



VA APN NEWS

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Inside this issue:

New Beginnings: Starting an APN Group

By

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Occupational Health

Minneapolis VA Medical Center

VHA Advanced Practice Registered Nurses (APRNs) strategically plan for the successful establishment of a work group that supports their professional life. It begins with frank discussion among allied colleagues, projecting your view of what you, as a group, bring to the greater mission and what you all want. Steps include: Determine what you value; Write objectives together; Divide the work; Anticipate strengths, weakness, obstacles and threats posed by local conditions; and Do appreciate the influence of strong personalities in your facility. When these preliminary ideas have taken shape and you have a committed group you can move to the next task.

Meet with your Associate Director of Patient Care Services/Nurse Executive (ADPCS/NE) and union leaders. See both during the same week to leverage momentum. Meet regularly with them, build trusting relationships, and make sure your group learns the facility and network goals. Meeting with the ADPCS/NE and union head sets you at the level of authority necessary to initiate your group. Ask for their approval. Meeting with union officials fosters trust and respect between you and the union representatives of APRNs. Remember, the union exclusively represents employees; thus, your group functions differently in that it cannot represent APRNs to management. Effective functional relationships among workgroups define successful organizations and there is a place for APRNs as one of these groups.

Write a policy that charters your group once you've organized yourselves, gained authority from your ADPCS/NE and done the preliminary vision, values, and

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VHA APN 2011 CONFERENCE

Chicago, Illinois

General registration will open May 15, 2011

THEME “ APN’S SAILING THE WINDS OF CHANGE”

DATE AUGUST 17-19 2011

strategic analysis. Use the pre-existing policy template your facility or network already uses. This will save you time and effort. Once written and concurrence is won among your group members, make a presentation before your facility director or nurse executive. By authority of the highest official, your group can then get started doing meaningful effective work.

Once you have organized and become an authorized group, then it is time to call a first formal meeting. Invite every qualified person. The first meeting is devoted to welcoming introductions and selecting group leaders. Election of officers by the group members ensures a group with genuine, democratically selected leaders accountable to the members. A chairperson or president, vice president, treasurer and secretary are basic and well-known offices. You may add other offices according the needs and functions of the group. Define authority and expectations of officers from the start and write this into your charter. Use V-tel and other technologies to allow access for APRNs at community based outpatient centers and elsewhere.

Once your group meets, adopt structures that permit orderly work. Organize yourselves by internal-email as a group. Write and publicize the meeting agenda well in advance of each meeting. Make sure anyone with an interest knows how to get to meetings and voice her/his ideas or concerns. Write minutes of each meeting. These documents make the official record of your group's decisions and they capture key points of discussion. Most often minutes record date, time, location of a meeting and who was present and the main topics discussed or acted on. Minutes are circulated to members of the group for correction and acceptance before they are approved for wider distribution and archiving.

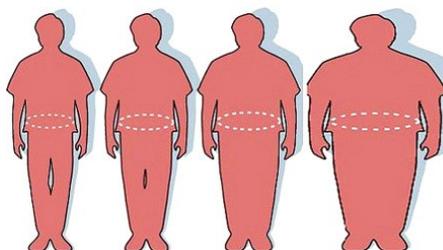
The introduction of your group can have disruptive effects. Leaders may not know how to accommodate your group and may feel threatened by a new group of higher-caliber professionals. They may not know where you fit in the organization. The ordinary APRN may not identify with the group or reject its people and processes. Failed groups become insulated from new, varied or diverse ideas and viewpoints. They can perilously fall into "groupthink." Leaders' bias may stifle varied input from members. Counterproductive forces affect group dynamics and stability. We are "human, all too human" [Nietzsche] after all. Progress may go slow and volunteers may wane from the effort doing collateral duty such as this. Consequently, group leaders can regularly check your expectations against your values and vision.

By remaining open and welcoming to any APRN, your group enriches professional community within your facility; its discussion of issues is enhanced; its decisions and work are validated by diverse input. As the late Senator Paul Wellstone of Minnesota said, "we all do better when we all do better." Bring together APRNs. Demonstrate that organizational commitment to professional nursing is a driver of high quality care for the veterans.



About the author: Peter Mitchell is in his 9th year at the Minneapolis VA Health Care System. He has worked as a nurse practitioner in the medicine clinic, urgent care and currently in occupational health. Peter's travels have taken him to central Bolivia twice and to Iceland.





The Obesity Epidemic...is Orlistat an Option?

The use of Orlistat in Primary Care

Susan Croteau, RN, MS, & Laura Chapman, RN, MS

Obesity has become an epic problem for Americans. The Centers for Disease Control (CDC) calls the American society obesogenic meaning that our society has made it easy to support the individual in becoming obese (CDC, 2011). American trends in obesity seem to meet new limits with each passing year. In 1985, the heaviest eight states had of 10 – 14% of their population being obese (having a body mass index (BMI) of >30). By 2009 the map is astoundingly different with nine states having greater than or equal to thirty percent of their population considered obese, and twenty five states with 25 – 29% of their population considered obese. These trends are a remarkable change, in the wrong direction, for such a relatively short period of time. The statistics from the CDC are astounding, considering all of the research which points to many health conditions associated with obesity, including diabetes mellitus, heart disease, joint disease, depression, and sleep apnea. This article will examine what the APRN can do to assist patients with weight loss, specifically looking at the use of Orlistat.

In evaluating the obese patient, a complete history and physical exam must be completed. The history includes questions about weight milestones, diet history (number of meals per day, snacks), home and work stressors, amount and type of physical activity completed weekly, types of past diets and results, personal and family medical history including diabetes, cardiovascular disease, thyroid disease, hypertension, arthritis, mental health problems, symptoms of sleep apnea, current use of tobacco and current medications (Uphold & Graham, 2003). The physical exam should include weight, waist circumference, height, blood pressure and complete body exam, noting the presence of acanthosis nigricans, intertriginous dermatitis in skin folds. Diagnostic tests include fasting lipid profile, glucose, and chemistry. Consider the possibility that obesity is related to pituitary/adrenal dysfunction, hypothalamic disease, thyroid and polycystic ovarian disease. Patients with a BMI of ≥ 30 and those with a BMI of 25-29.9 and a waist circumference of >35 in women and >40 in men and at least two additional risk factors should be advised to lose weight. Diet, physical activity, and behavior therapy are the first lines of treatment. Consider adding pharmacotherapy for patients with BMIs >30 and in those that have not lost one pound per week after six months of combined therapy (Uphold & Graham, 2003).

Orlistat (Xenical) aids weight loss by inhibiting pancreatic and gastric lipases, inhibiting approximately 30% of fat absorption. Side effects include decreased absorption of fat soluble vitamins, soft stools, abdominal cramping, oily stools, bloating and anal leakage. Patients should be scheduled follow up appointments in two to four weeks after beginning medication therapy, monthly for three months, every three months for the first year (Uphold & Graham, 2003). Weight, blood pressure, pulse should be checked at each visit and side effects should be discussed at each visit as well as conducting follow up lab tests. Fat soluble vitamin supple-

Orlistat, continued.

mentation should be considered (Goroll & Mulley, 2006, Arcangelo & Peterson, 2006). Vitamins should not be taken within two hours of Orlistat administration. It is contraindicated in patients with chronic malabsorption syndromes or cholestasis. Concomitant administration of Orlistat and cyclosporine can cause a drug-drug interaction resulting in lower levels of cyclosporine. Orlistat and cyclosporine should not be taken within two hours of each other. Orlistat is pregnancy category B medication and is not recommended to be taken during pregnancy or breastfeeding.

Orlistat should be prescribed at 120mg three times a day. It should be taken during or within one hour of ingesting a meal containing 30% or less fat. It should not be taken with meals that contain no fat. Max daily dose is 360mg. Daily intake of fat, carbohydrates and protein should be equally distributed over three main meals. Use of Orlistat has not been studied beyond four years.

Weight loss of up to 10%, improvements in lipid profiles and optimized insulin levels have been found in several studies of Orlistat (Goroll & Mulley, 2006). Overall, after one year, patients on Orlistat plus diet lost 13.4 pounds compared to 5.8 pounds in patients on a placebo plus diet. Five studies have shown that patients on Orlistat were five times more likely to maintain a 10% body weight loss compared to patients on placebo. The studies have shown that just under 9% of participants stop the use of Orlistat due to the side effects. In the Louisiana Obese Subjects Study (LOSS), the use of usual care condition for weight loss was compared to patients undergoing intensive medical intervention (IMI) in primary care settings (Ryan, et al, 2010). IMI included the use of a low calorie liquid diet, behavioral counseling, structured diet and the use of sibutramine, Orlistat or diethylpropion hydrochloride. Thirty-one percent of patients in the intensive management group had a weight loss of 5% of their body weight compared to 9% of those in the usual care group. Additionally, 7% had a weight loss of 21% of their base weight in the intensive group compared to 1% of those in the usual care group, demonstrating that primary care practitioners can effectively reduce obesity through the use of multiple interventions and concentrated management strategies, including pharmacotherapies (Ryan, et al, 2010).

Use of Orlistat may also slow the development of diabetes. A study by Heymsfield, et al, 2000, provided evidence that patients with impaired fasting glucose but were taking Orlistat progressed to diabetes type II at a slower rate (3%) compared to those on placebo (7.6%). More patients who had impaired fasting glucose at baseline had normalized glucose at the end of the study, 71.6% compared to 49% of those on placebo.



About the authors: Laura Chapman and Susan Croteau are Nurse Practitioner students with Clemson University, both completing their final clinical rotations at the Greenville SC OPC. During their clinical rotation, they have been instrumental in starting the MOVE program at the Greenville CBOC and counseling Obese patients on the use of Orlistat and life style changes for weight loss and healthy living. Susan has worked for the VA for 18 years and is currently the nurse manager of the Spartanburg SC OPC.

Nursing care comes in many forms. Sometimes it is the ability to make someone feel physically comfortable by various means. Other times it is the ability to improve the body's ability to achieve or maintain health. But often it is an uncanny yet well honed knack to see beyond the obvious and address, in some way, the deeper needs of the human soul.

~Donna Wilk Cardillo, A Daybook for Beginning Nurses

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APRN Spotlight:

Dr. Penny Kaye Jensen, VA NP Salt Lake City, AANP President

Dr. Jensen is a board certified Family Nurse Practitioner at the George E. Wahlen Veteran Affairs Medical Center in Salt Lake City, Utah and Assistant Professor at the University of Utah College of Nursing. She became President of the American Academy of Nurse Practitioners (AANP) in 2010 after serving as a state and regional director. In addition to serving as President of AANP, representing 140,000 NPs nationally, she is an appointed member to the Joint Commission Ambulatory Professional and Technical Advisory Committee (PTAC) 2010-2012 and The United States of Veterans Affairs, Office of Academic Affiliations Primary Care Medical Home Academic Subcommittee 2010-2011. Dr. Jensen was in the first cohort of DNP students in the University Of Utah College Of Nursing. She was inducted as a Fellow of the American Academy of Nurse Practitioners in 2006. This honor is held by less than 1% of NPs in the nation. Dr. Jensen speaks routinely on the subjects of health care reform, access to care and health care policy. She has briefed a panel of U.S. congressional officials on the role nurse practitioners will play in the future of primary care delivery. She was invited and attended an exclusive briefing by the Robert Wood Johnson Foundation for a small group of nursing leaders before the public release of the IOM Future of Nursing Report.

In an interview on a webcast debate sponsored by Modern Healthcare, Dr. Jensen emphasized that this is an exciting time to be a Nurse Practitioner (NP) due to the national focus on healthcare reform. Discussion has centered on access to healthcare for millions of Americans, and NPs are well-positioned to revolutionize access to comprehensive, cost effective, high quality, personalized and patient-centered care. It is her goal to continue to increase the public awareness of NP practice and advocate for the profession. NPs need to speak with a unified voice. AANP is building coalitions with other NP organizations, other healthcare providers and stakeholders. She will continue to advocate for licensed independent practice for NPs in each of our states.

Looking ahead to the future of the NP profession, Dr. Jensen points out that the nation is currently experiencing a shortage of primary care providers and this trend looks to continue. Changes in the healthcare system are inevitable and whatever system emerges from the current reform efforts, NPs will play a dominant role in improving Americans' access to primary care.

Dr. Jensen believes that on a daily basis, NPs have an opportunity to impact the public's perception about NPs, our abilities, and those we serve. NPs are constantly challenged with countering misinformation or verifying the positive outcome data that are published, but unfortunately we spend a large amount of time correcting misleading or erroneous information reported by the media.

VA APRNs are pleased that Dr. Jensen is representing NPs in such a positive light and working toward goals that will benefit both NPs and the public, including the Veterans we serve daily. We congratulate her on her accomplishments and wish her great success.

By : Rebecca Waldon, NP, APNAG Representative VISNS 9 & 10 with appreciation to "Clinician Reviews" September 2010-Volume 20, Number 9.



VA Establishes Centers of Excellence in Primary Care Educators

In August, 2010, VA issued a request for proposals to establish **Centers of Excellence in Primary Care Education**. Part of the VA's New Models of Care initiative, the centers will utilize VA primary care settings to develop and test innovative approaches to prepare health professions trainees (including physician residents, nurse practitioners and others) for primary health care practice in the 21st Century.

After a very competitive peer review process, five VA Medical Centers were selected: **Boise, Cleveland, San Francisco, Seattle and West Haven**. Each Center for Excellence will be funded at a level of approximately \$1 million per year for five years (funding beyond fiscal year 2011 will depend on VA's budget allocation). In addition to this core programmatic support, VA will make available additional trainee positions and funding, as necessary.

VA has also established the **Educational Centers of Excellence Coordinating Center**. The Coordinating Center will oversee the overall project, facilitate collaboration across sites, and disseminate lessons learned within VA and throughout the national academic community. It is anticipated that sites will take different approaches to curriculum and faculty development, interprofessional learning, trainee and program assessment and the long-term sustainability of innovations. The Coordinating Center will work closely with the approved sites to develop and implement a comprehensive evaluation plan for the project.



Updated VA/DoD Diabetes Guidelines

By Sharon A. Watts DNP, RN-C, CDE Louis Stokes Cleveland VA

The VA/DoD diabetic guidelines have recently been updated. An inter-professional collaborative team of experts reviewed the latest high level evidence to ensure safety and optimal patient outcomes with their unbiased recommendations. The guideline supports shared provider and veteran decision making and assisting the incorporation of individual preferences into an agreed upon care plan for diabetes. This is an excellent resource for the APRN, to review the most up to date literature and recommendations in the rapidly changing world of diabetes. I highly recommend you visit the site if you have not already done so to see for yourself the quality of work put into compiling this document. As professionals we need to be cognizant of the conflicting interests and biased advertising that our veterans are bombarded with daily for the latest and purportedly greatest treatment of diabetes. These guidelines represent a compilation of solid science and discernment of safe best practices for the veterans we serve. Some important highlights of this revised Guidelines/Toolkit include:

- Comprehensive review of evidence
- A1c targets are individualized not generalized at 7% (to promote patient safety from hypoglycemia)
- BP goal < 140/80 (A level evidence, ACCORD, VADT)
- Diagnosis of Diabetes with an A1c of 6.5% and confirmed with a FPG ≥ 100 mg/dl and > 126 mg/dl

Diabetes, continued from previous page

- No supporting evidence found for routine SMBG in patients not on insulin
- Discussion of how to interpret A1c test results in the context of laboratory variation due to assay accuracy and precision. (Do you know how your laboratory performs?)
- Importance of shared decision making to negotiate glycemic targets

The new VA/DoD Management of Diabetes Mellitus Clinical Practice Guideline is available at http://www.healthquality.va.gov/Diabetes_Mellitus.asp

VHA APN 2011 CONFERENCE UPDATE

SAVE THE DATE!!!!

CONFERENCE THEME “APRN’S SAILING THE WINDS OF CHANGE”

DATE AUGUST 17-19 2011

LOCATION CHICAGO ILLINOIS



The APN Conference planning committee has been meeting twice monthly to develop the 2011 National APRN Conference. We are excited to announce that approval has been received from VACO for 350 attendees. Registrants will be required to seek funding through their individual facilities in the same manner as for any conference. The conference agenda includes many topics relevant to VHA APRNs including: Opening session with Cathy Rick, Dr. Ruth Kleinpell on APN outcome research, Sharon Johnston from Office of General Counsel speaking on Federal Supremacy, Barbara Bancroft on Pharmacology for APRNs and many other exceptional plenary sessions. Breakout sessions include practice, research, and APRN issues tracks. There will be a poster sessions focusing on APRN research and Evidence-based Practice projects. There will be opportunities to network with other VHA APRNs including those from your own VISN. The conference will be 2 ½ days with the last day starting early in the morning and ending at 11:30 on the third day. CEU’s will be awarded for complete attendance for the first two days and a separate certificate will be awarded for the final ½ day which is focused on pharmacology. Abstracts are being accepted until April 29. General registration will open in May and information will be emailed to VHA APRNs via electronic email groups. For questions please contact(Julie.Marcum@va.gov) or Nora Krick (Nora.Krick@va.gov).

NURSES TRUSTED to CARE



National Nurses Week is celebrated annually from May 6, also known as National Nurses Day, through May 12, the birthday of Florence Nightingale, the founder of modern nursing.

Often described as an art and a science, nursing is a profession that embraces dedicated people with varied interests, strengths and passions because of the many opportunities the profession offers. As nurses, we work in emergency rooms, school based clinics, and homeless shelters, to name a few. We have many roles – from staff nurse to educator to nurse practitioner and nurse researcher – and serve all of them with passion for the profession and with a strong commitment to patient safety.



HAVE YOU BEEN PUBLISHED?



**Submit your articles or newsworthy items
for publication in the APRN newsletter!**

For questions or more information:
Send inquiries to Donna.becker@va.gov