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Transdisciplinary rehab takes teamwork to a whole new level

Therapists overlap tasks for patients' benefit

You, and everyone else you know in rehab, surely are familiar with the interdisciplinary model for health care. Everybody's doing it. But have you heard of the *trans*disciplinary approach?

Transdisciplinary is the newest buzzword in rehab, as hospitals around the country are beginning to experiment with a completely new way of doing therapy. It turns teamwork on its head, breaking down the walls between disciplines to eliminate barriers that keep patients from returning home.

In the interdisciplinary model, a speech therapist might hear from a nurse during a team meeting that a patient is having trouble transferring from the wheelchair to the toilet. In the transdisciplinary approach, that speech therapist would help the patient get to the bathroom and use the event as a teaching opportunity.

At SSM Rehab in St. Louis, the various rehab disciplines — nursing, occupational therapy (OT), physical therapy (PT), speech therapy, social work, psychology, and case management — work together to set a collective goal for a patient's discharge and then identify the barriers to that discharge, says **Lori Adams**, MSP, CCC/ SLP, regional speech therapy manager.

"The issues that are important are mobility, ADLs [activities of daily living], communication, discharge, and medical status. Everybody involved in the team is involved in all those areas to some degree," she explains.

"There's a lot more overlap; there are less boundaries. Truly, the patient is the center of all the care that occurs. It makes rehab occur throughout a 24-hour day instead of just when the patient is in therapy," Adams says.

Under the interdisciplinary model, a speech therapist would work on communication goals but wouldn't worry about carrying over PT or OT goals. But with the transdisciplinary approach, the speech therapist might go to the PT area, walk the patient back, and help the patient

transfer to a regular chair to start the speech session. And instead of asking the patient to talk about the sequence of steps required to brush his teeth, the speech therapist might go to his room in the morning and ask him to tell the steps and then actually do them.

"You're helping them to become more functional," Adams says. "Interdisciplinary is certainly team-oriented, but there are still those boundaries between the therapies and nursing because I'm gearing in on my specialty only."

In just a year of using this approach, the results have been unbelievable at SSM Rehab, she adds. Patient satisfaction scores rose from 93% willing to recommend SSM's service to 100% in the first three months. Discharges home increased 3% on average. The hospital goal is 75% discharges home, and the transdisciplinary team has consistently met that goal and, at times, has gone as high as 88%. Communication has improved with the model, according to the Staff Perception of Communication Effectiveness Survey.

In October 2002, the effectiveness on a scale of 1 (poor) to 4 (good), was 2.5 overall. By March 2003, the score rose to 3.32 overall. Adams says the transdisciplinary team also has been significantly better at predicting functional patient outcomes with the accurate setting of goals.

One of the reasons for the increased discharges home is that caregiver education begins preadmission. "Usually, it is only close to discharge that they get the hands-on training. But we're finding that if you don't bring in the caregivers until the end, they think the patient hasn't made much progress," she explains. "They get scared and think they couldn't possibly take the patient home. But if they see the progress along the way and have the chance to practice while the nurse or therapist is there, they feel much more comfortable. We've had some patients who would have gone to a nursing home go home instead."

Team conferences have changed from going around the room and letting each discipline speak to focusing on the barriers to discharge. Those barriers are set by the patients, not just by the therapists. SSM staff have found that often the things they are most concerned about are not what the patient feels will keep him from going home.

"Now it's problem-oriented," Adams says. "We'll say, 'How is his mobility? How's he doing with his ADLs?' and it opens the meeting up for anyone to speak. We get a lot more input that way."

In one example, the speech therapist felt the patient was ready to discharge but the physical therapist said she was having trouble following directions in the gym. So the speech therapist joined in the PT session and saw a whole different person who could not process directions in a distracting environment. Since real life often is distracting, there was more work to be done, Adams points out.

It wasn't easy at the beginning to get therapists and nurses to hand over parts of their jobs to one another, she says. But once they saw how much better it was for the patients, the buy-in came.

"Speech therapists are not as proficient at transfers obviously as physical therapists, but really that gives more connection to how the patient will function at home with a caregiver who may not be great at transfers either," Adams says.

Angela Dietsch, MA, CCC/SLP, a speech language pathologist for SSM Rehab in St. Joseph

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Health Center in St. Charles, MO, says the biggest benefit of the new approach is that it is so patient-focused. "Everything that happens from before the patient ever arrives until after the patient leaves is individualized to that person's needs instead of the predetermined set of ideas about what a person should be achieving," she says.

One of the hardest aspects for therapists is separating what they might want if they were in a patient's shoes and what the patient actually wants. "Our training is very much, 'You work on this and then you work on this,' because normally skill retraining does happen in a sequence," Dietsch adds. "But the things that are obvious to work on from a therapeutic standpoint aren't always the things that are most important for that particular person."

For example, speech therapists might work on developing automatic speaking skills, such as saying, "Fine," when someone asks, "How are you?" Then they might move on to filling in the blanks, so the patient would respond to "salt and" with "pepper," she continues. "But in real life, those things don't happen in order. In real life, I might skip three of those steps in the process and go to a multimodal form of communication. This person needs to be able to tell me when they need to go to the bathroom. I'm not going to worry about whether they can fill in the blank but whether they have a way to get their immediate needs met."

Another patient might have his own goal of becoming independent at a wheelchair level. "Normally once a patient can stand, we would work on walking," Dietsch says. "But for that patient, walking might not be as important as the ability to transfer by himself. So we may put all our energy into transfer skills so he can be independent at home."

Any part of the patient's day can be used as a teaching opportunity, she says. If it's time for the patient's speech session but she is not yet dressed for the day, the speech therapist can help the patient dress while focusing on a speech goal such as answering yes-or-no questions or following a two-step command. "I have to use my creativity to make each activity a speech lesson," says Dietsch. "The big benefit as therapists is that we're all working on all these things that the patients will have to do when they get home. We're overlapping all day long."

Chris Walck, OTR/L, an occupational therapist also with SSM Rehab at St. Joseph, says she appreciates the way communication is continual among the staff throughout the day. "The red flags overlap between the disciplines, and we can brainstorm together on how to deal with them. For example, bowel and bladder used to be a nursing thing. Now, we look at it as an essential component for the patient to go home. The nurse might encourage the patient to use a walker rather than just getting them to the toilet the quickest way possible."

Therapists have to get used to new habits, but the effort is worth it, Walck says.

"This is the right thing to do. The intent with all therapists is to provide the best for our patients, but sometimes the mechanism to accomplish that isn't conducive to that. This has improved our communication from the morning huddle where we talk about barriers to the change in the team conference format," she says. "There's an openness to educate and train other disciplines about things that need to be reinforced throughout a person's stay." ■

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Get developmentally disabled adults exercising

Researchers tout benefits

Getting patients to start exercising and keep going is one of the biggest hurdles in rehab. Most patients probably know they would be better off taking walks and eating vegetables, but lying on the couch and eating chocolate may be much more enticing. Changing that mindset can certainly be a challenge.

But what if your patients have a disability that

not only affects their bodies but also their minds?

For people with developmental and intellectual disabilities, staying healthy can pose an even more difficult problem. They may not understand the importance of exercising, and even if they do, they may not know how to use fitness equipment. They may not have anyone to encourage them to go out for a walk or to drive them to a fitness facility. Or they may spend their days with caregivers who don't believe exercise is necessary for a person with such a disability.

That mindset is prevalent but untrue and potentially damaging to patients, says **Tamar Heller**, PhD, director of the Rehabilitation Research and Training Center on Aging with Developmental Disabilities at the University of Illinois at Chicago.

The center recently received a five-year, $3.75 million grant from the U.S. Department of Education's National Institute on Disability and Rehabilitation Research to continue its research on serving the needs of people with developmental disabilities.

People with disabilities such as Down syndrome or cerebral palsy have high health-risk factors because they tend to be obese and sedentary and often have poor access to health care. "Many people with developmental disabilities are in danger of developing secondary conditions at earlier ages than other people," Heller says.

"Often health professionals are not that knowledgeable about specific syndromes and what's associated with them. For example, if someone has Down syndrome, some of the aging processes may be different from someone with autism. We're starting to see that there are different trajectories based on syndromes as people age," she adds.

The reason is an increased life span for this segment of the population. Fifty years ago, the average life expectancy of a person with Down syndrome was nine years. Half of children born with the disability died within the first year. Now, people with Down syndrome live to an average age of 56.

Recent studies show that people with intellectual disabilities have an average life span of 65, not that far behind the general population at 70.

"There have been so many treatment advances for people with developmental and intellectual disabilities," Heller says. "People are living in better settings. More people are in the community; they're not being sent to institutions. They're being served in rehab settings. This is very much of a growing population. In many rehab settings, we're finding that more and more of the people we're serving are older."

Because of the dramatic improvements in life expectancy, there will be an estimated 1.2 million people with intellectual or developmental disabilities by 2024 as the last of the baby boom generation (those born in 1964) reaches the age of 60. The increased life span also means that people with disabilities are starting to outlive their parents, who tend to be the primary caregivers.

Heller notes that 76% of those with developmental disabilities live with family members and that 25% of those family caregivers are older than 60. "There is a clear, urgent need for both greater breadth and depth of information regarding aging and the needs of persons with these disabilities," she says.

12-step fitness

Some of the center's research has focused on developing a health promotion program and curriculum. Heller and her colleagues developed a 12-week exercise and education program that has resulted in big improvements in fitness, knowledge, motivation, depression rates, and life satisfaction.

"When they first come in, they have no idea how to use any of the equipment. People with Down syndrome have low blood pressure, so they come in with little energy. By the end, they're just really roaring," she says. "But we find that they go back to their place and not much happens. So we're working on developing the program in day or residential programs so they will continue exercising."

The program offers 12 weeks of activities specifically designed for people with developmental disabilities. Three one-hour sessions per week are offered to help participants achieve the following:

- understand attitudes toward health, food, and exercise;
- gain skills and knowledge about healthy eating and exercising;
- identify food and exercise preferences;
- participate in food preparation and exercise activities;
- locate places in the community where they can exercise regularly.

The curriculum focuses on stages of change: awareness, knowledge, action planning, and follow-through. "We work on the theory of self-efficacy. You have to feel that you can make the changes, and you have to feel that these changes can have a desired outcome for you," Heller says. "At the psychological level, we operated on that.

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You also have to provide social and environmental support, and you have to get rid of some of the barriers that people have."

Researchers studied 32 participants ages 30 to 55 who went through the 12-week program and compared them to an 18-member control group. Participants reported a variety of barriers to exercise, including cost (47%), lack of energy (47%), transportation (40%), no one to show them how to exercise (40%), lack of access to fitness centers (40%), boredom with exercise (37%), and exercises too difficult (37%).

But after the program, participants lost an average of 2 pounds and reported less pain in daily activity, increased confidence, more positive attitude for exercise, and lower rates of depression. Cardiovascular function, strength, and endurance improved, and participants had lower triglycerides. The results will be published in an upcoming issue of the *American Journal on Mental Retardation.*

"It doesn't work to say, 'Go to the Y.' They don't know how to use the equipment. There really need to be some special adaptations," Heller points out. "It's important that whatever we do, fits with their lifestyle and is something they like. It's got to be fun. There has to be a lot of group camaraderie."

One creative way the researchers came up with to help the participants learn the exercises was to use a digital camera. "We took pictures of them exercising, and they go home with a whole workbook that shows everything they did," she says. "They also go home with a video of themselves exercising. We make it very simple. We tried to think about what you need for people who have cognitive limitations. We worked with people who had moderate to mild disabilities, and they were able to learn the concepts."

The researchers also are working on educating staff members who work with disabled patients about the importance of health promotion. "In one of our studies, the biggest predictor of whether people would exercise or not was the attitude of their staff about whether they would benefit from it," Heller adds. "One study on people with cerebral palsy found that half of the staff who worked with those patients didn't believe they would benefit from exercise. Those were the people who didn't exercise.

"Some people think if you are disabled — and even physicians may be afraid — and maybe in a wheelchair that you're not going to benefit from exercise," she continues. "We still see a lot [of patients] who are pessimistic [about whether] they are going to do it, or they worry because they're so overweight. We do screen out people who have major problems, like heart problems, but the rest can do it; and they will do it if we help them."

Heller and her colleagues say they plan to use the grant to develop tools to assess the degree to which communities are environmentally friendly to this population. They also plan to look at ways to promote more accessible environments. ■

Rooftop garden helps rehab patients bloom

Plants should cut utility bills, too

Recreation therapist **Patricia Fitzgerald** has a new job description that includes battling ladybugs, spreading mulch, and digging in the dirt. She's learning about ornamental grasses and rose bushes and perennial flowers; she's dealing with irrigation systems and waterfalls and streams.

And she's doing it all on a Chicago rooftop.

That's because her employer, Schwab Rehabilitation Hospital, recently opened a therapeutic rooftop garden that not only provides patients with new opportunities for therapy but also contributes to improving the air quality of the city.

Funded in part by a $400,000 grant from the Chicago Department of Environment, through Commonwealth Edison, the garden features the latest greenroof technology.

"The whole principle behind it is it works as a cooling system to cool off your roof and, hopefully, to reduce your utility bills at your facility but then also to cool off the environment," says **Brenda Koverman**, MBA, MS, OTR/L, director of inpatient therapy services at Schwab.

"The idea behind this is that a bunch of rooftops

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in an urban area will have these gardens on them, which will lower the temperature of the whole city."

Schwab looks at the environmental edge as a bonus to the real advantage: the opportunity to provide innovative therapy in beautiful surroundings.

The garden, which had its humble beginnings as a wheelchair basketball court, now boasts a series of pathways that meander past lush plantings and a waterfront garden with a waterfall, pond, and stream. Butterfly bushes attract hundreds of butterflies. Children play in a special area with cushy pavers that allow them to get out of their wheelchairs. Families walk together or sit and visit at night. Staff members eat lunch or take breaks in the fresh air.

But most importantly, patients get therapy without even realizing it, Fitzgerald explains. Physical therapists use the garden to help patients practice walking and topographical orientation. Psychologists use the area as a calming environment for group sessions. Occupational therapists help patients practice standing balance and fine motor skills while they do activities in the garden. Speech therapists work on cognitive and memory skills by asking patients to name certain flowers or follow a direction to find a certain plant.

Recreation therapists offer horticultural therapy, encouraging patients to help plant, water, weed, and trim. The water and plants provide opportunities for relaxation therapy and aromatherapy.

"You can take stroke patients and work on their fine motor coordination, cognition, and problem solving, all while they're taking care of plants," she says. "They get to be primarily outside when the weather is nice and do things in a way that's different from what you can do inside. It relaxes people. They think of it not so much as therapy but as hanging out with the staff. Even though they are meeting their goals, they don't feel like they are in therapy."

In the spring and summer, Fitzgerald will spend half her hours working to maintain the garden. Because there is little shade on the rooftop, she expects to involve patients in continuous watering all day. "It's just a lot of fun for the patients and for me. I love to garden, so it's perfect."

A major benefit for Schwab's patients is that the garden provides a safe environment to be outdoors. "We're located in Chicago between North and South Lawndale, which are two of the poorest communities in Chicago," Koverman adds. "We're in gang territory, and we do get a lot of victims of violence. We do get people who are affiliated with different gangs in the surrounding area. For them to be able to be on the rooftop, whether they have gang affiliations or not, it's a safe place for them to be able to sit."

Schwab, a 125-bed hospital affiliated with the Sinai Health System, serves a population that is 45% Medicare and 45% Medicaid. "We're a not-for-profit hospital. Our mission is to serve the community," she says. "So this is huge that we could get something like this here. It's a wonderful, wonderful thing for our patients to have."

Koverman says the Joint Commission on Accreditation of Healthcare Organizations is considering a standard that would require patients to have some type of outdoor exposure. "It is a great benefit to our patients to be outside," Koverman says. "One of our patients had been in the hospital for almost six weeks with an amputation and a couple of complications. He came to us, and he went upstairs to the garden; and he said how nice it was just to be outdoors. That's a benefit we don't even think about. Most of us have the ability to go outdoors whenever we want." ■

Ergonomics program gives a lift to morale

Hospital survey shows satisfaction

Ergonomics is more than a way to lift patients. As Butler (PA) Memorial Hospital found, it can lift morale and employee satisfaction as well.

The challenge is to overcome negative perceptions and convince staff that hospital administration is serious about reducing injuries, says **Karen Bosley**, RN, manager of the employee health service of the western Pennsylvania hospital.

In a five-question survey, she found that employees did not feel they had adequate training or equipment. The survey indicated that employees believed that injuries were not a high priority to hospital administration. As a consequence, the employees paid little attention to the ergonomic devices the hospital provided. "We found we had employee reluctance to take the time to either use the equipment or get additional staff [to help with a lift]," Bosley explains.

During the following year, the hospital spent $80,000 on equipment, developed a training program, and initiated an incentive program to reward employees who complied.

Visible support for ergonomics was evident from administration. Injuries declined by 33%, and related medical costs were reduced by $123,000.

Just as important, however, was the change in attitude, as demonstrated in a post-implementation survey. "It's absolutely amazing," she says. "Now people think administration cares. They know they've gotten education. They know we've got equipment."

Ergonomics now has become one aspect of the hospital's efforts to be an "Employer of Choice" — a hospital that has an edge in recruitment and retention.

Butler Memorial actually began to investigate ergonomics because of concern over several serious injuries. It was not just the cost that concerned Bosley; although at $400,000 in workers' compensation, the cost was significant.

"We identified employees who had been injured previously, whose quality of life had been [permanently] changed." Employees had undergone back surgery, including fusions and diskectomy, due to work-related injuries, she says.

"They're still working here, but they are not able to do the job they were doing before," Bosley points out. "They are RNs who will probably never be able to go back to the nursing job they did before. Most of them are in nonpatient care-related jobs, such as data collection or staff education. We didn't want any other person to have to go through that. We wanted to see what we could do to prevent future injuries."

In July 2001, the hospital's safety committee decided to create a subgroup to investigate the injuries and develop a plan of action. The committee included Bosley, the safety officer/risk manager, an ergonomist, an employee educator, a floor nurse, the physical therapy director, and the systems improvement manager.

The causes identified by the team are common ones: Employees used poor transfer and lifting techniques. The hospital had no policy defining safe lifting techniques. It lacked adequate equipment. Employees needed patient assessment tools to define when equipment should be used, and employees were reluctant to take the time to use equipment or get additional staff.

Bosley and her colleagues wrote a policy and developed patient assessment algorithms. But they knew that was just the first step.

The safety team sought strong administrative support as well as employee buy-in. She and her colleagues were able to get a commitment for $80,000 to purchase equipment — and the team agreed to be accountable for results. They assured administrators they would achieve a reduction in lifting injuries by at least 25% and a savings of $100,000 in related costs. "We really were adamant that we could do it," Bosley stresses. "We asked for this money and asked for a chance to prove that we could make a difference."

The survey of 1,500 employees provided a way to measure another outcome: employee satisfaction. The safety team was very hopeful it would improve after the intervention.

Staff and managers were an integral part from the start of the program. Employees helped evaluate and select the lifting equipment. They acted in a video that became the training tool for the lift devices. Supervisors added ergonomics to their annual staff competency testing. Additionally, the hospital's ergonomist went to office workstations to make adjustments and improve comfort.

They also faced a common challenge: How do you keep employees motivated to use the equipment? She uses an incentive program to reward staff who were observed using lifts, Hover mats, gait belts, or other ergonomic items. Employees receive $5 gift certificates for pizza, ice cream, movie theaters, and other local stores, along with a congratulatory note. "It wasn't a great deal of money, but it's made a tremendous impact," explains Bosley, who estimates she spent about $1,000 on the incentives. "People really do appreciate that they've been noticed."

She adds that she was pleased recently when she learned of two employees who followed the appropriate lifting policy when a patient lost her balance and began to fall. The nurses eased her gently to the floor. Then, instead of manually lifting her, one stayed with her while the other got a lift.

"They didn't put their own backs at risk," says Bosley. "The patient wasn't injured, and neither were the employees. It's a win-win." ■

Fundraising software bolsters efficiency

More effective management of donor database

The RWJ University Hospital Foundation Inc. has improved the efficiency of its fundraising operations by switching to new software that allows more effective management of its donor database.

The foundation is the fundraising organization for Robert Wood Johnson University Hospital in New Brunswick, NJ, one of the nation's leading academic health centers.

The software it now uses allows the foundation to carefully select donors by their areas of interest, giving history, geographic area, and many other parameters.

RWJ University Hospital Foundation uses resultsplus! software from Metafile Information Systems Inc. of Rochester, MN, to track the response of every fundraising activity and generate targeted lists used for direct mailing and teleprospecting.

It has found that these appeals are far more effective than the untargeted kind, because they reach the right people. In addition, by tracking pledges against actual contributions received, the software helps the university hospital send reminders that ensure each pledge gets paid, without bothering those people who already have paid.

Querying the database makes it easy to create tailored invitation lists for the foundation's various events according to the interests and history of the invitee. "Resultsplus! helps us organize nearly every aspect of the fundraising process to the point where our results have been substantially improved," says **Jill Kolakowski**, accounts manager for RWJ University Hospital Foundation.

Kolakowski says that donations to the foundation come from a wide range of sources — from large pharmaceutical companies and foundations to individuals who are simply grateful for the treatment they received at the hospital. Foundation staff members quickly recognized the importance of moving donor information from the filing cards and spreadsheets typically used by most foundations in the start-up phase to a database specifically designed for the fundraising task.

"The donor database is the lifeblood of any fundraising operation. The problem with keeping this information in paper files is that as the files grow, a foundation's staff have to spend a considerable amount of time sorting through them to find files and record information," she explains.

"It's very easy to overlook or misplace a file, which means you will probably forget to contact that donor. The donor, in turn, might very well think that you have lost interest in them. And if a donor calls with a question, you have to tell them you'll get back with them after you have located their file," Kolakowski points out.

"This [paper file] approach also makes it very difficult to generate mailing lists. Selecting specific names from your donor database that would be likely to respond to a certain appeal takes so much time that it is not very practical," she adds.

Foundation managers evaluated a number of different fundraising software packages. They selected resultsplus! primarily because they felt it was easier to use than the other packages they looked at.

"I came from a nonprofit using a different software package," says **Debra Miller**, special events manager for the foundation. "When a new person joined the organization, it usually took them a considerable period of time before they became productive. With resultsplus!, on the other hand, all of the most common things you need to do on a daily basis are connected to icons that are always right in front of you on the screen. This makes the program very easy to use," she notes.

While user-accessible and easy to use, the software offers a full range of advanced features. For example, doing an advanced mail merge makes it possible to target mailings to specific individuals within corporations.

And the product allows you to attach gifts and pledges to either an individual for separate giving histories, or to a household or corporation for combined giving histories. Resultsplus! can process any gift, including tributes, split gifts, matching gifts, on-line gifts, and soft credits, as well as in-kind and effective value donations.

All standard reports can be tailored to the needs of an organization or users; staff can start from scratch and create their own reports while accessing all of the information stored in the database.

The foundation configured the software to track donations to nearly 100 separate funds, such as the emergency department, community outreach programs, hematology/oncology, cardiology, nursing education, medical equipment, pediatric programs, and so forth.

"Every gift that comes into the foundation is entered into resultsplus!, making it possible to

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go to one source to track every contribution and donation that has ever touched our organization," Kolakowski says. "One of the most important benefits is that we can focus our fundraising efforts on people who have proven interest in the area that we are targeting.

"Most of our contributors identify with one or several particular diseases or medical specialties and are primarily or exclusively interested in contributing to them. For this reason, nearly all of our appeals are targeted to a specific field of medicine. Resultsplus! lets us very quickly generate lists that target any particular specialty in a matter of minutes," she continues.

"I simply query the database for a list of people who meet certain criteria, such as having given a contribution to a particular fund in the past or having given a certain number of contributions or a certain dollar amount," she says.

"The software instantly pulls up a list of everyone in our database who meets my criteria. I can then merge a letter to that list of people or export a file for an outside telemarketing firm to call. The big advantage is that we now spend our resources only on communicating with people who are likely to be interested. At the same time, we protect our contributors from feeling they are being bombarded and ensure that they pay attention to the few targeted appeals they do receive from us," Kolakowski explains.

The foundation also receives lists of prospective donors from affiliated institutions such as the Heart Center of New Jersey, she notes. "The first thing we do is to enter them in resultsplus! and filter them against our existing contributors to make sure we don't contact a donor as if we are talking to them for the first time.

"By the same token, we have the telemarketers send us their pledge lists on a daily basis so we can update our database and make sure we don't send a reminder to someone who has just made a contribution. The bottom line is that we avoid annoying our donors by contacting them as few times as possible while also saving money in the process," Kolakowski adds.

Having a detailed record of every contribution also makes it easy to give recognition to your contributors, she observes. "We generate a report at the end of each year that lists the contributors for our annual report. All we have to do is export the list to a Microsoft Word format and send it to the people who lay out our annual report for us."

Miller says the new software is very helpful in planning the foundation's special events.

"We sponsor golf outings and participate in the Auxiliary's Charity Ball. We use resultsplus! queries to generate an invitation list for each of these events. The lists are based on a variety of factors, such as whether or not the person has previously attended the event, their level of giving, and their interest in the specific area. We can be almost certain the names and addresses in the database are correct because they are checked every time we contact each donor. Generating these lists manually would be a nightmare, but with resultsplus!, it is a breeze," she adds. ■

AMA ethical guidance now available for e-mail, web

E-mail only in established relationships

As new information technologies continue to make person-to-person communications easier and more varied, they also are transforming the way that health care can be provided.

Patients frequently make appointments and receive information via e-mail, and some even get second opinions from on-line web sites. While these advances have enormous potential to improve access to care, it's important that medical professionals address potential ethical and legal complications new technologies pose.

Last month, the American Medical Association's (AMA) Council on Ethical and Judicial Affairs (CEJA) in Chicago published two reports offering guidance on the appropriate use of e-mail and health-related on-line sites.[1,2] **(For CEJA's Internet use guidelines, see box, p. 10.)**

"These are the first in a series of reports that we are planning that address ethical uses of emerging technologies," explains **Michael S. Goldrich**, MD, chair of the CEJA and a practicing otolaryngologist in Highland Park, NJ. "We wanted to address the increasing potential for medical care to be delivered at a distance. Primarily, we are beginning to look at the practice of telemedicine, but we also

Guidelines for Internet Use

E-mail recommendations

1. E-mail correspondence should not be used to establish a patient-provider relationship. Rather, e-mail should supplement other, more personal encounters.
2. When using e-mail communication, providers hold the same ethical responsibilities to their patients as they do during other encounters. Whenever communicating medical information, physicians must present the information in a manner that meets professional standards. To this end, specialty societies should provide specific guidance as the appropriateness of offering specialty care or advice through e-mail communication.
3. Providers should engage in e-mail communication with proper notification of e-mail's inherent limitations. Such notice should include information regarding potential breaches of privacy and confidentiality, difficulties in validating the identity of the parties, and delays in responses. Patients should have the opportunity to accept these limitations prior to the communication of privileged information. Disclaimers alone cannot absolve providers of the ethical responsibility to protect patients' interests.
4. Proper notification of e-mail's inherent limitations can be communicated during a prior patient encounter or in the initial e-mail communication with a patient. This is similar to checking with a patient about the privacy or security of a particular fax machine prior to faxing sensitive medical information. If a patient initiates e-mail communication, the provider's initial response should include information regarding the limitations of e-mail and ask for the patient's consent to continue the e-mail conversation. Medical advice or information specific to the patient's condition should not be transmitted prior to obtaining the patient's authorization.

Source: The American Medical Association, Council on Ethical and Judicial Affairs, Chicago.

realized that there was some groundwork that needed to be done first." There are a number of communication technologies that have become more frequently used in health care settings — fax, e-mail, interactive web sites — that need closer examination, he says.

The CEJA wanted to examine how different communication methods are being used and how these uses may affect the physician-patient relationship. In their research, they discovered a wide variety of practices:

- Some practitioners use e-mail to recruit new patients and communicate a variety of clinical and diagnostic information this way, while others use e-mail exclusively as a method to reserve appointments or communicate routine, nonsensitive information.
- Institutions sponsor or participate in interactive web sites to provide a wide variety of health information to patients and the public. Some web sites provide general information, but some provide — or attempt to provide — detailed, individual medical advice.

"The quality of the sites varies a great deal. Some are maintained by physician's groups or other institutions to offer information to patients, while others were started by various e-business ventures," Goldrich says. "Some provide information tailored for specific patients, while others offer more general medical information, but that sometimes crosses the line and gets into more what we would consider to be patient care and advice."

The guidelines developed by the CEJA are meant to give guidance about how these information technologies can be used ethically and to enhance relationships with patients.

In general, the CEJA recommends that e-mail between practitioners and patients be limited to correspondence with an already established patient, and that the provider — in a face-to-face meeting with the patient — explain the limitations and vulnerabilities of e-mail communications and determine whether e-mail might be an appropriate means of communicating with that patient.

The provider and patient also should determine what kinds of information can be communicated via e-mail, whether the patient's e-mail address is secure, and what personnel on the practice's end will have access to the patient's e-mail messages.

For example, a patient who uses an e-mail account at his place of employment might need to understand that his employer might have access to messages he receives at work and, thus, any medical information contained in them.

Several on-line sites now are offering medical advice on-line — both to established patients and to nonaffiliated members of the public, Goldrich notes. For example, individuals can seek on-line consultations at Johns Hopkins Radiosurgery (www.hopkinsmedicine.org/radiosurgery), or inquire about a second opinion at the Cleveland Clinic's site, e-Cleveland Clinic (http://ecleveland clinic.org). At e-Cleveland, people may upload medical records and diagnostic test results for a second opinion. This involves entering a secure site and filling out an on-line questionnaire that

Need More Information?

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documents patients' medical conditions.

Provided appropriate measures are put in place, these methods of patient encounters are not necessarily as problematic as they might appear, Goldrich adds. "These are examples of technologies developed that are appropriate to the existing practices of the institution."

At a major center such as Johns Hopkins or the Cleveland Clinic, a patient's medical information may be sent to someone in a specialty area, such as radiology, or reviewed by the chairman of the department of medicine in order to confirm a diagnosis or get another opinion about a treatment option. This is not so different from a patient seeking similar input through the on-line site.

"Some patients travel an entire day's journey for a consultation at such a center, while this method might allow them to get the same information without a long journey," he says. As long as appropriate procedures have been established, both methods should be equally sound, Goldrich notes. It's important for providers to consider the specific benefits and limitations of each kind of technology and develop policies and procedures concerning their use that reflect that understanding, he says.

Emerging technologies have the potential to facilitate and ease communication between patients and providers, and eliminate access barriers to those in remote areas for whom traveling is difficult or impossible. But it is the responsibility of the AMA and other medical societies to determine the ethical issues that individual technologies may present and educate their members about how to address the issues, Goldrich says.

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2. Bovi AM. Use of health-related on-line sites. *Am J Bioethics* 2003; 3(3):InFocus. Accessed on-line at www.bioethics.net. Also, go to: www.ama-assn.org/ama/pub/category/5496.html. ■

Washington voters reject ergonomics rule

Vote may impact other ergo efforts

In an action that may have national repercussions, voters in Washington state have rescinded the only preventive ergonomics rule in the country.

Ballot Initiative 841 passed by a vote of 54% to 46%, eliminating the ergonomics rule and preventing state Department of Labor and Industries from developing another one until the federal government enacts a regulation. The department now will focus on consultation and education, says public affairs manager **Steve Pierce**.

"If people had a more honest understanding of what that was about, there's no way it would have [passed]," says **Bill Borwegen**, MPH, health and safety director of the Service Employees International Union (SEIU) in Washington, DC. "It's a very sad day for people who are concerned about employee health."

A Washington business coalition ran a radio and television campaign that asserted that the ergonomics rule would kill jobs in the state. "The costs of doing business are very high in Washington compared to a lot of other places in the country," says **Don Brunell**, president of the Association of Washington Businesses (AWB), the state's chamber of commerce. "We looked at the jobs that would not be created and jobs that would be eliminated. People could just not afford to have any more regulations put on them." Although it was opposed to the rules, which it considered ambiguous, the AWB supports ergonomics, he points out. In fact, the AWB has announced an ergonomics education effort, including an ergonomics workshop.

Worker advocates had hoped the Washington ergonomics rule would be a springboard for similar actions in other states.

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California has an ergonomics rule that is triggered after at least two workers report repetitive motion injury within a 12-month period. Unions there have tried unsuccessfully to revise the standard to make it stronger.

Washington's rule required businesses to identify "caution zone jobs" that put workers at risk and to reduce the hazards of musculoskeletal disorder injuries. The rule was to become effective on a staggered timeline, with the more hazardous industries, such as nursing homes, taking priority. Hospitals were required to begin assessing job hazards by July 1, 2003, and to begin reducing those hazards by July 1, 2004.

Gov. Gary Locke delayed enforcement for two years based on recommendations from a Blue Ribbon Panel on Ergonomics. But business coalitions continued to fight the rule in the legislature, the courts, and the ballot box.

"They bombarded people with what we considered to be lies about the rule," says **David Groves**, spokesman for the Washington state labor council, an umbrella organization for unions and the state federation of AFL-CIO.

"They said the rule was certain to kill jobs in the state, to play upon people's economic insecurity. They said the rule will limit some people's jobs to four hours a day, which isn't true. They also said that children would lose health care benefits. I guess the rationale is that if you went from full time to part time, you'd lose health care insurance. It was a ridiculous claim."

Ergonomic hazards still can be addressed through the "general duty clause" of the Occupational Safety and Health Act, which requires employers to maintain a workplace free of serious, recognized hazards. While issuing some ergonomic citations, the Occupational Safety and Health Administration (OSHA) is focused primarily on voluntary guidelines and educational efforts related to ergonomics. Congress rescinded OSHA's ergonomics rule in 2001.

"Whether we're going to use that [enforcement clause] is too early to say," Pierce adds. "We have a lot to sort out [with the passage of the initiative]. He notes that Washington has about 50,000 work-related musculoskeletal injuries per year.

Meanwhile, unions plan to continue other efforts to address ergonomic hazards. The debate over Initiative 841 brought ergonomics into the spotlight and provided an opportunity to education workers about the hazards, Groves says. ■