

aaacn ViewPoint

The Voice of Ambulatory Care Nursing

JANUARY/FEBRUARY 2003

Inside



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Nurses and other clinicians have become more active in efforts to provide better end-of-life care.

Palliative and End-of-Life Care *Are Nurses Ready to Take the Lead?*

Sandra W. Reifsteck, MS, RN, CNAA
Geoffrey H. Gordon, MD, FACP

Palliative and end-of-life care has only recently received the attention it deserves. The bad news is that much of it falls short of the goal of meeting patients' physical, psychological, and spiritual needs. The good news is the success of end-of-life care depends largely on the quality of clinician-patient communication.

Specific communication skills such as eliciting the full range of patients' concerns without interrupting or blocking; making explicit empathic statements; providing information in the context of patients' values and goals; and sharing decisions to the extent desired can reduce patients' distress.

Effective communication can also improve patient satisfaction, ability to cope, and quality of life as patients with progressive chronic illness enter end-of-life care.

In addition, collaboration and communication skills are needed between physicians, nurses, social workers, and all members of the team who work with the chronically ill and their families.

Where does nursing fit into the latest research on patient and family involvement on this issue? Nursing educators and researchers are addressing the needs and sharing in this research at two levels: including end-of-life education in colleges of nursing and educating practicing nurses across the country.

continued on page 16

FEATURES

Page 3

The Health Care Team's Most Difficult Role

Delivering bad news is never easy, but careful planning and sensitivity help both providers and patients.

Page 5

Nurses' Advocacy in the 'Work of Dying'

Along with offering support and compassion, nurses need to inform patients about two crucial legal documents.

NEWS

Page 8

Crystal Clear Connection: Telehealth Nursing Defined

Page 13

AAACN Committee Launches Staffing Study

Page 20

AAACN Election Results

DEPARTMENTS

From the President.2

Willingness to Serve Form . . .7

AAACN Committee News . . .13

Call For Abstracts
See Insert Inside

AAACN ANNUAL CONFERENCE

April 10-14, 2003

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see page 15

From the PRESIDENT

AAACN Viewpoint

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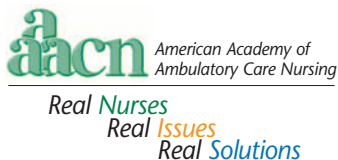
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Dear Colleagues,

Happy New Year! Born along with the year 2003 is Viewpoint's new look. AAACN's leaders consistently receive feedback from members that the newsletter is a valued benefit, so we want it to express the excitement and enthusiasm of our organization and provide you with appealing, as well as informative reading.

The redesign is the result of a collaboration between Bob Taylor, layout designer; Janet D'Alesandro, managing editor; Cynthia Nowicki, executive director; Rebecca Pyle, Viewpoint editor; and myself. I hope you like this fresh new look as much as I do. Please feel free to send your feedback and suggestions about the redesign to Janet at janetd@ajj.com.

Additionally, for the New Year, we are launching our new AAACN tagline, "Real Nurses. Real Issues. Real Solutions." Please look at the bottom left corner of this page to see the tagline as it makes its first appearance. It will also be used on the AAACN Web site and in other promotional materials. To give a little background, we polled AAACN members about several tagline choices and this one received the most votes (see Viewpoint, May/June 2002, p. 9). Different from the AAACN mission, the tagline is a catchy expression of our identity and is intended to draw people to learn more about the association.

Another tribute to you, AAACN's members, is that you selected excellent leaders to succeed those of us currently serving as your officers, directors, and Nominating Committee members. Please see page 20 for results of the election. Congratulations to these talented and generous volunteers.

Strategic Plan 2000-2003

In September, the Board completed an update of AAACN's strategic business plan. Given the "Mega Issues" and the membership scanning we have performed, we determined some new priorities, objectives, and strategies, although the core values and primary goals have not changed. We did collapse some of the goals (from six down to four), given that the objectives and strategies overlapped.

AAACN's Strategic Plan

Identity Statement

The American Academy of Ambulatory Care Nursing is the association of professional nurses and associates who recognize ambulatory care practice as essential to the continuum of high quality, cost-effective health care.

Vision: AAACN is the premier nursing organization for ambulatory care

Mission: To advance the art and science of ambulatory care nursing.

Goal 1. Be the Voice of Ambulatory Care Nursing

Objective 1. Participate meaningfully at the table of decision-makers for ambulatory health care, both nursing and non-nursing.

Objective 2. Increase the visibility of ambulatory care nursing in health-related media.

Objective 3. Enhance member and organizational communication and collaboration through publications, networking groups, SIGS, educational forums, and electronic technology.



Candia Baker Laughlin

continued on page 19

The Difficult Task of... Delivering Bad News



Open Door Images / Picture Quest © 2001

Nurses should keep patients and families well informed from the very beginning of treatment.

Linda Brixey, RN

The dying need the friendship of the heart – its qualities of care, acceptance, vulnerability, but also need the skills of the mind – the most sophisticated treatment that medicine has to offer. On its own, neither is enough.

Dame Cicely Saunders (Kuhl, 2002)

No one likes to be the bearer of bad news. However, breaking bad news is part of the health care team's job.

The medical field tends to focus on a "cure" model of treatment, creating a situation where the comfort level of most health care providers is very low when it comes to delivering bad news to a patient. This delivery is very important, a legal obligation, and takes skill. Fortunately, the skills needed in such circumstances can be learned.

An expert in breaking bad news is not someone who gets it right every time – he or she is merely someone who gets it wrong less often and who is less flustered when things do not go smoothly.

The Process

Bad news is any news that drastically and negatively alters the patient's view of

his or her future. The "badness" of bad news is the gap between the patient's expectations and the medical reality.

The process of delivering bad news starts before the diagnosis is made, and much depends on how well the nurse and other providers have prepared the patient for the possibility of a bad outcome. When the first test is ordered there should be a straightforward dialogue with the patient regarding all possibilities. These discussions open the paths of communication and lay a foundation of trust and understanding between the provider, nurse, and patient.

In ambulatory care settings, the nurse should be included throughout this process. When the doctor is busy, the nurse may be able to have an open discussion with the patient to answer questions and respond to concerns and fears the patient has regarding health issues. The nurse and doctor need to work together to meet the patient's needs.

Communicating Effectively

Good communication in the health care setting is not always an easy task. There are many distractions, interrup-

tions, and time demands that can interfere. If we do not do the work of communicating, we usually find ourselves at odds with an upset patient.

There are several basic communication strategies (see Table 1, next page). Start by preparing to listen. Sit down, give the patient your full attention, make eye contact, and look relaxed. This sounds time consuming but takes no more time than standing at the door with one hand on the knob, while glancing at your watch while the patient asks a question. The hurried appearance of the provider can cause the patient not to ask questions they need answered, and patient satisfaction is greatly increased when the provider appears unhurried.

The nurse can help collect information by interviewing the patient during his/her visit. The nurse should ask questions while keeping in mind the following: closed questions are good for collecting demographic data; open questions require the patient to respond with more than a yes or no answer. This can help determine what the patient wants to know, what is worrying him/her most, and what he/she already knows.

Getting the patient to talk is an important part of the process but it is only the beginning. The nurse needs to listen and validate what she thinks the patient said. We tend to color what others say with our own experiences and feelings, so nurses need to be aware that this may totally change the meaning of what the patient was trying to say. Be sure to repeat and reiterate your interpretation of the conversation to assure you understand what the patient actually said.

Respond to the patient's feelings by answering questions. Try to identify expressed emotions and feelings, find their causes, and acknowledge them.

Nurses should also observe nonverbal cues. For example, the patient may not say "I'm angry" but the nurse perceives anger in his/her body language and tone of voice. This needs to be acknowledged. The nurse could say "I think I would feel very angry if I were in your situation. How are you dealing with your feelings of anger?" This removes any judgmental or negative connotations associated with

‘Truth is like a drug. Insufficient doses are ineffective and may harm patients’ trust.’

Table 1.
**The Basics of
Communication**

- **Prepare to listen** – sit down, look relaxed
- **Ask questions** – closed and open, reveal what the patient knows and what he/she wants to know
- **Listen** – start the patient talking
- **Hearing** – repeat and reiterate to assure you understand what the patient has said
- **Respond to the patient’s feelings** – answer questions, identify emotions and their causes and acknowledge them

anger and sets the emotion forth as normal and expected. The patient and caregiver can deal more effectively with each other and issues related to the patient’s health if underlying emotions have been acknowledged, discussed, and accepted.

The Six-Step Protocol for Bearing Bad News

The six-step protocol is summarized in Table 2 (next page). The following explains details of the method:

Start well. Be sure to get the physical context right. Consider the location – is it a comfortable environment and does it provide privacy? Decide as a team whom to include: the primary doctor, who should take the lead; the nurse who has developed a good working relationship with the patient; and family members or friends chosen by the patient. The nurse can facilitate the logistics of the meeting and make sure all are able to be present.

Find out how much the patient knows. If this information has not been ascertained in prior discussions, it is important to know what information (or misinformation) the patient may have. Much anxiety comes from partial truths and false information.

Find out how much the patient wants to know. In the 1950s and 1960s, doctors as a rule felt it inappropriate to tell their patients the whole truth. The common thought was the patient doesn’t want to know. Recent studies show that 50% to 97% of patients want to know the truth about their illness, even when dealing with bad news (Buckman, 1992).

Share information. Set an agenda that includes crucial objectives such as specifying the diagnosis and explaining it in terms the patient can understand. Include the treatment plan and be sure to allow the patient to make choices when possible. Give realistic pros and cons to the options. Discuss the prognosis including what the patient can expect as realistic outcomes. Do not give false hope; remember that while it can be painful, most patients want to know the truth. Truth is like a drug that has its own pharmacology – insufficient doses are ineffective and may harm the patient’s trust in the provider; overenthusiastic dosing may cause symptoms of overdose. The manner in which truth is shared may be a significant predictor of the patient’s response to the bad news (Garrett, 1998).

Also, make sure to provide support to the patient. This takes many forms, from offering immediate comfort through a compassionate touch to discussing symptom management and resources for support groups that are available.

Start from the patient’s starting point – you don’t want to be redundant by giving information the patient already knows but you also should not assume the patient has knowledge by virtue of having the disease.

In addition, keep in mind that patient education is best given in small chunks. A patient who is receiving all the information at once may feel overwhelmed and not be able to digest all of it. Schedule revisits for this purpose and remember to use language that is easy to understand rather than medical jargon. While jargon is a very comfortable hiding place for the health care provider it rarely communicates and can be a source of great anxiety for the patient. Check fre-

quently to see how the patient is receiving the news – how is he/she reacting? Reinforce and clarify, have the patient restate what you have told him/her to validate understanding. Listen for the patient’s agenda and discuss the topics that seem to be of utmost concern.

Respond to the patient’s feelings. Identify and acknowledge the patient’s reactions to the bad news. Validate these feelings: they are neither right nor wrong, they just are. Help the patient begin to accept these feelings.

Plan and follow-up. Make an agreement with the patient regarding the treatment plan and follow through with it. Reassess the plan’s validity with the patient on a regular basis and revise as necessary. The patient has a right to make care decisions for him or herself. We may not agree with the decision but must respect and support the patient’s right to make choices, especially when a cure is not an option.

Conclusion

This is not the end of the story for the patient. Throughout the process from diagnosis and treatment to death, we must strive to meet the patient’s needs. Not just physical but spiritual and psychosocial. Maintaining straightforward communication with the patient and family regarding *all* possibilities lays a foundation of trust and understanding between the patient and the health care team. In this kind of setting the patient is more likely to receive comfort measures and palliative care at the appropriate time in the process not as a last resort or an afterthought to care.

As nurses, we must help the patient to a kinder and more compassionate end of life experience. While technology provides more opportunities for better outcomes than ever before, there comes a time when more is not better but gets in the way of the patient’s ability and need to say goodbye.

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Table 2.
The Six-Step Protocol for Bearing Bad News

- 1. Start well**
 - a. Get the physical context right. Consider:
 - Location.
 - Who will attend discussion.
- 2. Find out how much the patient knows.**
- 3. Find out how much the patient wants to know.**
- 4. Share information.**
 - a. Set agenda. Crucial objectives for structuring your agenda:
 - Diagnosis.
 - Treatment plan.
 - Prognosis.
 - Support.
 - b. Start from the patient's starting point.
 - c. Education.
 - Give information in small chunks.
 - Use easy-to-understand language, not medical jargon.
 - Check reception frequently – how patient is coping with the news.
 - Reinforce and clarify, have the patient restate what you said.
 - Listen for patient's agenda, main concerns.
- 5. Respond to the patient's feelings.** Identify and acknowledge reactions.
- 6. Plan and follow-up.** Make an agreement regarding the treatment plan, then follow through.

Nurses' STORIES

The Ultimate Advocacy Role

For nurses, end-of-life care isn't just about providing compassion. It is also about two very important legal documents.

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

At any given moment, most nurses know of someone who has just received a terrible diagnosis and who is likely to die – even if the medical interventions are aggressive, available, and well done. In many ways, it's a part of our clinical practice and part of our personal lives.

And for nurses, the roles of personal and professional caregiver frequently merge. One such case for me is that of my dear friend Jay, 59 years old.

In July 2001, Jay was diagnosed with inoperable pancreatic cancer. The outcome was predictable but the grief felt by everyone who learned of his initial diagnosis was truly unexpected. Immediately, we knew that the unpredictable "work of dying" was what lay before us.

My response to Jay's diagnosis is very similar to how most nurses would react in a similar situation. We educate others about the medical world, support them through our actions, try to calm the situation by our presence, and then alone or with others, we cry.

Fulfilling Our Role

You may be as surprised as I was to learn that in America, less than 10% of the population dies a sudden death. According to a 1996 Gallup

continued on page 6

Poll, more than 90% of Americans said that they would like to die at home. Yet, of that group, about 74% will die in institutions of some kind (Hot Topics in Hospice, 1997). What a paradox between where Americans want to be when they die and what actually occurs. It is truly a disservice to our patients and their families.

This very serious issue leads me to wonder how ambulatory care nurses can help. How can we communicate and educate others about their desires relating to end-of-life care? How do we learn to make a difference on this often sensitive topic?

This issue falls into the arena of patient advocacy, one of the core values of the nursing profession. Educating patients about two important legal documents - an Advance Directive ("Living Will") and a Durable Power of Attorney for Medical Care - could be a first step in the process.

The Patient Self-Determination Act of 1991 is a federally-mandated process for all patients admitted to acute care, home health care, nursing homes, and hospice programs. This translates into the Advance Directive document that many Americans know about but very few actually review and sign. The law requires that patients entering these selected programs be asked if they have an Advance Directive, however, this is not the best time or place to broach the topic. In these circumstances, it is often a challenge for the health care provider to understand and grasp the meaning of what the patient wants and why regarding their end-of-life care.

Wouldn't it be much better if this discussion began in ambulatory care clinics across America? Ambulatory care nurses are deeply involved in caring for the elderly, the disabled, and for patients whose conditions include chronic illnesses. Care is provided over time and episodically, but it is often administered by health care providers who know and understand the evolution of the illnesses and the needs of these particular populations.

Patients frequently identify with the clinic setting as their health care provider. Reaching a decision about what an individual wants for end-of-life care is best done in an environment that is familiar and with people who the person trusts. In the 1999 and 2000 Gallup Polls for Honesty/Ethics in Professions, nurses were rated as the most trusted professionals by the public. In 2001, nurses were second only to firefighters in the same poll (The Gallup Organization, 1999, 2000, 2001). Keeping in mind such trust, ambulatory care nurses are in a perfect position to partner with physicians, patients, and families during a discussion on end-of-life care. Ideally, such conversations are best done before a health care crisis arises.

Most of today's clinic settings are fast paced, with limited resources and not enough time for in-depth discussions. Also, patient wait times are often lengthy. Perhaps the ambulatory care nurse could begin educating patients about end-of-life issues by providing literature about Advance Directives and Durable Power of Attorney for Medical Care in the waiting area along with directions on how and where to follow up. In other words, the nurse should consider how to begin a process that *allows* for this kind of discussion to happen.

Once the nurse makes patients and families aware of

The vast majority of Americans say they would choose to die at home, however few do. This discrepancy is truly a disservice to our patients.

these legal documents, they should seek a qualified attorney for assistance.

Which leads to another thought, as well as a personal question: Do you (the AACN member) have an Advance Directive and a Durable Power of Attorney for Medical Care completed and communicated to the appropriate sources? If you don't, then why not? What better way to understand your state laws and rules as they

relate to this topic than to educate and complete Advance Directive and Durable Power of Attorney documents for yourself? Consider obtaining such documents for yourself this year, regardless of your age or stage in life. Doing so would not only help you better inform your patients about the process but will also help you take care of you and yours.

About Jay

My friend Jay died peacefully at home on July 7, 2002, surrounded by his wife and family, 1 year after being diagnosed. With the exception of symptom management, he chose to have no medical intervention. Before he died, Jay had excellent hospice nurses and various hospice services for 9 months. He had both an Advance Directive and Durable Power of Attorney for Medical Care, both of which were followed.

In many ways, Jay taught me a lot about choices and about staying connected to personal values and beliefs. It was difficult for him to stay focused on decisions made months earlier as he became fatigued, weak, and sad as he realized what was happening to his physical being. But his strength and determination to put the last pieces of his life in order was truly courageous. I hope my choices are equally courageous.

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CALL FOR ABSTRACTS Emergency Nurses Association Submission Deadline: March 1, 2003

The Emergency Nurses Association invites you to submit abstracts for research posters and papers as well as clinical posters for its Scientific Assembly, September 18-20, 2003, Philadelphia, PA.

Criteria/guidelines for submission are available for download from the ENA Web site at www.ena.org, or by calling the ENA Research Department, 915 Lee St., Des Plaines, IL 60016-6569 at 800/900-9659, ext. 4119; e-mail: res@ena.org.



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Telehealth Nursing Practice SIG Adopts Teleterms

The focus of the AACN Telehealth Nursing Practice Special Interest Group (TNP SIG) is to advance telehealth nursing and promote it as a specialty practice.

The Clinical Practice/Quality Improvement (CP/QI) Workgroup is one of four strategic committees whose members work toward meeting the SIG's overall goals. The CP/QI workgroup is comprised of 12 SIG members, all TNP experts. Four members of the workgroup, the co-authors of this article, constitute the core workgroup.

The 2002-2003 goals of the CP/QI workgroup are to define and clarify telehealth terminology and to develop a glossary of terms relevant to telehealth nursing practice.

Clarifying the Terminology

Last year, the CP/QI core workgroup identified five key terms: telehealth, telemedicine, telehealth nursing, telephone nursing, and telephone triage. These five terms are currently

and historically the primary terms used in telehealth practice, publication, education, and research. They were selected, defined, and described because of their prevalence; inconsistent use; public and professional confusion; and evidence that even telehealth practitioners had difficulty differentiating between the terms (Greenberg & Espensen, 2001).

Based on a thorough review of the literature, the five terms were defined and described and are shown below (also see Table 1). Broad, nonrestrictive definitions were used to differentiate among the terms and accommodate the continually evolving changes in telehealth.

Telehealth

"Telehealth" is the inclusive term used to describe the wide range of services delivered, managed, and coordinated by all health-related disciplines via electronic information and telecommunications technologies.

Table 1.
Definitions and Descriptions of Five Primary Telehealth Terms

Terminology	Definition	Description
Telehealth	The delivery, management, and coordination of health services that integrate electronic information and telecommunications technologies to increase access, improve outcomes, and contain or reduce costs of health care.	An umbrella term used to describe the wide range of services delivered across distances by all health-related disciplines.
Telemedicine	The delivery, management, and coordination of care and services provided via telecommunications technology within the domain of medicine.	A broad term describing the subset of telehealth pertaining to the practice of medicine at a distance.
Telehealth Nursing	The delivery, management, and coordination of care and services provided via telecommunications technology within the domain of nursing.	A subset of telehealth encompassing all types of nursing care and services delivered across distances.
Telephone Nursing	All care and services within the scope of nursing practice that are delivered over the telephone.	A component of telehealth nursing practice restricted to the telephone.
Telephone Triage	An interactive process between nurse and client that occurs over the telephone and involves identifying the nature and urgency of client health care needs and determining the appropriate disposition.	A component of telephone nursing practice that focuses on assessment, prioritization, and referral to the appropriate level of care.

Table 2.
Percent Agreement with Teleterms Definitions

	Survey Participants	Workgroup Members (N=12)	Total (Participants & Members)
Telehealth	95% (180/196)	100%	96% (199/208)
Telemedicine	94% (186/197)	100%	95% (198/209)
Telehealth Nursing	94% (188/200)	100%	94% (200/212)
Telephone Nursing	85% (169/199)	100%	86% (181/211)
Telephone Triage	95% (186/196)	100%	95% (198/208)

The term telehealth has replaced “telemedicine” and represents the provision of health care beyond diagnosis and treatment to include services that focus on health maintenance, disease prevention, and education.

The three primary functions of all telehealth services are to increase access, improve outcomes, and contain or reduce the costs of health care. The prefix “tele,” meaning “at or over a distance,” is affixed to terms describing health care services that use telecommunication technology (such as the telephone, Internet, interactive video, remote sensory devices, and robotics) to transmit information from one site to another. Distance and telecommunication technology therefore are the common denominators of telehealth services.

Telemedicine

“Telemedicine” is a subset of telehealth that focuses on the delivery, management, and coordination of care and services provided via telecommunications technology within the domain of medicine.

Specialty applications of telemedicine currently include teleradiology, telecardiology, telepathology, telepsychiatry, teledermatology, and teleoncology; however, it is important to remember that within telehealth, changes occur at a phenomenal rate (existing services grow and new services and issues emerge).

Telehealth Nursing

“Telehealth Nursing” (also known as “telenursing”) is a subset of telehealth that focuses on the delivery, management, and coordination of care and services provided via telecommunications technology within the domain of nursing.

Recognized by both AACN and the American Nurses Association (ANA, 1998), telehealth nursing is defined as nursing practice using the nursing process to provide care for individual patients or defined patient populations over a telecommunication device (AACN, 2001).

Telehealth nursing is a broad term encompassing practices that incorporate a vast array of telecommunications technologies (telephone, fax, electronic mail, Internet, video monitoring, interactive video) to remove time and distance barriers for the delivery of nursing care.

The continually evolving telehealth nursing interventions encompass the delivery of nursing care other than direct,

hands-on patient care. Guided by nursing standards, the major components of telehealth nursing practice include assessment, triage, health education, consultation (information, advice, and symptom management), disposition, surveillance, and follow-up.

Some established applications of telehealth nursing are currently telephone nursing, telehomecare, case management, disease management, and utilization review.

Telephone Nursing

“Telephone Nursing” refers to all care and services within the scope of nursing practice that are delivered via telephone or POTS (plain old telephone system).

As a component of telehealth nursing, telephone nursing practice relies on the nursing process to provide care to patients and is also guided by nursing standards (AACN, 2001). It is currently the largest subset of telehealth nursing.

Telephone Triage

“Telephone Triage” (TT) is an interactive process between nurse and client that occurs over the telephone. TT is used to identify the nature and urgency of the client’s (patient’s) health care needs and determine the appropriate disposition for the client (AACN, 2001). Although health education plays an essential role, the focus of TT is on prioritization and disposition. TT is the largest and most well-known component of telephone nursing.

Reviewing the Terms

All members of the CPQI workgroup were asked to review, accept, reject, and edit these full definitions and descriptions. Workgroup members reported that the information for each term was consistent with their knowledge, experience, and practice (telehealth, 100%; telemedicine, 92%; telehealth nursing, 100%; telephone nursing, 92%; and telephone triage 83%). Minor changes in the content were made by the Core Workgroup in response to suggestions received by remaining members.

Workgroup members were also asked to review Table 1. Table 1 was developed as a reference tool using condensed versions of the term definitions and descriptions. The table was accepted unanimously by the workgroup.

The content from Table 1 was formatted into a survey and offered on-line to AACN members via the association’s

Table 3.
Percent Agreement with Teleterms Descriptions

	Survey Participants	Workgroup members (N=12)	Total (Participants & Members)
Telehealth	87% (172/197)	100%	96% (199/208)
Telemedicine	80% (154/193)	100%	95% (198/209)
Telehealth Nursing	94% (188/200)	100%	94% (200/212)
Telephone Nursing	85% (169/199)	100%	86% (181/211)
Telephone Triage	95% (186/196)	100%	95% (198/208)

Web site. In addition, a hard copy was given to telehealth practitioners (clinicians, educators, and administrators) at the 2002 Contemporary Forums Telehealth Nursing conferences. Participants were asked to indicate whether they agreed or disagreed with the definition and description of each term.

The total rate of agreement with the teleterms (workgroup members and survey participants) and the rate of agreement for workgroup members and survey participants, are shown in Table 2 (definitions) and Table 3 (descriptions).

Characteristics of the survey participants included the following:

- 90% were currently active in TNP.
- Experience in TNP ranged from less than 1 year to more than 10 years with an average of 5 years experience.
- Participants worked in a variety of settings including hospital-based, after-hours, 24/7 regional call centers, primary care clinics (pediatric, adult, specialty), and health education.

Terms Approved, Work Continues

Based on the high rate of acceptance described above, the definitions and descriptions of the five teleterms were approved and adopted by the TNP SIG. We encourage all telehealth nursing practitioners to incorporate these definitions into their practice to improve communication, contribute to the understanding and organization of the many

services available, and enhance our ability to distinguish newer and more specific telehealth applications.

The CPQI workgroup is committed to the development of a glossary of telehealth terms and concepts. The next phase in this project is to identify and prioritize common or emerging glossary terms for definition, clarification, and reference.

Telehealth nursing as a specialty practice belongs to each of us, and the end product from the TNP SIG should reflect the expertise of all AAACN members. Suggestions for glossary terms are encouraged and welcome. Please send your suggestions to the following CPQI Workgroup Leaders: Liz Greenberg, (520) 298-8647, maryg@nursing.arizona.edu; or Maureen Espensen, (602) 604-1215 (w), (480) 4601401 (h), maureen.espensen@mckesson.com.

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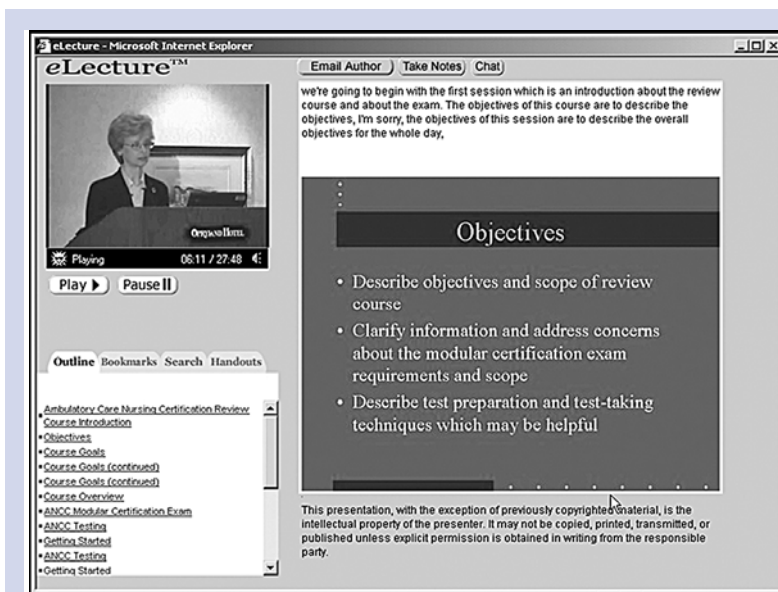


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Nancy Kowal, MS, RN, C, ANP
Kathy Hoare, PhD, FNP

Practice Evaluation and Research Committee Launches Staffing Study

During the last two decades, one of the challenges of ambulatory care has been to manage the expectations patients have for access to services. The way ambulatory care settings are staffed affects clinical outcomes.

The clinical experience has changed from 24 hours ongoing to a short episodic encounter. Changes in hospital utilization policies and reimbursement policies have shifted acute health care experiences to the ambulatory care setting. These changes have driven proactive health maintenance as a component to care (Haas & Hackbarth, 1997; Phillips, 1994; Schroeder et al., 2000).

Most ambulatory services are based on a medical model. In contrast, the nursing model is more holistic including the family and environment (Haas et al., 1995). In this context, new leadership roles for ambulatory nursing are being developed especially in the managed care setting (Schroeder et al., 2000). Emphasis on system performance indicators will be critical (Androvich & Hastings, 1996).

Donabedian in 1966 defined the structure-process-outcome model in quality care evaluation. Ness and Cucuzza in 1995 attempted to cost out each step and define value via the concept of activity-based costing (ABCs) (Ramsey, 1994). Peter Drucker in 1995 advanced the concept which "starts with one assumption that there is only one cost over any time period" (p. 56).

In the past, the nursing cost has been the largest piece of the pie. As the future progresses and the patient acuity rises, there will be a great need for highly educated and trained nurses to manage the care (Phillips, 1994). As inpatient areas have developed patient staffing models, outpatient areas are in need of the same staffing models based on quality research.

Claire Hastings in 1987 viewed the ambulatory experience as a focus on cost of care, universal access, and the relationship of care to results defined as outcomes (Hastings,

1987). She further expanded her concept across health care systems and the continuum of care, looking at the quality experience.

Haas et al. in 1995 identified eight core dimensions of a nurse's role in outpatient settings and the levels of nursing preparation required for each.

Haas and Hackbarth in 1997 advanced this further by looking at three added dimensions involving quality improvement, research, and continuing education.

Schroeder et al. in 2000 looked at justification, role development, impact on outcomes of cost, quality, provider, and patient satisfaction of nurses in ambulatory managed care. The evidence suggests the impact of the role has benefits far beyond its costs (Schroeder et al., 2000; Verran, 1981).

Staffing Study

Currently, AACN's Practice Evaluation and Research Committee has reviewed the literature and defined the need for research regarding staffing in the ambulatory care arena. An exploratory study was designed to identify and examine staffing models currently in use in the ambulatory care settings and facilities where AACN members work. The objectives of the study are to:

1. Identify the various staffing patterns on a typical day in the ambulatory care setting.
2. Identify types of clinics, their commonalities and differences, using similar staffing patterns.
3. Determine dimensions of clinical practice currently in existence and the type of personnel who perform them.
4. Determine the criteria or process used to determine the number and mix of staff in clinics utilizing similar staffing patterns
5. Identify the title and credentials of the individual making staffing decisions.
6. Identify quality and/or outcomes measures currently in use.

Within this context, Phase I will develop the picture of ambulatory care staffing and allow us to move on to the measurement of patient, provider, and general ambulatory clinical outcomes. We invite AACN members to participate and be part of a national revolution in ambulatory care staffing designed and identified by the ambulatory nurses who know it best. A challenging and dynamic opportunity lives within AACN's research. The future is here and now. Join us in the quest.

continued on page 14

The vision is to
develop an
ambulatory care
staffing model
that supports
positive clinical
outcomes.
AACN members
are invited to
participate.

AAACN Endorses Federally Funded Alcohol Screening Program

AAACN has endorsed the 5th Annual National Alcohol Screening Day (NASD) on April 10, 2003. As part of the program, AAACN members will receive at no charge materials to screen patients for alcohol problems as well as educate patients about alcohol's effect on medical conditions and drug interactions.

Addressing a range of alcohol problems from at-risk drinking to alcohol dependence, the materials are designed to help primary care and specialty providers identify and manage patients with existing or developing alcohol problems.

NASD is a program of Screening for Mental Health, a nonprofit organization in partnership with the National Institute on Alcohol Abuse and Alcoholism (NIAAA), the Center for Substance Abuse Treatment (CSAT), and the Center for Substance Abuse Prevention (CSAP), three federal agencies. Because of the federal support, the program is free to all primary care and specialty providers.

Registered providers receive a kit of ready-to-use education and screening materials, including brochures, educational flyers, videotapes, and screening forms. Sites also receive step-by-step instructions for planning and conducting a screening event as well as a publicity guide.

The materials can be used in two different ways. Clinicians are invited to con-

duct a special outreach event on National Alcohol Screening Day (April 10) or they may incorporate the screenings into their day-to-day procedures and screen regularly scheduled patients or clients.

Incidence

NIAAA reports that one in five men and one in ten women who visit their primary care providers meet the criteria for at-risk drinking or problem drinking (alcohol abuse) or alcohol dependence (alcoholism).

An estimated 25% of adults in the United States either report drinking patterns that put them at risk for developing problems or currently have alcohol-related problems, including alcohol abuse or dependence. While most adults who drink alcohol do so in moderation and are at low risk for developing problems, all drinkers should be aware of the health risks associated with alcohol consumption.

Multiple and conflicting news stories about alcohol's effects often confuse the public. Patients look to and trust their clinicians to advise them about the risks and benefits associated with drinking. Research demonstrates that simply discussing concerns with patients can be effective in changing many patients' drinking behavior before problems become severe or chronic.

Simple screening procedures and

straightforward information on how alcohol affects the body, interacts with medications, and can complicate treatment for medical problems can save patients' lives, reduce morbidity, and increase the likelihood of better outcomes.

NASD

Since its inception in 1999, NASD has provided thousands of health care facilities, treatment centers, mental health clinics, colleges, and primary and specialty care providers with a ready-made, easy-to-use program for conducting free, voluntary alcohol screenings with referrals for individual evaluation and treatment. Over the last 4 years, NASD has attracted over 150,000 people to the event, screening some 1 million individuals and educating friends and family about signs, symptoms, available treatments, and where to seek counseling and help.

Registration Details

To participate, sites can register online by going to [www.nationalalcohol screeningday.org](http://www.nationalalcoholcreeningday.org) or by calling the NASD office. To receive a registration form or for more information about National Alcohol Screening Day, contact NASD at One Washington Street, Suite 304, Wellesley Hills, MA 02481; phone (781) 239-0071; fax (781) 431-7447.

Staffing Model Study

continued from page 13

Please contact the AAACN National Office at 800-AMB-NURS or AAACN@AJJ.com if you wish to participate.

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aacn 28th Annual Conference

Networking in Ambulatory Care:
Advancing Innovative and Professional Practice

April 10-14, 2003 • Tampa, Florida

The theme for the AACN 2003 28th Annual Conference, "Networking in Ambulatory Care: Advancing Innovative and Professional Practice," sets the stage for participants to connect with colleagues, share ideas, and learn about the latest advances in practice. The conference features diverse presentations on the most urgent issues facing ambulatory care nurses today.

Program

On April 10, Colleen Conway-Welch, PhD, CNM, FAAN, and Cmdr. Angela Argabrite MS, FNP, MPH, will present a special pre-conference workshop, **Preparing the Nursing Workforce for Bioterrorism**. The session continues the work of the International Coalition for Mass Casualty Education (INCMCE), a group dedicated to preparing nurses to respond to mass casualty events. Topics will include the threats to health care providers during a mass casualty crisis, the impact of terrorism-related funding on public health, and the continuing work of INCMCE.

On April 11, Connie Curran, EdD, RN, FAAN, will deliver the conference Keynote Address. Dr. Curran, a nationally known speaker, author, editor, and consultant, will discuss three key issues facing today's organizations: regaining public trust, the bottom line, and winning the talent war.

Concurrent sessions will run from April 11-13 and include such topics as assessment and intervention for HIV disease; effective nurse retention strategies; applying the *AACN Telehealth Nursing Practice Administration and Practice Standards* to professional practice; legal and regulatory issues in telehealth nursing; women's cardio-

vascular health; the crucial role of leadership skills in team formation; and much more.

Post-conference workshops on April 14 include the **Ambulatory Care Nursing Certification Review Course** and the **AACN TeleHealth Nursing Practice Core Course (TNPCC)**.

Special Interest Groups

AACN's Special Interest Groups (SIGs) also meet during the conference. These groups represent Pediatrics, Staff Education, Telehealth Nursing Practice, Tri-Service Military, and Veterans Affairs. This year, the Tri-Service Military SIG is holding a pre-conference, **Military Contributions to Innovative and Professional Nursing Practice** during which United States Army, Navy, and Air Force Nurse Corps Chiefs will brief attendees on the current status of the nurse corps and visions for the future.

Continuing Education

Attendees have the opportunity to earn up to 20.3 contact hours for the conference. Additional hours will be given for the poster sessions and the pre-and post-conference workshops, ranging from 1.2 to 9.1 contact hours for each.

Registration

Complete conference information and on-line registration are available on AACN's Web site, **www.aacn.org**. For additional registration information, contact the AACN National Office, East Holly Avenue, Box 56, Pitman, NJ 08071-0056; phone 1-800-AMB-NURS or (856) 256-2350; fax (856) 589-7463; e-mail aaacn@ajj.com.

Silent Auction Returns

The AACN Silent Auction will be held during the Opening Reception of the conference on Thursday, April 10, 2003. Proceeds from the auction benefit the AACN Scholarship and Research Fund.

For the auction, AACN members and vendors generously donate items such as vacation timeshares, vintage-nursing items, theme baskets, handcrafted items, and gift certificates. During the auction, participants place their bids into containers in front of each item. The person who submits the highest bid wins the prize.

The auction is an enjoyable event that has raised thousands of dollars in scholarship money. Please make sure to attend.

If you, your committee, or your AACN Special Interest Group (SIG) would like to donate an item, please contact Kitty Miller Shulman at millerki@slrnc.org, Pam Del Monte at myoneace@erols.com, or the AACN office at aaacn@ajj.com.

When you contact us, please make sure to provide a brief description of your item, as well as an estimated value. Also keep in mind that donated items must be small and portable enough to fit easily in a suitcase.

Kitty Miller Shulman

Co-chair, 2003 Program Planning Committee

Call for Moderators

Each year, we ask AACN members who are attending the Annual Conference to become involved by acting as moderators for the concurrent sessions. A moderator introduces the speaker(s), dispenses handouts, collects evaluations, and helps make sure the session goes smoothly.

To acclimate AACN volunteers to the job, a short moderator meeting is held in the late afternoon the day before conference. Volunteers receive "Moderator Tips" and packets for each session they are to moderate. The time and location of the moderator meeting will be posted at the conference registration desk.

If you have moderated before, we look forward to having you with us again; if not, please make this year's conference experience even more enjoyable by volunteering. Moderating a session is a wonderful way for first-time attendees to get the most out of their conference experience.

To volunteer as a moderator, call the AACN National Office at (800) AMB-NURS or e-mail aaacn@ajj.com by **April 1, 2003**.

Telia Emanuel RN, MHA, CNAA

Chairperson, 2003 Program Planning Committee
(386) 676-7189 • temanuel@floridahealthcares.com

Palliative Care

continued from page 1

Background

An article in the journal *Continuing Care* reported last year that nursing schools across the country are offering the training necessary for nurses to meet the challenge of improving quality of life for the dying based on recommendations by the National Cancer Policy Board, the Institute of Medicine (IOM), and the National Research Council (Cox, 2002).

In the same article, Betty R. Ferrell, PhD, RN, stated that "The need to improve palliative care, including end-of-life care, has been regularly and rightly publicized since the late 1990s and became more focused after the IOM issued recommendations. Funding by the Robert Wood Johnson Foundation in collaboration with the American Association of Colleges of Nursing and City of Hope has also supported the need for improvement of palliative care issues. This group is referred to as the End-of-Life Nursing Education Consortium (ELNEC). Their program is the most far-reaching national educational end-of-life program for nurses that has been launched to date as reported by IOM study director Helene Gelbard" (Cox, 2002, p. 30).

The Institute for Johns Hopkins Nursing in Baltimore, MD, is leading an educational effort which is referred to as the Nursing Leadership Academy for End-of-Life Care. This initiative, funded by the Open Society Institute Project on Death in America consists of a 4-day workshop for leaders of professional nursing organizations.

In 2002, the workshop was held on August 25-30 in Baltimore. Participants represented over 40 national professional nursing organizations and a total of 1.5 million nurses. As part of an ongoing effort, the participants will reconvene in August to report on progress within their respective organizations.¹

The explicit goal of the Academy is to improve end-of-life care by increasing leadership capacity within national professional nursing organizations. The objectives include:

- Educating nurse leaders
- Creating a system of support and mentoring
- Developing and implementing innovative strategies

Prior to the commitment of the American Association of Colleges of Nursing (AACN) and the creation of the Nursing Leadership Academy for End-of-Life Care, an educational program for physicians, Educating Physicians in End-of-life Care (EPED), was developed and disseminated with support from the Robert Wood Johnson Foundation, the American Medical Association, and the Soros Project on Death in America. The

project's core curriculum provides basic knowledge and skills for physicians to appropriately care for dying patients. It also includes information for advanced care planning, pain management, and communication skills (vonGuten, 2000).

The efforts listed above show that physicians, nurses, and many other disciplines are increasingly interested in the palliative care movement and end-of-life issues that the nation faces as America's aging population grows.

Nursing-Based Theory

Bonnie J. Miller, RN, DMin, Associate Professor of Nursing in Cincinnati, Ohio, shares her view on nursing theory: "Many nursing theorists theorize and make scientific inquiries to make us fit into academia. Thus we may lose our depth of understanding of the human soul that is important at times of illness and suffering" (Miller, 2002, p. 10).

A leading nurse theorist Martha Rogers, who has served for 21 years as professor and chair of the Division of Nursing at New York University, is a well known influential theorist in nursing and is often quoted in the nursing field. The central concern of Rogers' theory is the concept that human beings are dynamic. Her philosophy and science of caring focuses on the belief that *caring* is the role that guides the nurse in practice (Miller, 2002).

Nurses who are able to nurture the growth and development of patients and families facing chronic progressive illnesses, can have a great impact on patients' acceptance and understanding of their disease or condition. Nurses and physicians alike can help them achieve

this growth by learning to recognize, support, and connect with patients as other people.

This in turn allows personal growth for the nurse. Some theorists refer to this as "defining the soul."

"The soul can be thought of as a place for each of us where deeper thoughts and feelings exist. It is a place where we go to think, feel, and communicate on a different, more intentional level, than in our every day busy work life. It is a place that encourages us to free our mind, feel with our hearts, and experience the moment. It is a part of us that feels, experiences, and communicates on our deepest and most intimate level" (Fazid, 1999, p. 53).

Some examples of this connection and communication with patients might be:

- "Actually seeing the patient's eyes or face"
- "When you know a person's need without him or her saying a word"
- "When you feel someone else's pain, embarrassment or frustration"
- "Listening to patients and families with our hearts"

Learning from the Hospice Movement

Frank Ostaseski, founder of the Zen Hospice Project in San Francisco and director of its educational arm, The



Sandy Reifsteck, RN, (center) in her role as parish nurse brings patient Sybil Hartz, 84, (left) to meet with Jessie Houston, MD. As Ms. Hartz's physician, Dr. Houston has been trained in the "Care Not Cure" course which promotes palliative care measures to keep the patient comfortable and at home.

1. AACN was one of the national nursing organizations participating in the Nursing Leadership Academy for End-of-Life Care. Please see the report on page 18 of the September/October 2002 issue of *Viewpoint* for more information.

Institute on Dying, feels death is one of life's biggest problems.

"People in our country mostly die in fear – and we can do something about it," according to Ostaseski. "You want to have health care reform? This would be health care reform" (Flowers, 2002, p.17).

Exhausted clinicians, including nurses, know that many of their patients die with symptoms that have not been well managed, the needs of the family not addressed, and the patient's pain not controlled as well it could be. Nurses and other health care providers may shy away from patients with the greatest needs. The literature supports these needs and recommends nurses look internally and individually with discipline and focus to those with the most urgent needs.

This can best be accomplished by turning toward compassion for the individual and the family. The nurse can do this by sitting down with the family giving them an opportunity to say good-bye to the patient, staying calm in the middle of an emergency, including a few minutes to share with the family comments of the deceased person as a human being, and including personal thoughts. The next step might be to focus on listening and trying to understand what the patient and family are thinking and feeling at that point. Showing compassion for the situation helps the family and also soothes the stress of the staff involved in the patient's care (Flowers 2002).

Why Communication is Needed

Communication skills for end-of-life care are easy to understand but hard to implement. Current literature supports three important reasons for conversation, before, during, and following a medical crisis:

- Reduces anxiety
- Prepares patient and family for medical, social, and spiritual care which they may need or experience in the future
- Reduces the risks of any misunderstanding between the clinician and patient/family.

End-of-life care is not simply relearning skills for managing death and dying, but instead is being proactive and increasing conversation and actions in order to prepare for a better end, regardless of the age or situation of the patient (Flowers, 2002).

Compassionate presence in end-of-life care goes a long way in preventing the "burn-out" nurses experience caring for dying patients. Compassionate care can take place in the clinic, at the bedside, in the patient's home, or in the nursing home. Being able to celebrate death with an individual can be as soul-searching and gratifying as celebrating life.

In an article from *Health Care Forum*, Ostaseski said "Hospital systems should consider including death and end-of-life training for all staff in their institutions. Love and death are the two greatest gifts that are passed on to us, and usually they are passed on unopened" (Flowers, 2002, p. 21).

Nurses know well the extent to which family, friends, and even acquaintances call upon them to help with health care needs. This is more than reinforced during a crisis, which many times is at the transition from curing a patient to caring for a patient. Patients and families seek out nurses when the medical care system no longer has a cure for a terminal or chronic disease. During such times, patients and families need the nurse to reinforce the diagnosis, provide information and resources, and explain the next steps.

Nurses, can be extremely helpful and supportive by fulfilling the patient's needs, listening to concerns, answering questions, and referring the patient to appropriate resources. Nurses across the country serve in this role with their friends, family, churches, and other contacts they have in their communities.

The current emphasis on nurses' involvement in palliative and end-of-life care, which is being included in both nursing curricula and professional nursing organizations, allows individuals to examine the reasons they chose nursing in the first place. It is an important consideration as nurses pursue their careers and assume responsibility in palliative and end-of-life care for their patients and their own families.

Many nurses chose the field because they knew they would always have a job, they love the work, they enjoy the flexible hours. The goals of most nurses are also often expressed by nursing students who say they want their patients to feel love, caring, and compassion from their presence.

Model of Care

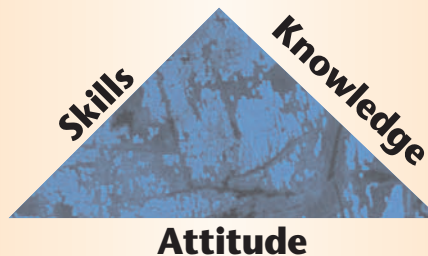
One model that can help with encounters with patients and families is the Competence Model involving three sides of a triangle. This model has been supported by Vaughn Keller, EdD, Associate Director Research and Education for the Bayer Institute for Health Care Communication. The three sides of the triangle are shown as follows:

Competence = Knowledge, Attitude, and Skills

Knowledge (the information) is communicated through journals, books, and newsletters.

Attitude (beliefs and values) is supported in literature referring to nursing as the "caring profession."

Skills (our behaviors) is the area where nurses and other clinicians are most lacking in order to provide competent end-of-life care. However sometimes, "we do not know what we do not know."



Role of the Institute

The Bayer Institute for Health Care Communication is a nonprofit organization whose mission is to enhance health care through education, research, and advocacy in the area of clinician-patient communication.

In 2001, the Institute developed two programs aimed at improving clinicians' skills in discussing palliative and end-of-life care with patients. This information can be used as a resource for both individual nursing practice and also as a personal "springboard" for nurses and their families and friends as they face these issues in their own lives.

"*Care Not Cure: Dialogues at the Transition*" is a workshop for staff. It allows time for team support and planning as it

relates to the care of patients and their families when treatment fails to cure or control disease and the focus of care shifts from quantity to quality of life.

The 4-hour workshop alternates short didactic descriptions and demonstrations of skills with opportunities for skills practice in small groups based on video and workbook cases. Participants receive a workbook including the text of the workshop slides and exercises, an annotated bibliography, and follow-up exercises.

This is an ideal environment to bring together physicians and nurses to learn and discuss skills that they can use to assist patients in the palliative stage of care.

The skills are organized into a conceptual model that parallels the tasks of patient care. The skills include the following:

- *Relate* to the patient and elicit concerns and preferences for information and decision making.
- *Review* available information to achieve a shared understanding of the data and meaning.
- *Revise* treatment and expand the goals and methods of care in an ongoing manner.
- *Reflect* on your approach as a clinician and consider your own roles, resources, and rewards. This reflecting will make you understand and realize your role in this type of palliative care delivery to both patients and their families.

Nurses and clinicians also may take an additional "Train-the-Trainer" course to help prepare them to teach the *Care Not Cure* workshop. The trainer course involves 5 days of training. The participants:

1. Learn how to present the *Care Not Cure* workshop.
2. Practice the skills in small groups with simulated patients.
3. Coach each other on communication skills.
4. Advocate for greater use of the skills at their home institutions.

The *Train-the-Trainer* course also includes an introduction to an additional series of seven, 1-hour modules on a variety of end-of-life communication topics. This program, "Conversations at the End of Life," was developed jointly by

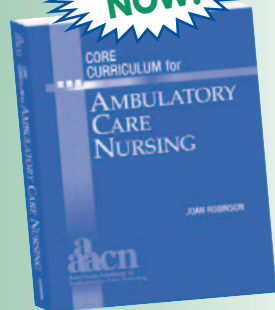
Module 1	Defining Palliative Care and "A Good Death"
Module 2	Discussing Advance Care Plans
Module 3	Shifting Focus to Palliative Care
Module 4	Preparing for a Death, Death Notification, Grief
Module 5	Managing Family Anger and Distrust
Module 6	Resolving conflict Arising from Cultural Differences
Module 7	Talking with Families

the Bayer Institute and Southern California Permanente Medical Group.

Based on the needs of the organization or institution, the modules can be presented as 1-day seminars or retreats for staff, or in 1-hour modules during lunch hours or after work (see Table 1 for content). Each module has a short evidence-based description of skills followed by a case presentation. The video and case presentation are the basis for an interactive exercise where participants in groups of three or four people observe and practice skills. The educational literature is very clear that skill-based learning requires observing and practicing with feedback, discussion, and more practice.

Continuing education is provided for all participants in these workshops, which are conducted by trained faculty. The Bayer Institute for Health Care Communication is accredited as a provider for continuing education by the American Nurses Credentialing Center's Commission on Accreditation and assigns contact hours appropriately. Health care organizations can either sponsor workshops by a trained faculty member or arrange for one or more members to participate in a *Train-the-Trainers* program.

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Conclusion

Regarding death as more of a natural process rather than as a failure of the medical system is an issue for the 21st century. Baby boomers don't want to talk about it for themselves yet, but due to their direct involvement with aging parents, they want more control over quality of life outcomes.

Surveys show that three-quarters of Americans die in medical institutions, yet only 3 out of 10 would choose to do so. The ambulatory care nurse can be dynamic in palliative care and end-of-life care and have a great deal of influence with these patients.

Resources are now available to assist in conversations and actions needed for nurses to become advocates of the switch from cure to care for those patients involved in terminal and long-term chronic illness. These conversations and dialogues support the competence model for health care delivery that requires a knowledge base, appropriate attitude toward death and dying, and communication and other clinical skills to handle palliative and end-of-life care.

This can all be accomplished with support from material now being developed by national nursing organizations and enlightened institutions to make this a national priority for America and for nursing. Nurses can be involved (many currently are), as patients and families seek them out to answer questions and provide support.

President's Message

continued from page 2

Objective 4. Enhance the functionality of the AAACN Web site.

Goal 2. Promote Professional Practice

Objective 1. Serve as a resource for evidence-based practices in ambulatory care settings and articulate the value of ambulatory care nursing practice.

Objective 2. Engage and develop education activities that promote the knowledge and capabilities of professional ambulatory care nurses.

Objective 3. Promote ambulatory-focused nursing research.

Objective 4. Build awareness of the interrelationship of ambulatory care, regulatory environment, and changing professional and societal norms and values.

Goal 3. Strengthen AAACN Resource Base

Objective 1. Maximize current revenue sources.

Objective 2. Broaden membership base.

Objective 3. Retain AAACN members.

Objective 4. Build collaborative resource base.

Goal 4. Develop AAACN Leadership Ability and Capacity

Objective 1. Identify methods for ongoing Board development.

Objective 2. Recognize innovative thinking.

Objective 3. Develop future AAACN leaders, incorporating intergenerational and multicultural factors.

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Strategies for each of these objectives have been identified and have had lead persons and time frames assigned for implementation. My future "Operations Updates" will be based upon this renewed and refreshed plan. I congratulate the Board for all their hard work in developing the plan and their commitment to making it real.

The Alliance

In mid-November, Catherine Futch, AAACN president-elect; Cynthia Nowicki, executive director; and I attended the Nursing Organizations Alliance's (the Alliance) inaugural meeting in Indianapolis, IN. The Alliance has 56 member organizations, representing nursing specialties in clinical practice, education, administration and research. The Alliance was created to increase nursing's visibility and impact through communication, collaboration, and advocacy using the collective power of all these organizations. We are proud to participate as charter members and feel that AAACN does and will continue to benefit from this collective work, as well as the networking opportunity it affords us.

Reflection

"I long to accomplish a great and noble task, but it is my chief duty to accomplish small tasks as if they were great and noble."

Helen Keller

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Reference

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**MISSION
STATEMENT**

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AAACN Election Results

The 2002-2003 AAACN Nominating Committee, chaired by Past-President E. Mary Johnson, is pleased to announce the results of the 2003 elections. There were 287 AAACN members (20%) who returned the ballots.

Elected officials will assume their positions at the close of AAACN's 28th Annual Conference on April 13, 2003. The new board members for 2003-2004 begin their terms that day as well. The new AAACN elected officials are:

President-Elect

Kathy Krone, MS, RN

Board of Directors

Karen Griffin, MSN, RN, CNA
Carole Becker, MS, RN

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Susan Paschke, MSN, RN, CM, CNA
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