the main conference. End your trip by sitting for the American Nurses Credentialing Center (ANCC) Ambulatory Care Nursing Certification Exam on Sunday, March 29. Registration begins at 1:30 p.m. The exam finishes at 6:00 p.m.

Fees: $249 regular/$199 member
Course fee with Core Curriculum textbook: $329 regular/$259 member

American Nurses Credentialing Center (ANCC) Ambulatory Care Nursing Certification Exam – March 29, 2009

Exam fee: $320 regular/$250 AAACN member/$180 for members of ANA Constituent Member Association
Visit the AAACN Web site to link to the Exam Application.
Deadline for mailing your application to the American Nurses Credentialing Center (ANCC) is December 19, 2008. Be sure to write “AAACN 3/29/09 Philadelphia Conference Exam” in the location section.

*Number of awards given and amount ($100-$1000) based on number of applications and funds available in scholarship account.
Empowering Patients
continued from page 1

mid in the lower right corner compares the HbA$_{1c}$ test results to corresponding blood sugar results. The Self-Care Report helps both the patient and the provider quickly identify successes and areas for improvement.

The Action Plan is a colorful, simply written form that places control and decision making firmly with the patient. The Action Plan concentrates on guidelines for physical activity, diet, tobacco and alcohol avoidance, health management, and stress relief. Activities that are both realistic and affordable are encouraged. For physical activity, walking is recommended. Setting a goal of walking just 5 to 10 minutes a day for a previously sedentary patient can start making a difference. Patients are reminded to use footwear that does not pinch or apply unnecessary pressure to the feet.

Diet can be a challenge for anyone; the Action Plan provides an opening to discuss portion sizes, the need to eat three evenly spaced meals daily, and to consider replacing juice and soda with water or other sugar-free alternatives. Smoking cessation and alcohol avoidance are encouraged for all patients. The state of Maine provides the Maine Tobacco Helpline, a free service for Maine residents. The Helpline provides materials and telephone support to anyone interested in smoking cessation. Health Management, including foot checks, blood sugar monitoring, medication compliance, aspirin therapy, eye examinations, and keeping scheduled office visits, is governed by the patient, with the support and encouragement of the team. Stress management is particularly important for people with a chronic illness, and the Action Plan offers several suggestions and resources on ways to relieve stress.

The MMC Internal Medicine Clinic is a primary care residency training practice, consisting of five “firms” that function similar to independent physician-office practices. Each firm is a health care team composed of attending physicians, resident physicians, a nurse practitioner, and a registered nurse. Support staff include certified nursing assistants, a licensed practical nurse, practice coordinators (secretaries), MaineHealth care managers, a social worker, and a dietitian.

The clinic provides care for an under-served patient population that is approximately 30% non-English speaking, with a payor mix of 15% insured or self-pay, 14% uncompensated care, and 71% insured by federal and state programs (Maine Medical Center, 2006). As a result, many barriers to health care exist, including literacy, finances, transportation, and multi-cultural issues. Patient education in several languages is provided, and language interpreters and language telephone lines are used. A medication assistance expert is available to help patients in obtaining medicines and diabetes supplies.

The addition of chronic care managers to the teams has been exceptionally helpful. The care managers’ primary role is diabetes education. They are able to visit patients in their homes to see how they manage in their own environment. Latino and Somali Community Health Outreach Workers (CHOW), who are culture brokers from the community who act as liaisons between the patient and the health care team, are also used. The CHOWs are respected and trusted, and they better understand the social and cultural complexities of the groups they represent.

Resident physicians spend roughly five hours per week in the clinic, so nursing staff provide continuity for patient care. There are 4,877 active patients in the five-team practices; 647 are diabetics – 287 of these patients have a Body Mass Index (BMI) greater than 29.9. An additional 1,269 patients also have a BMI greater than 29.9, predisposing them to develop diabetes (Maine Medical Center, 2008). Statistics show that early intervention can slow or even prevent progression of diabetes-associated complications (National Institute of Diabetes and Digestive and Kidney Disease, National Diabetes Information Clearinghouse, 2007).

Members of each firm who volunteered to pilot the “Target Diabetes” model attended MaineHealth diabetes education and training sessions. These sessions focused on topics such as chronic care management, motivational interviewing, nephropathy screening, PDSA (Plan, Do, Study, Act model for process improvement), overcoming obstacles to change, evaluating patient depression, planning for changes at home, and the role of the certified diabetes educator. Participants were charged with taking information back to their practice to share with health care team members. The teams disseminated information by using Powerpoint presentations, “Lunch and Learn” sessions, regular team meetings, and participation in several internal and statewide quality improvement seminars. The clinic practice model was standardized to care for patients with diabetes, and focus shifted from provider-driven management to empowering patients to participate actively in their plan of care.

At each visit, patient data are entered into the electronic medical record (EMR). The EMR provides onscreen prompts to remind staff when core measures, such as blood pressure, foot checks, eye exam, lipid profile, urine microalbumin, and immunizations, are needed. These core measures are based on the American Diabetes Association standards of care. MaineHealth has set up an electronic Clinical Improvement Registry (CIR), which extracts information from the EMR to populate the Self-Care Report.

By engaging the health care team and patient, everyone has a role in implementing changes. The process starts with the practice coordinator, who prints the Self-Care Report; RNs and certified nurse assistants (CNAs) “huddle” (brief meeting to plan the patient care for the day using the Self-Care Report). CNAs assist by preparing patients for foot checks and obtaining urine specimens. RNs review patient EMR and Self-Care Report and send alerts to the provider, while providers discuss report scores with the patient. The patient learns their Self-Care Report “scores” and joins with the health care team to celebrate successes and identify areas for improvement. In this collaborative and supportive environment, the patient is empowered to make lifestyle changes.

Evidence shows that most diabetic complications (including lower extremity amputations and blindness) are preventable through aggressive management of lifestyle.
### Self-Care Report - Diabetes

**Patient’s Name**

**Address**

**Last visit: 07/01/2008**

#### Risk Factors

<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>Most Recent</th>
<th>Goal</th>
<th>Past Result</th>
<th>How Often/Due</th>
<th>Actions YOU Can Take and Why This is Important</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood Pressure</td>
<td>135/89</td>
<td>Less than 130/80</td>
<td>Annual/Next visit</td>
<td>You can lower your blood pressure by eating a healthy diet, being physically active every day, and avoiding salt and alcohol. Talk to your doctor about medicines to lower blood pressure. Controlling blood pressure can help prevent heart disease, stroke, and kidney damage.</td>
<td></td>
</tr>
<tr>
<td>Body Mass Index (Weight)</td>
<td>29.2</td>
<td>BMI: 25 or less (107 - 141 lbs)</td>
<td>30.4 Annual/Next visit</td>
<td>BMI is a measure of your weight compared to your height which relates to the amount of body fat. Talk with your doctor about seeing a dietitian to help find a healthy eating plan for you. Aiming for a healthy weight can help you feel better and lower chances of developing many chronic illnesses.</td>
<td></td>
</tr>
<tr>
<td>HbA1c</td>
<td>6.7</td>
<td>Less than 7%</td>
<td>7.4 6 months/10/20/2008</td>
<td>Checks for control of your blood sugars over the past 2-3 months.</td>
<td></td>
</tr>
<tr>
<td>LDL “Bad” Cholesterol</td>
<td>115</td>
<td>Less than 100, less than 70 mg/dl optional</td>
<td>105 Every 6 months/Now</td>
<td>You can lower your LDL and raise your HDL by eating healthy, being physically active every day, and aiming for a healthy weight. Your doctor may advise medications.</td>
<td></td>
</tr>
<tr>
<td>HDL “Good” Cholesterol</td>
<td>53</td>
<td>Greater than 40 mg/dl</td>
<td>Annual/05/03/2009</td>
<td>HDL helps prevent cholesterol from building up in the arteries.</td>
<td></td>
</tr>
<tr>
<td>Triglycerides</td>
<td>50</td>
<td>Less than 150 mg/dl</td>
<td>Annual/Now</td>
<td>Triglycerides are a form of fat in your blood that can raise your risk of heart disease. Triglycerides can be high if your blood sugar is very high.</td>
<td></td>
</tr>
<tr>
<td>Cholesterol</td>
<td>213</td>
<td>Less than 200 mg/dl</td>
<td>200 Annual/Now</td>
<td>Keeping your LDL low and raising your HDL can lower your risk of heart attack and stroke.</td>
<td></td>
</tr>
<tr>
<td>Kidneys/urine protein</td>
<td>300</td>
<td>Less than 30 mg/mg</td>
<td>100 Annual/07/07/2009</td>
<td>Checks for protein in your urine, a sign of early kidney damage.</td>
<td></td>
</tr>
<tr>
<td>Comprehensive Foot Exam</td>
<td>12/21/07</td>
<td>Healthy feet</td>
<td>02/13/06 Annual/12/20/2008</td>
<td>Checks circulation, nerves, and skin. It can prevent amputations.</td>
<td></td>
</tr>
<tr>
<td>Dilated Eye Exam</td>
<td>09/20/07</td>
<td>No retinal changes</td>
<td>01/01/05 Annual/09/20/2008</td>
<td>Checks for eye damage from diabetes, can prevent blindness.</td>
<td></td>
</tr>
<tr>
<td>Flu Shot</td>
<td>Contra</td>
<td>Get a flu shot every year</td>
<td>Every year/N/A</td>
<td>People with diabetes are at high risk for developing complications from the flu.</td>
<td></td>
</tr>
</tbody>
</table>

**Things you need to do:**

- See your Primary Care Clinician for diabetes care at least four times a year or as advised by your clinician.
- Take aspirin as directed by your doctor to prevent blood clots and lower your risk of stroke or heart attack.
- Diabetes Education We encourage you to actively participate in the Diabetes Education you were referred to On 12/13/05.
- Stay Smoke Free. Call the Maine Tobacco Helpline If you need additional assistance at 1-800-207-1230.
- Check blood sugar levels regularly.
- Increase physical activity to reduce your risk of heart attack.
- Take medications as prescribed.

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**Figure 1.**

Name: ____________________________________________ Date: __________________________

You can begin to take care of yourself by choosing one or more of the activities listed below and setting a goal for yourself to do that regularly.

Choose something you want to do. Not something, you feel you should do.
Choose a goal that you really think you can do.
Choose a friend or family member to help you track your success in meeting your goal.

Stay Physically Active
During the next week I will (walk, bike, run, etc.) for ______________ at least _____ minutes at least ____ days (make it easy/reasonable).

Eat a Healthy Diet
During the next month:
___ I will decrease my portion sizes.
___ I will eat 3 evenly spaced meals each day.
___ I will replace juice/soda with calorie free beverages.
Other: __________________________________________

Avoid Tobacco, Alcohol and / or Other Drugs that are bad for my health
___ I will call the Maine Tobacco Helpline at tel. 1-800-207-1230 for help to quit smoking.
___ I will decrease my alcohol intake to 1-2 drinks with food each week.
Other: __________________________________________

Practice health management (check one or two)
During the next month:
___ I will examine my feet at least ____ times per week.
___ I will check my blood sugar ____ times per day each week.
___ I will take my medicine as prescribed.
___ As advised by my doctor, I will take an aspirin each day.
___ I will keep all of my health care appointments.
___ I will make an appointment to get my eyes examined.

Practice relaxing to relieve stress (check one or two)
Every day during the next week, I will practice relaxing by:
___ Deep breathing or meditation.
___ Laugh more.
___ Taking a warm bath.
___ Talking with a friend.
___ Finding a quiet, peaceful place for reflection/thought.
___ Make time for fun activities such as: hobbies, playing with kids, getting together with friends.
Other ____________________________

Lessons Learned

- When making practice changes, buy-in improves when the education and development of the workflows incorporates all team members.
- Visual aids, such as the Self-Care Report, are helpful for the patient and provider team to see progress and identify areas of successes, and areas for improvement.
- Reflecting data in different formats aids greater patient understanding of complex concepts.
- Using a collaborative approach is empowering for the patient and for motivating the provider team to address chronic illness and lifestyle changes.
- Printed Action Plans assist the patient to set goals that they consider “do-able.”
- Sharing statistics with all teams helps maintain momentum and enthusiasm.
- Identify resources and make them available to patients and providers.
- Involve administration early and provide regular updates.
- Enjoy the process.

The majority of what it takes to control diabetes is done by the patient (MaineHealth, 2006). The Action Plan guides patients as they decide which behaviors they are willing to change, and assists them in setting realistic and attainable goals. Instead of telling patients what they “need to do,” patients decide what goals they want to set and what lifestyle changes they are willing to make.

Since implementing the chronic care model for diabetes management, MMC standardized its care and empowered its patients. When patients make lifestyle changes, they improve their glycemic control, thus improving diabetic outcomes. Maximizing resources, early interventions, and achieving patient buy-in can avoid many diabetic complications.

With a consistent plan of care in place for patients, momentum needs to be sustained. New employees receive a comprehensive orientation about the program and their role in the process. Bi-monthly Diabetes Quality meetings are held with clinic administration and staff to review statistics. This is an opportunity for teams to encourage one another, and team meetings foster a sense of camaraderie even if friendly competition between firms as they compare monthly statistics.

A collaborative approach to diabetes care leads to better patient outcomes. The team approach engages all members in reaching a common goal. Patients receive support and encouragement from the moment they arrive until they are discharged. By reaching even small goals, patients gain the confidence to work toward other goals. An unexpected benefit of including the entire team was increased staff satisfaction. By changing our way of thinking, we have increased staff participation and changed our delivery model to collaborate with patients toward a common goal.

For more information about the “Target Diabetes” program or MaineHealth, visit www.mainehealth.org and click on Health Information. For more information about the Maine Tobacco Helpline, call 1-800-207-1230.

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References

President’s Message

The third concept, “Empower,” provides the space to get the tasks completed, the space to innovate, and the feedback mechanism to both improve results and to motivate the person. Empowerment builds trust. Our patient will need to do a return demonstration on the machine and be given information on whom he can contact if he has any problems or needs follow-up care.

Energize

The fourth concept, “Energize,” is “individual success” that results from “winning” and achieving a sense of personal success and satisfaction. The leader’s task is to reinforce and support successes. When our patient does a successful return demonstration or calls us needing assistance, we reinforce the positive actions the patient has taken. The last step “Execute” is a “surrounding” concept that applies at every stage of the Leadership process.

The examples that can be used to explain the 4 Es of Leadership are as varied as the roles of the ambulatory care nurse. Remember as you mature in your role as an ambulatory care nurse and grow those basic traits you possess, you become a more remarkable individual. Be proud of your role and be the leader you can be!

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An elderly gentleman knows that the nitroglycerin he has will relieve chest pain. This same elderly gentleman is the caregiver of his 7-year-old granddaughter. When she complained of chest pain one day after falling on the school playground, he gave her nitroglycerin three times and then brought her to the emergency department. Our patient did just what we told him to do – “Use the nitroglycerin for chest pain, and if, after 3 doses it doesn’t help, come to the hospital.” Of course, we didn’t mean for our patient to give the nitroglycerin to his granddaughter. He seemed to understand how to use his medication when we discussed it at his appointment. We even wrote it down for him. What happened?

Health literacy is the degree to which individuals have the capacity to obtain, process, understand, and act on health information and services needed to make appropriate health decisions (Ad Hoc Committee on Health Literacy for the Council on Scientific Affairs: American Medical Association [AMA], 1999). It has been identified as a crosscutting area for research and intervention to improve population health (Adams & Corrigan, 2003). It is impossible to tell just by looking at patients who might struggle with low health literacy. Moreover, the stress of visiting a provider can decrease anyone’s ability to understand, regardless of literacy ability.

Prevalence of Low Health Literacy

Public health experts were aware of issues surrounding low health literacy as early as the 1970s. The field of inquiry exploded to the forefront in the 1990s when in 1992, the National Adult Literacy Survey (NALS) study was conducted, which found that almost 90 million adults across the United States read at an 8th grade level or lower. Results from this study gained further national attention with the release of Healthy People 2010 (U.S. Department of Health and Human Services [DHHS], 2000), in which Health Communication was listed as a primary objective; improving health literacy listed was identified as a sub-objective.

A second national survey, National Adult Assessment of Literacy (NAAL), was conducted in 2003. The more recent NAAL survey specifically addressed the notion of health literacy, and its results suggest that 87 million adults struggle to understand written health information. That translates into missed appointments and missed opportunities for health promotion and disease prevention, and contributes to ever-escalating health care costs. Low health literacy affects people of all races, income, and education levels, and poses a significant problem for older adults. The NAAL survey suggests that almost 59% of adults over the age of 65 struggle to understand even the most basic health information (White, 2008).

Short of assessing everyone’s reading ability, what can ambulatory care nurses do to insure that patients clearly understand the information provided to them? The purpose of this article is to outline some resources that may help address issues surrounding low health literacy, including identifying low health literacy, using “living room language”, evaluating written materials, and using “teach back” as a method by which to help ensure patient understanding. Furthermore, a listing of key Web sites is included in this article.

Identifying Patients with Low Health Literacy

It is important to note that screening for health literacy ability is controversial, and experts disagree on the value of screening patients except for research purposes (Berkman et al., 2004). Moreover, screening patients in an ambulatory care setting may prove to be difficult given space and time constraints.

There are three widely used, reliable, and valid measures by which nurses can assess health literacy abilities. Although not typically recommended for everyday clinical use, they may be helpful for some specific projects or ambulatory care research. The measures include the Test of Functional Health Literacy in Adults (TOFHLA), the Rapid Estimate of Adult Literacy in Medicine (REALM), and the Newest Vital Sign. The TOFHLA consists of three short reading passages where patients are asked to fill in the blank with a correct word from a list of four word choices. The passages are written at the 4th, 7th, and 10th grade reading levels. Additionally, the TOFHLA has a section on numeracy to evaluate a patient’s ability with dates and other numbers, including simple laboratory values. The REALM consists of a list of medical terms and asks patients to simply read the list. The REALM does not assess comprehension of the terms, which range from single to multi-syllabic words. The Newest Vital Sign takes about 3 minutes to administer and consists of asking 6 questions.
about a patient’s understanding of numbers and words on an ice cream label.

Chew and colleagues (2008) identified a single-item-screening question, which may lend itself well to evaluating health literacy levels in busy ambulatory care settings. The question simply asks patients, “How often do you need help filling out forms in the doctor’s office?” This question, while helping to identify the patient who may struggle to read, is not likely to compromise a patient’s dignity and lead to shame, which can occur when such a struggle is uncovered. Health care professionals may find this single-question approach useful in everyday clinical practice.

It is important for everyone in the office or clinic to be attentive to certain “red flags” that suggest the possibility of inadequate health literacy in the patient population. Patients who struggle to read may:

• Seek help only when illness is advanced.
• Have difficulty explaining health concerns.
• Pretend they can read.
• Use excuses, such as “I forgot my glasses.”
• Have lots of papers folded up in purse or pocket.
• Lack follow through with tests/appointments.
• Ask questions Infrequently.
• Say “pain killer” instead of “analgesic.”
• Define new terms, such as hypertension, “hamburger” instead of “red meat,” or “oranges” instead of “foods high in vitamin C.”

Analogies are also helpful; for example, when talking about your patients’ aortic stenosis, explain the faulty valve as something like “a gate that lets blood in and out, and the gate is kind of rusty and now does not open the right way.” For a valuable resource for re-thinking verbal and written communication using plain language, visit http://www.plainlanguage.gov/

Evaluating Written Resources

Patient education materials are most frequently provided as written materials. It is important that these materials are written in such a way that they are usable and suitable for most patients. Even very qualified readers prefer materials that are easy to understand.

When assessing materials for appropriateness, the Suitability Assessment of Materials (SAM) is an excellent resource (Doak, Doak, & Root, 1996). The SAM suggests you first assess reading level. A word of caution is that the reading level evaluation, Flesch-Kincaid Grade Level (available on most word processors), is not reliable and typically underestimates the reading level. If you are using the software available on word processors as a quick screening of reading ease, it is better to use the Flesch Reading Ease Score, which scores on a range from 0 to 100. The closer the score is to 100, the easier the material is to read. When creating easy-to-read health information, try to aim for a Flesch Reading Ease Score between 70 and 80. A more formal method of assessing read-

Using Plain Language

We all know what it is like to visit the mechanic when the car is making funny noises. What happens? Often, we hear all about the inner workings of valves and pistons and nod our heads when in reality we have no earthly idea what any of it means. That language comes so easily to our neighborhood mechanics. Could it be that all we really want to know is if the car will leave us stranded, how long the car will be out of commission, or how much it will cost to fix? Tell me what is wrong with the car in a way I can understand. How important is clear language when it comes to talking to our patient about their health?

It seems so simple that we should be able to talk in easily understood terms to our patients. Yet, that is not the case. Ambulatory care offices and clinics have a culture and language all their own, and health care providers often take this for granted, just like the mechanics when they talk about troubled vehicles. What can nurses do? For starters, slow down your pace. Use plain non-medical language or “living room language.” Say “pain killer” instead of “analgesic.” Define new terms, such as hypertension. It may come as a surprise that many patients believe hypertension means they are overly tense! Be specific; what do you really mean by “watch your fluid intake?” Avoid concept words; say “hamburger” instead of “red meat,” or

continued on page 19
Meet Linda Kleinsasser, RN-BC. Linda describes herself as a true “California girl” (tall, blond, and loves the beach). When her daughter was small, Linda was able to be a stay-at-home mom, working as an owner/operator of a small, home-based business that specialized in window drapes, blinds, and home decorations. After her daughter graduated from high school, she found herself searching for other career options. After searching various career options, Linda found that nursing was a perfect fit for her. She attended Ohlone College in Fremont, California, and earned an associate degree in nursing in 1994. During her nursing education, Linda realized the importance of being part of a professional organization. She was active in the Student Nurses Association (SNA) and served as the local SNA President during her last year of school. (Maybe Linda will consider running for the AAACN Board of Directors!)

Linda’s first job was on a medical/sub-acute unit at the local VA hospital in Livermore, California. She writes, “I felt very fortunate and honored to be able to serve our nation’s veterans. During my two years there, I increased my nursing skills and confidence, and moved from a novice nurse, to a nurse who felt comfortable caring for patients with complex diseases. I also developed strong patient education skills as I cared for patients with diabetes and respiratory diseases.”

Linda’s transition into the world of ambulatory nursing occurred when the Veterans Administration Palo Alto Health Care System decided to open a new community-based ambulatory clinic in San Jose, California. Linda applied, was hired, and happily accepted the challenge of providing nursing care in an ambulatory setting. She has been working in this community-based clinic for the past 12 years, and in her words, “I love it more each day.” A typical day usually finds Linda in the nurse-run treatment/injection clinic. In this clinic, patients are seen by appointment for blood pressure checks, wound care, routine vaccinations, and case management issues. In addition to these daily tasks, Linda also serves as the Women’s Health Liaison Nurse for the clinic and is a member of the hospital-wide Patient Education Committee. She explains, “I am excited because I have recently been appointed to a sub-committee related to the issue of health literacy. This is an extremely important topic, and I am hoping that the work of this subcommittee will positively impact the education we provide our patients. It has been very helpful to me to read the articles on Health Literacy in Viewpoint. They have provided me with important information I can share with members of this new sub-committee.”

Linda is passionate about the mission of ambulatory care nursing and recognizes the importance of certification. In 1997, she became Board Certified in General Nursing Practice, and in 2007, she passed the ANCC exam and became certified in ambulatory care nursing. She is also a member of NOVA, the professional nursing organization for VA nurses, and has served as a Board member for two terms.

Linda found AAACN thanks to her nurse manager, who was a member of AAACN and who spoke frequently about the benefits of membership. Linda remembers, “My manager would bring back valuable information from the AAACN conferences, and would share stories about the people she met and the wonderful networking opportunities she had experienced. Because of her enthusiastic support for AAACN, I decided to find out for myself. I attended my first conference in 2007 in Las Vegas. Believe me, I was not disappointed! Membership in AAACN has given me the opportunity to meet other professional nurses and nursing leaders from all over the country, as well as those serving in the military. I now feel that I have an entire team of nurses who I can contact with issues or to share solutions.”

What does the future hold for Linda? She tells us, “My older clients teach me about life. They urge me to do the things I want to do now and not wait until the future. They encourage me to find the time, money, or whatever it takes to follow my dreams and live my dreams. So when I’m not at work, I’m working hard to read more books, do more scrapbooking, and walk more beaches.”

Our AAACN spotlight moves away from the beaches of California to the beaches of the Gulf Coast, where we meet Peggy Church, BSN, RN, Nurse Manager of the Biloxi Outpatient Clinic at the VA Gulf Coast Health Care System in Biloxi, Mississippi. In this capacity, Peggy manages a clinic that includes 12 physicians, 1 nurse practitioner, 1 physician’s assistant, and 19 nurses (13 RNs, and 6 LPNs).

As an employee of the Gulf Coast Veterans Administration for 25 years, Peggy has “seen it all.” She begins her day making rounds to talk with her staff and to ensure that the day is starting off with everything and everyone in place. Peggy explains, “Because this is a primary care clinic, we are always very busy, and the work is challenging. Handling patient complaints can often be difficult and time-consuming, but we try to view each complaint as an opportunity to improve the care we provide.” Peggy recently implemented a pilot project for the care coordinators in her clinic. According to Peggy, “the purpose of the project was to provide a safety net to prevent patient care from falling through the cracks and to promote continuity of care. As a result of this project, RN satisfaction levels have increased, and most importantly, patient satisfaction has also increased.”
Looking back at Peggy’s career, one is struck by the circuitous route she has taken to arrive at her present position. She remembers, “As the mother of four children, seven grandchildren, and two dogs, I started my medical career as a nurses’ aide in 1976. I decided that I really enjoyed caring for patients, so I went back to school and became an LPN in 1980. With a strong desire to expand my career options, I became an EKG technician in 1987 and a pharmacy technician in 1989. When I finally realized that nursing was what I really wanted, I went back to school and earned an associate degree in nursing in 1997 and a BSN in 2003. Although it has been a long road, this experience has enabled me to work effectively with all levels of health care personnel and to be successful in my job. I truly enjoy working in the ambulatory setting where we are able to help patients stay healthy and remain out of the hospital for as long as possible. My greatest job satisfaction comes from implementing programs that teach patients self-care and provides them with the tools they need to monitor their disease processes.

Peggy explains that she joined AAACN in 2006 because she “wanted to be a part of the force that is shaping ambulatory care nursing. [She] also wanted a process for staying current in ambulatory care practices.” Peggy has made very good use of her AAACN membership. She has purchased and distributed the **AAACN Core Curriculum** and the **Ambulatory Care Nursing Standards** to five clinics within the VA Gulf Coast system. Peggy notes, “The Core Curriculum is being used to teach nurses who are transitioning from acute care into ambulatory nursing and is used as a reference to validate practice.”

Like many of us, Peggy wanted to become certified in ambulatory care nursing, but found herself procrastinating and finding excuses not to complete the task. However, when she discovered that the review course and certification exam could both be completed at the annual conference, “that was just the incentive I needed,” Peggy explains, “It was so convenient to have the exam immediately following the conference. It really pushed me to get it done. Thank you AAACN.” Now Peggy is a member of the American Nurses Credentialing Center’s Content Expert Panel, where she participates in role delineation studies, develops or updates test content outlines, and evaluates, revises, and approves test items.

AAACN also thanks Peggy for her volunteer service to the organization. Peggy is a member of the Leadership Special Interest Group (SIG) and will Chair the SIG next year. Without active members and volunteer leaders like Peggy Church and Linda Kleinsasser, AAACN would not be the premier professional nursing organization it is today.

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**I trust MY INNER STRENGTH**

I continually find inspiration. Believe in inner strength. And know there is always more we can learn about ourselves, and each other. At Kaiser Permanente, I work in an environment that supports my needs and allows me the freedom to excel in ways I didn’t think possible. Here, I’ve discovered my potential. Backed by my colleagues and the organization, I have the resources, opportunities and encouragement I need to be my best. No matter where my daily activities take me, I’m continually learning new things. About my patients, my colleagues, and myself. If you believe empowerment comes from within, this is the place to put your beliefs into practice.

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[kp.org/jobs/nursing2008](http://kp.org/jobs/nursing2008)
‘It’ – Does Your Nursing Call Center Have ‘It’?

**What Any Nurse Can Do to Bring ‘It’ into the Workplace**

Recently, I attended a Global Leadership Summit where I listened to a passionate speaker, Craig Groeschel, talk about ‘It.’ As he described ‘It,’ I realized his words could be used to describe a nursing call center environment, or any nursing unit you or I have ever worked in. When asked to define what exactly ‘It’ is, Craig Groeschel responded he did not know! He explored the concept by sharing that ‘It’ cannot be created. ‘It’ cannot be manufactured. There is no formula to find ‘It.’ It is easy for one person to kill ‘It.’ ‘It’ is not a system, nor is ‘It’ a model. ‘It’ is something that just happens. If your nursing workplace has ‘It,’ you are likely happy in your current job. Yet, just because your unit has ‘It’ doesn’t mean it will keep ‘It.’ If your workplace does not have ‘It,’ you might not be as satisfied at work as you could be. Maybe you are searching for a new workplace environment right now because of a lack of ‘It.’ If ‘It’ is not there, it does not mean your nursing organization can’t get ‘It.’ I believe every nurse has the ability to make an important contribution to the quality of their workplace by encouraging ‘It’ to be present. Here are a few thoughts and examples of what you can do to attract ‘It’ into the call center environment.

The best way to get ‘It’ into the nursing call center is for each nurse to discover his or her leadership potential, and lead in the position currently held. You do not have to be near the top of your nursing organization to take on a leadership role, nor do you have to wait for a “tap on the shoulder” from your supervisor to lead. Every nurse, right now, already has the spark of leadership. The challenge, then, is for individual nurses to discover how to nurture, develop, and use their talents to create a phenomenal workplace environment. In other words, nurses must decide for themselves if they are owners of their workplace or just hourly workers. Hourly workers simply show up for their shifts and do the minimal required job assignments. Owners, however, show up, step up, and lead. Owners don’t sit on their talents. Owners inspire other nurses around them. Owners are authentic and engaged. Owners are mentors. Owners lead up, laterally, and down within their nursing organization, families, and communities.

I cannot suggest what you should do to lead where you are because this is something each nurse must discover for himself or herself. I can share some simple examples of using your talents at work that I have recently witnessed in the large call center environment where I work. Each of these deliberate acts, done by individual nursing staff member “owners” contributes to the ‘It’ factor in the workplace. For example, one of the nurses I am privileged to work with has a crippling case of multiple sclerosis. Yet, I do not think she has ever taken a sick day. I have never heard a word of complaint come out of her mouth about her life struggles or her work environment. On good days, she is seen using a cane to get to work, while on bad days, she uses a walker. Every day a smile is on her face, every day she cheerfully greets her co-workers, every day she sets a positive example, everyday she gives her best to her clients and her colleagues, every day she tackles more than her share of the workload, and in doing so, every day she inspires every person around her. She quietly and uniquely leads and makes an important contribution to the workplace environment.

Each of us has the power to attract ‘It’ to the workplace. Regrettably, we also each have the ability to smother and kill ‘It.’ ‘It’ is slowly strangled, suffocated, and choked by negativity. Therefore, a second important decision each individual nurse can make to attract ‘It’ to the nursing unit is to be a morale booster, not a morale buster. Sadly, each of us has either worked with, or is guilty of, being a morale buster at one time or another. Morale busters often spend their breaks and time between calls complaining about some policy, person, or aspect of the nursing unit they consider undesirable. When your colleagues speak this way, it may be easier to smile at the morale buster and quietly nod your head in agreement or say nothing at all. Agreeing with or ignoring this behavior is destructive to the nursing unit. Instead engage the complainer. Confront and challenge his or her thinking in a kind and supportive manner. Ask morale busters what strategies they have devised that will create workable solutions. Inquire if they have discussed the problem with the person who they can work with to solve this problem. In most cases, morale busters will not have taken these steps. Often when asked these questions, morale busters stop complaining. If you don’t confront negativity as it is happening, it will spread and grow. Once the seeds of discontent have been sown, the ‘It’ factor begins to fade. The quality of your workplace environment will diminish, and nursing engagement, along with nursing morale will suffer.

Morale boosters keep watch over their own attitudes. They are careful not to wound others with their words or tarnish their organization by spreading gossip and complaints. They realize they are responsible for solutions. They are part of a team and a community of fellow nurses. As a result, they fully participate and contribute to the team-working environment and positive nursing morale on each shift. Morale boosters stay connected to their nursing manager leaders. Active problem solving, constructive critique of workplace issues, and a willingness to participate are techniques used by morale boosters. Morale boosters challenge themselves to step out of their comfort zones, step up their game, and lead.

Finally, to attract ‘It’ to the nursing workplace, you must consider one of the fundamental principals of classic physics, the principle of inertia. Simply stated, inertia is the principle that a body in motion tends to remain in motion, while a body at rest tends to remain at rest. ‘It’ is attracted by inertia, by motion, by activity. The author of *Axiom: Powerful Leadership Proverbs*, Bill Hybels (2008), described this principle in a similar way as he coaches his readers to have a bias toward action. With these words, he questions inactivity or comatose work engagement. “Why would a person sit when they could soar, spectate when they could develop...so role up your sleeves and shovel something – anything!” – rather than
lean on the shovel’s handle, pontificating about the horrible state of affairs” in your nursing environment (Hybels, 2008, p. 136).

All nurses should take the time to look at the needs of their nursing environment and decide how they can best serve their colleagues. Nursing leaders serve others. ‘It’ is definitely attracted by service. Do not sit on your talents; use them! Recently, one nurse in our call center volunteered to become our “official call-center decorator.” Her effort put a smile on our faces, adding to an otherwise bleak and boring landscape. She makes certain that every holiday on the calendar is acknowledged. Her simple act of putting flowers on the lunchroom tables raises morale. Another nurse with the gift of organization recently decided to re-organize the workstation resources. She did an amazing job, making it easy to instantly put our hands on the resources we need. There are many more meaningful acts or initiatives that have occurred recently in this call center. I am proud to say my workplace has adopted several charities over our five years of existence. We have collected goods and raised monies for a variety of causes, including food pantries, military families, World Vision, and disease prevention programs. A call-center cookbook is currently in the works. It will be for sale before the holiday season, with the proceeds being donated to a local women’s shelter. Working together, serving each other, and serving others diligently can pay huge dividends to any nursing unit. It not only fosters a sense of community, it builds morale, and ups the ‘It’ factor at the same time. Don’t wait to be asked to make a contribution to your workplace. Instead, have a bias toward activity and use the concept of inertia to get the ball rolling and the ‘It’ factor building.

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Author’s Note: I would like to credit Craig Groeschel with the original concept of ‘It’ used in this article, which was the topic of a session he presented at the Leadership Summit, 2008, in South Barrington, IL. If you have any comments on what you have read or would like to share an idea you have I would love to hear from you. I can be reached at patricia.chambers@calgaryhealthregion.ca

Reference


Staff Nurse Advisory Panel

continued from page 3

- Being completely transparent regarding the goals and outcomes of the initiative.
- Transitioning language surrounding the initiative and re-packaging the message.
- Disseminating information widely in diverse venues.
- Enhancing the CNL curriculum.

The implications for the CNL role in ambulatory care are many and varied depending on the actual practice setting. Although AACN seeks to standardize the role, there are opportunities for customizing the position to the needs of the practice setting. Some possibilities could include (but are not limited to) large outpatient clinics to provide teaching and long-term follow up with patients, telehealth nursing where triage and decision-making related to patient care is an integral part of practice, and home health care with chronically ill patients requiring ongoing teaching/coaching nursing support. Any outpatient practice setting managing complex patients who require ongoing teaching and/or follow-up care to prevent hospitalization and promote better long-term patient outcomes could potentially benefit from implementing this role in their practice setting.

I hope to continue to represent AAACN. There will be an In-Brief presentation at the annual AAACN Conference in Philadelphia on Saturday, March 28, 2009. I welcome any feedback from the AAACN Board of Directors, the leadership group, or the membership that would help me to represent AAACN in this endeavor.

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References


Additional Reading

Multiple Questions

In this situation, a caller contacts the physician’s office or call center and begins by asking a question, and the triage process is initiated. The nurse begins to address the reported concern. Instead of relaying symptoms, the caller proceeds to ask for information. Then another question is posed, and then another and another. The answers do not seem to satisfy the caller’s inquiry. If the nurse does not know the caller, the reason for the series of endless questions may not be discernable. Does this patient have limited understanding? Has the caller received education from their primary provider? Does the patient have an underlying cognitive deficit?

The nurse needs to problem solve and try to identify the reason for intense information seeking and then direct the patient appropriately. If the nurse knows the caller, information may be provided and an appointment offered for further education and evaluation.

Critical Lesson: Answering a myriad of questions seems benign, but do not overlook the potential underlying complexities.

Multiple Symptoms

Some calls start very basic; a caller wants information about a symptom that he or she is experiencing. But then like a cascading event, more symptoms are revealed. An example of this type of call is as follows. A 52-year-old male patient contacts the call center inquiring about a toothache. He is seeking advice for pain control. However, as the call proceeds with the triage process, he furthers relays jaw pain, which radiates into the shoulder. As the information gathering process continues, he adds indigestion and nausea, then sweating. The nurse asks more questions, the caller divulges more symptoms. The situation escalates into a life-threatening situation.

Critical Lesson: Assume there’s more to the story than what is initially introduced until proven otherwise.

Multiple Medications

When a patient contacts a nurse via technology with questions or reports symptoms and is on several medications, caution must be exercised. A patient who is on multiple medications that are prescribed, alternative, complementary, or over-the-counter can alter any triage situation. Reported symptoms can be side effects from medications or even risky interactions. If patients are on multiple medications, their medical history may include chronic conditions that may influence their current health status.

A patient who is on many over-the-counter or alternative therapies may be attempting to self-treat a significant underlying undiagnosed condition. This can be a complex situation. Keep in mind when patients begin asking detailed questions about medications, their pharmacists or physicians should be utilized as a resource.

Critical Lesson: Medication implications must never be overlooked during the triage process.

Multiple Diagnosed Chronic Illnesses or Conditions

Patients who have chronic illnesses or conditions should always be considered at higher risk in the triage process. Acute illness symptoms may have more dramatic implications for a patient who has any underlying chronic illness or condition. There is a benefit when the call is made to the primary provider’s service. Many of these calls, because of complexity, should be medically managed face-to-face. If the nurse is familiar with the patient, a thorough assessment and collaboration with the patient’s primary provider must occur; if the caller is unknown to the triage nurse, extra caution must be exercised. In many of these situations, the caller should be directed to contact his or her primary provider and/or be seen for evaluation in person in accordance with the acuity of the situation.

Critical Lesson: Know your scope; use caution when patients present with a complex medical history.

Multiple Questions

In this situation, a caller contacts the physician’s office or call center and begins by asking a question, and the triage process is initiated. The nurse begins to address the reported concern. Instead of relaying symptoms, the caller proceeds to ask for information. Then another question is posed, and then another and another. The answers do not seem to satisfy the caller’s inquiry. If the nurse does not know the caller, the reason for the series of endless questions may not be discernable. Does this patient have limited understanding? Has the caller received education from their primary provider? Does the patient have an underlying cognitive deficit?

The nurse needs to problem solve and try to identify the reason for intense information seeking and then direct the patient appropriately. If the nurse knows the caller, information may be provided and an appointment offered for further education and evaluation.

Critical Lesson: Answering a myriad of questions seems benign, but do not overlook the potential underlying complexities.

Multiple Possibilities

A 36-year-old woman contacts her physician’s office and states that she has had a 12-hour history of a “stomach ache.” The patient interview process begins. The patient describes her discomfort “around her navel.” She denies vomiting but reports nausea for 1 week. The nurse continues with the assessment process. The caller denies change in bowel pattern. The main reason for
her call is identified – home treatment for abdominal pain.

The nurse assesses the caller pain level utilizing a 1 to 10 pain scale. The caller’s voice sounds calm, yet she reports a pain level of 9. The nurse clarifies with the patient that a rating of 9 is severe pain; caller confirms that this is accurate. The focus of the assessment transitions to menstrual-related questions. Caller cannot recall the dates of her last menstrual period. She does state that her periods are irregular. She does remember her last menstrual period was “very light and lasted only two days.” She admits to being sexually active and does not routinely use birth control because “she has issues with infertility.” This situation is becoming increasingly complex, and several potential causes for the abdominal pain are becoming evident. The astute triage nurse knows immediately that abdominal pain rated at this high level needs immediate evaluation, regardless of the cause. The nurse will not provide this caller with home care recommendations. The work of the telehealth nurse is not to diagnose conditions. This is practicing outside of nursing scope. The nurse directs the patient to seek medical attention immediately, and this advice is based on thorough assessment, critical thinking, evidence-based decision support tools, and nursing judgment.

Critical Lesson: A caller with multiple symptoms presents a complexity requiring tests that can only be done in a hospital setting.

## Conclusion

Finally, AAACN has established a list of excellent resources available through the efforts of AAACN’s Patient Education Special Interest Group. The list can be found via the AAACN Web site (click on “Patient Education” under Special Interest Groups in the left margin of the home page).

Inadequate health literacy costs billions of dollars every year. Moreover, inadequate understanding contributes to poor health outcomes. Ambulatory care nurses can and must do our part to “transform the nation’s health” by working to help improve low health literacy using a variety of resources.

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## Health Literacy

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ing level is the Fry Formula. Doak and colleagues (1996) present a thorough resource for understanding and using the Fry Formula. In addition to evaluating the reading level, it is important to consider other factors when choosing or creating teaching materials, including print size and type style, color contrast between the ink and paper, self-efficacy, concept density, unfamiliar context, and cultural appropriateess. Information from Doak et al. (1996) can be found in its entirety at http://www.hsph.harvard.edu/healthliteracy/doak.html

### Teach-Back Method

There is growing evidence that patients recall only about one-half of what providers tell them in the office. The “teach-back” method is a simple technique providers can use to help clarify a patient’s understanding of instructions (Shillinger et al., 2003). The teach-back method not only can uncover misunderstanding, but it can also reveal the specifics of the misunderstanding and allow for opportunity to better individualize teaching. When asking patients to teach back (or “show me”), clinicians should preface their request by placing accountability for poor understanding not on the patient, but on themselves (the treating clinicians). For example, phrasing the request as, “Can you show me how you’re going to do this when you get home? I want to make sure I did a good job explaining this to you,” clearly places the burden of learning on both the teacher and the learner (the provider and the patient) and not just the learner (patient). Another teach-back script might be, “I want to make sure I explained everything clearly. If you were talking to your neighbors, what would you tell them we talked about today?” Such scripts help assure understanding while protecting a patient’s dignity. In the case of the grandfather who gave nitro to his granddaughter, if the nurses had taken the opportunity to use teach back, they may have averted that situation entirely. It is important to note that evidence suggests using teach back adds no significant time to patient encounters.

## References


Nurses have always carried the torch when it comes to improving patient care. The American Academy of Ambulatory Care Nursing (AAACN) will give nurses the tools and education they need to problem expert care far into the future at its 34th Annual Conference to be held March 26-30, 2009, at the Philadelphia Marriott, Philadelphia, PA.

The conference will offer a broad slate of education sessions that focus on the theme “Leading the Revolution in Building Healthier Communities.” The conference offerings have been designed to meet the needs of ambulatory care nurses who practice in all settings, including military and telehealth.

Concurrent sessions will run from March 27-29. Topics include, managing depression in primary care, hiring the best candidates for a telehealth position, immunization update (newly recommended vaccines and new recommendations for existing vaccines), making clinical research in ambulatory care a reality, building healthy communities by providing consumers responsive service and continuity of care, resourcing evidence-based practice to enhance quality and safety, and an Ask the Experts’ panel discussion (open forum for information exchange between ambulatory care nursing leaders).

Telehealth Offerings
Following the main portion of the conference, there will be a Telehealth Nursing Practice Core Course (TNPCC) on Monday, March 30. The course presents baseline knowledge for nurses who handle telephone/telehealth inquiries. The content is perfect for nurses new to telehealth, those who want to develop their skills further or train staff. Participants are encouraged to purchase the new TNPCC Manual (3rd Edition) as a comprehensive reference tool.

In addition to the TNPCC course, there will be 9 special telehealth sessions offered at the conference. Topics include staffing strategies, Magnet designation issues, critical thinking skill development, and telehealth performance metrics.

Going Green
To be environmentally responsible and to increase convenience for attendees, all written presentation materials will be available on-line. In previous years, the documents were distributed in a syllabus that was over 200 pages. Prior to the conference, attendees may print out only the materials they will need for the sessions they will attend. In addition, evaluations of the conference and individual speakers will be completed on-line, with continuing education certificates printed immediately upon completion. Participants will also receive an eco-friendly tote bag for use at the conference.

On-line Library
AAACN has partnered with Digitell, Inc. to create a 2009 Annual Conference on-line library. Attendees will receive unlimited free access to all approved main conference education sessions for one full year. Attendees may invite two colleagues to access the library online, also for free. Content in the library will be available 14 days after the conference. For more information on the library, visit www.aaacn.org