Volume 29 Number 1

aacn ViewPoint

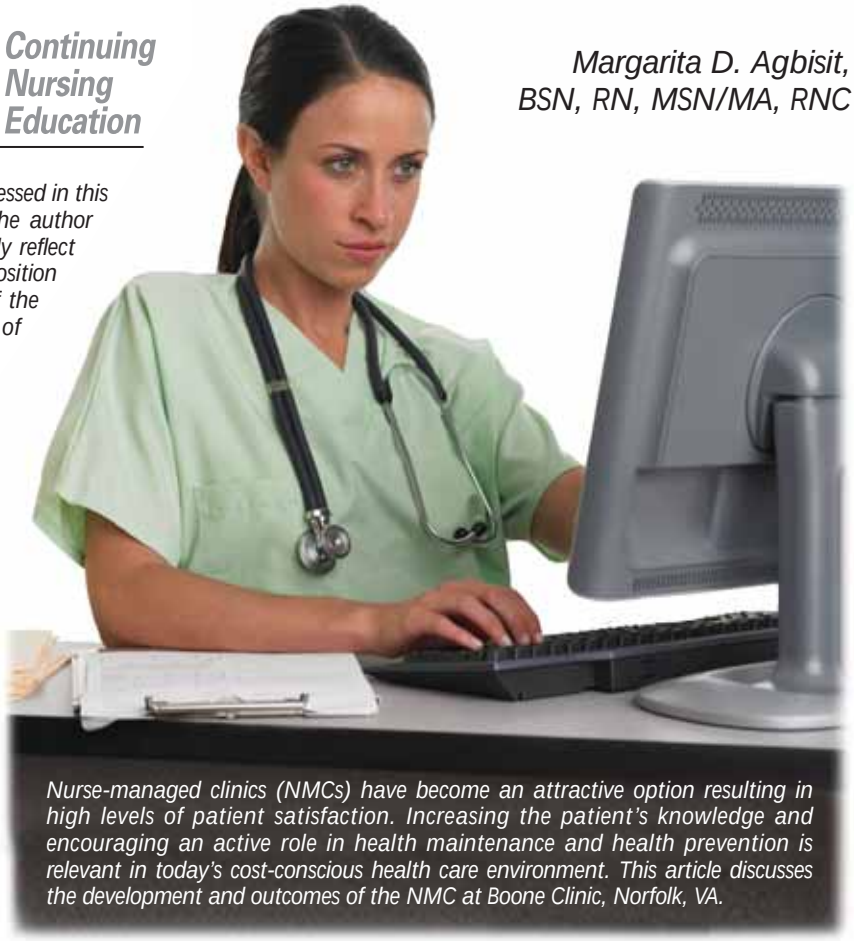
The Voice of Ambulatory Care Nursing

Nurse-Managed Clinics: Opportunity and Benefit

CNE Continuing Nursing Education

Margarita D. Agbisit, BSN, RN, MSN/MA, RNC

Note: *The views expressed in this article are those of the author and do not necessarily reflect the official policy or position of the Department of the Navy, Department of Defense, or the U.S. Government.*



Nurse-managed clinics (NMCs) have become an attractive option resulting in high levels of patient satisfaction. Increasing the patient's knowledge and encouraging an active role in health maintenance and health prevention is relevant in today's cost-conscious health care environment. This article discusses the development and outcomes of the NMC at Boone Clinic, Norfolk, VA.

There are over 200,000 military members and their families in the Hampton Roads area, which includes Norfolk, Virginia Beach, Portsmouth, and Chesapeake. Virginia is known to be home base for the United States Navy's Atlantic Fleet (50states.com, 2006) and is one of the largest military concentrations in the world. Years of patient satisfaction surveys have shown that access to medical care is a major and constant health issue in this region. Common complaints received from the military staff and their families focus on the unavailability of daily appointments. Active duty military personnel, retirees, and their beneficiaries have expressed difficulty in getting appointments for their acute symptoms and chronic conditions.

In 2001, the concept of the nurse-managed clinic (NMC) was institutionalized to improve access to medical care. Using clinical practice guidelines and the Joint Commission on Accreditation of Health Care Organization (JCAHO) standards, two nurses, a clinical nurse specialist and a nurse practitioner, were asked to create the policies and

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JANUARY/FEBRUARY 2007

Inside

SPECIAL ISSUE:
NURSE-MANAGED CLINICS

From the PRESIDENT

Developing and Disseminating Knowledge for Ambulatory Care and Telehealth Nursing Practice

Beth Ann Swan

As I write my President's column, there are 15 days left in 2006. This is usually the time of year people reflect on their accomplishments and shortcomings, and make resolutions for the New Year. For those of us who are procrastinators, this may not be *the most wonderful time of the year*. Yes, I am a procrastinator; ask my family or the AAACN Board. I have been working on one of those short-term charters now for over 18 months! Therefore, I resolve by the end of this column to complete the deliverable for the knowledge charter.

In the last two columns, I described AAACN's work and progress on two goals: community and advocacy. The focus of this column will be Goal 1 – Knowledge. "AAACN will be the recognized source for knowledge in ambulatory care nursing." The objectives of this goal are to 1) increase the development and dissemination of ambulatory care nursing knowledge and 2) increase recognition of AAACN as a source of ambulatory care nursing information (AAACN, 2004). The first objective defined one strategy as developing a systematic process to gather and disseminate knowledge. The challenge was how to go about developing such a systematic process, and once developed, how would AAACN measure its success?

A task force, consisting of Lyn Gehring, Traci Brooks, Elizabeth Dickey, Peg Mastal, Ruth Ann Obergon, Becky Pyle, and Carol Ann Attwood, began working on this challenge at the 2005 conference. The group proposed a continuous feedback loop graphic representation. First, the group identified the following as AAACN's current sources of ambulatory care nursing knowledge (knowledge identification):

- AAACN Web site.
- AAACN *Viewpoint.*
- AAACN's column in *Nursing Economic$*.
- Special Interest Groups (SIGs).
- AAACN members.
- AAACN products.
- List serves.
- Discussion forums.
- Annual conference.
- Audio seminars.
- Board of Directors.

The group identified the second step as knowledge gathering. Through surveys, interviews, and focus groups over the last several years, AAACN has gathered knowledge about what is known about promoting ambulatory care and telehealth nursing practice. By scanning the environment, AAACN identified its knowledge assets and gaps that were then targeted for product development and for future potential knowledge sources. This step is critical and needs to be formalized so that AAACN is recognized as the source of knowl-

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aacn American Academy of Ambulatory Care Nursing

Real Nurses. Real Issues. Real Solutions.

A Case Management Model For the Ambulatory Care Patient Experiencing Chronic Pain

Esther Brooks, MN, RN
Julia Younce, MSN, RN

Abstract

This article describes the development and implementation of a Case Managed Opioid Program managed by an ambulatory care section nurse at the James A. Haley Veterans' Hospital, Tampa, FL. The authors will discuss the program from a historical perspective and the positive outcomes that were achieved.

Historical Overview

The Primary Care Section of the James A. Haley Veterans' Hospital in Tampa, FL, had approximately 100 patients a day who would walk in without an appointment. Many of these patients needed new medication or a refill of medication for relief of chronic pain. The practice had been to schedule appointments every 30 days for patients who required narcotic refills; however, the schedule could not accommodate the need. High numbers of unscheduled patients affected the ability of providers to see their scheduled patients in a timely manner.

In addition to inadequate parking and extensive travel time for veterans commuting long distances, lack of available appointments resulted in low levels of satisfaction for this population of patients with chronic pain. Furthermore, many patients expressed inadequate pain relief.

An interdisciplinary task force was developed to explore and problem solve the issue of patients walking into the Emergency Room without an appointment and in need of pain medication refills. One suggestion was to explore the advantages of caring for these patients using an RN case management model. The goal was to help decrease the number of unscheduled patients seeking relief from their chronic pain and/or seeking refills on their medication, and to provide better relief of pain.

Other RN case management programs within the Veterans' Integrated Services Network (VISN) were explored as possible models for implementation. A common feature of many chronic pain case management programs is the use of an interdisciplinary approach with the nurse in a pivotal position to manage and coordinate the care of the veteran in chronic pain. The nurse performs a pain assessment and evaluation, and orchestrates the process for the patient to obtain his or her prescriptions. Positive outcomes of the RN case management programs that were evaluated in the satellite clinics and implemented at the James A. Haley VA include the following:

- Better pain control.
- Enhanced customer satisfaction, due to decreased wait times to obtain medications.
- Decreased walk-ins and unscheduled visits to the provider.
- Increased cost effectiveness.
- Increased nurse participation in the veteran's pain management and increased role satisfaction for the nurse.
- Enhanced quality of life for the veteran with the ability to engage in a more normal lifestyle.

Opioid Case Managed Program Implementation

With support from providers, the Tampa VA implemented a nurse case managed clinic in ambulatory care in March 2003. The clinic was initially implemented in one of the primary care teams and was then expanded to the rest of the ambulatory primary care clinics at the Tampa VA.

The following are criteria for enrollment into the nurse case managed program for chronic pain at the Tampa VA:

- The program is intended for veterans on Class II control substances (oxycodone, morphine, methadone, fentanyl patches, and Percocet®).
- A veteran must be under the care of a primary care provider 3 to 6 months prior to enrollment into the program.
- The veteran needs to have been on a stable dose of analgesic for at least 3 months.
- The veteran consents to a pre-enrollment urine drug screen and a drug screen every 6 months. The veteran can also be tested at random.
- If the veteran is found to be using an illicit substance (marijuana, cocaine), he or she is tapered off the pain medication and referred to a drug/alcohol drug rehab program.
- The provider agrees that the veteran is a candidate for the program.
- The veteran agrees to abide by all the terms of the Pain Agreement, which is an agreement that details the responsibilities of the veteran while enrolled in the Opioid Program.
- The veteran must have a permanent home address available because the pharmacy will not deliver opioids to a Post Office Box.

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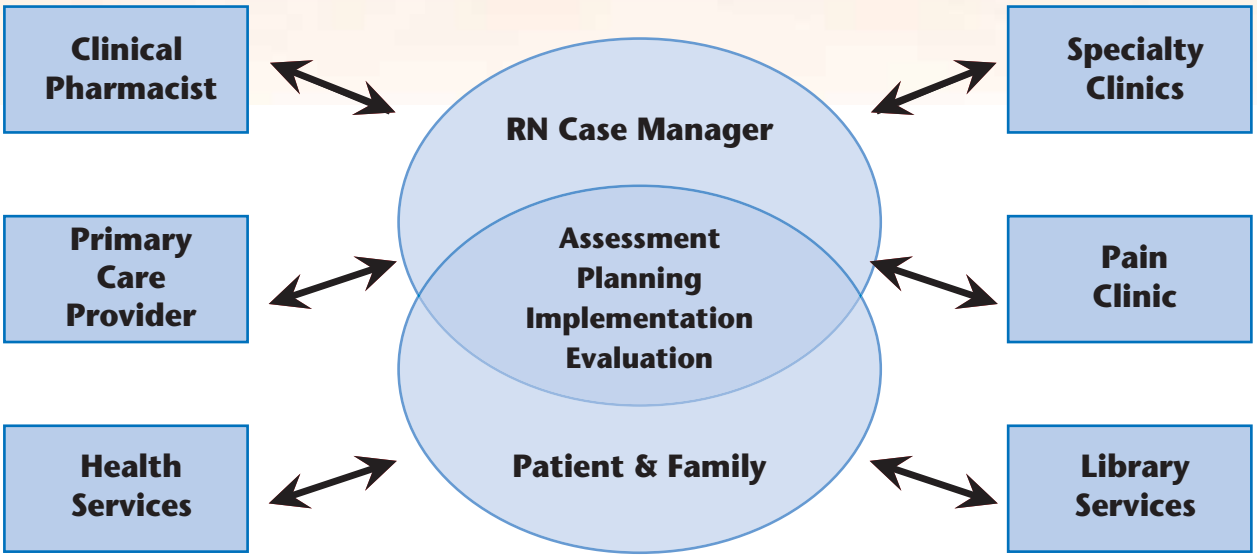
Contact hour instructions, objectives, and accreditation information may be found on page 9.

Figure 1.

Opiod Case Management Program



- Prior to enrollment in the program, the provider determines that appropriate referrals have been made (physical therapy, occupational therapy, or the pain clinic) for the veteran to assure that other optimal treatments for relief of chronic pain have been considered.

Program Operation

The nurse case managed pain clinic program at the Tampa VA operates as follows: each primary care team has a *pain resource nurse*, who is assigned his or her own panel of patients who have been referred to the clinic by the provider. In the absence of the pain resource nurse, staff nurse colleagues, trained and oriented to the Opioid Program, manage the panel. Once the patient has been accepted into the program, the nurse conducts an initial baseline in-depth patient self-screening evaluation, provides the patient with extensive pain education describing the pain program, and obtains the patient's consent to enroll in the chronic pain program. On a monthly basis, each veteran submits a self screening pain evaluation. These are mailed to the pain resource nurse (in a pre-addressed and stamped envelope provided) about 10 to 15 days prior to the monthly renewal due date for their narcotic prescription(s).The nurse enters the patient self-screening tool data into the Computerized Patient Record System (CPRS) for the provider to view. After the provider has viewed the self assessment, the nurse collaborates with the provider and obtains the pain medication prescriptions, which are delivered to the pharmacy. Any change in the patient's condition or any problems with this process triggers a referral by the nurse to the primary care provider. The pain medication is mailed by the pharmacy monthly via certified mail to the veteran, thereby minimizing the veteran's need to come to the facility. The veterans see their primary care provider and the pain resource nurse every 6 months, where a face-to-face interview is conducted to review the treatment plan.

The veteran is encouraged to call the RN case manager if questions or issues pertaining to his or her therapy or treatment plan arise. Pain education remains an important component of the ambulatory care nurse case managed pain clinic program. The pain resource nurse instructs patients on modalities for pain relief should any exacerbations occur. These modalities may include proven effective home remedies, such as relaxation techniques, exercise, heat application, and breakthrough pain management.

Opioid Case Managed Program Outcomes And Evaluation

The James A. Haley Primary Care Section successfully implemented a nurse case management program to meet the needs of veterans in chronic pain who require a long-term treatment plan. Nurses continue to play a pivotal role in caring for these patients. This role involves an interdisciplinary approach where the nurse interfaces collaboratively with the health care team to more effectively address and meet the needs of veterans experiencing chronic pain. Figure 1 illustrates the RN Pain Resource Nurse (or RN Case Manager) interfacing with the interdisciplinary health care team (such as the primary care provider or clinical pharmacist) to orchestrate the delivery or care. If the veteran has any additional questions concerning medications, he or she may also be referred to the patient library, as well as online

Table 1.

A Primary Care Team's Opioid Program Statistics

Year	2005 Oct	2005 Nov	2005 Dec	2006 Jan	2006 Feb	2006 Mar	2006 Apr	Totals
Active Patients	134	37	142	146	145	142	144	Average 141.42
New Enrollments	4	4	9	4	3	1	1	26
Discharges	3	1	4	0	4	4	1	17
6 Month Face-to-Face Visit	15	19	27	29	19	37	14	160
Monthly Reevaluations	70	115	107	102	101	106	90	691

resources available for further research and educational opportunities. Pain resources nurses meet monthly to discuss and problem solve issues of concern involved in coordinating the care.

The Opioid Program has succeeded in diminishing veteran visits to the facility for their relief of chronic pain, while making more appointment time available for other veterans. The program has succeeded in achieving better pain control for patients with chronic pain while simplifying the process to obtain medication. Improved customer service and positive outcomes have been achieved for patients as indicated in followup patient satisfaction surveys and face-to-face interviews. Table 1 shows that for a 7-month period, one of the primary/ambulatory care teams has had a stable panel of patients with few discharges from the program. This team had 144 patients enrolled in the Chronic Opioid Program for the 7-month period reviewed, and it had 17 patient discharges. With 160 face-to-face visits, each patient enrolled has only been seen twice a year, which is down from the previous practice of monthly visits.

Conclusion

Patients continue to be enrolled in the Opioid Program. The Chronic Pain Program has successfully expanded to all primary care teams. While the program initially started with approximately 30 patients, there are currently over 600 veterans enrolled. This program won the *2005 Office of Nursing Services Innovation Award*, which is a VISN (regional) Award. It is in the process of being examined for adoption nationally.

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President's Message

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edge for ambulatory care and telehealth nursing practice. Growing our inventory of knowledge assets enables AAACN to respond to our members' needs and to external knowledge needs. In addition, AAACN is able to expand its sources of knowledge. For example, AAACN is recognized as a source of knowledge and information for Magnet preparation.

The third step is knowledge evaluation (the ability to assess the big picture). Assets and gaps identified in the knowledge-gathering process need to be to critiqued and judged for importance and value (for example, what should be acted upon immediately versus what is a short-term project and what is a long-term project). The ability to respond quickly to member and practice needs, as well as to allocate necessary resources to product development, are critical aspects of this step.

Knowledge dissemination is the final step in the process. To increase recognition of AAACN as a source of ambulatory care nursing information, the process must support information utilization and dissemination to ensure that knowledge-generated sources are available and can be fully used by members, non-members, employers, and policymakers to improve service delivery in ambulatory care and telehealth nursing practice.

This systematic process is based on four steps: knowledge identification, knowledge gathering, knowledge evaluation, and knowledge dissemination. The process is depicted by a continuous feedback loop of identifying gaps in ambulatory care and telehealth nursing practice knowledge, gathering data and information about the identified area of need, evaluating the data and information related to the area of need, planning the knowledge resource, and method of knowledge delivery and dissemination. Now that the process is developed, how will AAACN go about measuring its success in terms of dissemination? One method is to track each source of knowledge and its utilization. For example:

- AAACN Web Site Activity Report compares visits over time, how many members are logging in and how many non-members are visiting the site, how many pages visitors are viewing during one visit, and the most popular pages. We know that our Web site traffic has increased over the last year.
- The *Nursing Economic$* "Perspectives in Ambulatory Care" column utilization can be tracked not only by journal subscriptions, but also by how many times the articles are cited in other papers and how many times the articles are requested and/or downloaded. In the last 6 months, some of the articles have been downloaded more than 75 times, and the articles are cited frequently in other papers.
- AAACN members have been featured and quoted in media coverage over 10 times in the last 6 months.
- AAACN products are tracked by sales, and this is a proxy for utilization and dissemination; one strategy of moving forward is to promote and market our products not only internally to our members but also externally to non-members.
- AAACN annual conference attendance has been increasing over the last three years, and we are looking forward to record attendance in Las Vegas.
- AAACN audio seminars have gained momentum, and we are tracking the number of sites that register, the number of listeners, and the number of CDs sold.
- AAACN "On the Road" Courses have gained momentum, and I spoke about the increased number in my last column.

These are some examples of the progress AAACN is making related to Goal 1: Knowledge. I would like to thank all our volunteer leaders and members who support and promote AAACN as the source of knowledge for ambulatory care and telehealth nursing practice. As always, thank you for your active participation and volunteer leadership. I am interested in your views, and you can reach me at beth.swan@jefferson.edu.

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Understanding Cancer Survivorship Issues And the Ambulatory Care Nurse's Role

In response to the Institute for Medicine's report on cancer survivorship, more than 20 representatives of national and international nursing organizations gathered November 3-4, 2006, at the National Academy of Sciences in Washington, DC, for a Cancer Survivorship Nursing Stakeholders Meeting. AAACN member Becky Eggleston, BS, RN, OCN, attended.

The objectives of the meeting were to evaluate several published recommendations addressing the needs of adult cancer survivors as well as engage key nursing organizations that are willing to support a nursing-led agenda. The group's ultimate goal is to enhance long-term outcomes of adult cancer survivors.

By the meeting's end, each participating organization provided an action plan and a commitment to achieve nursing's goals for improving cancer survivorship. The group reached consensus and developed a tactical master plan incorporating education, nursing practice, and research that will allow nurses to use their expertise to better meet the needs of the adult cancer survivor.

Becky Eggleston (left) chats with Mary Alice Ehrlich, MSA, RN, representative from the American Association of Occupational Health Nurses (AAOHN), about ways AAACN, AAOHN, and the University of Michigan can enhance long-term outcomes of adult cancer survivors.

What Does All This Mean for the Ambulatory Care Nurse?

With more than 4 of 5 cancer care encounters for the most common types of cancer occurring in community-based treatment settings – and with increasing numbers of cancer survivors having their care provided in non-oncology settings – it becomes extremely important that the ambulatory care nurse:

- Have an opportunity to participate in educational programs that will provide information regarding the physiologic, cognitive, and psychosocial impact of a cancer diagnosis and cancer treatment.
- Have an awareness of – and access to – reliable information resources and services for patient referral to best provide assistance in addressing the many cancer-related issues of the cancer patient and survivor.
- Understand that end-of-cancer treatment is not the end of the cancer experience and that many patients with comorbid conditions are seen routinely in ambulatory care settings.
- Realize that cancer survivors may be unaware of the emotional and physical risks following treatment and do not have a life-long plan for follow-up care.

There is little doubt that cancer and cancer survivorship issues can impact the care we provide as ambulatory care nurses. AAACN's recognition of the significance of this issue provides us with an opportunity to become educated about cancer survivorship and to offer a contribution to this important national nursing initiative.

For more information about cancer survivorship issues, visit:

The National Coalition for Cancer Survivorship –
www.cancersurvivaltoolbox.org/
www.canceradvocacy.org/resources/

Centers for Disease Control & Prevention –
www.cdc.gov/cancer/survivorship/

Lance Armstrong Foundation – www.livestrong.org

Becky Eggleston, BS, RN, OCN
University of Michigan
Ann Arbor, MI

March 29-April 1, 2007 • Las Vegas Hilton

New Products to be Introduced At the Conference

Many member volunteers have been diligently working on updating several products for a conference release. New items to be available at and following the conference are:

- Ambulatory Care Nursing Administration and Practice Standards, 2007.
- Telehealth Nursing Practice Administration and Practice Standards, 2007.
- Ambulatory Care Nursing Self-Assessment, 2007.
- Self Learning Module titled, "Review of Current Litigation Relative to the Practice of Telephone Nursing," which will offer continuing nursing education (CNE)* credit earned at your convenience.
- Telephone Nursing Practice Core Course (TNPCC) on DVD.

*This educational activity has been co-provided by AAACN and Anthony J. Jannetti, Inc.

Anthony J. Jannetti, Inc. is accredited as a provider of continuing nursing education by the American Nurses' Credentialing Center's Commission on Accreditation (ANCC-COA).

Core Signing

Editor Candy Laughlin, and the chapter authors of the *Core Curriculum for Ambulatory Care Nursing,* 2nd edition, will be on hand at a booth in the exhibit hall to autograph your copy of the *Core*! Bring your copy to Vegas or purchase one onsite, then stop by the booth for a few autographs!

Founders' Scholarship

In honor of AAACN's Past Presidents, new members and first-time conference participants can win complimentary registration to the Chicago conference. To be considered for the Founders' Scholarship, you will be asked to submit a 100-word or less description at the Las Vegas conference, stating how the conference inspires you and why you would recommend AAACN to your colleagues. The winner will be announced at the Closing Ceremony. Stop by the *Viewpoint* booth to pick up an application.

Silent Auction Donations Sought

If you are coming to the conference, please consider bringing an item to donate to the Silent Auction. Small items, such as jewelry or books, are easy to pack. Larger items, such as hand made quilts, baskets of goodies from your state, pictures, etc., could be shipped to yourself at the hotel. Nursing memorabilia is always sought by participants. Please drop off your item at the AAACN Registration Desk prior to Thursday evening. Your donation helps raise funds for the AAACN Scholarship Fund.

Pam DelMonte, Silent Auction Coordinator
Pamela.delmonte@va.gov

AAACN Moderators Needed

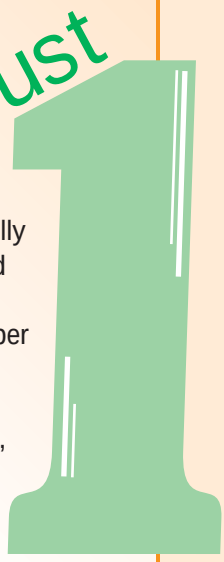
AAACN program planners are currently seeking moderators for the 2007 Annual Conference in Las Vegas.

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

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

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

JUST 1 Winners Announced



The JUST 1 membership campaign added 105 new members to AAACN. The winner of the top prize was Molly McBrayer, who recruited her colleagues at St. Francis Hospital and Roper St. Francis Healthcare in South Carolina. Molly receives airfare, housing, and registration to the 2007 AAACN Annual Conference in Las Vegas.

Kudos to runner up Debra Willis, who recruited six colleagues from Presbyterian Hospital of Plano, Texas. Debra, along with Judy Aponte, Barbara Gilbert, Rebecca Marshall, and Louise Murraine will receive a one-year renewal of their AAACN membership.

AAACN's membership has reached over 2,000 – a milestone that has not been reached for several years. Start thinking about who you could recruit in the next campaign, which will kick off at the Las Vegas conference and begin on April 1, 2007.

AAACN Ends the Year with Over 2,000 Members!

Membership in AAACN has grown to almost record-breaking numbers! The membership count as of December 31, 2006, was 2,071, and membership has not been at this level since 1998. This means many things, all of them exceptionally good. Some reasons our membership has grown are that our products and services, which are designed to meet the needs of a broad array of nurses providing ambulatory care, were expanded. Our interactive/informative Web site, convenient LIVE audio seminars, the second edition of the *Core Curriculum*, cutting-edge annual conferences, and more are providing needed education to improve practice and provide a higher level of patient care. Most importantly, our members are spreading the word about the value and benefits of AAACN membership. Congratulations to AAACN and our members for making 2006 an exceptional year!

Instructions for Continuing Nursing Education Credit Activity

To Obtain CNE Credit

1. For those wishing to obtain CNE credit, please use the evaluation form inserted in this newsletter, or visit the AAACN Web site (www.aaacn.org). Read the 3 articles listed below and complete the answer/evaluation form.
2. Photocopy and send the answer/evaluation form along with your credit card payment or check ($15 members/$20 non-members) payable to AAACN, East Holly Avenue Box 56, Pitman, NJ 08071–0056.
3. Evaluation forms must be postmarked by February 28, 2009. Upon completion of the answer/evaluation form, a certificate for 2.9 contact hour(s) will be awarded and sent to you.

Objectives

The purpose of this continuing nursing education series is to increase the awareness of nursing management issues in nurses and other health care professionals. After studying the information presented in this series, you will be able to:

1. Outline the development process for establishing a nurse-managed clinic in Norfolk Beach.
2. Summarize the implementation of an Opioid Development nurse-managed program.
3. Describe the recommended steps to follow when using a self-care management education plan.

Articles

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Sally S. Russell, MN, CMSRN, disclosed that she is on the Advisory Board for Roche/Abbott Labs.

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AAACN is a provider approved by the California Board of Registered Nurses, provider number CEP 5336. Licenses in the state of CA must retain this certificate for four years after the CE activity is completed.

These articles were reviewed and formatted for contact hour credit by Sally S. Russell, MN, CMSRN, AAACN Education Director; and Rebecca Linn Pyle, MS, RN, Editor.

Nurse-Managed Clinics

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ed to the outpatient setting and offers a comprehensive education based on approved guidelines and protocols for the purpose of health maintenance and health promotion.

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CNE Continuing Nursing Education

Self-Managed, Patient Centered Goals

Krista D. Grey, BSN, RN

As an ambulatory care nurse for over 4 years, I did my best to help patients with chronic disease to make healthy choices but often felt that my efforts were ineffective. I put a lot of effort into patient education, but while my patients may have known more, their knowledge often did not translate into behavior change or improved health. I assumed that if I gave patients information, they would make logical decisions to lead their lives in a healthier way. I am a firm believer in patient autonomy and felt that telling patients what to do with the information I gave them was overstepping my professional boundaries.

I decided on public health nursing as my major for graduate education partially in hopes of learning how to be more effective in disease management. During my public health nursing practicum, Denver Health offered me the opportunity to participate in their Diabetes Collaborative initiative by educating their ambulatory care nurses about diabetes self-management and patient-centered care goals. During my experience, I was able to learn about an important concept in disease management, which I am excited to share with other nurses.

As I read about self-management, I found that research has shown that didactic teaching, the kind I was practicing, increases knowledge but does not consistently lead to improved health outcomes (Norris, Engelgau, & Narayan, 2001). It does not make sense to continue to spend scarce health care resources on an intervention that is ineffective, especially when a more effective approach has already been designed and tested.

A move away from didactic teaching requires a paradigm shift. Previously, acute disease was the primary cause of illness, and didactic interventions were effective because they required following directions for a short time until the patient recovered from the illness. Now, the principal medical problem is chronic disease, which requires permanent lifestyle adjustments. Because of this, "the patient must become a partner in the process, contributing at almost every decision or action level" (Holman & Lorig, 2000, p. 320).

What is a more effective approach to patient education? How do patients become "partners in the process?" Research shows that approaches that improve patients' sense of self-efficacy improve health (Lorig & Holman, 2003). One approach to accomplish this goal is called self-management education.

Self-Management and Self-Management Education

According to Barlow, Wright, Sheasby, Turner, and Hainsworth (2002), self-management is "the individual's ability to manage the symptoms, treatment, physical and psychosocial consequences, and lifestyle changes inherent in living with a chronic condition" (p. 178). Basically, it is how a person lives with their disease on a day-to-day basis.

Self-management education differs from traditional, didactic patient education in several ways (see Table 1). Self-management education involves learning several skills, one of which is "taking action" (Lorig & Holman, 2003). One way for the patient to learn this skill is by formulating patient-centered goals. The nurse can assist the patient to do this by using the 5 As Behavior Change Model (Glasgow et al., 2002; Whitlock, Orleans, Pender, & Allan, 2002). The 5 As are *Assess, Advise, Agree, Assist*, and *Arrange.* Sixta (n.d.) thoroughly explains the 5 steps in "Diabetes Self-Management Manual for Providers and Staff." The following is a summary of Sixta's description of the 5 As.

Assess

Step 1 is to assess the patient. Assessing the patient's knowledge level of the disease as well as his or her beliefs and behaviors about its management can help the nurse tailor advice and goal setting. It is also important to take the patient's cultural background into account because it will affect the advice given.

Four areas to include in the assessment are the patient's usual diet, exercise, weight, and medications. Other assessment factors to keep in mind while interacting with the patient include the patient's acceptance of the diagnosis as well as readiness to learn and to change his or her behaviors. If the patient has not accepted the diagnosis or if he or she is not ready to learn or change, then goal setting would be inappropriate. Some of the most important things to ask the patient while engaging him or her in self-management goal setting are, "What are you most concerned about?" and "What would you like to work on?"

Contact hour instructions, objectives, and accreditation information may be found on page 9.

Table 1. Comparison of Patient Education Approaches	
Traditional Patient Education	Self-Management Education
One-way communication Provider-centered Increases knowledge	Two-way communication Patient-centered Helps patients adopt healthy behaviors

Source: Sixta (n.d.)

Advise

Step 2 is to advise the patient. This step is built upon the previous step. The nurse gives advice to the patient on topics about which the patient is concerned and builds upon what the patient already knows. It is important not to overload the patient. The goal is to convey one or two ideas to the patient per visit. This will help the patient to avoid feeling overwhelmed and confused. Patient education in chronic care occurs best over a long period of time unlike acute care in which interventions can quickly resolve a health problem. Answering questions that the patient may have in a way that is appropriate for the patient's individual characteristics (such as education, cultural background, and experience) is also important.

Agree

Step 3 is to agree with the patient on goals. In order for behavioral change to occur, goals must be patient-centered. This means that the goal needs to be something that the patient wants to change and that the patient believes is an important behavior to address to improve his or her ability to manage the disease.

The nurse's role is to help patients formulate their own goals, not to tell patients what their goals should be. The nurse can help patients ensure that the goals are measurable and are achievable within a week or two. Patients should state specifically what, where, when, and how often they would like to engage in the particular behavior.

Once the goal is formulated, the next action of the nurse should be to assess patients' perceptions of the importance of and confidence in achieving the goal by having them rate their perceptions on a scale of 1 to 10, with 10 being most important or most confident. If the patient rates the importance of a goal as 7 or below, the nurse should ask the patient to select another goal that is more important. If the patient rates his or her confidence at 7 or below, the nurse should help the patient to problem-solve barriers or select another goal.

Assist

Step 4 is to assist with problem solving. Prompting patients to think about things that might get in the way of achieving their goal is important. Potential solutions can be brainstormed with each patient and a solution selected for the patient to try for two weeks. If that solution does not work, then another solution can be tested. If that doesn't work, the nurse and/or the patient can find a resource for ideas. If that does not work, it is time to move on to a new goal.

Arrange

Step 5 is to arrange patient followup. A two-week followup visit or telephone call needs to be arranged during the goal setting-interaction. The followup visit should include discussing whether or not the patient met his or her goal, and if so, what goal will be worked on next. If the patient did not meet the goal, then the nurse should ask the patient to describe what interfered with meeting the goal. The nurse should then help the patient with problem solving, revise the goal, and set another followup date.

Conclusion

Sixta's (n.d.) manual was written for diabetes self-management, but the 5 A's could be applied to virtually any health care situation that requires patients to change their behavior. This evidence-based intervention can help improve outcomes in chronic illness. It is logical, ethical, and practical, and it can be implemented by all members of the health care team during any patient encounter. Consider this effective intervention for your daily practice.

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TELEHEALTH NURSING PRACTICE

In the early stages of telehealth nursing, according to certain assumptions, nursing practice using the telephone was not considered to be "real nursing." However, because of its application and widespread use in the managed care environment, it rapidly gained recognition as a significant field of nursing in the health care industry. Along with this came the realization that similar to nurses in other areas, nurses engaged in telehealth also use the nursing process to establish a therapeutic nurse-client relationship when providing patient care. Since that time, telehealth nursing practice has advanced to become what the American Academy of Ambulatory Care Nursing (AAACN) organization, among others, considers to be a subspecialty of nursing. As a result of this recognition, telehealth nursing practice has developed its own set of specialized knowledge and skills. Therefore, in order for nurses to successfully practice telehealth nursing, it is imperative that competencies specific to telehealth nursing practice be incorporated into the orientation process to provide for a safe as well as an effective medical legal practice.

The specific telehealth nursing competencies that should be addressed during the orientation processes are:

- Technical skills.
- Professional knowledge.
- Interpersonal skills.
- Documentation.
- Professional development.
- Resource management.
- Practice and administrative issues.

In meeting these competencies, the nurse/individual:

- Adapts to equipment and demonstrates efficient use of technology devices to perform role (technical skills).
- Is expected to use clinical judgement and effective interventions to enhance patient/caller outcomes (professional knowledge).
- Is required to establish a trust relationship to illicit accurate patient/caller information and use effective interpersonal skills to engage in, develop, and disengage in a therapeutic interaction (interpersonal skills).
- Documents telecommunications that reflect care specific to the actual or potential health care needs of the patient/caller (documentation).
- Accepts personal responsibility for maintaining and improving the knowledge and skills necessary to assess, triage, and manage patients (professional development).
- Locates and utilizes appropriate resources to meet the needs of the patient/caller (resource management).
- Practices in accordance with an ethical, legal, and organizational framework that ensures that the patient's/caller's safety, interest, and well being are met (practice and administrative issues).

Key components of each of these topics have been defined, and examples are provided in Chapter 5 of the *Ambulatory Care Nursing Orientation and Competency Assessment,* which is available on the AAACN Web site at www.aaacn.org

Charlene Williams, MBA, BSN, RN,C, BC
The Cleveland Clinic Foundation
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Finally – The Perfect Resource For Triage Nurses!

The Telehealth Nursing Practice chapter in *The Guide to Ambulatory Care Nursing Orientation and Competency Assessment* recognizes the unique features of telephone triage and provides direction for the training and evaluation of staff. The table format of the information presents a clear and comprehensive overview of the distinct dimensions of telehealth as well as the key elements of each dimension. As with other specialty areas of nursing, the practice of telehealth nursing is guided by the nursing process and is well outlined in this chapter. This will be the only telehealth manual on my shelf!

Gina Tabone, RNC
Medical Concierge Triage Department
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Chapter 5, Telehealth Nursing Practice Guidelines in *The Guide to Ambulatory Care Nursing Orientation and Competency Assessment* were very easy to follow. They provided a practical approach in the work setting. It was an effective tool for orienting new staff and a useful monitoring tool for experienced staff.

Julie Shainoff, RN
Cleveland Clinic Nurse – On Call
Cleveland, OH

Cleveland Clinic Nurse on Call Nursing Practice Staff

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We welcome your questions, so feel free to contact us at 800-262-6877 or aaacn@ajj.com

Telehealth Pearl of Wisdom

Patient Assessment

Nurses know that patient assessment includes both subjective and objective parameters. While subjective assessment is the "meat and potatoes" of a telephone assessment, it is possible (and necessary) to do an objective assessment as well. Objective parameters fall into two categories: signs and symptoms the nurse can *hear* and information that is *self-reported* by the patient.

Signs and symptoms the nurse can hear include:

- Respiratory (wheezing, coughing, hoarseness, tachypnea, etc.).
- Neurological (slurred speech, confusion, disorientation, inappropriate verbalization, etc.).
- Affect (calm, excited, flat, crying, etc.); *Note:* Although it's difficult to interpret affect, it can be observed.
- Background noises (oxygen, taking a drag off a cigarette, a baby's weak or inconsolable cry, etc.).

Information that is self-reported by the patient includes:

- Quantitative measurements (temperature, weight, blood pressure, blood sugar, urine ketones).
- Anything the nurse could observe using her or his eyes, hands, or nose could be assessed by the patient (urine output and color, character and amount of emesis, description of rash, etc.).

As in the face-to-face setting, no assessment is complete without both subjective and objective parameters.

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Nurse-Managed Clinics

continued from page 1

procedures. The project took one year to implement; this was partly to ensure patient quality care and appropriate disease management, and identify the scope of care to be provided by the nurse clinic. New senior medical leadership presented disease management protocols to the Executive Committee of Medical Service (ECOMS), and once approved, the senior physician presented the NMC protocols and guidelines and discussed pressing issues with all the providers. With mutual agreements in place among the clinic providers and identification of the physician champion and nurse, the NMC was realized.

Qualifications of the registered nurse include one to two years' experience in the ambulatory care setting, experience with adult and pediatric asthma patients, diabetic education, physical assessment, and triage. Ambulatory care certification is encouraged but not required. The NMC follows specific protocols for patient care, with the role of the NMC nurse being centered on patient education. The nurse position is very autonomous, adheres to approved protocols, and involves critical thinking and prompt decision making. The NMC physician champion is consulted for advice regarding patients on a case-by-case basis. Crucial duties of the NMC nurse include daily calls, and utilizing protocols to interview and triage patients scheduled with the providers. Patients who fall within the parameters of an NMC visit are encouraged to utilize the NMC. For example, patients with urinary tract symptoms without other complaints can choose to keep their appointment with their provider or cancel that appointment and be seen in the NMC. The cancelled appointment slots are then available for patients who need same-day appointments.

Patients with the following conditions are seen at the NMC: diabetes, hypertension, hyperlipidemia, asthma, possible pregnancy, urinary tract infections (UTI), and attention deficit hyperactivity disorder (ADHD) screening. Patients diagnosed with diabetes, hypertension, hyperlipidemia, and asthma are referred to the NMC for education, followups, and tracking. Walk-ins are accepted for patients with UTI, pregnancy testing, and ADHD screening. Pregnancy testing has the highest volume of monthly visits to the NMC since its inception. The NMC is responsible for the initial teaching that emphasizes diet modification, avoidance of alcohol and smoking, exercise, and the early danger signs and symptoms of pregnancy expectant mothers may experience that warrant an emergency room visit. In addition to obstetric instructions, prenatal vitamins are given to the new mothers.

The NMC has been open for three years. About two to six months after the NMC began, NMCs were opened in other military medical clinics. A second NMC was opened at Boone less than a year later. It is well received and

Table 1.
Tricare Prime Boone Nurse Clinic 2003 Annual Report

Reason For Visit	Month of Visit												Total
	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	
HCG	73	64	88	67	66	95	112	106	116	98	77	108	1070
ADHD	10	5	13	9	6	2	2	4	11	8	7	11	88
Hypertension	35	37	25	41	13	13	16	20	16	42	32	23	313
Hyperlipidemia	9	3	7	5	6	1	4	7	11	6	8	3	70
Diabetes Type II	31	33	29	29	39	29	26	38	28	41	27	34	384
Other										3	7	12	22
Asthma	1	5	7	9	3	1	2	1	1	3	5	8	46
Dysuria	11	11	4	2	10	8	14	10	10	10	10	10	110
Type of Visit													
Telephone Consults	89	65	91	108	58	39	57	66	70	113	67	81	904
Nurse Clinic Visits	170	158	173	162	143	149	176	186	193	211	173	209	2103
Other													0
Grand Total	259	223	264	270	201	188	233	252	263	324	240	290	3007
Saved Appointments	23	23	26	16	11	9	19	17	32	30	25	23	254

Table 2.
Tricare Prime Boone Nurse Clinic 2004 Annual Report

Reason For Visit	Month of Visit												Total
	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	
HCG	96	87	75	72	72	101	56	81	74	76			790
ADHD	12	13	6	3	9	7	1	1	5	5			62
Hypertension	16	5	6	9	6	4	7	11	13	3			80
Hyperlipidemia	3	4	2	3	3	3	10	9	9	5			51
Diabetes Type II	39	31	29	31	36	47	60	39	52	45			409
Other	3	6	2	5	7	3	6	4					36
Asthma	4	1	4	2	3	1		4	1	2			22
Dysuria	8	5	4	8	8	3	7	13	10	7			73
Type of Visit													
Telephone Consults	115	81	59	57	110	91	119	121	106	73			932
Nurse Clinic Visits	181	152	120	133	143	169	147	162	164	143			1514
Other													0
Grand Total	296	233	187	190	254	260	266	283	270	216	0	0	2446
Saved Appointments	20	13	11	11	23	11	13	16	10	11			139

Note: The importance of the numbers in Tables 1 and 2 signifies that the providers and patients are utilizing the NMC, and the need for its service is overwhelming. The November and December 2004 numbers were recorded and counted under the provider's name. The NMC increased patient access, with the 254 saved appointments in 2003, and the 139 saved appointments in 2004 resulting in extra available patient appointments with providers for managing patients with higher acuity or more complex medical conditions.

accepted by both providers and patients. The first-year data of the NMC visits are unavailable; however, Tables 1 and 2 show data from January 2003 to December 2003 and from January 2004 to October 2004 respectively (NMC File 2003-2004).

Survey Results

The importance of the data signifies that providers and patients are utilizing the NMC and that the need for its service is overwhelming. Random patient surveys were conducted from November 2001 to November 2003. Patients were asked what medical condition they were being seen for, if this was their first visit to the NMC, and if they were seen within 15 minutes of their appointed time.

One hundred percent of the chronic population patients (including those with diabetes, asthma, hypertension, and hyperlipedimia) strongly agreed that the care and education they received at the NMC will help them better understand and manage their health condition. Other aggregates surveyed were pregnant women and patients with UTI. One hundred percent of them said that the care and education they received at the NMC was useful and informative, and that service was prompt and quick. Ninety percent said they would use the NMC again. The remaining 10% of the population can be attributed to the pregnant women who do not attempt to get pregnant again. Most patients expressed gratitude for the creation of the NMC. The majority of the comments are summarized as follows:

- "Very informative."
- "Quick and prompt service."
- "Education is thorough and easily understood."
- "The nurse is caring, she cares about my health."
- "I will use the NMC again."
- "She covered a lot of material."
- "Information is relevant and useful."
- "I was satisfied with the information and service received."

Conclusion

The results of this survey have justified continuing and growing the NMC at Boone. The concept of the NMC is well suit-

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2007-2008 Officers Elected

New Board members will assume their responsibilities at the close of the Las Vegas conference on April 1. Nominating Committee representatives assume their responsibilities prior to the conference to permit them to start identifying future candidates for office while at the conference. Special thanks to all candidates who were on the ballot for their willingness to serve AAACN. If you would like to run for office next year, please contact Beth Ann Swan, the incoming chair of the Nominating Committee at beth.swan@jefferson.edu, speak to a member of the Nominating Committee while in Las Vegas, or fill out a Willingness to Serve form at the conference or download one from the Web site.

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