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Patient Education Management™

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INSIDE

APRIL 1999

VOL. 6, NO. 4 (pages 37-48)

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Automate patient documentation with pop-up menus and mouses

System must be uncomplicated, forms configured for efficiency

Is computer technology the answer to increased compliance for documentation of patient education? It can be if the system is configured correctly, says **Mary L. Bennett**, RN, MS, senior systems analyst at The Ohio State University Medical Center in Columbus.

Bennett worked with a team to get documentation on-line at the medical center. The team made sure all the standards of the Oakbrook Terrace, IL-based Joint Commission on Accreditation of Healthcare Organizations were being met by the computerized documentation format.

Certain computer software makes the act of documenting more efficient. The ability to cut and paste information between notes increases the speed of documentation because information documented on a sheet specific to a discipline can be copied to a generic form so staff don't have to document twice. Information such as a patient's readiness to learn can be quickly copied forward if there is no change from day to day.

On-line prompts reinforce knowledge

Depending on your system, prompts and directions can be placed on-line so staff can refresh their memory on what to teach, making teaching and documentation more thorough. Reference information on policies, procedures, and protocols can be called up on the screen to reinforce the caregiver's knowledge.

It's also possible to configure your system so multiple users can look at a patient's chart simultaneously. When staff don't have to wait for a chart, documentation of patient education is enhanced, says Bennett. With the computer system that is currently being installed at The Ohio State University Medical Center, any number of people can log on to the system at the same time to document education in the patient's record. Also, placement of a computer in every patient's room makes documenting convenient.

"The computer documentation system is incredibly more efficient than paper documentation," adds Bennett. However, the format for the computerized documentation system is based on the paper format. If an institution does not have its documentation forms perfected, the computer won't fix the problems, she warns.

It takes time to create a good documentation system for patient education, but the process is expedited if a paper form that works is already in place, says **Virginia Forbes**, MSN, RNC, CNA, patient education coordinator for New York Presbyterian Hospital and New York Weill Cornell Center in New York City.

The computer documentation format for patient education at this hospital system is currently being configured. It is based on a paper documentation form, but the electronic form will be much more flexible, says Forbes.

For example, clinicians can type information into the computerized form or use the mouse to click on choices from pop-up lists such as "Barriers to learning," "Methods of teaching," and "Outcomes." "Pop-up lists will be customized to meet discipline-specific needs. When staff click on an item from a pop-up list, it immediately appears in the flow sheet," explains Forbes. Compliance should improve because staff won't have to hunt for paper forms or look in various areas of the chart.

Learn new system's capabilities

Sound too good to be true? It's not, but patient education managers should know it takes vigilance to create a computerized documentation system that works right. **Diane Moyer**, MS, CS, patient education coordinator at Mount Carmel Health System in Columbus, OH, advises patient education managers to become involved in on-line documentation projects from the start. An important part of this is learning the capabilities of the system the hospital purchased, she says.

Forbes agrees: "Thoroughly understand the system you will be working with in order to design a form that will work well within the system," she recommends.

It's also important to know the patient education documentation requirements of regulatory and accrediting agencies such as the Joint Commission, says Moyer. This will allow a committee to determine how a system would meet these requirements as documentation is configured.

(For information on how outside regulators shape patient education, see *Patient Education Management*, February 1999, pp. 13-16.)

"Once you understand how the system works, you need to collaborate with an interdisciplinary team to be sure that what you are identifying to be included on the form is complete," says Forbes.

The type of computerized form used would be determined by the interdisciplinary needs identified, but might include a flow sheet, history, or note format. It takes a lot of brainstorming to determine all the possible routes and then choose the route that will provide the most of what is needed, she explains.

Good training program gains compliance

"You want to make sure the documentation system won't be complicated for the staff, or it will defeat the purpose. You want compliance," says Forbes.

Once the system is in place, training comes into play. Staff won't be compliant if they don't understand how to document patient education on a computerized form.

Before the computer system was introduced at Ohio State, every registered nurse on the units where it was to be implemented attended two four-hour workshops. These training sessions required them to work through scenarios to familiarize themselves with the system. Bennett also worked with each nurse one on one.

"As we were teaching them, the computers were in their units and they could simultaneously document on the paper format and on the computers. They had about three months to practice. Once we went live, it was computer-only," says Bennett. Anyone who needed additional help was given individualized teaching.

There currently is a staff member dedicated to computer education at Ohio State. Newly hired employees attend a class limited to four people in order to provide time for one-on-one teaching.

Staff education must include patient confidentiality. At New York Weill Cornell Center, where computer charting has been operational for a while, nurses are keenly aware of their surroundings and they log off promptly, says Forbes. The position and location of monitors also ensure confidentiality. Of course, no one can log onto the system without a password.

To maintain patient confidentiality at Ohio State, each employee qualified to use the computer is given an ID number. That ID number not only allows staff to log on to the computer; it also restricts access to certain portions of the chart. "We set up the forms an employee can look at or be able to document on by level," explains Bennett. For example, if a staff member was not qualified to discharge the patient, his or her ID would not provide access to this portion of the chart and the screen would read, "You don't have the right to perform this function."

A computerized documentation system can resolve many common problems, says Bennett. For example, all documentation is legible. Also, if staff decide they need another item in a choice list used to prompt documentation, Bennett can add it to the system instantaneously. The system also provides a way to ensure abbreviations of terminology are consistent between environments, so when staff see an abbreviation they know what it means.

The computer makes documentation in the patient record consistent across the board from the clinic to the in-house patient, says Bennett.

Does everything fall apart if the system goes down? Not if you have a plan in place. "At New York Weill Cornell Center of New York Presbyterian Hospital, if the system goes down for four hours, paper is used until the end of that shift. If the system goes down for less than four hours, electronic documentation will be resumed," explains Forbes. ■

SOURCES

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Incorporate therapeutic touch into patient care

Educate patients before using technique

The nurse manager of cardiac surgery at Mercy San Juan Hospital in Sacramento, CA, promotes the use of therapeutic touch with patients pre- and postoperatively in the cardiac intensive care unit. Nurses there have found it assists with general relaxation and some pain relief. At times, they have seen changes in the heart monitors as a result of using therapeutic touch.

Cardiac surgery patients are not the only ones to receive therapeutic touch. Mercy Healthcare Sacramento offers therapeutic touch as a staff development course so patients on every unit can benefit from this complementary therapy. "We have taught therapeutic touch to between 200 and 300 nurses and other health care providers within the Mercy system. They use it to varying degrees in their clinical practice," says **Marcia Taylor-Carlile**, RN, CDE, team leader for healthy member/healing environment in Strategic Learning Development at Mercy. **(To learn how to incorporate complementary therapies into a health care setting, see article on p. 42.)**

Therapeutic touch is being incorporated as a complementary therapy into more and more health care settings. It is being used in clinics, hospitals, hospice, and home health to enhance well-being, reduce stress, accelerate the healing process, reduce pain, and provide physical and mental relaxation. While some patients ask for therapeutic touch, most are introduced to it by nurses who have embraced the technique.

Speeding up the therapeutic process

Kate Dean-Haidet, RN, MSN, CS, a psychotherapist and clinical nurse specialist in adult psychiatric mental health in Columbus, OH, uses therapeutic touch with her clients who suffer from depression and anxiety. "I found that what might have happened in the therapeutic relationship was happening sooner. Issues were being dealt with more quickly and clients were getting better faster," she says.

Therapeutic touch is based on the premise that a human being comprises physical, mental, emotional, and spiritual energy fields. This paradigm

Workshops, practice fine-tune TT skills

Quality of intervention based on ability to center

Although there is no certification for the practice of therapeutic touch, there are good standards of practice. The basic concepts are taught in an eight- to 12-hour workshop, but it takes time to develop clinical skills. Nurse Healers-Professional Associates in Philadelphia recommends a one-year mentorship with a qualified therapeutic touch practitioner and an intermediate-level workshop to become a therapeutic touch practitioner in a health care setting.

It takes practice for the nurse to be able to reach the proper frame of mind quickly, says **Linda Turner**, RN, MN, a clinical nurse specialist for pain management at Vancouver Hospital and a practitioner at The Healing Touch Centre in Vancouver, Canada. "The therapist needs to be in a meditative state to do the treatment, and that is not easy to learn. It is a discipline that takes practice. The more you do it, the better you become," says Turner.

The quality of a treatment depends on how well the practitioner can attain this meditative state, says **Kate Dean-Haidet**, RN, MSN, CS, a clinical nurse specialist in adult psychiatric mental health and an instructor of nursing at Capital University School of Nursing in Columbus, OH.

It's important for practitioners to study with qualified teachers, says Dean-Haidet. Nurse Healers-Professional Associates publishes on its Web site a list of qualified teachers who will conduct workshops at health care facilities to train staff.

Nurse Healers-Professional Associates can provide medical facilities with the following tools to incorporate therapeutic touch into a list of complementary therapies:

- standards of care and scope of practice for therapeutic touch;
- policies and procedures for practicing therapeutic touch in a medical setting;
- guidelines for qualified teachers and mentors for therapeutic touch.

It's quite easy to incorporate therapeutic touch into patient care, says Dean-Haidet. "It could be as simple as when you help give a bed bath, you incorporate the principles of therapeutic touch into the experience." ■

holds that when a person is diseased, his or her energy is blocked, depleted, or unbalanced. The therapeutic touch practitioner uses a series of hand movements to release blockages and rebalance the patient's energy flow. **(For more information about how therapeutic touch works, see article on p. 41.)**

It is important to have policies and procedures in place that govern the use of therapeutic touch with patients, says Taylor-Carlile. Because some patients might be uncomfortable with the procedure, it's important to provide education beforehand. "Our philosophy is to explain the basics of therapeutic touch and how it may assist the patient with anxiety or pain management issues before offering it. We don't require a written consent, but we do ask our nursing staff to do verbal consenting with the patient and or family," she says. **(For information on training in therapeutic touch, see article above.)**

Although many consumers are seeking complementary therapies and have become well-informed about many modalities, they aren't as familiar with therapeutic touch. **Judi Cantone**, MSN, RN, an educator at the Hospital of the University of Pennsylvania in Philadelphia, finds that 99% of the patients she mentions therapeutic touch to haven't heard of the technique. When a clinical specialist on a unit asks Cantone to see a patient for the purpose of performing therapeutic touch, she gets physician approval first. Before working with the patient, Cantone explains the process and asks the patient for permission to use therapeutic touch.

No magic cures in holistic treatments

It's important to tell the patient that more than one treatment might be advisable, says **Linda Turner**, RN, MN, clinical nurse specialist for pain management at Vancouver Hospital in British Columbia, Canada. "The patient also needs to understand that in order to heal itself, the body needs all the basic requirements, such as good nutrition, adequate sleep, and stress reduction. One of the functions of holistic treatment is to put all the components together to heal a person quickly. There are no magic cures," Turner says.

Therapeutic touch involves five elements

Practitioners follow step-by-step process

Therapeutic touch was developed by Dolores Krieger, PhD, RN, a professor at New York University, and Dora Kunz, a natural healer. The two began teaching their techniques in 1972. Philadelphia-based Nurse Healers-Professional Associates, an organization that oversees this form of therapy, has defined the five aspects in the process of therapeutic touch as follows:

• **Centering.**

Bringing the body, mind, and emotions to a quiet, focused state of consciousness. Centering is using the breath, imagery, meditation, and/or visualizations to open one's self to find an inner sense of equilibrium to connect with the inner core of wholeness and stillness.

• **Assessing.**

Holding the hand two to six inches away from the individual's energy field while moving the hands from the head to the feet in a rhythmical, symmetrical manner. Sensory cues such as warmth, coolness, static, blockage, pulling, tingling are described by some practitioners.

• **Unruffling (also called clearing).**

Facilitating the symmetrical flow of energy through the field. Unruffling is achieved by using hand movements from the mid-line (vertical line down center of body from head to feet) while continuing to move in a rhythmical and symmetrical manner from the head to the feet (hands move from mid-line out to sides of body).

• **Treatment (also called balancing, rebalancing intervention).**

Projecting, directing and modulating energy based on the nature of the living field; assisting to re-establish the order in the system. Treatment is accomplished by moving the hands to the areas that seem to need attention; energy may be transferred where there is a deficit or energy may be mobilized or repatterned from areas of congestion.

• **Evaluation.**

Finishing the treatment — using professional, informed, and intuitive judgment to determine when to end the session. Reassessing the field continuously during the treatment to determine balance and eliciting feedback from the individual are cues as to when to end the therapeutic touch treatment.

Source: Nurse Healers-Professional Associates International, Philadelphia. Reprinted with permission. ■

Patients need to know that therapeutic touch is not an intervention like massage where they must take off their clothes. It's very brief, usually lasting no longer than 20 minutes. Also, patients need to know that the practitioner doesn't necessarily touch their body. "The practitioner may be working in what we think of as blank space, and that is perplexing for people," says Dean-Haidet.

Give the patient a brochure on therapeutic touch, suggests **Donna Anderson**, RN, MS, MAN, CS-FNP, program coordinator and nurse practitioner in the Pain Management Resource Center at St. Luke's Hospital in Duluth, MN. The brochure Anderson created provides patients with a definition of therapeutic touch, explains the process, and lists the benefits. **(For more about therapeutic touch, see the resource box on p. 42.)**

Anderson advises staff to develop a relationship with a patient before offering the technique. "I find it is best to have an established relationship with the individual so there is some trust involved," explains Anderson. Before handing a patient a brochure, she offers a simple overview of the therapeutic touch process and explains that its effectiveness has been documented.

Although a lot of research has been done and is currently under way to validate the effectiveness of therapeutic touch, many people in the health care field are skeptical. "Since we have not up to this point been able to measure the human energy field that surrounds the body, there are a lot of naysayers around this technique," says Taylor-Carlile. She notes that humans have always had brain waves, but scientists only discovered how to measure brain waves relatively recently.

"I am a practitioner and have been using therapeutic touch for a number of years, so I know that it works. I know that it induces the relaxation response," says Taylor-Carlile. ■

Don't push staff into complementary therapies

Implement slowly for best results

Shortly after **Paulette Swanson**, RN, BSN, education coordinator at Lakeview Hospital in Stillwater, MN, attended a conference on integrating complementary therapy into a health care system, she helped form a task force at her institution to investigate the possibilities.

"One of the speakers said that a wave is coming, and we would either be on the crest of it or buried underneath it. I thought his statement was true when you look at how many people are using complementary therapies. Depending on what study you read, there is anywhere from 50% to 70%," says Swanson.

Taking the pulse of all involved

The task force at Swanson's facility investigated the need for complementary therapy by surveying physicians, nurses, and patients. They found that most physicians who responded were in favor of using some form of complementary therapy. Their top four choices were therapeutic massage, bio-feedback, relaxation therapies, and acupuncture. Physicians also were asked if they had any experience in using complementary therapies, and most did not.

Most nurses who responded to the survey also thought patients would benefit from complementary therapies. However, their top four choices differed from the physicians. They selected relaxation therapies, therapeutic massage, herbal remedies, and healing touch.

Patients were interviewed as part of a pain management survey. Patients were asked if they would use complementary therapies if they were offered for pain management. Sixty-seven percent of the patients said they would use them.

Based on these surveys and on site visits to regional medical centers that had implemented complementary therapies, the task force determined that a need existed at Lakeview.

Working with the pain management committee (which was investigating ways to better control pain), four complementary therapies have been implemented, and all have standing physician orders for their use. They include therapeutic massage, acupressure, relaxation therapy, and guided imagery to be used for pain control.

While staff still are working on ways to incorporate these complementary therapies, a few of the problems have been ironed out. The massage is done by physical therapists who have been trained in the technique. Nurses have been taught how to do acupressure so they can use it with patients on the units. Several relaxation therapy tapes and headphones have been purchased for patient use. The task force is investigating the possibility of providing access to a dedicated cable channel that has guided imagery.

Guest speakers to educate staff

Staff need to be educated so they in turn can educate patients about complementary therapies, says Swanson. Therefore, guest speakers will be brought in to address staff on the various therapies. A column on complementary therapies also will be included in a biweekly newspaper written for staff.

Although nothing has yet been compiled for patient education, the task force will be working on it. However, the hospital did have a women's wellness dinner that focused on holistic health. Several interactive displays introduced such

Therapeutic Touch Resources

The following books are available from the Philadelphia-based Nurse Healers-Professional Associates:

- *A Doctor's Guide to Therapeutic Touch* by Susan Wager. Published by Berkeley Publishing Group. Cost is $14 plus $8 shipping and handling.
- *Accepting Your Power to Heal: The Personal Practice of Therapeutic Touch* by Dolores Krieger. Published by Bear & Company Publishing. Cost is $14 plus $8 shipping and handling.
- *Spiritual Healing: Doctors Examine Therapeutic Touch and Other Holistic Treatments* by Dora Kunz. Published by The Theosophical Publishing House. Cost is $12 plus $8 shipping and handling.
- *Therapeutic Touch Inner Workbook* by Dolores Krieger. Published by Bear & Company Publishing. Cost is $14 plus $8 shipping and handling.

To order, contact: Nurse Healers-Professional Associates International, 1211 Locust St., Philadelphia, PA 19107. Telephone: (215) 545-8079. Fax: (215) 545-8107. Web site address: http://www.therapeutic-touch.org.

modalities as acupressure, journaling, meditation, herbal therapy, aromatherapy, yoga, and gardening therapy.

Complementary therapies are even being addressed on the nursing assessment form. Patients now are asked what herbal therapies they are taking in addition to their regular medications, says Swanson. ■

SOURCES

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Reader Questions

Structure of patient education can vary

Systems govern development and overview process

Question: How is your patient education department organized? If you are combined with another department, how does that affect patient education needs? What are the benefits or drawbacks of the model under which you currently operate? Have you made any changes lately that have improved the organizational structure of patient education, or do you have any changes planned?

Answer: When *Patient Education Management* asked this month's reader question, one point became clear: There doesn't seem to be a single blueprint for organizing patient education within a health care facility. The one common thread among all the institutions we contacted is that each one has an organizational structure for patient education.

In light of the answers to our question, we determined that the best way to present the information was to write a short description of each institution we contacted.

• **Baptist Health Systems of South Florida.**

This four-hospital system in the Miami region uses a patient education liaison to coordinate patient education within the system. "I am a consultant to all four hospitals and the resource center," explains **Yvonne Brookes**, RN, patient education liaison for the system. Her position is part of the education department, which also oversees staff development.

Brookes attends all patient education meetings at each hospital and does the research for program changes and resource development. The difficult part of the system is that Brookes does a lot of traveling, and although she oversees patient education, no one is accountable to her.

The goal is to eventually standardize the programs and materials throughout the hospital system under Brookes' supervision.

• **Hartford Hospital.**

Patient education is decentralized at Hartford (CT) Hospital, with each clinical division responsible for designing, implementing, and evaluating

patient education. One person in each department coordinates the efforts.

A patient education committee sets policy and procedure and coordinates the development of materials and programs. Health care teams develop critical paths for the patient groups they manage, and that includes the patient education component, explains **Joan MacRae**, RND, MS, education coordinator and chair of the patient education committee at Hartford.

The advantage of this model is that there is multidisciplinary input and buy-in, and disciplines work together to coordinate patient education activities. The disadvantage is that each department has its own budget for patient education and funds can get diverted. A database of materials currently is being created to improve communication between departments and stop duplication of efforts.

• **Methodist Hospitals.**

Patient education is part of the nursing educational services department at Methodist Hospitals in Memphis, TN, which also oversees staff development. "I look after the in-house production of Learning for Life materials," which are patient handouts, says **Marie Gill**, RN, BSN, MS, patient education coordinator at Methodist. She also helps select materials for the CCTV system and conducts inservices on patient education. Her duties encompass four Memphis hospitals.

"The benefit of the system is that our program is the same from hospital to hospital and we have some continuity of care," Gill notes.

• **Mid-Florida Medical Services.**

The educational department at Mid-Florida Medical Services in Winter Haven oversees all education at the health system and assigns education coordinators to each category. The system includes two hospitals.

"All of us are titled 'education coordinators,' and then we each have different responsibilities. Mine is patient education and continuing medical education," says **Laurel Spooner**, RN, BSN, education coordinator at Mid-Florida.

The drawback of this system is that there is not a separate patient education budget. Also, there are only two secretaries working with eight coordinators and the director.

• **Provena Mercy Center.**

The director of education at Aurora, IL-based Provena Mercy Center recently resigned, and administration is not filling the position. Now the person in charge of community education will report to public relations, and the patient education coordinator and two instructors in charge of staff education will report to the vice president of organizational structure.

The patient education coordinator is responsible for making sure staff have the resources they need for patient education, says **Rita Smith**, MSN, RN, education coordinator for Provena Mercy. To do so, she communicates with each department via a liaison.

Although Smith puts the processes for patient education in place and develops them, she has no authority to enforce them, and this is one drawback of the system. However, there are positives. "Having a patient education coordinator for the hospital really is better for consistent teaching. Also, having just one person dedicated to looking at patient education and making sure the standards are being met ensures a better quality," says Smith.

• **Southeast Missouri Hospital.**

Patient education at Cape Girardeau-based Southeast Missouri Hospital is part of the educational services department, which includes staff

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development, patient education, community education and outreach, and the fitness and wellness program.

"Combining all these areas under one department gives the staff resource and peer support. Each area still has its own operational budget and there is no cross-over of responsibilities," says **Gwen Thoma**, MSA, BSN, RN, director of educational services at the hospital.

Another benefit is having all educational functions under one umbrella so other department heads know where to go if they have an education issue, says Thoma.

• **Trihealth.**

At Trihealth in Cincinnati, a patient education committee is responsible for coordinating the patient education function across the organization. Members of the committee are from the three hospitals in the system and several remote sites, says **Joyce Fugate**, RN, MS, clinical team manager of cardiac and pulmonary rehab and co-chair of the committee.

The drawback of the system is that busy committee members find it difficult to get to meetings and work on projects.

"The committee sets the policy and guidelines for patient education. We believe that the actual patient education content should come from the experts who are doing the work," says Fugate. Each department puts together patient education programs and materials following the guidelines set by the committee. ■

Game identifies patient goals, priorities

Provides evaluation tool for patient choices

When a patient undergoes rehabilitation for disabling injuries, do the rehab clinician's goals match the patient's goals?

That's what researchers at the University of Pennsylvania Health System wanted to know when they developed a board game that helps doctors and patients entering rehabilitative regimens to clarify demands and expectations of treatment.

"Understanding differences in perceptions between clinicians and patients is essential to achieving optimal outcomes," says **Margaret G. Stineman**, MD, associate professor of rehabilitation medicine at the University of Pennsylvania Health System in Philadelphia and lead author of the study.

In addition to revealing differences between the goals of clinicians and patients, the study showed that there are differences in goals between patient groups depending on their gender and environment. For example, women value grooming and want to control the way they look and appear to people, while men tend to value their mobility more. Participants in Philadelphia valued stair climbing more than participants in Houston, revealing that their decisions were based on the architecture of the buildings in their community.

At the time of a disabling injury, patients are faced with many choices. While clinicians need to provide information grounded in their knowledge, patients must make their choices according to their life experiences and the environment in which they live, says Stineman.

The board game is based on several theories and scientific thought including economic theory. Basically, people must make trade-offs. Just as they would have to decide whether to go to the movies or buy a hamburger if they only had $5, they must choose between different functional activities. "During the game you can choose to improve the ability to manage your bowels and bladder, but if you choose to do that you will have to accept greater dependence in eating, walking, or remembering," says Stineman.

When playing the game, each participant is asked to move a peg forward one notch for one of 18 functional skills. Their choices include such activities as eating, bathing, dressing, and bowel and bladder control.

Each category starts out with maximal assistance, which means that the disabled person can't do the task at all, and progresses through seven levels. The final level is that the person requires no assistance to complete the task. In the first stage of the game, each player gets 18 moves, at which time he or she can move a peg from any category, even repeating categories during a turn.

During the free-form phase, when participants make their initial moves, no one is allowed to speak. They are only allowed to move their pegs. "The reason is to be sure there is no one person who dominates the group. We wanted to make sure that all people are contributing equally," explains Stineman.

In the second phase, each participant views the board as it stands and determines which function

he or she would like improved upon. For example, the player may want to be able to eat with less assistance from another person. Players are allowed to move an item up one, but he or she has to move a different item back one to compensate for it.

During this phase, the team discusses each move and votes on whether the peg is moved or stays where it is. "The game creates a situation where people who are playing have an opportunity to express what they value and why they value it. They also hear what other people's values are," says Stineman.

At the time of the study, four panels were involved in playing the game. Two panels consisted of clinicians only, and two had disabled patients. The reason the panels were separate is that the researchers wanted to look at the differences between consumers with disabilities and the professionals who care for them.

Since the study was conducted, Stineman has played the game during residency training programs to teach young doctors the value of choices relative to the functional status of disabled patients. She also has played the game at national meetings for physicians. There is a very large game board that can be seen from across a room during group presentations, and then a small version that can be played while participants sit around a table.

Although the game was created as a research tool, Stineman is considering making it a clinical tool. If patients played the game with family members, they would have an opportunity to discuss goals. It also could be played with the therapist and a patient.

"When we developed the game, I wanted to determine if the values were the same between people who are scientists and clinicians and have gone through an intellectual training half their lives, and the people they are serving — and also what the differences are. I think these are very important questions," says Stineman. ■

SOURCES

For more information on using Stineman s research tool to assess the goals of disabled patients, contact:

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Cyber-solace provides patient support

On-line groups provide good alternative

Support for computer-literate patients is available 24 hours a day . . . on-line. That makes Internet support groups particularly beneficial for homebound patients, according to **Paula Klemm**, DNSc, RN, OCN, associate professor at the University of Delaware department of nursing in Newark.

Health care professionals needn't fear the unstructured format, either. "If there is bad or incorrect information given, you'll have 10 people correcting it immediately, so that is an advantage," says Klemm.

To determine what type of messages were left in "cyber-solace" groups, Klemm examined the contents of 300 messages to an Internet support group for people with colon cancer. A qualitative analysis of what people talked about yielded eight different categories. These included information giving and seeking, relating personal experiences by both patients and caregivers, notes of thanks, humor, prayer, and miscellaneous messages.

"Basically, people sought information about the disease as well as treatment and its side effects. They gave advice and personal opinions about treatment and how they felt," says Klemm. Because it was colorectal cancer, both men and women

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were involved in the support group, and Klemm saw no difference in their level of participation.

A second study was set up to determine if message content would be different for an all-female group vs. an all-male support group. To obtain this information, Klemm tracked messages on an on-line breast cancer support group and an on-line prostate cancer group.

She determined that men were technically oriented and most often sought or gave information. Women sought information too, but they also left a lot more personal support messages, such as "Keep up the positive spirit." Klemm says her findings agree with the literature that states men join traditional support groups to share information, while women are more social. **(For more information on traditional support groups, see *Patient Education Management*, March 1999, p. 25.)**

There are many benefits to participating in on-line support groups, says Klemm. Because there are no geographical restrictions, people can communicate with others all over the United States and around the world to inquire about the latest treatments. Also, the groups are available 24 hours a day, and a posted message often gets 25 to 50 responses. "People get home from work or home from chemotherapy and they just pop on the Net anytime. There are messages posted all times of the day and night," says Klemm.

Yet convenience doesn't ensure ongoing participation. Certain people post a lot of messages, and then there are others who only post once.

One of the drawbacks of on-line groups is that it costs money to have a computer and connect to the Internet. Also, there is no actual personal contact. A third drawback is the fact that there is no professional facilitator. Most traditional groups are facilitated by such professionals as a social worker or a nurse. Without expert guidance, it is more likely for participants to pick up incorrect information, even though Klemm found that people do correct erroneous facts.

Before suggesting an on-line support group, patient education managers should subscribe to it for a day or a week to see what kind of information the group is sharing, advises Klemm. "It is good to know what people are saying on-line," she explains.

Just how much time people spend in on-line support groups is difficult to determine. Some answer a lot of messages, and others belong to more than one group. In Klemm's next study, she will be asking people about the amount of time they spend on the Internet.

SOURCES

For more information about on-line support groups, contact:

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Research has suggested that people who spend a lot of time on the Internet are more depressed than other people. Therefore, she will compare cancer support groups in the traditional setting to the cancer support groups on-line to see if there are any differences in depression levels.

Information seeking usually draws people to an on-line support group, but once there they will realize many other benefits. They find they will receive support, get information they didn't think to ask for, and make new friends, says Klemm. ■

Patient Education Management (ISSN 216) is published monthly by American Health Consultants®, 3525 Piedmont Road, N.E., Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodical postage paid at Atlanta, GA 30304. POSTMASTER: Send address changes to **Patient Education Management**, P.O. Box 740059, Atlanta, GA 30374.

Subscriber Information

Customer Service: (800) 688-2421 or fax (800) 284-3291. Hours of operation: 8:30 a.m.-6:00 p.m. Monday-Thursday; 8:30 a.m.-4:30 p.m. Friday EST. E-mail: customerservice@ahcpub.com. World Wide Web: www.ahcpub.com.

Subscription rates: U.S.A., one year (12 issues), $319. Approximately 18 nursing contact hours annually, $359. Outside U.S., add $30 per year, total prepaid in U.S. funds. One to nine additional copies, $255 per year; 10 or more additional copies, $191 per year. Call for more details. Missing issues will be fulfilled by customer service free of charge when contacted within 1 month of the missing issue date. **Back issues**, when available, are $53 each. (GST registration number R128870672.)

This continuing education offering is sponsored by American Health Consultants®, which is accredited as a provider of continuing education in nursing by the American Nurses Credentialing Center s Commission on Accreditation. Provider approved by the California Board of Registered Nursing, provider number CEP 10864.

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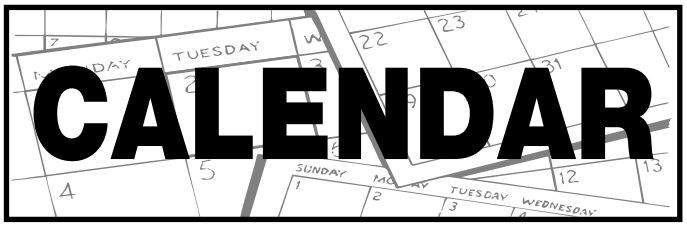
Improve staff training with tools that prompt

To improve documentation of patient education, The Ohio State University Medical Center in Columbus added the topic to the list of annual mandatory education for staff. But a yearly class is not enough to make sure documentation is consistent, says **Sandra Cornett**, RN, PhD, program manager for consumer health education at the medical center. She has introduced two additional tools as well.

She created a self-instructional package on documentation of patient education that takes about one to 1½ hours to complete. As an incentive for participation, all disciplines can obtain continuing education credits for completing the packet.

A third tool is a pocket card that lists the steps of documenting on the form used at the medical center. The card will prompt people who educate patients to complete such tasks as checking off the "readiness to learn" column. "It will have the specifics on how to document using our form. It is something staff can put into their pocket as a reminder," explains Cornett. ■



• **Cultural Competency: Building Bridges to Understanding for Health Care Professionals** — May 7, 1999, at Ala Moana Hotel in Honolulu. The fee for the one-day conference is $115 before April 16 and $135 after that date. An optional workshop on May 8 costs $60 before April 16 and $75 after that date. The workshop is restricted to those who attend the conference on May 7.

This conference is designed to help nurses, dietitians, pharmacists, health educators, therapists, social workers, physicians, and others in the health care field expand their cultural sensitivity and develop skills they can use to work well with clients of all cultures. The featured speaker on May 7 is Marjorie Kagawa-Singer, RN, MN, PhD, assistant professor at the UCLA School of Public Health and the Asian American Studies Center in Los Angeles. The workshop on May 8 will provide highly interactive training in cultural competency.

For more information, contact: The Queen's Medical Center, Health Education & Wellness, 1301 Punchbowl St., Honolulu, HI 96813. Telephone: (808) 547-4823. Fax: (808) 537-7828. ■