

aaacn Viewpoint

The Voice of Ambulatory Care Nursing

Patients with Anxiety Disorders: A Challenge for Primary Care

Claudia R. Miller, MS, RN, CS, NP

Anxiety disorders are the most prevalent group of mental disorders in the United States, according to two major epidemiological studies conducted over the past 20 years.

More than 15.7 million people in this country suffer from anxiety disorders alone and another 11.7 million experience both anxiety and one other psychiatric disorder.

The estimated economic burden of anxiety disorders in 1998 was \$63.1 billion. Loss of productivity in the workplace, pharmaceutical costs, and mortality

costs constitute 15% of the total. The largest component of the societal costs of anxiety disorders was found to be nonpsychiatric direct medical costs (primary care settings, emergency room) accounting for 54% of the total, while direct psychiatric costs accounted for an additional 31% (Greenberg et al., 1999).

Because primary care providers carry the burden of recognizing patients with anxiety disorders, these are promising locations for identifying individuals who could benefit from treatment. Therefore, this article focuses on recognition and management of two of the more common anxiety disorders seen in primary care: panic disorder and generalized anxiety disorder.

Illusive Diagnosis

Recognizing anxiety disorders in the primary care setting can be a difficult task because of the association of anxiety with unexplained physical symptoms and/or medical illness.

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AAACN expresses profound sympathy to each individual who has suffered as a result of the September 11 terrorist acts. We pledge utmost support in helping the victims of this tragedy. Visit www.aaacn.org for relief and rescue resources.



President's Message

AAACN Viewpoint

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E. Mary Johnson

In My Opinion

I work in a clinic in the inner city of Cleveland, OH. Long ago, I gave up using the freeway system to get there because my all-too-frequent experience was that something or someone would break down and bring traffic to at least a major slow-down, if not a complete stop. I'm not good in traffic slow downs! So I avoid major freeways for getting to work and instead travel the back streets through impoverished neighborhoods. On my route are several elementary schools. One, in particular, Miles Avenue, always gives me pause to stop and think

about the nursing world.

Miles Avenue has a special school guard handling both the traffic and the children. She's 40ish, petite and slim, and her blond hair sticks out of her cap. She wears a neon orange vest, a whistle, and carries a "STOP" sign. Her mission is to insure the safe delivery of the children to school and she does an exceptionally fine job every school day of the year. She is diligent and focused on her mission and never seems to get confused.

Her style includes blowing her whistle, shaking her sign, pointing her finger at the school street zones sign. She doesn't hesitate to loudly remind people to SLOW DOWN. She has me trained to begin slowing down to 10 mph at least a block before the school zone begins. She's fearless in taking on everyone who's driving on East 93rd Street every school morning. Then she smiles and greets the children, walking with them across the street. For all I know, this woman's warm greeting and encouragement may be the best part of their day. After all, they have their own personal school guard who cares enough to protect them fiercely!

At first, I was annoyed with her antics, but over time I've come to respect and admire her. Her actions demonstrate the importance of advocacy for a vulnerable population.

Advocacy is a critical role for nursing in today's health care system as well. Nursing's commitment as a profession includes possessing the knowledge, skill, and diligence to uphold the moral and legal standards of due care (AAACN Core Curriculum, 2001). Performing this role includes ethical decision-making leading to advocacy behaviors, which are fundamental to nursing practice in ambulatory care.

One of AAACN's values includes "welcoming the opportunity to advocate for patients and families." The question then becomes how does this happen in everyday clinic operational flow?

Appropriate access to the right level of care is the beginning. Nursing staff often decides when to add patients to an already busy schedule. Educating patients and their family members helps them to make informed decisions or plan for continuity of care. The education process also allows you to advocate based on your decision making.

I often think of telephone triage nurses as being a special kind of patient advocate. They use a combination of knowledge, experience, sensitivity, sensibility, and confidence in their decision making and planning without the benefit of seeing the patient.

It's becoming more apparent that the current state of health care delivery is seriously lacking in many ways. It's not unlike a traffic slow down or STOP on a major freeway that requires us to take alternate routes! Access roads vary based on where you are in the system and what's available to you. The types of cars traveling on this highway reflects the population. A few BMWs, many Fords, and some "wrecks" are traveling on this highway toward the goal of good

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Kary L. Van Arsdale, EdD



Postpartum Depression

Early Intervention Screening Program Identifies Those At Risk

Several alarming cases of infanticide reported recently in the United States suggest that the need for early identification and treatment of postpartum depression is greater than ever.

In an effort to address this issue, Magellan Behavioral Health has developed and implemented its Postpartum Depression Prevention Program. Magellan, which serves over 3,000 client organizations, specializes in managed mental health and substance abuse services. In addition to managing the delivery of mental health and substance abuse services to people, Magellan also operates an Employee Assistance Program (EAP) to customers.

Magellan's corporate office is located in Columbia, MD, with a number of regional service centers located across America. Magellan's parent organization, Magellan Health Services, is a Fortune 1000 company and is a specialty managed care organization.

Pinpointing Symptoms

Through the Postpartum Depression Program, Magellan screens new mothers for depression using the Edinburgh Depression Scale (EDS). This scale consists of 10 questions designed to detect symptoms of depression in new mothers.

The directions on the EDS instruct each new mother to select one of four responses for each item. For example, item number 9 reads: "I have been so unhappy that I have been crying..." The four response choices for this item include: "Yes, most of the time"; "Yes, quite often"; "Only occasionally"; and "No, never." Respondents are instructed to place a check mark next to the response that best summarizes how they have been feeling during the past 7 days. Each response has a corresponding point value for scoring purposes, and all screens with a score of 12.5 or higher are considered positive. A Magellan care manager arranges support services for women who yield positive scores on the screening tool.

The primary intent of the program is to catch and treat postpartum depression before it has a chance to worsen or result in fatalities such as those that have recently plagued women and babies across our nation.

Incidence Sparks Program

Magellan began developing the Postpartum Depression Program in 1998 by soliciting the input of psychiatrists, therapists, primary care physicians, consumers, and representatives of managed care organizations. Implementation of the program began in early 1999 and has continued on a rolling basis due to its success and popularity.

The initial decision to develop the screening program was based on two factors: the relatively high incidence of depression among the Magellan membership and the incidence of postpartum depression in the general population.

Inpatient and outpatient treatment records indicate that Major Depressive Disorder is one of the most prevalent behavioral health conditions affecting members covered by Magellan. General scientific research shows that postpartum depression affects 10%-15% of all new mothers. In some cases, the condition is so severe that women have thoughts of hurting themselves or their children. In isolated cases, women actually act upon these thoughts, and fatalities result.

In addition to the direct morbidity associated with the mother who is depressed, the mother's family can suffer as well. Studies have shown that children of depressed mothers see their primary care doctors more often and have higher rates of hospitalization than children of nondepressed mothers. Moreover, postpartum depression is the largest risk factor in the development of paternal postpartum depression.

Despite its prevalence and severity, many women who develop postpartum depression do not ask for help. Women who do seek care often wait months before asking for assistance. The screening program was developed to fill a vital niche by providing services to women who otherwise may not have received the help they need.

Screening Packet

As the first step in the screening process, Magellan mails each eligible new mother a screening packet about 3 weeks after the mother gives birth. The screening packet contains the following materials:

- **An introductory letter** that explains the purpose of the program and ensures confidentiality. This letter also encourages new mothers to complete the screening materials and return them to Magellan.
- **A short demographic survey** that contains questions regarding age, marital status, employment status, number of children, and ethnicity.
- **A copy of the Edinburgh Depression Scale**, which is known for its excellent statistical properties and is available in Spanish.
- **An educational brochure** that contains information on the symptoms of postpartum depression as well as self-help tips.
- **A stamped envelope** for members to use in returning the completed materials to Magellan.

Upon receipt of the returned materials, Magellan's Regional Prevention Coordinator scores the returned screens and enters the member's score on the screening tool into an electronic log. All responses to the demographic survey are also recorded.

A score of 12.5 or higher on the EDS suggests that the member is suffering from depression. A Magellan care manager, who assesses the case and arranges an appropriate course of treatment, contacts any woman who screens positive for depression. If Magellan is unable to reach positively screened members by telephone or if the member has requested not to be contacted by phone, Magellan sends a certified letter directly to the individual. This letter notifies the woman that she has screened positive for depression and encourages her to contact Magellan using the toll-free number provided.

Personalized Design Encourages Results

Numerous steps were taken to maximize the response rate for this program. The screening tool and demographic survey are both short and are appropriate for people who are able to read at a 5th grade level. The introductory letter is also concise and exists in two versions: an 8th grade version, which is primarily used with members covered by commercial plans, and a 6th grade version which is appropriate for members covered by Medicaid-based health plans.

Additionally, at Magellan's Louisville, KY, office, the prevention coordinator includes a personalized handwritten note in the screening packet. This note addresses the member by name and thanks her for taking the time to review the screening materials.

Finally, the member's name and address on the mailing envelope are also handwritten to further personalize the screening packet.

Positive Results

The response to this screening program has been tremendous. Since the inception of the program in March 1999, Magellan's Louisville office has reached out to over 5,000 new mothers across the states of Kentucky, Indiana, Ohio, Wisconsin, Kansas, Missouri, Maryland, Virginia, and the District of Columbia. In most areas, over 50% of women have completed the screening materials and return them to Magellan. In some areas, over 60% of new mothers have completed and returned the materials.

Approximately 12% of women responding to the program screened positive for depression. Significantly, an average of 23% of women covered by Medicaid-based health plans screen positive for the condition as opposed to 9% of members covered by commercial health plans.

A subsidiary analysis of the data showed that levels of depression for divorced or separated women were significantly higher than those found in single or married women. Moreover, approximately half of all women who screen positive for postpartum depression had indicated a past history of depression.

Levels of depression are also higher among unemployed respondents as opposed to those found in women who work either full- or part-time, and the average EDS score was higher (suggesting higher levels of depression) among African American respondents compared to Caucasian, Hispanic, or Asian women.

A follow-up telephone satisfaction survey indicated that 99% of program respondents agreed that it is a good idea to screen for postpartum depression in women. Approximately 10% of women noted that they were unfamiliar with postpartum depression prior to receiving the screening packet, demonstrating the educational benefits of the program. Magellan has also received numerous complimentary letters from program participants. The positive impact of the program can perhaps be best illustrated by the written words of one program participant who wished to remain anonymous:

"I suffered in silence with the birth of my first child from postpartum depression. Thankfully I got treatment and recovered. This survey could reach out to those who don't understand what's happening to them or how to make it better."

As the statement above indicates, the potential benefits of this early intervention screening program are immeasurable. The ultimate outcome is clear: the program helps identify those who need assistance and helps save their – and their children's – lives.

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Ambulatory Care Nursing Resources

Telehealth Nursing Practice Core Manual (2001)

The TNPC focuses on the essential competencies associated with delivering nursing care to patients via telecommunications technologies. This 260 page manual was developed by telehealth experts. Use this manual to understand practice issues related to telehealth nursing; orient new nurses to the role of telehealth practice; brush up on the skills needed to practice telehealth successfully and to study for the NCC's Telephone Nursing Practice Certification Exam.



Telehealth Nursing Practice Administration and Practice Standards (2001)

This document identifies the practice standards that define the responsibilities of both clinical practitioners and administrators responsible for providing telephone care across a multitude of practice settings.



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- **PROVIDES** a comprehensive bibliography
- **CONTENT** outlines can be used to design your individualized study plan for the exam

2000 Edition Ambulatory Care Nursing Administration and Practice Standards

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Beyond Invasive Therapy

Nancy R. Kowal, MS, RN, C, NP

Chronic Nonmalignant Pain and the Cognitive-behavioral Perspective

The complexity of pain involves sensory stimulation and an intricate combination of psychological factors. Chronic nonmalignant pain (CNMP) is pain over time which is directly influenced by affective, cognitive, and behavioral components (Turk & Rudy, 1986).

The role of psychological factors affecting patient outcomes clearly must be evaluated during patient assessment. This process will allow a quality clinical experience based on a multidisciplinary assessment.

Patients with chronic nonmalignant pain differ from other patients. Potentially, within their psyche, there are underlying traits predisposing these patients to a chronic pain state.

In the past, research drove pain assessment as a solely sensory experience. The development of sophisticated surgical interventions ablated pain pathways and potent analgesic therapy was used to treat pain. Sadly, this unidimensional assessment process proved unsatisfactory in the treatment of chronic nonmalignant pain (Tollison, 1989).

In the mid-1960s, this changed dramatically with Melzack and the onset of the Gate Control Theory. Psychological factors influencing pain were viewed as part of an integrative process of pain evaluation (Melzack & Casey, 1968).

Another point of view came from Fordyce's model which described pain more from a subjective report evaluated from the patient's subjective pain experience (Melzack & Wall, 1983). This presentation evaluated "pain behaviors" which communicated pain without words. This nonverbal presentation received positive reinforcement from family, friends, and health care providers.

Fordyce's operant conditioning model defined pain as a perception, not a pain stimuli. This was observable in the low-back pain population and affected the outcomes achieved (Fordyce, 1976).

Turk and his colleagues further advanced the process and discussed a comprehensive intervention model with a multitude of pain syndromes (Kerns, Turk, Holzman, & Rudy, 1986).

Paul Arnstein conducted research published in 2000. It clearly supported the positive effect of a cogni-



tive-behavioral program on chronic pain. Coping skills improved significantly with a decline in disability and pain levels continuing beyond 1 year (Arnstein, 2000).

It is important to make certain assumptions regarding cognitive-behavioral treatment approaches to chronic nonmalignant pain (see Table 1).

It must be assumed that CNMP behavior is influenced by the individual and his/her surroundings. The barriers to integration of these techniques lie in the culture for health care providers in their clinical care setting. The argument of subjective versus objective evidence in

evaluation is key. Chronic pain patients were demoralized and labeled as "frequent flyers" in the health care system.

Pain perception from the patient's perspective is a dynamic process involving many factors. These factors are categorized as physiological, psychological, and behavioral-functional. Suffering, disability, and self-image affect the whole picture. Assessment parameters must include:

- History and physical exam with specific neurologic focus
- Objective information
- Psychosocial and behavioral data with testing (MMPI, McGill Questionnaire)

Table 1.
Assumptions of Behavioral-Cognitive Management

1. How patients feel and process thoughts have an impact on behavior.
2. The patient is the active evaluator of pain information.
3. Patients can be taught behavior modification techniques.
4. Patient support systems must be involved in the process of change.

This process better defines classifications of patients and suggested treatment modalities related to diagnosis.

Psychological Testing

Once the physiological and objective evaluation is complete, the components of psychological and behavioral assessment must begin. Evaluation via testing as well as education regarding patient knowledge of these components is critical. Skills must be acquired to promote self-help/wellness techniques to provide strategies to assist in the pain treatment process. The patient is not looked at as a helpless victim but as interactive in the treatment techniques. Critical to the cognitive-behavioral approach are therapy sessions with homework via support groups or one-on-one therapy. This helps the patient and the support system better interact and treat pain issues.

Depression is the most common co-morbid diagnosis in the CNMP population: it is diagnosed in greater than 50% of patients in the primary care setting.

In addition, depression is under-recognized and under-treated. The history and physical exam need to include questions regarding depression, routine screening, and treatment.

Suicidal patients have seen their primary providers close to the actual suicide attempt (Barnes, Gatchel, Mayer, & Barnett). Clearly this issue needs to be treated to prevent serious ramifications such as suicide.

Treatment includes antidepressant medication such as tricyclic antidepressants and selective serotonin reuptake inhibitors (SSRI) in conjunction with pain treatment. Side effect profiles are important to monitor and patient education is critical to long-term compliance.

Some of the medications used are:

- Amitriptyline (Elavil®).
- Atalaprām (Celexa®).
- Clonazepam (Klonopin®).
- Paroxetine (Paxil®).
- Sertraline (Zoloft®).
- Venlafaxine (Effexor®)

Medications such as Elavil can treat multiple problems such as pain levels, sleep patterns, and depression.

Case Studies

Case studies can demonstrate the usefulness of cognitive-behavioral/psychological treatment on actual patient cases.

Case #1

JP is an 82-year-old man who fell and fractured his right elbow. After 12 weeks of treatment for his bone fracture and long-term severe pain, his level of functioning decompensated. He stated poor sleep patterns; 8-10/10 pain levels; right upper extremity edema with

color and temperature changes along with allodynia (severe pain with light touch); and depression.

The fracture had healed and the new physiologic process had intervened: CRPS (complex regional pain syndrome). Research indicated that a stellate block series would improve the objective symptoms. Long-term outcome would depend on stress loading physical therapy to the right shoulder and upper extremity.

JP feared the invasive approach but agreed to learn relaxation techniques with the nurse practitioner. His depression was treated with Elavil® with positive results after 6 weeks and no suicidal ideation. The results of the three stellate blocks were reduced symptoms (pain, temperature, and color changes). Follow-up physical therapy returned the patient to full function and vastly improved his quality of life.

Clinical hunches are valuable but quality knowledge is critical in the evaluation and treatment of pain in the ambulatory setting.

Case #2

HB is a 32-year-old male with HIV and a newly diagnosed Kaposi's sarcoma. The medication he is taking to treat his HIV is known to have side effects such as neuropathic pain. Due to his prior substance abuse history, he fears opioid treatment and the stigma his past history gives him with providers.

This patient requires psychological assessment to prepare for the necessary treatment of his pain and disease. A one-on-one provider approach is identified after a full evaluation of physiology; objective and subjective data; and psychological and behavioral impacts.

HB wants pain management but fears being labeled as "an abuser." A verbal and written contract is established with a treatment plan. Short-term medication protocols via one pharmacy ordered by one provider are established with the introduction of adjuvant analgesia therapy (Neurontin®) to further diminish his neuropathic pain. Sleep patterns are treated with antidepressants (nortriptyline) and relaxation techniques are introduced.

Implications

These case studies clearly demonstrate the effect that psychological, cognitive, and behavioral techniques can have on patient outcomes.

Cognitive and behavioral techniques greatly influence pain management by their effect on patient attitudes and beliefs regarding treatment. It is obvious that

continued on page 22

Telehealth Nursing and Information Resources

So you've set up a desk, a telephone, put out guidelines/protocols, and added "Telephone Triage" to the job description, and now you're ready to take calls...or are you?

Whenever the subject of advising callers over the telephone (telehealth nursing) is discussed, the conversation seems to revolve around two points:

- Who is going to take the call? (RNs, LPNs, or unlicensed staff)
- If you use guidelines, what kind should be used? (paper vs. computerized and algorithm-based or not)

While a majority of the calls may be symptom-based, an increasing number of consumers are turning to telehealth nurses to answer their health care questions. Handling information calls takes just as much planning and preparation as symptom-based, triage calls.

Reliable Resources

Resources to be referenced for information calls should be planned in advance and limited to those that are pre-approved and up-to-date. If they aren't, they tend to accumulate or "grow" haphazardly as staff bring in or obtain books and articles of their own choosing.

The first step to avoiding this is to choose and limit the resources available. This helps reduce the chance that staff members will disseminate outdated facts, give misinformation, or provide conflicting answers to the same question.

To establish an approved resource library, an individual (or a committee) with the involvement of the medical director and the call center/office manager should be selected to review and approve suggested references. This ensures that all information provided to callers is accurate, current, and consistent.

In planning a resource library it is best to involve staff members in the process as early as possible. This way, staff can identify the resources they prefer to work with while attempting to represent the widest possible variety of information resources.

The library should be useful in identifying normal variations as well as answering general questions about specific disease entities. References should be based on accepted health care practices and should be clear to the majority of people such as the "What to Expect" pregnancy, infant, and toddler series by Arlene Eisenberg, Heidi E. Murkoff, and Sandee Eisenberg Hathaway. By pre-approving acceptable resources, such as professional journals (*AJN, Nursing20001*, etc.) and health-related Web sites (www.CDC.gov or RxList.com), you eliminate some of the need to review and approve individual articles and Internet listings as questions arise. (Specific texts, journals, and Web sites are listed here as examples only and are neither recommended nor endorsed.)

Other sources of information listed on Internet sites and in the media will need to be addressed individually. The Internet can be a valuable tool, but care should be used when accessing information. It is often difficult to identify who posted the material on a Web site, the source of the information, and if the material is valid.

Internet sources should be reviewed and approved the same as any other reference materials before they are used. Having a timely process to address items that appear in the media concerning health-related issues such as new treatments and procedures; outbreaks of contagious diseases; contaminated food; or medical product warnings and recalls will be greatly appreciated by the staff. When topics such as these are raised in the media, the telehealth nurse should research and prepare information from the approved resources to be used in answering the anticipated calls. The information should then be made available to anyone who may be taking such calls.

The more proactive you can be in obtaining, organizing, and ensuring that all staff have and use the same current information, the more consistent the level of care provided to your callers.

David Trout, RN,C

Cleveland Clinic Nurse On Call, Cleveland, OH

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Pearl of Wisdom Telephone Nursing Practice



Keep in mind that, even though there may be specific policies and procedures governing your particular practice setting, that telehealth nursing principles must be applicable to a wide variety of practice settings.

It is inevitably and understandably easy to feel and become insulated by one's own telehealth nursing role but therein lies the importance of coming together to communicate and share unique and diverse qualities and characteristics with others in the specialty of telehealth nursing.

Remember, the sum of the parts is more than equal to the whole.

Karen Trout, BSN, RN,C
*Cleveland Clinic Foundation
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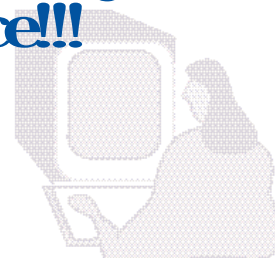
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Update: Telephone Nursing Practice Certification Exam

Over the last 2 months, there have been several comments on the TNP electronic mailing list related to the National Certification Corporation (NCC) Telephone Nursing Practice Certification Exam. In response to these comments and questions, the TNP SIG leadership broadcast the following statement on the TNP e-mail list. Realizing that not all membership has access to this list, we are also publishing the communiqué below. We will keep you posted on further exam developments.

It is both exciting and challenging to be part of the initial group to take this exam. As with many subspecialties, it takes a particular type of nurse to practice telehealth nursing successfully, and to enjoy doing it. We have waited for this type of certification, not to particularly certify that we are knowledgeable, competent, professional nurses but to afford the recognition to telehealth practice that we believe it should have among the various nursing subspecialties.

Just as it has been a long process for AAACN to define and develop standards for telehealth nursing practice, there continues to be other efforts nationally to define the practice. Although AAACN was supportive of NCC developing and offering this certification exam, there are other professional groups interested in telehealth nursing practice that NCC had to consider with exam development.

A pool of telehealth nursing experts developed test questions. NCC as an organization compiled the test from the questions they submitted and therefore, the test represents a composite of telehealth nursing practices from across the nation. Though there may not be consensus

that every question on the exam represents telehealth nursing as defined by AAACN practice standards or nursing's scope of practice, the intent of the exam is to provide us with the opportunity to validate our skills. The exam is a work in progress. It is important that each qualified telehealth nurse participates in the continued development and evolution of this exam. By taking the NCC exam and providing your reaction to the exam to NCC, you can influence its future.

An evaluation form is provided at the conclusion of the test, along with a self-addressed envelope. If you did not receive an evaluation form, you may call NCC at (312) 951-0207 to request one. If, after taking the exam, you feel that there are concerns or opinions about the exam, it is critical that NCC receive this feedback. Thoughtfully fill out the evaluation, and if you have additional comments, send those along also. The only way NCC can truly know how well this exam speaks to telehealth nursing practice is by experienced nurses taking the exam and providing honest, objective feedback. Together, we continue to pioneer telehealth nursing practice."

To request the registration catalog for the exam, contact NCC (312) 951-0207; or (800)-367-5613 to request documents by fax.

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Slice of the Pie: Results of Telehealth Benchmarking Survey



This is the second installment on the results of the TelehealthSurvey© recently endorsed by AAACN. We are presenting one data point (or "slice") from the survey at a time in *Viewpoint*. We will feature data points that are of most interest to our readers.

This survey is sponsored by HMS Northwest. It was available on-line in 2000 and open to anyone to enter data during August and December 2000. Sixty-seven organizations registered and over 30% participated by completing various sections of the survey. Most are large health care systems or independent service bureaus.

In the development of this survey, the authors were motivated by several driving principles: first to document what is happening in the industry; second to add to the body of research building within the industry; third to contrast and compare reality in the field to the professional's understanding of the work; and lastly to provide a venue where individuals and organizations can obtain peer group comparisons.

The survey is intended to be a continuous process in benchmarking the telehealth industry. The 2001 edition is available for data input until December 31, 2001 and can be accessed at www.thehealthsurvey.com.

If you have feedback or if you would like to suggest survey questions for future publication in *Viewpoint*, please e-mail Julie Cartwright at cartwright.julie@hmsnorthwest.com.

Data Query: Interstate Nurse Licensure Compact

Most of us are aware of the interstate nurse licensure compact for licensing across state lines. It is a mutual recognition of licenses developed by the National Council of State Boards of Nursing for the benefit of the traveling nurse, telehealth nurse, and nurses who live in one state but work in another. A series of questions in the survey attempt to define the participants' knowledge of the compact if nurses in their program take calls from outside the state in which they are licensed. It also asks if their program has policies on how to manage people calling them from outside the state in which the nurses are licensed and how they plan to address the problems raised by the interstate compact discussions.

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James A. Haley Veterans Hospital Achieves Magnet Status

Elaine Patterson, MSN, RN, C



Sandra K. Janzen, Associate Chief of Staff/Nursing, holds up her Magnet Recognition Award at James A. Haley Veterans Hospital in Tampa, FL, on May 1, 2001. She is joined by Linda Urden, Chair, Commission on Magnet Recognition, American Nurses Credentialing Center.

Editor's Note: Elaine Patterson, AACN member and member of the AACN VA SIG, has written this article about the Tampa VA's recent recognition of magnet status. Elaine is the Assistant Nurse Manager, Primary Care Clinics, at the Tampa VA.

James A. Haley Veterans Hospital (Tampa VA) is the recipient of the 2001 Magnet Nursing Award. The Magnet Recognition Program for Excellence in Nursing Service was developed by the American Nurses Credentialing Center (ANCC) in 1994 to recognize facilities that provide the best in nursing care.

The program provides a vehicle to disseminate successful practices and strategies among hospital nursing systems and is based on quality indicators and standards of nursing practice as defined by the American Nurses Association Scope and Standards for Nurse Administrators (1996). Jones-Schink (2000) notes some of the key characteristics of magnet as:

- Professional autonomy over practice
- Nursing control over its practice environment
- Effective communication among nurses, physicians, and administrators

Quality Care

Under the leadership of Sandra K. Janzen, MS, RN, CNAA, Associate Chief of Staff/Nursing, Tampa VA incorporated all these elements in its practice setting to achieve the prestigious Magnet Award. Ms. Janzen creates a work environment that is visionary for patient care and nursing practice by promoting staff **motivation, achievement, growth, networking, excellence** and **teamwork** in the daily operation of the facility.

Motivation – The challenge to retain valuable employees and encourage top performance is satisfied by providing incentive programs and compensation plans tailored to the needs of each employee.

At Tampa VA, nurses who carry out the work of the mission are rewarded by the leader who recognized that “One Size Fits All” plans do not suit today’s multi-generational workforce, but that incentives play an important role in motivating, rewarding, and energizing employees.

Nursing personnel are entrusted with decision-making regarding patient care and unit operations. For example, when restructuring of

the nursing service was necessary to improve operational cost and patient care outcomes, the evening and night tour supervisors’ positions were eliminated and staff nurses were empowered to make autonomous decisions regarding staffing and patient care issues.

Programs such as the Gold Star that recognize excellence in customer service and the Recruitment and Retention Program, which is a peer-to-peer recognition program, were established to reward staff nurses and other nursing personnel for their contributions to patient care and the mission of the organization.

Periodic step increases or monetary awards are given based on performance appraisals. Opportunities for promotion and flexibility for lateral transfers are practiced. These management strategies support employee motivation, facilitate the needs of the staff, both individually and collectively, and contribute to employee satisfaction and willingness to perform.

Achievement – Professional development of the nurses is encouraged. Collaboration between Tampa VA and area nursing schools has resulted in many nurses receiving their advanced practice and BSN degrees. To facilitate easy access to education, an on-site BSN and MSN program was established in the facility. At least four nurses successfully completed the nurse practitioner distance-learning program, which is fully supported by the Associate Chief Nurse. In the year 2000 alone, \$90,000 was spent on academic advancement and more than \$50,000 on outside continuing education for assuring ongoing competency and upward career mobility opportunities for

nursing staff (Hixon, 2000). Advanced Practice Nurses in the facility share their expertise by mentoring other nurses in undergraduate programs. This staff education and training is transcended into patient care delivery resulting in highly competent nursing practice and quality health care to the veterans.

Growth – The Tampa VA nursing leader embraces productivity as the key to keeping the organization viable. This concept is evident by nursing involvement in clinical program changes that affect the overall care of patients. Restructuring the nursing department to facilitate expansion is an innovation to support the mission of moving from a hospital to a health care system. Outpatient care at Tampa VA (the busiest in the nation) is improved by developing a community-based outpatient clinic and telephone liaison care to bring health care closer to the veterans. Registered nurses are the key coordinators and facilitators in the operation of these community-based clinics.

Networking – The Tampa VA nursing department uses organizational stewardship to build links between individuals and groups in the organization through networking and participation on *action* teams. Mentorship programs between multiple local universities and the VA use the knowledge of the experienced staff nurse to enlighten and enable the student nurses on the many facets of nursing and, at the same time, open an avenue for potential recruitment of young nurses for the VA. Opportunities are provided for staff nurses and managers to engage in VISN-Wide (Veterans Integrated Service Network) and national work groups, task forces, and councils to maximize professional contributions and career development.

Excellence – The Tampa VA nursing leader is committed to abide by the mission to provide excellence in customer service. One element of excellence is promoting quality care and positive patient outcomes through the use of interdisciplinary collaboration. An interdisciplinary nursing assessment form is used to capture patient health care needs and referral to other services. Clinical guidelines and performance measures are consistently used to communicate and ensure high-quality care outcomes. Computerized medical records and customized templates are developed and used to enhance charting capabilities and information accessibility for providers throughout the facility and VISN.

Teamwork – Most accomplishments at the Tampa VA are attributed to team-driven changes. Nursing plays an integral part in sparking these changes. For example, nurse managers are responsible for identifying and prioritizing problems that need improvement in each department and for reporting to the Nursing Performance Improvement Steering Committee (PI). This committee identifies topics to improve aspects of care annually; it established a systematic approach to track, trend, and monitor compliance.

Teamwork empowerment training is second nature at Tampa VA. Training on team building, a high-performance development model, and a performance-based

interview is provided in orientation and in mandatory reviews.

Many chartered interdisciplinary teams and task groups are established based on problems identified by the PI committee. Some of the outcomes that emanate from partnership of nurses and health care teams throughout the system are:

- Improved narcotic documentation
- Decreased restraint use (not used in VA nursing home since 1999)
- Non-injury to staff and patients during a violent behavior episode during fiscal year 2000
- Improved patient assessment
- Decreased nosocomial skin breakdown

Keys to Success

Tampa VA's success in achieving the prestigious Magnet Award is attributed to a nurse leader who leads by example and promotes synergy among her nursing staff to align their goals with the goal of the organization to effect changes and improve patient care outcomes.

At Tampa VA, nurses are dedicated to patient care, safe and competent nursing practice, and to the support of their colleagues. This bond and sense of community provides the creativity and the drive to achieve remarkable feats.

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Calling all LNGs... Calling all LNGs...

The AACN Membership Council is attempting to locate and contact all current Local Networking Groups (LNGs). We are in the process of developing communication links and want to be sure to include these important local groups.

Please forward the name and location of the LNG and the name, phone number, and e-mail address of the LNG chairperson to:

Susan Paschke
Membership Council Co-Chair
paschks@ccf.org
(216) 444-2169

2002 AAACN Election

Meet the Candidates

The 2002-2003 AAACN Nominating Committee presents the candidates for the 2002 elections. AAACN members will be asked to vote for one person for President-Elect and one person for the Nominating Committee. Ballots will be mailed in November.

President Elect Candidates

Catherine J. Futch, MN, RN, CNA, CHE, CHC



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Kaiser Permanente: Georgia
Region
Nine Piedmont Center
3495 Piedmont Road NE
Atlanta, GA 30305-1736
Phone: (404) 364-4707
E-mail: Catherine.futch@kp.org

It is a privilege for me to be considered for election to the office of AAACN president-elect. If elected, I bring to this position my past experiences as President, Georgia League for Nursing; and President, Board of Directors, Parent to Parent of Georgia, Inc. I have also had the opportunity to serve on a variety of professional and state boards in addition to my tenure as a member of the Board of Directors of AAACN. Each of these experiences has allowed me to develop the skills necessary to serve as an effective board member and as an effective leader.

I have been actively involved in AAACN for more than 6 years. During that time, I've invested my energies in making meaningful contributions to the continued growth and development of AAACN as the premier organization for ambulatory care nurses. Whether helping to plan annual meetings, finding sponsors for speakers, writing articles for *Viewpoint*, revising policies and procedures, or serving in my role as a member of the Board of Directors...I have been surrounded by individuals committed to their profession and to the growth of ambulatory care nursing.

I seek the office of president-elect in order to continue and further my involvement in AAACN. If elected I would focus my energies on continuing to meet and exceed the goals of AAACN, expanding our membership, and achieving our vision of being a vibrant organization focused on meeting the professional and educational needs of its membership.

Practice Setting: Health Maintenance Organization
AAACN member since 1995.

AAACN Activities: Member, AAACN Board of Directors, March 2000-present; Co-Chair, Program Planning Committee, 1998-2000; Co-Chair, Workforce Planning SIG, 1995-1997.

Nancy Kowal, MS, RN, C, NP



Nurse Manager – Pain Consultant
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ummed.edu

The challenge of health care in the ambulatory care setting is exciting, professionally innovative, and creative for all professionals involved. In the new context defined as ambulatory, each member must be fast, fluid, and flexible moving toward quality patient outcomes.

As a member of AAACN since 1988, I have participated in membership, research, and clinical redesign. Over the years my annual meeting sessions have included one-stop-shopping designs, pain management, JCAHO, and the nurse practitioner role as an entrepreneur. As Immediate Past President of the American Society of Pain Management Nurses (ASPMN), I understand the value of leadership especially in times of great change. Some of the projects I was involved in included activating the JACHO pain standards, core curriculum development for ASPMN and AAACN, writing a research chapter for pain management nurses and development/publication of a pain management nursing journal. As a past recipient of the AAACN clinical "Excellence Award," I feel a sense of enthusiasm for the future of the organization and wish to participate in its continual evolution. Key future issues include:

- National leadership representation of ambulatory care
- Professional practice standards for staffing, physical models, and process evaluation of health care outcomes and the impact of the ambulatory RN in a cost-contained environment
- Innovative educational presentations

Visions for the future move the excellence forward, building blocks from the past creates a strong foundation. I am honored to be a candidate for president-elect of AAACN.

Practice Setting: University Group Practice.
AAACN member since 1988.

AAACN offices and committee work: Research committee, 1990-1992; Membership, Massachusetts State Representative, 1995-2001; author, multiple articles in *Nursing Economic\$* and *Viewpoint*; multiple presentations/posters in the annual meeting forum.

Nominating Committee Candidates

Cynthia D. Pacek, RN, MBA, CNA



Ancillary Services Manager
Family Health Center of
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Work: (508) 860-7718

AAACN is the one organization that represents us, the ambulatory care nurses in the forefront

of health care. We in ambulatory care have the opportunity to make a real difference in the delivery of care to all members of the community, through direct service, through outreach efforts, and through the education of populations, often one person at a time. We have the unique opportunity to see the "big picture" while at the same time to see the needs of one individual.

The standards developed by AAACN, the **Core Curriculum for Ambulatory Care Nursing**, the **Telehealth Nursing Practice Administration and Practice Standards**, and now the certification of ambulatory care nurses are examples of the leadership of this great organization and are tools that support us and guide us in our practice. I am proud to be an active member of such a professional and dynamic group.

My interest in becoming part of the nominating committee springs from my desire to serve AAACN in more direct and personal model and to represent you in the nominating process. It is an honor to have been nominated for this position. I thank you for considering me and ask for your vote.

Practice setting: Community Health Center
AAACN member since 1988

AAACN offices and committee work: Co-Chair, Standards SIG (3 years); attended 8 AAACN annual meetings; served as moderator (4 years) and presenter (1 year); member of the 2000 Standards Revision Task Force; and member of the leadership group, 1998-2000.

Helen R. Butler, MSN, RN



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Over half of my 28 years of nursing experience have been in the ambulatory setting in a group practice located in an academic setting. My membership and participation in AAACN has been a major influence in shaping the nursing structure and developing key nursing roles within my organization as ambulatory nursing has become a major nursing specialty.

I consider it an honor to run for this key position within the leadership of AAACN. This opportunity will enable me to contribute to an organization that has provided the leadership needed to maintain and move nursing forward.

With your support, as a member of the Nominating Committee, I would be in a position to participate in selecting members in key positions who embody the qualities and strengths needed for leadership during this new century.

Practice setting: Academic Health Center Group Practice

AAACN member since 1997

Activities: Served as monitor during the annual meeting. Our area does not have a networking group, so one of my goals is to establish a group in this area.

Silent Auction Returns to the 2002 Conference

The Silent Auction has been a fabulous success at the AAACN 2000 and 2001 annual conferences. We will again be featuring this enjoyable event during the Opening Reception of the 27th Annual Conference on Thursday, March 7, 2002. The conference will be in New Orleans, LA, March 7-10, 2002.

In 2001, the auction raised \$3,800 for the AAACN Scholarship and Research Fund.

In the past, bidding items have included vacation timeshares, vintage-nursing books, theme baskets, and much more.

If you are interested in donating an item for the auction and are attending the conference, please stop by the Registration Desk on March 7 and drop off your item before 5 pm. If you are not attending the conference and would like to donate an item, please contact Pam Del Monte at pamela.s.delmonte@kp.org or Telia Emanuel at temanuel@floridahealthcares.com.

We would ask that the items be small and portable enough to fit easily in a suitcase. Gift certificates are always welcome and easy to transport.



Do you know an ambulatory nurse who personifies excellence in ambulatory care? Every day, nurses like you do outstanding work in patient care, education, administration, and research. Unfortunately, too many nurses are never recognized for their contributions. You can change that by nominating a colleague for either of the AAACN Excellence Awards:

Excellence in Administrative Ambulatory Nursing

Excellence in Clinical Ambulatory Nursing Practice

CRITERIA – The candidate must be:

1. A registered nurse currently providing administrative leadership or clinical nursing practice in an ambulatory setting.
2. Recognized as a positive role model in ambulatory nursing as characterized but not limited to:
 - A. Mentoring peers and colleagues and willingness to share expertise.
 - B. Promoting interdisciplinary collegial working relationships.
 - C. Demonstrating effective management of rapidly changing situations, and/or clinical nursing practice.
 - D. Demonstrating improvement of patient care outcomes with effective implementation into practice.
 - E. Being recognized as a nursing expert by nursing colleagues.

ELIGIBILITY – The candidate must:

1. Be a member of AAACN in good standing.
2. Not be a current member of the Nominating Committee or the Board of Directors.
3. Have at least 3 years experience in ambulatory nursing and currently practice in an ambulatory setting.

AWARDS – Each recipient will be awarded \$500 which will be presented at the annual conference. The awards are sponsored by the Anthony J. Jannetti, Inc. Nursing Economic\$ Foundation.

Nominating Procedure

1. The candidate may be nominated by a colleague or supervisor.
2. Self-applications are encouraged.
3. Nomination submission must include:
 - A. Two letters of recommendation from nursing colleagues addressing the identified criteria (preferably one AAACN colleague).
 - B. Candidate's resume/curriculum vitae, if available. If not, describe the candidate's experience.
 - C. Completed nomination form (see below).
4. Nominations must be received in the National Office by **February 1, 2002**.
5. Nominations will be reviewed. An objective point system will be used in the selection process. Selection will be submitted to the Board of Directors for approval. Applicants will be notified prior to the annual conference.

NOMINATION FORM

1. Name of nominee _____
2. Nominee is an active member of AAACN. Yes No
3. Nominee is not currently serving on the Nominating Committee or Board of Directors. Yes No
4. Nominee has the experience required as specified under eligibility requirements.
5. Please attach: Nominee's curriculum vitae or brief description of nursing experience and two letters of recommendation. These letters must document how the candidate meets the nominating criteria.
6. Return this form and requested materials to:

AAACN
East Holly Avenue Box 56
Pitman, NJ 08071-0056
(800) AMB-NURS; Fax (856) 589-7463
E-mail: aaacn@ajj.com

AAACN 2001 Financial Profile

As Treasurer, I am reporting to you on AAACN's financial status at the close of fiscal year (FY) 2001. An independent audit of AAACN's statements of assets, liabilities, and fund balance was conducted by Certified Public Accountants Gold, Meltzer, Plasky, & Wise. This audit concluded that our financial statements "presented fairly, in all material respects, the assets, liabilities, and fund balance" as of June 30, 2001.

Compared with FY 2000, there was a 2% decrease in total revenues, primarily a result of decreases in membership and annual conference revenues. The Board of Directors is taking active measures to increase membership, and the membership has recently changed the AAACN bylaws to allow for new categories of membership. Although this membership decrease is consistent with national trends, a market survey was recently conducted to attempt to define a root cause for the attrition of members. Annual conference revenue was down, secondary to fewer registrations and a decrease in exhibit and grant income. This is also consistent with national trends.

There was a decrease in revenue related to educational offerings and publications. This is related to the transition to new products in each of the areas where revenues have decreased. Several publications are under revision, or have been replaced by the new **Core Curriculum for Ambulatory Care Nursing** text. Revenues from the core curriculum have not yet been realized. The **Ambulatory Care Certification Review Course** and the **Telehealth Nursing Practice Core Course (TNPCC)** are both being converted to an electronic format to make it more convenient for members to participate in these offerings.

Other revenues included income from *Viewpoint* advertising and subscriptions, as well as investment income. *Viewpoint* rev-

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Statements of Assets, Liabilities and Fund Balances Modified Cash Basis

June 30,	2001	2000
Assets		
Current assets		
Cash	\$ 60,442	\$ 36,768
Accounts receivable	2,304	3,040
Accrued interest receivable	1,123	1,646
Prepaid expenses	<u>10,582</u>	<u>9,824</u>
Total current assets	74,451	51,278
Other assets		
Investments	<u>380,837</u>	<u>424,243</u>
	<u>\$ 455,288</u>	<u>\$ 475,521</u>
Liabilities and fund balance		
Liabilities		
Accounts payable	\$ 25,245	\$25,832
Deferred revenues	<u>110,702</u>	<u>87,207</u>
Total liabilities	135,947	113,039
Fund balance	<u>319,341</u>	<u>362,482</u>
	<u>\$ 455,288</u>	<u>\$475,521</u>

Statements of Revenues and Expenses Modified Cash Basis

June 30,	2001	2000
Revenues		
Membership dues	\$ 168,270	\$ 174,030
Annual conference registration	190,189	201,434
Annual conference exhibit and grant income	25,675	46,146
Certification review course	18,120	16,250
Standards publication sales	13,427	13,442
Telephone standards	8,441	7,853
Telephone nursing practice resource directory	341	247
Interest and dividend income	22,076	30,851
Grants/contributions	6,985	9,605
VP advertising and subscriptions	26,280	4,356
Miscellaneous income	3,089	15,121
Certification products	12,005	-
Royalties	169	-
Gain on sale of investments	10,377	4,678
ANA/AAACN monograph	2,048	4,496
TNPC course	<u>10,813</u>	-
Total revenues	<u>518,305</u>	<u>528,509</u>
Expenses		
Administration expenses	174,940	170,723
Membership expenses	143,270	129,117
Committee expenses	6,627	5,867
Educational programming	230,201	243,293
Educational materials	<u>6,408</u>	<u>12,350</u>
Total expenses	<u>561,446</u>	<u>561,350</u>
(Expenses) in excess of revenues	<u>(43,141)</u>	<u>(32,841)</u>
Fund balance, July 1	<u>362,482</u>	<u>395,323</u>
Fund balance, June 30	<u>\$319,341</u>	<u>\$ 362,482</u>

Results of SIG Survey

In 1994, AACN formed special interest groups (SIGs) to better support the needs of its members. Some SIGs served a specific purpose then disbanded. New ones formed to meet new needs and interests.

In the past 3 years, many SIGs have struggled to maintain an active work group. The SIG oversight committee, a group comprised of all SIG chairs and co-chairs, has explored this problem in depth. In addition, the SIGs have worked to improve their membership by developing a Web page within the AACN Web site, using e-mail lists to improve communication (see article, page 18), and increasing visibility by contributing articles to *Viewpoint*.

The SIG oversight committee decided last year that a "needs assessment" would be helpful. In developing the tool they identified the goals of the project:

1. Why has there been a decrease in active SIG membership?
2. What are the barriers members find to active SIG participation?
3. What do members expect and want from a SIG?

In January we polled the members through the AACN Web site and at the national conference. The results helped give us insight on ways to boost SIG participation.

Survey Results (Synopsis)

- 80% of the respondents had joined a SIG
- 73% of the respondents attended a SIG meeting
- 42% of the respondents reported reading *Viewpoint* articles by SIGs
- 30% of the respondents visited SIG Web sites

We then used a scale of 1=strongly disagree, 2=disagree, 3=neutral, 4=agree, 5=strongly agree, and received the following results:

- SIG mission and purpose are clearly defined: 3.7.
- SIGs provide networking opportunities: 4.5.
- AACN supports SIG work: 3.8.

- SIG ability to communicate how a member can become involved in a SIG: 3.2.
- SIG involvement is valuable to them: 3.6

Barriers

The following barriers were cited:

- Inconsistent or poor communication
- Feel left out of the information loop
- No time to actively participate
- Not sure how to become involved
- Not really interested in topics
- No access to e-mail
- Not knowing other SIG members

Good Points

Those who responded cited these positive aspects:

- E-mail updates
- Networking opportunities
- Opportunities to write articles for *Viewpoint*
- TNP standards and resource guide
- Opportunities to be involved in a national organization

Ways to Increase Activity in SIGs

- 72% want more networking opportunities
- 51% want to participate in special projects
- 37% want more SIG work time at the conference

Comments

- More e-mail or newsletters to communicate SIG activity
- SIG dinner or activity at conference
- More information on how to become involved
- Clearly defined goals and objectives of SIGs
- Beyond networking, produce outcomes
- Better communication

What Are We Doing with the Information?

Many of the initiatives we had begun were on target but needed to be improved and expanded.

Improved Communication: The Telehealth SIG has created a welcome letter that is sent to all new members. The Veterans Affairs (VA) created and mailed a newsletter to all its members.

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Financial Report

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Revenue was up 17%, as a result of corporate sponsorship of several issues. Interest and dividend income was down 28%, which is consistent with current economic trends. The gain on the sale of investments was \$10,377.

Due to a significant effort to contain expenses, total expenses remained constant from FY 2000 to FY 2001. Member service expenses increased by 10%, which is consistent with the AACN strategic plan. The largest member service increase in expense (29%) was related to Internet charges due to significant enhancements to the AACN Web site. *Viewpoint* expenses also increased, as a result of expanded issues and efforts to market subscriptions to non-members, but were offset by sponsorships of specific issues.

Additional member service expenses included the printing of the revised **Telehealth Nursing Practice Administration and Practice Standards** and external professional relations fees. Expenses for educational programming and materials decreased by 7%. While significant monies were used for the development of the TNPCC, total education expenses were down due to the annual convention and not having an education director for several months. There was a 2% increase in administrative expenses, primarily due to a need for additional management, secretarial, and legal services.

Total expenses amounted to \$561,446. Expenses in excess of revenues were \$43,141, which required a planned allocation from dedicated reserves. The AACN fund balance as of June 30, 2001 was \$319,341.

Kathleen P. Krone, MS, RN
AACN Treasurer

Electronic Mailing Lists:

Valuable Member Benefit at Your Fingertips

One benefit of being a AAACN member is access to e-mail discussion lists for many ambulatory care nursing specialties. E-mail lists provide a method of communication that is fast and tailored to your needs.

The AAACN Web site, www.aaacn.org, offers members the opportunity to subscribe to these lists. (See box, this page, for the e-mail lists available to you.) These lists allow members to join other people with similar interests for discussions and networking.

Once you subscribe to a list via the Web site, you will receive all e-mail sent by the other people who subscribe to the list. This type of rapid communication is invaluable to nurses who need to stay current in their practice.

AAACN's electronic communication system includes e-mail lists for the association's Special Interest Groups (SIGs). Members of these groups use the lists constantly. In addition, lists are set up for special projects (such as the core curriculum) and can be developed for AAACN members' and groups' other communication needs.

To Subscribe

If you would like to subscribe to an e-mail list, follow these steps:

1. Go to www.aaacn.org.
2. Click on "For Members."
3. If you know your password, click on "Enter Member Services Area." If not, fill out the form to request a password.

4. Click the "I accept the above disclaimer..."
5. Enter your user name and password.
6. Under "For Member Contents" in the pull-down menu, select "Electronic Mailing Lists."
7. Enter your e-mail address and select the type of subscription you want (you can get mail individually or in batches). You may subscribe to more than one list.
8. Click "Subscribe."

Once you have subscribed, you will receive a welcome message in your e-mail inbox with instructions on how to use and post messages.

We hope you will take advantage of these lists as they are powerful communication tools. If you have any questions, please e-mail AAACN at aaacn@ajj.com.

AAACN E-mail Lists

Case Management: aaacn_casemgt

Guestbook: aaacn_guest

Informatics: aaacn_informatics

Members: aaacn_members

Military SIG: aaacn_mil

Pediatric SIG: aaacn_ped

Staff Education SIG: aaacn_staffed

Telehealth Nursing Practice. SIG: aaacn_tnp

Veterans Affairs SIG: aaacn_va

SIG Survey Results

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All SIGs had created e-mail lists, but use was sporadic to nonexistent. This year, all SIGs have had multiple communications to their members and many excellent discussions have taken place on the Telehealth and VA e-mail lists. The Staff Education and Pediatric lists have had intermittent use. The Tri-Service Military list has been fairly quiet.

Projects: The Telehealth SIG is working on revising the Telehealth Resource Manual. Last year, many SIG members participated in the development of the **Telehealth Nursing Practice Core Course** (TNPCC). The SIG is also actively involved in clarifying roles and terminology relevant to telehealth nursing. The Staff Education SIG has been asked to contribute to JCAHO's Staff Education Guide and has used the discussion forum on AAACN's Web site to promote discussions. The Tri-Service Military SIG is planning and producing their preconference for the upcoming 29th Annual Conference (March 2002, New Orleans, LA). The VA SIG is also developing a speaker forum for the conference. The Pediatric SIG plans to produce a pediatric nursing networking resource.

Future Plans: An experienced mentor has been recruited for each SIG. We plan to use the mentors' expertise to develop improved communications within the SIGs and promote remote project work facilitation. We are also planning to place our revised goals and objectives on the AAACN Web site. We will soon be conducting a Quick Poll via the Web site to get members' input on changes we have made and how we can better meet their needs. Please look for the poll: it is fast, easy (and fun!) to do and we appreciate your response.

If you have ideas, if you want to get involved, or if you would like more information about AAACN SIGs, please contact the chair or co-chair the Oversight Committee (below). We look forward to hearing from you.

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Anxiety Disorders

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In specific subsets of patients with unexplained physical symptoms, the rate of anxiety disorders is particularly high. Panic disorder in non-cardiac chest pain and palpitations is 40%-45%; labile hypertension 40%; irritable bowel syndrome 40%; and unexplained syncope, vertigo, and dizziness 20%. Generalized anxiety disorder (GAD) is also over-represented in these areas.

Gastroenterologists are the medical specialists most often seen by patients with GAD, and otolaryngologists and neurologists are most often seen by panic disorder patients (Roy-Byrne & Katon, 2000).

Anxiety can also be a co-morbid complication in diagnosed medical illness. The anxiety may be a response to the illness or may have pre-

existed the illness.

Either way, anxiety has the potential to aggravate the medical illness. Recent studies document increased rates of anxiety coexisting in patients with cardiac, gastrointestinal, respiratory, and otoneurologic illness.

The 16% rate of panic disorder in cardiac patients is thought to be higher than the general population. Panic disorder can have potential deleterious effects in the patient with coronary

heart disease by increasing smooth muscle contraction, elevating heart rate and blood pressure, and decreasing vagal tone and heart rate variability.

The decreased vagal tone frequently seen in anxiety disorder patients, along with smooth muscle abnormality, may also be a contributing factor in gastrointestinal disorders. Conversely, intermittent intestinal distention as in irritable bowel syndrome can increase the rate of noradrenergic activity ultimately worsening anxiety.

Respiration is particularly unstable in panic disorder. Therefore, it is not surprising that there is an increased rate of anxiety disorders in patients with respiratory disorders, as well as increased rate of respiratory illness in patients with panic.

In early onset respiratory disorders, a conditioning effect may have progressed by repeated episodes of shortness of breath. Also, studies have shown increased carbon dioxide sensitivity in panic disorder,

One of the current theories on the development of panic disorder asserts that some individuals have an “anxiety sensitivity” to particular somatic symptoms.

which could explain the development of panic in chronic obstructive pulmonary disease (COPD) patients.

In the area of otoneurologic disorders, studies have shown that 75% of panic patients have an increased rate of abnormal vestibular testing, without diagnosed Meniere's disease or vestibular neuritis. In addition, there is increased rate of panic in those patients with a diagnosed vestibular disease (Roy-Byrne, 2000).

Symptoms

One of the current theories on the development of panic disorder asserts that some individuals have an “anxiety sensitivity” to particular somatic symptoms. In addition, the individual believes that the bodily sensations predict a catastrophic outcome. This theory would explain the vulnerability to panic in those with the aforementioned medical illness, and how panic symptoms can be misinterpreted (Bouton, Barlow, & Mineka, 2001).

According to the Diagnostic and Statistical Manual of Mental Disorders (2000), four or more of the following symptoms must occur for the diagnosis of panic disorder:

- Palpitations, pounding heart, or accelerated heart rate
- Sweating
- Trembling or shaking
- Sensations of shortness of breath or smothering
- Feeling of choking
- Chest pain or discomfort
- Nausea or abdominal distress
- Feeling dizzy, lightheaded, or faint
- Derealization (feelings of unreality) or depersonalization (being detached from oneself)
- Fear of losing control or going crazy
- Fear of dying
- Paresthesias
- Chills or hot flashes

Panic symptoms characteristically develop abruptly and reach a peak within 10 minutes. Episodes are recurrent and patients begin to worry about having future attacks. Agoraphobia is a frequent complication of panic disorder, as patients begin to fear and avoid situations in which attacks have occurred or where escape may be difficult. Consequently, panic disorder is frequently associated with significant impairment in overall quality of life as it affects social, marital, and vocational functioning (Pollack & Marzol, 2000).

Generalized Anxiety: Chronic Worry

Generalized anxiety disorder, according to some studies, is the anxiety disorder most commonly seen in the primary care setting, as the patient usually presents with various somatic complaints.

Generalized anxiety is very common in the general population, and as in panic disorder, females are more likely to be diagnosed. Despite its preponderance, most patients do not seek treatment other than that provided by their general practitioner (Roy-Byrne & Katon, 2000).

Worry is the main characteristic of GAD. The worry is pervasive and out of proportion to the likelihood of the feared event. It is more than transient worry, lasting 6 months or longer. The individual often awakens with apprehension and unrealistic concern about future misfortune. This chronic and excessive anxiety about life circumstances is accompanied by symptoms of vigilance, autonomic hyperactivity, and motor tension

In order to meet criteria for GAD, according to the DSM-IV-TR (2000), three or more of the following symptoms are required:

- Restlessness, feeling keyed up or on edge
- Fatigue
- Difficulty concentrating
- Irritability
- Muscle tension
- Sleep disturbance

Due to the symptoms, there is marked distress or significant impairment in functioning.

Today's New Treatments

Over the last decade, there has been a shift in the selection of first-line agents in the treatment of anxiety disorders. This shift is due to the introduction of the selective serotonin reuptake inhibitors (SSRI). These agents increase the amount of serotonin in the neuronal synapse by blocking the reuptake pump that reabsorbs serotonin into the presynaptic neuron (Rivas-Vazquez, 2001).

Although SSRIs were initially developed to treat depression, anxiety pathways in the brain are also affected by antidepressants. Efferent pathways from the amygdala mediate a wide range of physiological and psychological reactions such as sympathetic and parasympathetic activation, increased startle response, hyperventilation, hypervigilance and subjective fear of dying.

The locus ceruleus (LC) and the raphe nuclei (RN) are also involved in physiologic sensations associated with anxiety. The amygdala, LC, and RN are intricately connected and fluctuations in serotonin levels affect

their activity in either an inhibitory or excitatory way resulting in subsequent anxiety states (Rivas-Vazquez, 2001). Consequently, by correcting the serotonin imbalance in these neurotransmitter systems, the anxiety pathways gradually return to a nonpathological level of functioning.

Because SSRIs are safer and better tolerated, they have replaced the older antidepressant medications, the tricyclics and monoamine oxidase inhibitors (MAOIs) to become the first-line agents in treating anxiety disorder. However, SSRIs have their own side effects including CNS activation, GI disturbance, headaches and sexual dysfunction. The CNS activation may be particularly problematic for anxiety-sensitive patients as the CNS activation causes an initial jitteriness characterized by increased anxiety and

Table 1.
Current Selective Serotonin Reuptake Inhibitors and Recommended Dosages

Generic name	Trade name	Initial dosage (mg/day)	Therapeutic dose range (mg/dy)
Fluoxetine	Prozac®	10	20-80
Paroxetine	Paxil®	10	20-80
Sertraline	Zoloft®	25	50-200
Fluvoxamine	Luvox®	50	100-300
Citalopram	Celexa®	10	20-60

Albers, L., Hahn, R., & Reist, C. (2000). Handbook of psychiatric drugs. CA: Current Clinical Strategies Publishing.

shakiness. This side effect can be minimized by starting at a low dose and increasing slowly. Table 1 lists the current SSRI's and recommended dosages.

Sometimes the addition of a benzodiazepine helps minimize CNS activation while tapering up on the SSRI. Benzodiazepines have usually been the first choice for the acute treatment of GAD, as their ability to relax muscles and aid sleep are helpful for some of the somatic symptoms. And in panic disorder, their rapid onset brings immediate relief. However, due to concerns about tolerance, abuse and dependence, the SSRIs may be more efficacious. SSRIs have also been shown to be superior to buspirone (a nonbenzodiazepine antianxiety agent) in the treatment of GAD (Rivas-Vazquez, 2001)

Anxiety disorder tends to be chronic, relapsing, and remitting. As in any chronic illnesses, self-management must be promoted through the collaboration of patient and clinician in order to enhance health-promoting activities.

Cognitive behavioral therapy (CBT) contains many self-management techniques to enhance self-efficacy in the management of anxiety disorders. In one study, the addition of CBT resulted in remission of 40% of patients who had remained symptomatic despite medication treatment (Pollack & Marzol, 2000).

Cognitive behavioral therapy focuses on identifying cognitions and behaviors that contribute to and maintain anxiety. In anxiety disorders, the theme of danger is apparent in the patient's thought processes in contrast to themes of loss and self-devaluation in depressed patients. The overestimation of danger and underestimation of ability to cope are core beliefs that modulate and maintain anxiety in the anxious patient.

Panic Disorder: Devastating Fear

In panic disorder, these beliefs present themselves as catastrophic misinterpretations of bodily sensations. A cognitive model of panic proposes that a certain sequence of events leads to panic attacks. An internal or external stimulus is appraised as threatening, producing anxiety with bodily sensations.

When these symptoms are misinterpreted catastrophically, further escalation of anxiety occurs and the person becomes trapped in a vicious cycle that culminates in panic. In addition, selective attention to bodily sensations along with avoidance behaviors contribute to maintaining the anxiety. Correcting misinterpretations of body sensations as catastrophic is done through interoceptive exposure (exposure to the body sensation triggers), situational exposures, and cognitive restructuring (Wells, 1997).

Worry as Coping Method

Although the initiation and content of worry may be involuntary in both normal and GAD worry, the significance and maintenance of the worry differs. In GAD, positive and negative beliefs about worrying along with the general inability to cope predominate.

With positive worry, there may be a core belief that worry is a safety strategy. Positive beliefs about worrying may include the following:

- Worrying helps me cope.
- Worrying helps me be prepared for the worst.
- If I worry, I can prevent bad things from happening.

Unfortunately, using worry as a coping strategy generates its own problems, as the patient begins to perpetuate worst-case scenarios and elaborate negative outcomes. New negative outcomes then challenge the belief of coping abilities, and anxiety increases. Although patients with GAD often report that their worrying can be interrupted by distracting events, they worry about their worry. Examples of negative beliefs about worrying include:

- I could go crazy with worry.
- Worrying is harmful.
- My worries are uncontrollable.

(Wells, 1997)

The development of GAD takes place over time with patients reporting long histories of worrying.

When symptoms are misinterpreted catastrophically, anxiety escalates and the person becomes trapped in a vicious cycle that culminates in panic.

Maladaptive behaviors of avoidance and reassurance seeking also contribute to the maintenance of worry and anxiety. The patient with GAD may begin to avoid situations with potential negative outcomes and seek reassurance to interrupt their worry cycles. However, these behaviors tend to be counterproductive, as avoidance increases anticipatory anxiety and reassurance seeking can yield conflicting responses.

In GAD, cognitive distortions about worry are challenged and restructured. Worry exposure along with worry behavior prevention and relaxation training are also implemented.

Having established acute treatment strategies, the patient is educated about long-term management of anxiety. An assessment of sleep, exercise, stress and coping, relaxation, leisure, substance abuse, and nutrition is crucial in promoting a healthy lifestyle.

Overcoming Barriers to Care

Many patients tend to express their psychic distress through somatic symptoms and deny their need for psychiatric treatment. This reluctance, due to the stigma of mental illness, is one of the reasons most adults with a probable anxiety disorder do not receive adequate treatment (Young, Klap, Sherbourne, & Wells, 2001).

Another reason for inadequate treatment is lack of knowledge. If medication is prescribed, without sufficient education of the disorder or medication, the patient may experience side effects, increased concern, and subsequently discontinue the medication. Patients also tend to discontinue antidepressants prematurely when they begin to have symptom relief. Consequently, due to the chronic nature of anxiety, patients require:

- Prevention, education, and psychosocial support
- Side effect and outcome assessment
- Follow-up for chronic relapsing anxiety disorders

Time constraints in primary care settings do not always allow for sufficient time to meet these objectives. Studies of collaborative care between mental health professionals and primary care providers resulted in improved patient adherence to medication, improved patient outcome, and improvement in cost-effectiveness (Roy-Byrne & Katon, 2000).

With more widespread public awareness, recognition by primary care providers, and appropriate treatment of anxiety disorders, progress can be made in

decreasing their economic burden and improving the quality of care for these prevalent disorders.

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Chronic Nonmalignant Pain

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motivation for change and self-control over pain issues affects chronic pain outcomes.

Providers, especially in the ambulatory setting, must be aware that a multidisciplinary approach to pain management is clearly indicated in this population. Research in chronic low-back pain has reported that changes in MMPI profiles is correlated with successful treatment of this type of chronic pain.

The ambulatory area is driven by patient outcome and a defined process to measure that outcome. Experienced clinicians screen patients with specific disease states. There is a specific need to gauge clinical judgments and define patient suitability for invasive treatment based on working standards.

The complex assessment process for the chronic pain patient will provide future data for treatment process. Speculation for pain treatment must be based on knowledge and clinical research to provide a clear mode of pain assessment and treatment especially in the chronic population. Clinical hunches are valuable but quality knowledge is critical in the evaluation and treatment of pain in the ambulatory setting.

The history of pain treatment from a unilateral perspective has proven to be a failure. Clear understanding of the cognitive-behavioral perspective of pain will provide optimal treatment options for the pain patient. The integration of physiology, psychology, and behavioral-cognitive assessment will provide the key to a quality approach for chronic pain patients.

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Telehealth Survey Results

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Results

Of the organizations surveyed, 66% reported that their nurses take calls from constituents across state lines. Of those (66%) respondents, 36% reported that some of their nurses are licensed in those other states with 50% or more stating they are not.

In addition, 90% reported there are no specific departmental policies in place regarding licensure of nurse staff practicing across state lines.

So what are these organizations doing if the interstate compact was not passed in the states their nurses take calls? The report showed:

- 50% are taking "no action and are considering their options."
- 30% said they are waiting for the interstate compact to be approved

- 10% said they did not know multistate licensure was a requirement
- 10% said they are taking the risk of not acting at all.

Interpretation

These results show that we need to devote more work and attention to this issue. Please write your State Board of Nursing today. If you are a nurse in the practice of telehealth nursing, talk to your manager and fellow nurses about this topic. Contact your local board of nursing and tell them how important this issue is to your practice.

To learn more about this multistate licensure and the interstate compact in your state, contact the National Council of State Boards of Nursing or go to <http://www.ncsbn.org/>.

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President's Message

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health. As they travel they'll need to meet some special school guards (nurses) armed with special traffic signs and whistles. To help them STOP, LOOK, and LISTEN.

Through their advocacy, nurses make the system safer to travel. Like the children of Miles Avenue Elementary who depend on a dedicated school guard to lead them safely to school, so too do patients and families need dedicated nurses to guard them safely through the health care world.

Operations Update

Telehealth Nursing Practice (TNP): The TNP certification exam results are in and 109 nurses are TNP certified. The TNP SIG has written an article (see page 10) to keep you informed about the exam.

AAACN to join advisory committee: JCAHO has invited AAACN to appoint a representative to the Professional Technical Advisory Committee (PTAC) for Ambulatory Care beginning in January, 2002.

Sheila Haas honored: Congratulations to Sheila Haas, PhD, RN, dean of Loyola College and former AAACN president (1998-99), who will be inducted into the American Academy of Nursing on October 27, 2001. This honor recognizes nursing professionals with visionary leadership who advance the scientific knowledge and influence health care policies.

A random survey from AAACN: A survey, primarily to surgical arenas, may soon appear in your e-mail. Please take a few minutes and respond or forward it to the appropriate person in your institution.

AAACN Core Curriculum for Ambulatory Care Nursing: The textbook has sold 1,365 copies in the first 6 months of publication! Our colleagues say they're using it in many different ways...as a reference text in clinics, to prepare for certification exams, and as a home reference text.

AAACN Membership Directory: Your new directory is coming soon. Thanks to the hard work of AAACN's management company, Anthony J. Jannetti, Inc., especially Liz Van Dzura, we have more e-mail address listings than ever.

"Go the extra mile, it's never crowded."

Executive Speedwriter Newsletter

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Don't Forget MEMBERSHIP RECRUITMENT

E. Mary Johnson, AAACN president, issued a challenge at the AAACN 2001 conference in Nashville that " **Each member recruit a new member.**"

Why not recruit a **FEW** new members??

The AAACN member who recruits the most new members (six or more) between April 2 and December 31, 2001 receives paid registration, super-saver airfare, and lodging (double occupancy) to the 27th Annual Conference in New Orleans, March 7-10, 2002!!

In addition, all members who recruit at least three new members receive a \$100 certificate toward AAACN programs or merchandise.

Contact the national office at (800) AMB-NURS or (856) 256-2350 or visit the AAACN Web site (www.aaacn.org) for membership information.

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Along with outstanding opening and closing speakers, there are many educational opportunities available in which information will be shared that can be taken home and used immediately. Concurrent sessions, which many consider to be the working pieces of a conference, will include many innovative and creative ideas. Special sessions on Saturday morning will provide more time to focus on subject matter in an in-depth way.

Concurrent sessions will have something for everyone. Clinical information that will be available includes but is not limited to the following topics: pain management, allergy immunotherapy and the nursing implica-

tions of that treatment plan, treatment of fever in neutropenic patients on an outpatient basis, an update on multiple sclerosis, and immunizations for teenagers. These sessions will address not just the newest and the latest but hands-on information that can be used in our home settings.

Administrative sessions include information on standardized job descriptions, measuring effectiveness of RN-managed clinics, models for care coordination, and virtual call centers. Educational sessions, infection control sessions, and accreditation criteria will also be found in concurrent sessions.

So, mark the conference dates on your calendar today! We will keep you informed about the conference and how to register in upcoming issues of *Viewpoint* and on the AAACN Web site, www.aaacn.org.

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