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Cooper Bridges

A publication for nurses and healthcare professionals

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A Promising Future for Preventing the Spread of HIV/AIDS

Implementing the CDC Guidelines for Universal HIV Screening

Table of Contents:

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Conners-stephanie@cooperhealth.edu

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To Our Exceptional Nurses and Collaborative Teams,

National Nurses Day is celebrated each year in May to mark the contributions nurses make to society. It gives us great pleasure to celebrate our outstanding nurses and collaborative care teams during this national dedication period. You are the heart of our care delivery system, and our success as an organization is highly dependent on the exceptional care that you provide to all those we serve. More than ever before, nurses are stepping out of their traditional roles and becoming active contributors and innovators in the transformation of healthcare. Your ability to excel, despite obstacles, demonstrates your belief in yourself and strong commitment to your profession. You should be proud of the countless successes you have achieved, and know that you serve as a role model at Cooper.

Many of our team members have been recognized by colleagues and leaders as individuals who promote and foster an optimal healing environment with pride and tireless dedication. Through your commitment to excellence, you are leading Cooper Nursing in our quest to provide the highest safety, service and quality in a fiscally responsible way.

Nurses are paramount in our mission to serve, to heal, to educate. We recognize you as the real heroes in Saving Lives, Saving the World.

It is a privilege and honor to lead Cooper Nursing and the collaborative care teams. Thank you for all you do!

**If you save a life, you're a hero.
If you save a hundred lives, you're a nurse."**

AUTHOR UNKNOWN

Stephanie and Lisa

Email comments to **Conners-Stephanie@cooperhealth.edu** or **Laphan-Lisa@cooperhealth.edu**

Cooper Bridges Mission:

"To communicate and educate nurses and healthcare professionals to foster excellence in the delivery of patient care."

Cooper Nurses interested in authoring an article for a future edition of *Cooper Bridges* may obtain submission guidelines by contacting: **Staman-stacey@cooperhealth.edu**

Bedside Shift Report

Conor Cahill, BSN, RN

Abstract

Traditionally, nurses give each other report, face to face, at the nurses' station. This method has been used for years by nurses to exchange patient information during change of shift. These reports can sometimes be lengthy; the oncoming nurse may not see their first patient for up to an hour. During this "alone time", sentinel events are more likely to occur (Ofori-Atta, Brinienda, & Chalupka, 2015). These events include falls or changes in the patient's condition. In addition, the time gap decreases nurse-patient communication leading to patient dissatisfaction.

Bedside shift report, an alternative to traditional report, has been shown to improve patient-nurse communication leading to increased patient safety and satisfaction (Radtke, 2013). This alternative approach involves the patient during change of shift report. During this time, patients and families are able to ask questions regarding their care, voice any concerns and become updated on their plan of care. Additionally, mistakes or discrepancies in nursing report are less likely to occur because both nurses are at the bedside performing a congruent assessment of the patient and the surroundings.

Bedside shift report, an alternative to traditional report, has been shown to improve patient-nurse communication leading to increased patient safety and satisfaction.

Literature includes 3 studies that examined the effectiveness of bedside shift report in the acute care setting. One study focused on the communication technique during bedside shift report. The acronym SBAR (Situation, Background, Assessment, Recommendation) was designed for health care professionals to communicate effectively with each other and exchange important patient care information during report. The study concluded that overall, patients felt more comfortable asking questions regarding their health and more reassured that different members of the team were on the same page (Baker, 2010). Another study conducted surveys with a medical-surgical intermediate care unit, to examine the effectiveness of the introduction of bedside shift report. Surveys were handed out to patients upon discharge before and after the introduction of bedside shift report. Results included an increase of patient satisfaction from 75% to 87.6% (Radtke, 2013). The final study examined the implementation of the Transforming Care at Bedside (TCAB) process versus a control group with traditional nursing practices (Dearmon, 2013). The TCAB process consisted of improvement ideas initiated by staff members to help better care for their patient needs. Improvement ideas included bedside shift report, hourly rounding, and plan of care boards (providing patients with their plan of care, pain severity rating (1-10) and when the next pain medication is due). The unit held weekly staff meetings in which ideas could be brainstormed and put into practice. TCAB was utilized on a general surgery, orthopedic, and trauma unit. The control group was a medical unit, which provided care to patients diagnosed with stroke, oncology, HIV, and sickle cell disease. The Medical Unit did not use TCAB. The study showed an increase in pain control and patient satisfaction, as well as a significant decrease in the amount of time required to answer call bells.

Utilization of bedside shift report has been shown to be effective in improving nurse-patient communication, patient satisfaction, and comfort. It has also been shown to decrease "alone time" during change of shift, leading to a decreased risk of deterioration in patient condition during this time. Given this information, organizations would benefit adopting bedside shift report in order to better satisfy the needs of their patients.

Email comments to **cahill-conor@cooperhealth.edu**

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A Promising Future for Preventing the Spread of HIV/AIDS: Implementing the CDC Guidelines for Universal HIV Screening

Christina Y Smith MSN, RN, NE-BC, CPHQ; Lucy Suokhrie MSHCA, BSN, RN-BC

The first reported case of the retrovirus was reported over 30 years ago which came to be known as Human Immunodeficiency Virus (HIV). Infection with HIV, if untreated, leads to Acquired Immunodeficiency Syndrome (AIDS) and premature death. There is still no cure for HIV infection, but patients diagnosed through universal screening can be managed to live healthier, longer lives without developing AIDS (CDC, 2011).

Despite many successes, there is still much work to be done to stop the epidemic. According to the Center of Disease Control (CDC), HIV has claimed an estimated 600,000 Americans and more than 25 million people worldwide. In the United States, 1.2 million people are living with HIV and 1 in 8 (13%) are unaware of their infection because they have not been tested. Since the height of the epidemic in the mid-1980s, the annual number of new HIV infections in the United States has been reduced, however the estimated incidence of HIV has remained virtually unchanged with about 50,000 new HIV infections per year (CDC, 2013).

Within the overall estimates, however, some groups are affected more than others. Men who have sex with men (MSM), gay and/or bisexuals, continue to bear the greatest burden of HIV infection. Among races and ethnicities, African Americans continue to be disproportionately affected. At lower rates, heterosexuals and injection drug users also continue to be affected by HIV.

The HIV care continuum—also referred to as the HIV treatment cascade—is a model that outlines the sequential steps or stages of HIV medical care that people living with HIV go through from initial diagnosis to achieving the goal of viral suppression (a very low level of HIV in the body). The HIV care continuum consists of several steps required to achieve viral suppression. Specifically, the CDC tracks the proportion of people with HIV who are 1) diagnosed with HIV infection, 2) linked to care, meaning they visited a heath care provider within three months after learning they were HIV positive, 3) engaged or retained in care, meaning they received medical care for HIV infection, 4) prescribed antiretroviral therapy to control their HIV infection and 5) virally suppressed, meaning that their HIV viral load – the amount of HIV in the blood – is at a very low

level. By tracking the proportion of people living with HIV who are engaged in each of the five separate steps of the HIV care continuum, federal and state health agencies can identify gaps and, over time, pinpoint how, where and when to intervene to improve outcomes along the continuum **(see figure 1)**.

Of the 1.2 million Americans living with HIV in 2011, CDC data showed that 40% were engaged in HIV medical care, 37% were prescribed antiretroviral therapy (ART) and 30% had achieved viral suppression. In other words, only 3 out of 10 people living with HIV had the virus under control. AIDS-related deaths occur when people who are infected do not receive the testing, treatment and care they need.

HIV testing and diagnosis are the entry points of the HIV care continuum. The incorporation of HIV screening as part of a medical encounter can make great strides toward reducing the stigma that surrounds HIV. This routinization may one day place HIV screening in the same category as cholesterol screening and testing for other medical conditions. In 2006, the CDC's revised guidelines recommend that all patients ages 13 to 64 be screened for HIV. Many other professional groups, such as the American College of Physicians, advise routine patient screening as well. Unfortunately to date, routine universal screening, followed by appropriate care and treatment, has not been achieved in the U.S. The revised guidelines focus on increasing the number of health care facilities in which screening for HIV is routine, fostering earlier detection of HIV infection, identifying and counseling persons with unrecognized HIV infection, linking them to clinical and prevention services and further reducing perinatal transmission of HIV in the United States (Fenton, 2007, p. 213).

Fear and stigma continue to be a significant barrier to voluntary HIV testing and implementation of a routine universal "opt-out" screening can help overcome this barrier. Opting out simply means advising the person with unknown status that HIV testing is recommended regardless of risk factors and will be included in the routine labs ordered for them unless he or she declines. Opting out of HIV testing, rather than opting in, has been shown to encourage acceptance and agreement with testing (Branson et al., 2006). In a study published in the British Medical Journal (online) Journal of General Medicine, researchers demonstrated that small changes in wording can significantly affect patients' behavior and lead to clinically and statistically significant differences in test acceptance percentages (Montoy, Dow & Kaplan, 2016). This approach is very different from the previous guideline which included extensive counseling and testing, typically accompanied by written informed consent.

Figure 1

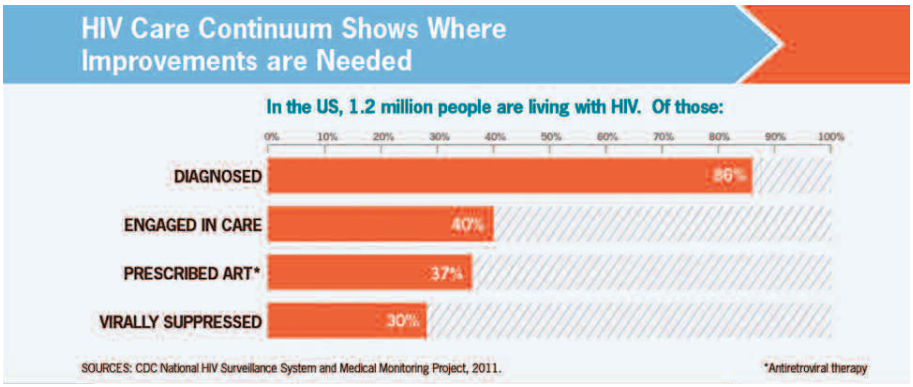
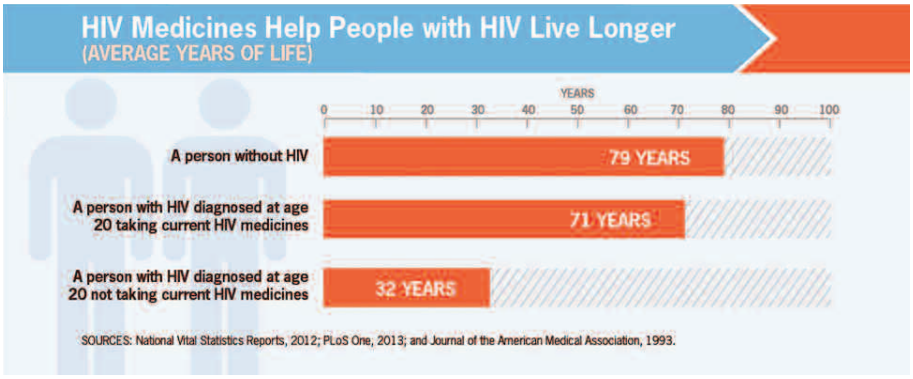


Figure 2



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A study published in 2015 by the Journal of the American Medical Association found that about 30% of new HIV transmissions were reportedly transmitted by people who are living with undiagnosed HIV (Skarbinski et al, 2015). Routine universal screening will identify asymptomatic people who are infected with HIV but who might otherwise go undetected until late in the course of an infection. It is essential to identify people for their own personal health and the health of others to whom they may unknowingly transmit the virus (Moyer, 2013). Because of advances in the care of HIV infection, early treatment is essential, both for individual benefit and for decreasing the likelihood of transmission. Taken together, there is a clear public health imperative to screen for this infection.

> "Fear and stigma continue to be a significant barrier to voluntary HIV testing and implementation of a routine universal "opt-out" screening can help overcome this barrier."

In the second and third phases of the HIV continuum, linkage and retention in medical care is extremely important. Knowledge of the infection has a direct impact on the health and well-being of that person, their loved ones and their community. Once an individual is diagnosed with HIV, people tend to take steps to protect their partner(s) ultimately preventing new infections. In 2012, the CDC reported that only 54% of all people with diagnosed HIV infection were engaged in care. Therefore, interventions that increase the likelihood that

According to the CDC, taking ART the correct way every day can reduce an HIV-positive person's chance of transmitting HIV by as much as 96%.

A comprehensive continuum of services is needed to ensure that all persons living with HIV infection receive the HIV care and treatment needed to achieve viral suppression.

people will seek and receive ongoing medical care are essential. Although some of those identified will have reasonable access to good treatment, it is crucially important to ensure proper linkage to care in community settings (Thompson et al., 2012).

Stanford University School of Medicine researchers demonstrated that screening all Americans for HIV at least one time in their lives, as well as more frequent testing for those at higher risk of contracting the disease, could prevent 212,000 new infections over the next 20 years. The study is the first to use a national model of HIV transmission to gauge the impact of scaling up screening and treatment. They projected that 1.23 million people would become newly infected in the next 20 years if things remained as they are today (Richter, 2010). In 2015, Nakagawa and colleagues assessed the association of improved HIV diagnosis, linkage to initial HIV care, and retention in HIV care and the projected lifetime cost associated with HIV infection. They suggest the main cost savings attributable to optimal engagement-in-care come from the prevention of HIV transmission to others. A single prevented HIV infection in the US saves the healthcare system lifetime $300,000 to $500,000. One hundred thousand prevented HIV infections could save $30–$50 billion (Nakagawa et al., 2015).

While a significant first step, screening alone is not sufficient to stem the HIV epidemic. Once considered a death sentence, HIV is now viewed as a chronic but manageable disease in patients who have access to medication and who achieve viral suppression, the fourth and final phases of the HIV continuum. Considerable improvements in survival among patients with HIV have occurred since the introduction of combination ART, as these drugs have become more effective, simpler to use and better tolerated over time. Studies have consistently shown that ART helps increase the lifespan of people with HIV and reduce risks for new infections (Lima et al., 2007). Based on the current patterns of ART use, a 20-year old on ART today in the U.S. or Canada would expect to live into their early 70s **(see figure 2)**.

People living with HIV are also less likely to infect others if they are on ART treatment as it lowers the amount of virus in their systems. According to the CDC, taking ART the correct way every day can reduce an HIV-positive person's chance of transmitting HIV by as much as 96%. Reducing the community viral load is not unlike recommendations to reduce secondary smoke exposure or trans-fat content in foods. Expanding testing and treatment improves individual health, but also reduces community-level morbidity and infection (CDC, October 2013).

(continued on page 9)

A Promising Future for Preventing the Spread of HIV/AIDS

(continued from page 7)

State and local health departments, community-based organizations and health care providers need to collaborate to identify and reduce undiagnosed HIV infections and ensure that comprehensive services promoting linkage to, and engagement in, HIV medical care are available to all persons diagnosed with HIV. A comprehensive continuum of services is needed to ensure that all persons living with HIV infection receive the HIV care and treatment needed to achieve viral suppression. Only with success at each step in the continuum can the ultimate goals of improving health, reducing disparities, extending lives and preventing further HIV transmission be achieved (Bradley et al., 2014).

We can achieve greater impact in the communities we serve by reducing the individual and societal burden of HIV/AIDS care and treatment.

Eliminating HIV is possible. A deliberate focus on universal testing and immediate treatment is the most promising method of ultimately ending the HIV/AIDS epidemic. We can achieve greater impact in the communities we serve by reducing the individual and societal burden of HIV/AIDS care and treatment.

Email comments to **Smith-christina@cooperhealth.edu** or **Suokhrie-lucy@cooperhealth.edu**

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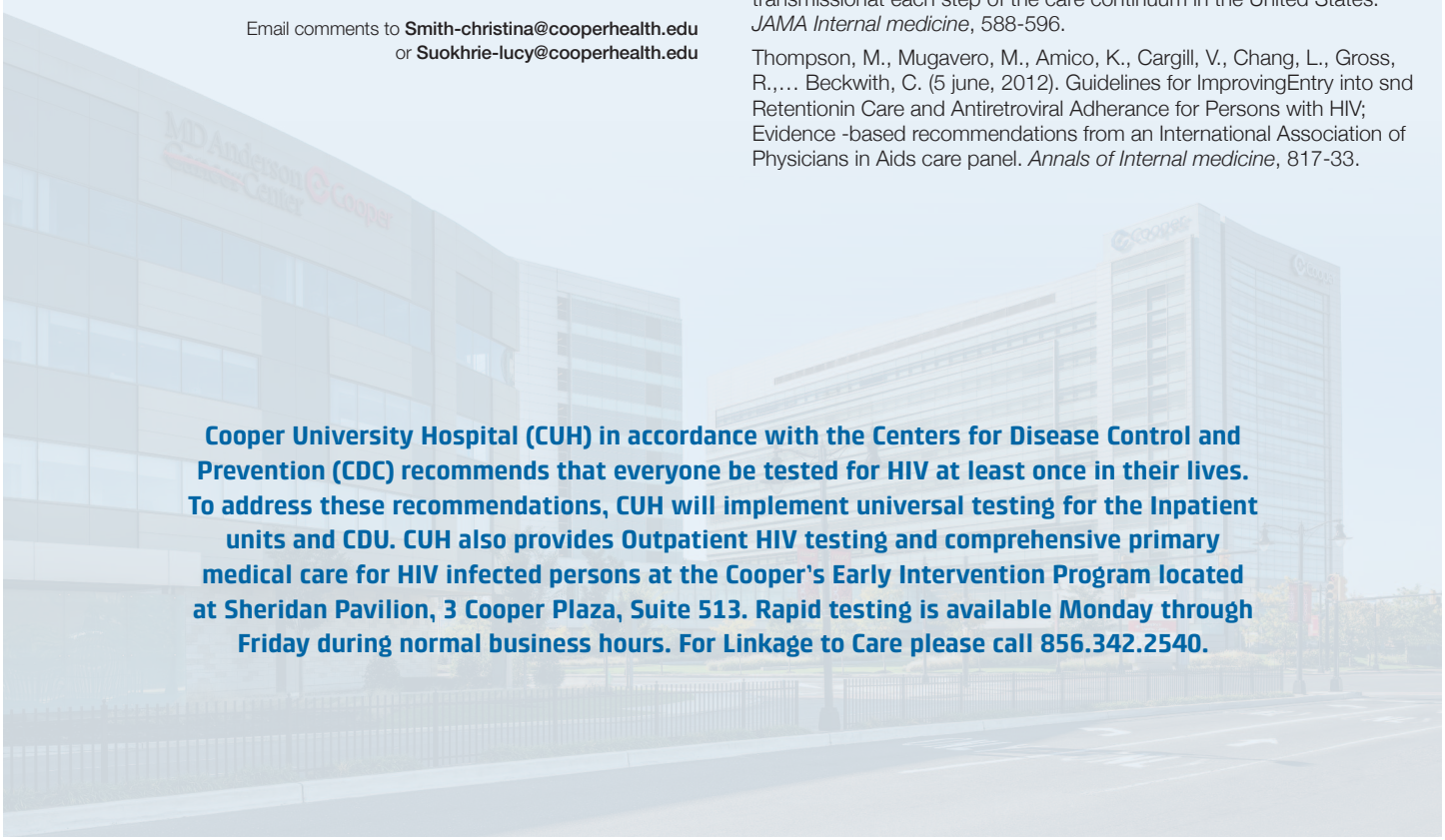

Cooper University Hospital (CUH) in accordance with the Centers for Disease Control and Prevention (CDC) recommends that everyone be tested for HIV at least once in their lives. To address these recommendations, CUH will implement universal testing for the Inpatient units and CDU. CUH also provides Outpatient HIV testing and comprehensive primary medical care for HIV infected persons at the Cooper's Early Intervention Program located at Sheridan Pavilion, 3 Cooper Plaza, Suite 513. Rapid testing is available Monday through Friday during normal business hours. For Linkage to Care please call 856.342.2540.

Cooper Air Medical Services: Care in the Air

Stephen Teitelman, BS, RN, CEN, CCRN-CMC, CFRN, CTRN, TCRN, FP-C, NR-P

When an acute injury or illness occurs, we rely on safe, rapid transportation to an appropriate healthcare facility. One of these modes of transportation is helicopter transport. Since April of 1944, helicopters have been used to transport patients to the hospital, with a "large scale implementation of helicopters for the dedicated transport of injured troops" during the Korean War in early 1950. The first hospital-based program in the US was developed in Colorado in 1972 (Smith & Sidwell, 2013). Today, the field of Air Medical Services, (also known as HEMS) is a robust system that is present in all 50 US states.

The mission statement of Cooper University Health Care (CUHC) states that we are "committed to world-class patient care, education and research resulting in a healthier community." For over a hundred years, CUHC has provided care to the residents of Camden as well as the outlying communities in Southern New Jersey. CUHC has expanded from a small community-based hospital into a tertiary care facility providing University Hospital-level care to the critically ill and injured in our region. We offer multiple services in multiple locations throughout the area. Since December of 2010, CUHC has also provided Air Medical Services to the surrounding communities in order to provide rapid transportation to patients in need of time-sensitive life-saving care.

Cooper Air Medical Services completed its first patient flight in December of 2010. Initially named "Air Two" from a prior partnership, the flight team is now "Cooper One," and currently has a partnership with Metro Aviation to provide our EC-135 helicopter and expert aviation services. Our partnership with Inspira Health System provides flight paramedic services. Cooper One is hangered in Millville at Millville Municipal Airport. Flight crew members work 12 hour shifts around the clock to provide services 24 hours a day/7 days a week. In addition to patient transport, flight crew responsibilities include outreach education, Quality Assurance via chart review, policy review and ongoing training. During public relation events, the crew enjoys demonstrating the aircraft and providing education about services to the region's communities.

Those unfamiliar might ask the question, "What does a flight nurse or flight paramedic do?" Patient flights can be either scene flights or inter-facility transfers. For scene flights, CUHC provides air medical support to the region's ground EMS providers. "The amount of time that elapses between injury and definitive care is a

critical factor in the survival of critically injured patients" (Brown & Gestring, 2013). Traumatically injured patients, those with Acute Coronary Syndromes and Stroke patients all require rapid transport for time-sensitive evaluation and interventions. Ground transport times to an appropriate facility can sometimes exceed 60 minutes and air transport can drastically reduce these times and save lives. Air Medical Services are preferable over ground transportation when ground transport times exceed thirty minutes due to distance, traffic and/or terrain.

For inter-facility transfers, Cooper One retrieves patients from referring hospitals and transports them to CUHC, or other facilities depending on the assignment. The referring hospital may request a patient transfer when specialized care (such as advanced cardiac, pulmonary or surgical critical care) is deemed necessary. CUHC, as the region's only Level One Trauma Center, also offers specialized care in vascular emergencies and trauma surgical care.

From the moment of patient contact at the bedside until the patient has arrived at the hospital, the flight nurses and paramedics maintain high levels of care. This care can include a wide range of skills such as management of IV medication infusions, airway/ventilator management, pain management and the initiation of new medications. Many of these patients are critically ill or unstable. Though our transport times are usually less than 45 minutes, we are often working very hard during the flights to keep our patients stable.

Flight nurses and paramedics are providers with specialty training that work together as a team. Nurses and paramedics complement each other's skill set to provide well-rounded care. Flight paramedics are preferred to have at least five years of experience working for a busy service. Experience in critical care ground transport is preferred, although not required for hire. Flight medics have additional training in critical care giving them exposure and familiarity with the management of critically ill patients including mechanical ventilation and critical care medication infusions.

Flight nurses bring their experience from working in-hospital and for ground Specialty Care Transport Units. Our nurses have many years of critical care experience (ICU, CCU, CTICU, NICU, PICU, ED) in addition to EMS experience. Providers must have the ability to work autonomously in austere environments. A flight crew's work is mainly protocol-based, with on-line Medical Command available for support (which is required for scene calls as per state regulation). Additionally, flight nurses are required to have specialty nursing certifications upon hire. Both paramedics and nurses are required to obtain their specialty flight certification within a year of hire. Being knowledgeable about flight safety is a requirement as part of the air medical team.

Cooper One supports CUHC referrals and extends our healthcare system's care to the southern-most areas of the state. It is our expectation to continue representing Cooper University Health Care while providing excellent, world-class care to patients transported by air.

Email comments to **Teitelman-steve@cooperhealth.edu**

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Cooper 1 flight crew members work 12 hour shifts around the clock to provide services 24/7. Shown from left, Flight Medic Dominic Parone, Pilot Keith Dunbar, Pilot Kosuke "Jack" Yamada and Flight Medic Steven Channell.

Prevention of Cardiovascular Disease in Women through Physical Exercise

Shannon Rodman, BSN, RN

Abstract

Implementation of change is needed in order to keep organizations up to date with evidence-based practice and to increase patient quality of care. The American Heart Association (2011) recommends a guideline for physical activity practices in order to prevent cardiovascular disease in women. In order to implement this change into practice, barriers from both the organization and the patients' own personal barriers need to be resolved. Once the barriers are addressed, the change can help increase the quality of care received by the patients.

Proposed Change in Practice

There is no specific amount of exercise that can be deemed healthy for every woman in the world. Due to everyone having different genetics there is no specific type of exercise that can be generalized for everyone. According to a new guideline by the American Heart Association, there is a recommendation of physical activity that should be taken into consideration for those who want to prevent cardiovascular disease. This recommendation shows the suggestions for preventing cardiovascular disease in women, including what physical activity should be incorporated into

daily living. Instead of thirty minutes of exercise, three times a week, many people are used to hearing; the American Heart Association includes specific types of exercise and the amount of time each should be practiced. Per the guideline, women should have at least 150 minutes per week of moderate exercise, 75 minutes per week of vigorous exercise, or a combination of vigorous and moderate intensity aerobic physical activity. Aerobic activities should be performed in at least 10 minute episodes. Women who want to achieve cardiovascular benefits should perform moderate intensity aerobic exercises 5 hours per week, or vigorous intensity activities 2.5 hours per week. Muscle strengthening exercises that encompass all muscles of the body should be performed more than 2 days per week and for women who want to lose or sustain weight loss 60-90 minutes of moderate intensity exercise are needed every day of the week (American Heart Association, 2011).

Target Groups

The guideline is recommended for women who are older than 20 years of age, especially those at risk for cardiovascular disease. This could include women with family history, past medical history and lifestyle choices.

Per the guideline, women should have at least 150 minutes per week of moderate exercise, 75 minutes per week of vigorous exercise, or a combination of vigorous and moderate intensity aerobic physical activity.

Perceived Strengths and Barriers

There will always be barriers when trying to implement new findings into care. When looking at the relationship between women and physical activity there are many factors that come into play that can persuade or dissuade women from exercising. Based on research by Thomson, Buckley, & Brinkworth (2016), there are many factors that are perceived strengths/benefits of physical activity for women. They found that women's perceived benefits of exercising included improving their overall cardiovascular function, improving the way their bodies look and increasing the levels of their own physical fitness. Preventative health was also reported as a perceived strength of physical activity (Thomson, Buckley & Brinksworth, 2016).

Unfortunately, the perceived strengths are not what will stop new evidence from becoming normal practice. Perceived barriers usually impede new evidence from becoming the norm. According to research by Brauth, Sharpe, Parra-Medina and Wilcox (2014), there are many perceived barriers that prevent women from being physically active. Based on their research there were

personal, social and environmental factors that inhibited women from exercising. Some of the factors included lack of motivation, not having fun, issues with body size, injuries and health conditions, being too busy and the high costs of exercise, especially at a gym. Knowing the perceived barriers to exercise will help providers develop strategies of how to bypass them. This can lead to different exercise plans for women who have specific perceived barriers. The perceived strengths will help serve as motivation for women even if they also have obstacles to get around in order to exercise.

Theoretical Framework

The Health Belief Model is a theoretical model used to explain health-related behaviors. Developed in the 1950s, the model was originally used to explain why programs developed by the Public Health Service were unsuccessful. The model is broken down into four components, people's perceived susceptibility, severity, benefits and barriers. Perceived susceptibility refers to a person's perception of their risk of contracting a certain health condition. Perceived severity is the worry of the seriousness of contracting the disease or what could happen if left untreated. Perceived benefits are the profits of taking preventative action against the disease. Perceived barriers are the negative opinions of the health action that could prevent the disease. All these factors attribute to a person's "readiness to act" which is the willingness that a person will engage in a behavior that can potentially prevent a disease. This theoretical framework can be used to help explain the perceived barriers and benefits patients may have with adding physical activity into their routines to prevent cardiovascular disease (Baum, 1997). As stated earlier, there are many different perceived barriers and benefits to physical activity. By using this framework, a plan can be created to inform women of their actual susceptibility of the disease and the seriousness of cardiovascular disease if they are diagnosed. By receiving the education, women can learn the importance of exercise and how it can potentially prevent the disease from occurring. The overall goal would be to increase perceived benefits of exercise while decreasing the perceived barriers.

By receiving the education, women can learn the importance of exercise and how it can potentially prevent the disease from ever occurring. The overall goal would be to increase perceived benefits of exercise while decreasing the perceived barriers.

Implementation Plan

In order to implement change, a plan needs to be created. The Iowa Model of Evidence-Based Practice to Promote Quality Care can be used to help healthcare organizations make changes that can ultimately improve patient outcomes (Melnyk & Finout-Overholt, 2015). The model starts by having an organization or healthcare providers identify "triggers" or a clinical question from their current practice. These questions ought to come from existing knowledge and should be able to question current practices. In order for the change to take place, the "trigger" has to be a top priority for the organization.

Forming a team who will be able to assemble and then critique and synthesize the research evidence is needed. Once the team decides the feasibility and possible good outcomes they can start to take steps to implement the change into practice (Melnyk & Fineout-Overholt, 2015).

When implementing change in a practice there are often barriers to overcome. A readiness to change is the first step in the implementation process (Melnyk & Fineout-Overholt, 2015). This can include the organization who is implementing the change and the people the change will affect. In regards to focusing on physical activity as a main preventative measure in cardiovascular diseases this change will affect both the providers who are implementing the specific physical activity routine, and the patients who are agreeing to take part in the exercise. In order for there to be a readiness for change, solutions to potential barriers need to be planned. Not only will there be barriers to implementing the change overall, but there will be barriers to the patients from ever implementing this change into their daily lives. Because of this, resolutions need to be made for both the organization and the patient population.

After assessing the readiness to change, in order to implement change a leadership team needs to be assembled. These leaders will need to understand, support and explain the change and be able to have the organization agree to it (Gesme & Wiseman, 2010). The leaders can be a physician or team of health care providers who want to execute this plan with their patients. Having one or two physicians implement the physical activity with their patients and help them overcome their barriers will allow others to see the change. Followers are also key in the

role of change (Gesme & Wiseman, 2010). These followers can be other physicians in the practice, other coworkers, nurses, etc. who are agreeable to listen to the change and potentially incorporate it into their practice. Coworkers who are able to convince their peers to join into the new practice and believe in the change can be identified and used. This may empower other staff to join the movement (Gisme & Wiseman, 2010). Unfortunately trying to implement a change can all fall through if there are resisters throughout the organization. Educating resisters on how this change can make their practice better and more efficient, and specifically their patients' lives better may help alter their mindset (Gisme & Wiseman, 2010). Including physical activity education into patient care can ultimately make the patient healthier. Healthier patients are the goal of everyone who works in healthcare. The quality of care for the patients is the most important aspect, and if the change really does help the patients hopefully there will be few resisters. Overall, communication with the organization and staff is very important and is the key to allowing change to happen.

Once barriers within the organization are resolved, barriers to the patients actually implementing the change in their own lives need to be resolved. Knowing patients' barriers to exercise before educating them, will allow practitioners to choose certain plans for their patients. Educating patients about exercise in general is essential. Many patients may not know what determines moderate-intensity aerobic exercise and vigorous-intensity exercise. According to the CDC (2015) moderate-intensity exercise includes exercises like brisk walking, water aerobics and riding a bike where there are few hills, while vigorous-intensity exercises include jogging or running. It is important for patients to know what types of exercises they should be putting into their routines. In regards to personal barriers patients may have, it is imperative to have plans for them to deter these barriers. For patients who state they have a lack of time to exercise, educate them to select activities that fit their routine. This can include changing transportation to walking or biking if possible, using stairs at work, or exercising while watching television. For patients who do not have a supporting group of friends or family have options for neighborhood exercise such as walking or triathlon clubs. For patients who are lacking motivation to exercise, have a calendar

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available for them to plan their work-outs ahead of time. This will keep patients accountable for their own schedules. If patients do not have equipment it would be best to focus on exercises that do not need resources. Walking and/or running is physical activity that does not require any equipment. It would be helpful to have resources or pamphlets of the available parks or recreation programs available in the neighborhood, and providing a list of the least expensive gym memberships so that patients can know what type of memberships are available and at what prices (American Heart Association, 2014). These are just a few options to help patients overcome barriers. Every patient will have their own reason they might not want to or "cannot" make this change in their life, but it is up to their healthcare providers to help them realize how important these changes can be.

Evaluation

Evaluating the effectiveness of the change in practice will show if the change in practice really change the health of patients. For this evaluation, patients' electronic health records can be the internal evidence used (Melnyk & Fineout-Overholt, 2015). Vital signs and lab values associated with cardiovascular disease can be reviewed using these records; specifically, blood pressure, heart rate, lipid panels, weight gain/loss, EKGs and stress tests. The medical records of the patients will help determine what the patient's baseline was like before they implemented physical exercise into their routine and after implementing exercise. This can also determine if any of the patients were diagnosed with cardiovascular diseases since implementing the practice.

Email comments to **Rodman-shannon@cooperhealth.edu.**

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The What, Why, and How of a CDI Program

Rebecca R. Willcutt RN, BSN, CCDS, CCS

No one in my family can explain what I do for a living. When people discover that I live in Alabama and I am a director at Cooper University Hospital (CUH) in Camden, New Jersey, they say "Wow, what does she do?" The response is usually something mumbled and the subject is changed. After 11 years in the Clinical Documentation Improvement (CDI) field, I have a hard time describing it myself unless I am talking to a physician. Case in point: My daughter is an ED physician in Ohio, and so is her significant other. One day Alex said, "Mom, tell Brett what you do, I can't explain it." I looked at him and said, "Have you ever received one of those clarifications asking to specify a diagnosis?" "Yes." "Well, that's what I do." "Oh!" he replied, and I watched dismay cross his face. So basically, the Clinical Documentation Improvement team reviews a record and if it is lacking in some way in terms of missing diagnoses, vague information, diagnoses documented without clinical findings, etc., we post an electronic query to the physician to clear it up so the record can be accurately coded.

That was the short answer, here is the long answer.

Diagnosis-related groups (DRGs) were implemented in the 1980's as a classification system that identified "products" used by the hospital patient to replace "cost based" reimbursement. These groups are based on ICD-10 codes for diagnoses and procedures, age, sex, discharge status and the presence of complications or comorbidities. Each DRG is assigned a relative weight (RW), and that weight tells how sick the patient is and assigns an average length of stay (ALOS). The weight of the DRG is multiplied by the blended rate of the payor, and that number is the payment the hospital is going to receive for that admission. Let's say that blended rate at CUH is $5000 and Mr. Smith was admitted for a CHF exacerbation:

Congestive Heart Failure	DRG 293 Heart Failure & Shock w/o CC/MCC	Relative Weight 0.6618 ALOS 3.0

We can see that Mr. Smith has a RW or Case Mix Index (CMI) of 0.6618, he should not stay in the hospital longer than 3 days and the hospital should expect a Medicare reimbursement of $3,309.00.

But wait a minute, Mr. Smith was really sick and was in the hospital longer than average, and we need to be able to demonstrate this. As is, it looks like we kept this patient longer than needed and we're over treating. In addition, the doctor becomes an outlier. This is where the Clinical Documentation Specialist (CDS) comes in. We know to look for CCs (comorbid

conditions) and MCCs (major comorbid conditions) that, if documented, will change and maximize the DRG. Not every diagnosis is a CC or MCC. In fact, they are few and far between and have to be worded precisely.

> **"Patient admitted with acute systolic heart failure. Na low, gentle hydration with NS, free water restriction, I&O's. Also with AMS, lethargy – not baseline – CT head negative, no stroke per neurology, likely Na related."**

Coders can only code the exact words the physician documents. In this instance, low Na+ is not a diagnosis and the coder cannot make assumptions. Therefore it is the responsibility of the CDS to "query" the physician for the diagnosis of hyponatremia. Hyponatremia is a CC, which will increase the DRG:

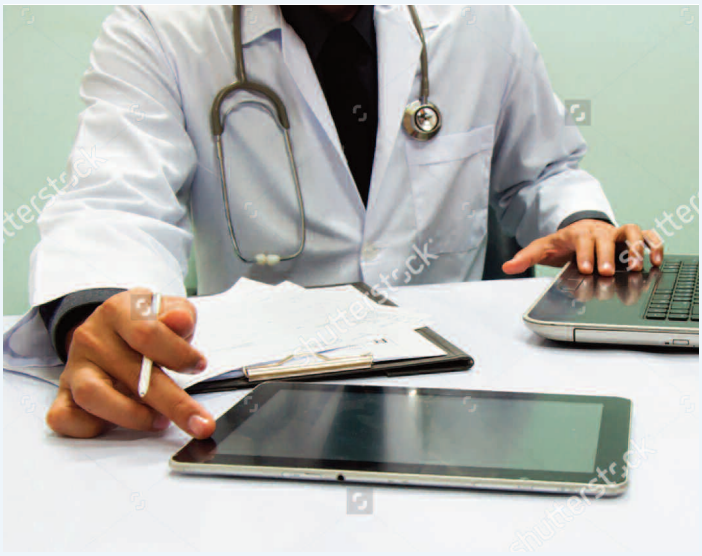
Congestive Heart Failure	**DRG 292 Heart Failure & Shock W CC**	**Relative Weight 0.9574 ALOS 3.5**

As you can see, the length of stay increased to 3.5 and reimbursement increased, as well as patient acuity. But the CDS nurse sees something else in the documentation.

The CDS nurse knows that we need a diagnosis for these mental symptoms of AMS (altered mental status) and lethargy, related to hyponatremia. At this point, she will also query the physician for metabolic encephalopathy, which is a MCC.

Congestive Heart Failure	**DRG 291 Heart Failure & Shock W MCC**	**Relative Weight 1.4796 ALOS 4.6**

By obtaining proper and compliant documentation of the diagnoses related to the symptom's exhibited, Mr. Smith's CMI has increased 123%, which shows that he is much sicker than the average CHF admission. The physician is no longer an outlier because he was discharged on day 4 and the hospitals reimbursement increased to $7,398.00 –to help cover the costs of the extra days, CT scan, neuro consult and extra nursing hours. This example explains the role of CDI at it's very basic. If I were to explain what CDI program (CDIP) does by comparing it to starting kindergarten and graduating from college, this example is the first day of kindergarten.



CDIP Evolvement over the Years

I have been a registered nurse since 1981 and on the business side of medicine for 30 years. When I became a CDS in 2006, I had no idea what it was or what part it played in the financial viability of the hospital. Maximizing the DRG was the starting point and what has exploded over the past decade is nothing short of astonishing.

CDIP has always been key for a smoothly running hospital. But now, there is so much regulatory pressure due to the demanding set of requirements over a wide range of departments. With CDIP, what generally comes to mind is clarification of diagnoses, whether it is principal diagnosis, secondary diagnosis, CC or MCC. While this remains the backbone of the program, we are involved or inherently responsible for so many other things. HIPAA, the Affordable Care Act, Compliance and Quality measures such as Patient Safety Indicators and Hospital Acquired Conditions, are all impacted by documentation. We check admission types and sources for inaccuracies because this affects reimbursement like split payments and the Trauma Activation Fee. We query for inpatient diagnoses that affect contract negotiations… the list goes on and on. I liken CDIP as a major cog in a wheel to improve patient outcomes, financial performance and ascertaining correct quality reporting in the highest standards of compliance. We have impacted medical necessity, reduced coding denials, fines and helped avoid costly penalties of non-compliance.

The Uniqueness of Cooper's CDI Program

I first "met" Cooper as the project manager for the vendor that was implementing the CDI program. Our implementation was very successful and about 8 months later I was hired to oversee the

(continued on page 18)

The CDI program at Cooper is one of the strongest programs in the country, continually raising the bar for advanced CDI practices everywhere.

CDI Program

(continued from page 17)

program and expand it with a remote staff. Remote CDIP is a fairly new concept because the general consensus is that the CDS needs to be onsite to develop a rapport with the physicians, participate in rounds when needed and get those queries answered. With the advent of the electronic health record, remote CDI became a real possibility. It takes approximately a year for a CDS to become a good CDS. Training is arduous because the coding concept and language is foreign to nurses; it is a complete new world and the first year is quite stressful to new CDSs. Many find it difficult, as the skill set is unique. Self-motivation and a spirit of excellence are crucial to success. Cooper currently has 4 onsite CDSs, 8 remote and 3 on the outpatient side. The requirements to be a CDS at CUH are stringent and non-negotiable: the remote CDS must already be a certified CDS, preferably a certified coder and proficient in the program software. Our remotes live in many different states such as Arkansas, Massachusetts and Florida. Our onsite nurses are house-trained and must obtain their CDI and coding certifications within a defined time period. Currently, we are in the midst of training our CDSs to obtain their risk adjustment coding credential as well.

These three things set us apart from any program in the country and are a testament to not only the dedication of the CDI staff, but to the support of Cooper Administration.

Speaking of administrative support, in the first part of this article I mentioned "the look of dismay" that crossed Brett's face. Many programs wrestle with the very real problem of lack of physician engagement. I remember physicians refusing to answer clarifications and even ripping them out of charts due to their frustration with the mounds of paperwork that can impede their patient interaction. This has never been an issue at Cooper. From day one, Administration, Compliance and physicians have supported us 100%, fully understanding that we are an integral part of this institution. Because of that support, and the dedication of our nurses, our Medical Director Dr. Nicole Fox and SVP QUALITY-OPS EXCELLENCE Adrienne Elberfeld, the CDI program at Cooper is one of the strongest programs in the country, continually raising the bar for advanced CDI practices everywhere.

Email comments to **wilcutt-rebecca@cooperhealth.edu**

This article is the first of 4 articles that will introduce Quality and Operational Excellence led by SVP Adrienne Elberfeld. The future articles include the Process Improvements Office, Population Health and Performance Improvement.

Reflections

(continued from page 19)

cern treatment, clarify specificity of the procedure and identify what is inherent versus a complication of that procedure as per CMS definitions. To complete the corrections found, communication with the physician is done electronically in EPIC through something called a Query process, face to face education participating in bedside rounding as a group, or one on one as requested by the physician. It is a CCDS's responsibility to keep up to date with CMS in regards to the changing definitions of our words, and alternating inclusion and exclusion criteria for what defines a patient safety indicator or hospital acquired condition. Due to the fluid nature of these definitions and inclusion/exclusion criteria of CMS, the CDI program also works closely with the departments of Health Information Management, Quality and Compliance assuring accuracy across the continuum.

I am now proudly a Certified Clinical Documentation Specialist (CCDS) and I am part of something bigger than myself. I am part of a team that impacts the whole system, working alongside 12 other highly skilled CCDSs; all nurses with diversified backgrounds. I have leaders that both empower and inspire me; Adrienne Elberfeld (Senior VP of Quality and Operational Excellence), Dr. Nicole Fox (Medical Director of Pediatric Trauma, Medical Director CDIP) and Rebecca Willcutt (Director of CDIP). As a team, we ensure that the physician documentation accurately reflects how sick our patients really are, the care we provide, invalid complications are removed and most importantly, the patient's REAL story is told. This requires book and practical knowledge, thick skin, strong communicating skills and the ability to critically think through a medical record. The learning curve is difficult and not easily accomplished. It takes a solid year to become a good CCDS and even then, we must stay abreast of new disease processes, physiology, pharmacology, regulatory and compliance, coding practices and guidelines, hospital reimbursement, CMS quality measures and so much more. It is a hard job with long hours, but fulfills me in so many ways. In this role, I am allowed to continue to be a patient advocate, a voice for physicians, a subject matter expert, and yes, a clinician rounding at the bedside. I am still a nurse, evaluating care from a third view that was completely foreign to me three years ago. As a CCDS we provide the real story of our patient's experience and reflect the quality of care I know we provide. As a certified clinical documentation specialist I discovered our bedside care has more than two sides. I have learned that we as clinicians are responsible for not only the care of our patients but, also the viability of our health system through proper documentation.

Email comments to **Swierczynski-patricia@cooperhealth.edu**

REFLECTIONS

A CCDS: Still a Clinician

Patricia Swierczynski, BSN, RN, CCDS

Left to right: *Patricia Swierczynski, Dr. Fox, Lizabeth Gsell, Mary Volpe, Francis Koomson.* **Team members not pictured:** *Rebecca Willcutt, Terri Mc Intyre, Teresa Barnett, LaPree Burgess, Matt Durfee, Kara Masucci, Deborah Petrucci, Stephanie Hatcher and Sarah LaSource*

"If you didn't write it, you didn't do it." How many times have you heard these words over the course of your life as a health care professional? Over and over this has been drilled into our collective minds as a defense mechanism to prove that we did indeed, give our very best care to the patient. Progress notes were something both physicians and nursing fit in at the end of the day with direct patient care being our first priority. This was my mindset for 20 of the 23 years I have been at Cooper. One would never imagine the final result of those words, which we all found burdensome and a waste of time, would play a key role in the viability of the hospital. None of us could have predicted that the quality of care we give, complications that may occur, resource consumption used and acuity of our patients, would be graded and publically reported from these very notes. We are now keenly aware that our documentation is translated into a summary list of codes and is used to publically report assumed complications, determines whether we earn reimbursement for providing quality care and actually assigns a lettered grade to clinicians and the health care system as a whole.

A little over three years ago, Adrienne Elberfeld (Sr. VP of Quality and Operational Excellence) approached me about something new that was coming to Cooper: the Clinical Documentation Improvement Program aka CDIP. Her exact words to me were "there is a job coming that I think you would be good at." "There is a test you need to take… I think you should." I took a required clinical test geared toward 3rd year medical students, passed and was hired as a Certified Clinical Documentation Specialist (CCDS). I had no idea what CDIP was and could never have anticipated that I was entering into such a transformative career that allowed me to directly and positively impact physicians and our health care system.

> "Clinical documentation is critical to surviving the new climate of health care. This directly affects our publicly reported quality of care and caliber of our physicians."

I have worked primarily in the intensive care units of Trauma, Critical Care, Thoracic surgery and Neurosurgery. Working side by side with peers and physicians, I have first-hand knowledge of the integrity of our staff, the skills we possess and the advanced medical care we provide. I am intimately aware of what it takes to practice as a clinician at Cooper: technical and people skills, clinical judgment, risky work, multi-tasking and dealing with rapidly changing situations. I have always believed and been passionate for the quality of care we give. While becoming a CCDS, I discovered that our story and the final results, out in the public, held radically opposing views from what I know first-hand of who we are and what we do. I have been a patient and nurse in our ICU and have now learned that there is a third dimension of care. This third dimension is clinical documentation, which is critical to surviving the new climate of health care. This directly affects our publicly reported quality of care and caliber of our physicians.

As a clinical documentation specialist, you learn that the medical terminology we use often does not equally translate to the coding language. Inherently clinicians under document what we do, therefore minimizing or even negating the layers of multiple diagnosis we may be treating. It has also been discovered the timing of our words in the record, or even how often we document a diagnosis matters. There are diagnostic words we use that may not even have a direct translation in the coding world. For instance, "urosepsis" codes to a simple UTI and bacteremia is just a lab finding, not an actual diagnosis. Practitioners must use the word "acute" or a condition will be coded as chronic, which indicates a lower level of patient severity. Words the medical community had never heard of are required in order for the diagnoses to even be coded, i.e. "brain compression." These are just a few of the things that lend itself to inaccurate reporting, lower reimbursement, denial of medical necessity and a host of other things that significantly impact our institution.

The inaccurate translation of the clinician's words motivates a CCDS every day to find those documentation issues which are lost in translation and negatively impact the physician, the patient and Cooper as a healthcare system. I am the translator between the physician and the REAL story of the patient's course of illness that is reported. By advising physicians of proper documentation, a CCDS has the ability to concurrently course correct what really happened during the patient's stay. Every word of the record is reviewed including; notes from ALL clinicians, all labs, imaging, procedures and flowsheets to solidify proof of a diagnosis that cannot be coded because it is not documented as required by payors. This is no different than practicing at the bedside – interpreting labs, ABGs, vitals, medications used and their timing of use, along with evaluating clinical indicators and symptoms to read between the lines of what is really happening with the patient. Operative reports are assessed on a granular level to dis-

(continued on page 18)

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Professional News

DEGREES:

Mary Sue Flaherty, BSN, RN, CEN, MICN, received her Bachelor degree in Nursing from Wilmington University and graduated Magna Cum Laude in May 2017

Melissa Pineiro received her Bachelor Degree in Nursing from Rutgers University in May 2017

Joanne Paraschak, BSN, RN, CRNI, received her BSN from Rowan University in December 2016

Mary Kate DePriest, MSN, RN, received her MSN from Wilmington University in April 2017

CERTIFICATIONS:

Diane Floyd, MSN, RN, BC-NE, TCRN, received her certification in trauma nursing

Rachel Rogalski, MSN, RN, TCRN, received her certification in trauma nursing

Jennee McMullen, BSN, RN, CEN, received her certification in emergency nursing

PRESENTATIONS:

Anthony Angelow, MSN, RN, provided a podium presentation on Seizure Prophylaxis in Traumatic Head Injury and co-taught 4 pre-sessions (Common Office Procedures, Basic Suturing, Advanced Suturing and Orthopedic Assessment /Upper Extremity Joint Injections) at the National Conference for Nurse Practioners.

Anthony Angelow, MSN, RN, provided two podium presentations: Bugs and Drugs: The Pathophysiology and pharmacology of infectious disease and Anticoagulation Considerations in Head Injury at the NJENA Emergency care conference, Atlantic City, NJ.

Janice Delgiorno, MSN, ACNP-BC, CCRN, TCRN, provided two podium presentations: Legal Implication of the Electronic Medical Record and Legal Aspects of Nursing: A Case Study Presentation at the NJENA Emergency care conference, Atlantic City, NJ.

Natalene Kramer, MSN, PhD(c), APN-BC, presented at the Society of Pediatric Nurses Annual Conference in West Palm Florida on April 7, 2017, a Podium presentation on "Parents of Children Who had Hypoxic-ischemic Encephalopathy: A Mixed Methods Exploratory Study."

Shawn Donnelly, RN, Christina Fox, BSN, RN, and **Elizabeth Lee, RN,** presented Nursing Panel: Continuum of the Stroke Patient at the South Jersey Neurovascular and Stroke Symposium on May 10, 2017.

Patricia Passarelli, RN, presented Assessment of National Standards of a GI Endoscopy Unit at the Society of Gastroenterology Nursing Association Conference in New Orleans on May 2017.

AWARDS:

Audrey Bennett-Axelrod, MSN, RNC-OB, Labor and Delivery: Charlotte Tobiason Memorial Award for Excellence in Obstetrical Nursing

John Chovanes, DO, FACS, Department of Surgery/Trauma: Nursing Alumni Excellence Award for Nursing-Physician Partnership

Jennifer Colligon, BSN, RN, RNFA, CNOR, Cardiothoracic Surgery: Philip and Carole Norcross Award for Excellence in Perioperative Nursing

Kathy Coyle, RN, Intensive Care Unit: William and Eileen Archer Award for Excellence in Critical Care Nursing

Pamela Crabtree, RN, CPHQ, Performance Improvement: Barbara and Jack Tarditi Award for Excellence in Nursing Mentorship

Catherine Daly, BSN, RN, ACLS, Kelemen North/South 10: Ruth Parry/Moorestown Auxiliary Award for Excellence in Geriatric Nursing

Rhonda DeMoulin-Bailey, BA, RRT, Respiratory Therapy: Carol G. Tracey Compassion Award

Samantha Epstein, BSN, RN, Kelemen North/South 10: Selma and Martin Hirsch Award for Excellence in Medical-Surgical Nursing

Colleen Gannon, BSN, RN, Pavilion 6: Shaina Horton Memorial Award for Excellence in Service

Jessica Hernandez, Pavilion 7: Barbara and Jack Tarditi Award for Excellence in Service (non-nursing)

Jacklynn Keegan, RN, Pavilion 5: Rose Smith & Sue Zamitis Memorial Award for Excellence in Oncology Nursing

Ryan Mennel, BSN, RN, CCRN, Trauma Surgical Intensive Care Unit: Award for Excellence in Trauma Nursing

Brian O'Toole, RN, TNCC, ALS, BLS, Emergency Department: Lynn Nelson Award for Excellence in Emergency Nursing

Evelyn Robles-Rodriguez, MSN, RN, APN, AOCN, MD Anderson Cancer Center at Cooper: Moorestown Auxiliary Award for Excellence in Advanced Practice Nursing

Sherry Schlagle, MS, CCLS, CT, Child Life Program: Barbara and Jack Tarditi Award for Excellence in Service (non-nursing)

Larissa Schoudt, BSN, RN, CCRN, Coronary Care Unit: The Cooper Heart Institute & The Heart House Award for Excellence in Cardiovascular Nursing

Laura Siemianowski, PharmD, BCPS, BCCP, Pharmacy/Viner Intensive Care Unit: Women's Board of Cooper Hospital Allied Health Professional Excellence Award (non-nursing)

Barbara J. Smith, RN, Cooper Digestive Health Institute: Women's Board of Cooper University Health Care Award for Excellence in Ambulatory Nursing

Nora Vizzachero, DNP, APN, Pediatric Neurology/Women's and Children's Health Institute: Dr. Ronald Bernardin Memorial Award for Excellence in Pediatric Nursing

Jackie Whitehead, RN, Department of Pediatrics/Neonatology: John Henry KronenbergerNeonatal Nursing

Pamela Young, BSN, Pavilion 7: Philip and Carole Norcross Award for Nurse Leadership

Pavilion 8, Pavilion 8: Outstanding Team Award

Kathy Coyle, RN, Intensive Care Unit: Nurse of the Year Award

PUBLICATIONS:

Autum Shingler-Nace, MSN, RN, NE-BC and **Judith Zedreck Gonzalez, DNP, MPM, NEA-BC** published "EBM: A pathway to evidence-based nursing management" in *Nursing: February 2017*, Volume 47, Issue 2, p 43–46.

Diana Filipek, APN published "Tranexamic Acid in Total Hip Arthroplasty: Management of Complications and Use" *Medical-Surgical Nursing: March/April 2017.*