Managing Patients' Pain

New Standards
Role of Ambulatory Care Nurse is Key

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

Over the past 20 years, unrelieved pain has been identified as a major public health problem. Unfortunately, many barriers exist for providers, patients, and families that prevent an objective and open-minded approach to quality pain management.

Pain is prevalent and costly and exists in virtually every clinical area. Nurses live the experience daily with their patients. The quality of pain management will depend on the knowledge and skill nurses have and the extent to which they assume their role as a patient advocate.

Recently, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) announced the development and approval of pain standards. These standards set new expectations for patient rights regarding pain assessment, monitoring, and management. The first scoring compliance will occur in 2001. While not all institutions or organizations are surveyed by JCAHO, these standards set a precedent for

Advances in Care
‘Cancer Doesn’t Have to Hurt’

Pamela J. Haylock, MA, RN

Perhaps in no other area of health care is the continued use of inappropriate and inadequate medications and adherence to outdated standards of care so accepted, tolerated, and ignored as it is in the management of pain.

There is evidence that tolerance is fading: several high-profile court cases resulted in decisions against health care professionals who undertreated or otherwise mismanaged cancer-related pain. More changes may occur as a result of the Joint Commission on Accreditation of Healthcare Organizations’ (JCAHO) mandate of effective pain management for all patients (see article on left).

Cancer Pain

Many human ailments are linked to pain, but the pain of cancer continues to be a source of fear for people who have or are at risk for developing cancer. And, with good reason. Pain is a common experience for the vast majority of people with cancer.

At the time cancer is diagnosed, nearly half of all patients have already experienced moderate to severe pain. Nearly 75% of people with advanced cancer have pain (Jacox et al., 1994).

Cancer-related pain is caused by the cancer itself and/or by the sequelae of many forms of cancer treatment. Despite the widespread acknowledgement of its presence and severity, cancer pain is generally undertreated in both adult and pediatric patient populations. Most confounding of all is the revelation that at least 90% of all cancer pain can be controlled via simple means, such as a scheduled oral analgesic alone or combined with adjuvant or nonpharmaceutical interventions.
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Mankind’s most universal fear is pain. One of the factors that can influence a person’s perception of the pain experience is culture. To more effectively manage pain, clinicians need to conduct culturally sensitive pain assessments and incorporate patient’s cultural beliefs and approaches toward traditional healing practices into the pain management plan.

Inadequate pain management is widespread, especially among minority groups, and a major reason for undertreatment is the failure to assess pain properly in culturally diverse patient populations. As the United States continues to become more culturally diverse, clinicians find it increasingly difficult to care for patients from various cultures whose primary language is not English.

Interest in developing culturally appropriate pain assessment tools is the first step in preventing undertreatment. You can assess pain in patients from many cultures by using assessment tools similar to those you usually use, and these will give you results that will have comparable meaning across cultures.

The horizontal 0-10 numerical pain rating scale and the Wong-Baker FACES Pain Rating Scale® (see page 5) can be translated into different languages. Refer to McCaffery & Pasero’s Pain: Clinical Management (1999) where you will find the 0-10 scale in 18 languages and the Wong-Baker scale in 8 languages. You may need to adapt these, for example, Chinese patients may understand a vertical presentation more readily than a horizontal one because Chinese is read vertically downward, from right to left. Also refer to the article Culture, Pain, and Culturally Sensitive Pain Care (Lasch, 2000) for a sample tool to elicit beliefs about pain that nurses can use to obtain a culturally sensitive pain assessment.

Pain and its Implications

Because the most accurate way to assess pain is via patient self report, health care providers should provide validation and support.

“Pain is whatever the experiencing person says it is, existing whenever the experiencing person says it does,” (McCaffery, 1999). Patients should be informed that pain relief is an important part of their health care, that information about options to control pain is available, and that they are welcome to discuss their concerns and preferences with the health care team.

Undertreated pain places patients at risk. Our cultural attitude of “no pain, no gain” has proved to be dangerously wrong. Research now shows that unrelieved pain can inhibit the immune system and enhance tumor growth. Pain causes increased oxygen demand, respiratory dysfunction, decreased gastroint...
Clinicians’ Cultural Beliefs and Values

Just as patients’ attitudes about and responses to pain are affected by their personal and cultural values, so are those of their caregivers. The more cultural differences that exist between patient and nurse, the more difficult it is for the nurse to assess and treat the patient’s pain. In a study led by Harrison (1996), the pain ratings of 50 hospitalized patients who spoke Arabic were compared with pain assessments made by nurses who spoke Arabic and those who didn’t. The results revealed that the nurses who shared a language with patients were much more likely to rate pain similarly to patients than those who didn’t. Thus, it’s wise to be especially careful when assessing pain in patients who don’t share your cultural background.

Physicians’ clinical judgements about pain are influenced by factors including age, gender, race, and ethnicity. In one study, women were given less pain medication than men because they were thought to be more fable emotionally and to exaggerate pain complaints. Both men and women under the age of 61 received more pain medication than their elders did. Also, younger men were medicated most frequently and older women least frequently. In another study, Hispanics were twice as likely as non-Hispanic whites to receive no pain medication.

Another issue is the balance of power between provider and patient. As long as the caregiver has control, the patient remains the passive victim of pain. The standard “prn” regimen requires patients to endure pain until the next scheduled opportunity to request medication. Even then the patient may not want to bother anyone, and the relationship between patient and nurse can get adversarial. Two well-established myths in western culture state: “Enduring pain is a character-building, moral-enhancing endeavor” and “Patients who receive pain medication will become addicted to the drugs.” These fears, plus concerns about legal liability, are reflected in the stringent laws regulating drug prescription and the suspicion of health care providers who see patient requests for pain relief as drug-seeking behavior related to addiction. The result is the undermedication of even terminally ill patients who may end up experiencing a painful, prolonged, death accompanied by needless suffering. What patients fear most is a painful death. Those who request assistance in ending their lives are really seeking their doctor’s help in ending their pain (Post, 1996).

Moved to Front Burner

Pain has gained an increasingly salient presence in the medical, nursing, legislative, research, funding, and advocacy arenas. In the past decade pain has come into its own and with it the knowledge that pain, more than a mere physiologic response to a painful stimulus, is a biopsychosocial phenomenon. At all times, pain has had different meanings for culturally disparate groups. The publication Culture and Nursing Care: A Pocket Guide [Lipson, J.G., Dibble, S.L., & Minarik, PA. (Eds.). (1996). University of California San Francisco, UCSF Nursing Press: CA. Available: http://nurseweb.ucsf.edu/www/book4.htm] presents an overview of several ethnic/cultural groups and offers nurses a snapshot of human diversity. It provides a set of general guidelines to alert nurses to the similarities as well as the differences within and among cultural groups.

References


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AAACN President • shirlkc@gateway.net

Pain Management Web Sites

Sites for Health Care Professionals
www.aspmn.org
American Society of Pain Management Nurses
www.painmed.org
The American Academy of Pain Medicine
www.halcyon.com/iasp
International Association for the Study of Pain
www.guide integrating.gov
The National Guideline Clearinghouse
http://mayday.coh.org/
Mayday Pain and Resource Center
http://allnurses.com/jump.cgi?ID=2648
University of Iowa, College of Nursing
http://www.pain.com
http://www.nursingcenter.com
http://www1.mosby.com/Mosby/Wong/

Sites for People with Pain
www.theacpa.org
American Chronic Pain Association
www.painfoundation.org
American Pain Foundation
www.ampainsoc.org
American Pain Society

For more information, contact
Documenting Pain

UCSF Uses Patient Report, Special Committee, to Meet New Standards

Treating Pain

Many ambulatory care provider-based practices are faced with the challenge of meeting the new Pain Management Standards set forth by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

Scoring for these standards began this year. The standard many ambulatory care practices may have difficulty with is PE.1.4: pain is assessed in all patients. The University of California San Francisco (UCSF) Medical Center recognizes that patients have the right to be involved in all aspects of their care including the right to appropriate and timely assessment and management of their pain.

The UCSF pain management policy states that all patients upon entry into the health care system, as part of ongoing patient care and assessment and at each subsequent ambulatory visit, when appropriate, will be asked if they are experiencing pain. If patients answer “yes” to the initial screening question, they will be asked to rate their pain using a pain intensity scale (for example, the 10-point scale or the 0-5 Wong Baker FACES Scale) and respond to additional questions. (See continued on page 6)

PATIENT PAIN SCREENING RECORD

University of California San Francisco (UCSF) Medical Center
Ambulatory Services

Have you experienced any pain within the past week? 

[ ] No [ ] Yes

(If “No,” stop here and give this to your provider. If “Yes,” please answer the rest of the questions)

Where is your pain?

______________________________________________________________________________________________

Circle a number from 0-10 that best describes how much pain you are having now?

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<tr>
<th>0</th>
<th>1</th>
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<th>3</th>
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<th>5</th>
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<th>7</th>
<th>8</th>
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<tbody>
<tr>
<td>No Pain</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
<td>9</td>
<td>Worst Pain Possible</td>
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</table>

For a child or non-English speaking adult, use Wong-Baker FACES Pain Rating Scale©.*

Ask the patient to circle the face that best describes how he/she feels:

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<tr>
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<tr>
<td>No Hurt</td>
<td>Hurts Little Bit</td>
<td>Hurts Little More</td>
<td>Hurts Even More</td>
<td>Hurts Whole Lot</td>
<td>Hurts Worst</td>
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What does your pain feel like? 

[ ] sharp [ ] dull [ ] burning [ ] aching [ ] throbbing [ ] tender [ ] numb [ ] stabbing [ ] gnawing [ ] shooting [ ] exhausting [ ] penetrating [ ] miserable [ ] unbearable [ ] continuous [ ] occasional

Circle response:

What makes the pain better?

____________________________________________________________________________________

What makes the pain worse?

____________________________________________________________________________________

Are you currently taking medication(s) or using some type of treatment for pain relief?  

[ ] No [ ] Yes

If yes, list medication and/or treatment:

____________________________________________________________________________________

Provider Use Only

TREATMENT PLAN / RESPONSE:  

____________________________________________________________________________________

____________________________________________________________________________________

_________________________________________  ________________________________
Signature                                      Date
Documenting Pain
continued from page 5

Patient Pain Screening Record for Ambulatory Services, previous page.

This form may be used as part of the new patient intake process (if the practice does not have a new patient intake questionnaire that addresses pain assessment) and for subsequent ambulatory visits.

Assessing the Pain

Self-reporting of pain by the patient is the most accurate and efficient way of capturing this information in a busy ambulatory care environment. If the patient reports pain, a provider (physician, nurse practitioner, and/or RN) will further assess and treat, as appropriate.

The patient’s treatment plan/response to pain interventions is documented by the provider on the patient pain screening record with details of the comprehensive pain assessment in the history and physical or visit note. Regular assessments of pain intensity are completed during an ambulatory episode of care/treatment when vital signs are taken, based on the scope of service and at frequencies appropriate to the situation.

Prior to and following the administration of pain medication or a nonpharmacologic intervention, pain is rated by the patient and is reassessed and documented to measure the effectiveness of the pain medication. Patients are asked about their satisfaction with pain management using an institutional patient satisfaction survey as well as through focused activities such as postprocedure and postoperative telephone calls.

Pain assessments, reassessments, treatments, interventions and outcomes are documented in the medical record and accessible to all members of the health care team. Pain identified during a visit that is not within the scope of the practice will be referred to an appropriate provider.

Pain Committee

UCSF Medical Center achieves this organizational commitment to pain management through the work of the Interdisciplinary Pain Committee (a subcommittee of the Quality Improvement Executive Committee). The scope of the committee’s work includes, but is not limited to:

- Conducting an institutional needs assessment.
- Oversight and implementation of policies, standardized procedures, and practice guidelines for pain management.
- Development of patient education materials and

Patients have the right to be involved in all aspects of their care.

organization-wide education and competency programs for staff and physicians in pain assessment and management.

- Measurement of baseline performance indicators for pain management using patient interviews and medical record review. There is continuous measurement of these indicators at regular intervals to assess ongoing performance improvement.

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UCSF Medical Center Ambulatory Services
tammy.wade@ucsfmedctr.org

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Ambulatory Care Nursing Resources

Ambulatory Care Nursing Self-Assessment (2000)
This valuable resource provides over 200 multiple choice test items covering various components of ambulatory care practice. You will be able to test your knowledge of your specialty and practice by answering multiple choice questions written in the same format as the certification exam.

The multiple choice items are grouped into 5 topic areas.
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- Systems
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2000 Edition Ambulatory Care Nursing Administration and Practice Standards
This 20-page, fifth edition of the ambulatory care nursing standards includes sections on Structure and Organization, Staffing, Competency, Ambulatory Nursing Practice, Continuity of Care, Ethics and Patient Rights, Environment, Research, and Quality Management.

Telehealth Nursing Practice Administration and Practice Standards (2001)
This document identifies the practice standards that define the responsibilities of both clinical practitioners and administrators responsible for providing telephone care across a multitude of practice settings.

Examination Preparation Guide for Ambulatory Care Nursing Certification (1999)
A 48-page guide designed to help you learn specifics about the exam, develop your own study plan, and review test taking strategies.

Nursing in Ambulatory Care: The Future is Here (1997)
This 53-page text, a collaborative effort between the American Academy of Ambulatory Care Nursing and the American Nurses Association, defines and describes the multiple roles and functions of nurses in ambulatory care and identifies the appropriate education and support needed as nurses make the transition from inpatient settings to ambulatory care settings.

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PON
Migraine is a common disorder that affects 28 million people in the United States. It is estimated that one in ten people suffer from migraine headaches (Lipton, Diamond, Reed, O’Quinn, & Stewart, 2000).

Epidemiological studies have shown that as many as 17.6% of women and 5.7% of men report one or more migraine headaches per year, yet primary headache disorder is still underdiagnosed and undertreated in primary care.

It is well established that patients with headaches generated nearly twice as many pharmacy claims as other patients in managed health care systems (Hu, Markson, Lipton, Stewart, & Berger, 1999; Clouse & Osterhaus, 1994; Ries, 1986; Solomon & Litaker, 1997). These patients also seek urgent care and emergency room help more often than non-migraine patients (Barton, 1994). As far as lifestyle is concerned, migraines can disrupt functional activities at work and home.

Improving Care

Research shows that the more time a provider spends with patients, the more satisfied they are and the better the outcome. However, headache patients are often dissatisfied with the care they receive.

On a positive note, nurse practitioners are able to spend more time with their patients, and as a result, can increase patient satisfaction.

In an effort to improve care, Kaiser Permanente in Southern California has established a “Center of Excellence” for primary headache patients. The center has developed a Headache Management Program coordinated by a neurologist and nurse practitioner that has achieved a 92% rate of patient satisfaction.

Educating patients about their headache types, promoting autonomy, listening to their needs, and developing individualized care plans are crucial to a successful headache management program.

Types of Headaches

Primary headache is one of the leading reasons for primary care consultation.

The majority of headache patients seen at Kaiser Permanente in the Headache Management Program have a mixed pattern of tension and migraine headache. The five main primary headache types include migraine, tension, cluster, rebound, and sinus.

The clinical features of primary headaches are as follows:

Migraine

The symptoms of migraine include unilateral headache that is described as throbbing and pulsatile. It occurs on an episodic basis with associated nausea or vomiting. Patients experience light and noise sensitivity. Of these patients, 15% experience an aura of visual and/or sensory disturbance. Exercise makes these headaches worse.

Tension

Tension or muscle contraction headaches involve a daily diffuse pressure behind the eyes, in the neck, shoulders, or temple area. Patients often describe this as a vise grip wrapped around their head or a tight squeezing pressure. Tension headaches generally occur in the morning and progressively get worse during the day. There is no aura or vomiting. A stressful event may precipitate this headache. On physical exam the trapezius and cervical muscles are tender to palpation.

Cluster

Cluster headaches are more predominant in males between 30 and 50 years of age. Patients say they feel an “ice pick” sensation through the periorbital area; usually a unilateral stabbing pain lasting 30 to 90 minutes. The cluster headache often wakes a patient from sleep at night and has associated symptoms of Horner’s syndrome. Horner’s syndrome includes ptosis, nasal stuffiness, constrict-
tion of the pupil, or decreased sweating on the side of the headache. A patient may experience a cluster headache every night for weeks to months and then be headache free for 6 months to a year. Some patients have reported being headache free for as long as 5 years.

**Rebound**

This type of headache is common in about 30% of the patients seen in the Headache Management Program in San Diego, CA. Rebound headache can occur on a daily basis from excessive use of over-the-counter (OTC) medications or caffeine. As little as one tablet of Fioricet® a day (30 per month), can cause rebound headache. The maximum dose of caffeine recommended to avoid rebound is 200 mg or less per day. As few as three caffeinated beverages a day can lead to a daily rebound headache. The symptoms of rebound headache are often characterized as a pounding pain around the front and back of the head that may be continuous. OTC medication often relieves the pain for a few hours but then the headache returns, creating a dependency cycle.

**Sinus**

A sinus headache is a rare finding. It is caused by the inflammation of the lining of the sinus cavities. The pain is often described as a deep dull ache around the nose, face, and forehead that worsens when the patient bends over. A sinus x-ray or CT of the sinus must show fluid in the sinus cavity to confirm the diagnosis of sinus headache. In our program, we have diagnosed only five patients out of a series of 500 with sinus headache.

Chronic sinus headaches are usually due to allergic sinusitis. Acute sinusitis from an infection results in fever and acute facial pain or headache.

**Attack Triggers**

There are a number of precipitants for migraines:
- **Dietary.** Includes caffeinated food and drinks, alcohol, dairy products, breads, peanuts, nuts, seeds, processed meats, citrus fruits, monosodium glutamate, chocolate, and hypoglycemia.
- **Environmental.** Subtle changes in the environment can trigger a migraine. Some of these include bright lights, loud noise, and strong odors; changes in temperature and atmospheric pressure.
- **Emotional.** Emotions, especially stress, are common triggers. Stress can be caused by life changes such as marriage, birth, death, or divorce. Both positive and negative stress can act as triggers.
- **Hormonal.** Hormonal fluctuations during ovulation and before a woman’s menstrual cycle can trigger migraines. Birth control pills and estrogen supplements may also cause headaches. Headaches usually improve with pregnancy.

**Pharmacologic Treatment**

It is difficult to find a consensus among physicians regarding the best treatment approach. Headache prophylaxis is recommended if there are more than four disabling headaches each month, but there is no agreement yet on which is best: beta-blockers, tricyclic antidepressants, serotonin re-uptake inhibitors, or anti-convulsants.

At Kaiser’s headache management program, the patient’s overall health is assessed. For example if there is pre-existing hypertension, then a beta blocker or calcium channel blocker is prescribed that will treat both conditions and allow for monotherapy with improved patient compliance.

Inderal® works well for migraines if given three times per day, however its efficacy tends to decrease after a year of treatment. Tricyclic antidepressants are effective for migraine and tension headaches. Pamelor® has fewer side effects than Elavil® and can be used
once a day, and Effexor® in recent studies shows promise. Depakote® is used for refractory cases, Topamax® and Neurontin® are not as well studied but have fewer side effects and based on results from the Kaiser program, are effective (Blumenfeld, YEAR).

A acute treatment needs to be considered in terms of the type of headache. Patients should be encouraged to use only triptans for migraine headaches. Injectable Imitrex® or nasal spray Imitrex® is preferred for patients with vomiting at the start of their headaches. Long acting Amerge® is useful for headaches that require multiple triptans. Reglan® and Naprosyn® are excellent but if the patient needs triptan for each headache, we suggest a stratified approach with early use of the triptan. Zanaflex® can be used for muscle contraction headaches.

Nonpharmacologic Treatment

Our headache program offers alternative therapies in conjunction with traditional medicine. Some of these modalities include magnesium and vitamin B therapy, biofeedback, massage, and physical therapy.

Headache Plan

The headache program used at Kaiser includes:
1. Educating patients so they are able to identify which type or types of headaches they have.
2. All precipitants are identified and addressed.
3. Patients know which treatments to use for acute treatment and preventative treatment.
4. Rebound issues are not left in place.

NP and Neurologist Roles

The Kaiser headache program was designed to determine whether a nurse practitioner specializing in headache treatment under the guidance of a neurologist could manage patients with primary headache disorder and increase patient satisfaction.

The program involves three parts: The initial phase consists of a 2-hour headache class taught by a neurologist. The class introduces basic information about different headache types and the various treatments. Lifestyle changes needed, caffeine, OTC medication use, medical and non-medical treatments are discussed.

Next, patients are scheduled for an appointment with the NP headache specialist. Each case is reviewed with the neurologist, and using the headache treatment guideline, an individual preventive treatment plan is developed. At the initial consultation, an 8-week follow-up is also arranged.

After each patient is on a well-established plan of care, they are returned to primary care with a treatment outline.

Results

Out of the 213 patients who have completed the headache class, 81% are female and 19% are male (see Figure 1).

The patients’ ages range from 18-92 years old. Over half of this population is between 30-49 years old, 32% are 40-49, 25% are 30-39, 18% are 50-59, 14% are 18-29, and 11% are 60 or more (see Figure 2). The majority of patients (79%) had more than one type of headache, 6% had migraine headaches, 9% had tension headaches, 2% had paroxysmal headache (this is a very rare type; it is unilateral and throbbing in nature and is generally responsive to Indomethacin®), 2% cluster headache, and 2% other (see Figure 3).
At their 8 week visit, patients respond as to whether their headache is much improved, improved, the same, worse, or much worse. As shown in Figure 4, 92% scored improved, 7% scored no change, and 1% scored worse.

Two questionnaires, one migraine specific and another that focused on headache status and overall quality of health, were completed by 173 patients. These questionnaires were filled out at baseline and at 8 weeks. As seen in Figures 5 and 6, there was a significant improvement in patients’ overall health.

**Conclusion**

Patients who are treated through the Headache Management Program show an increase in patient satisfaction and improvement in health status. The improvement was depicted from each patient’s baseline data questionnaire in comparison with his or her own 8-week data.

It is inferred that patients who have better outcomes will use the health care system less and therefore decrease utilization costs. A group model of care with a headache specialist nurse practitioner is a cost-effective method of providing care to primary headache patients.

**References**


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**Research and Clinical Practice Sessions**

continued from page 23

referred to the ER by telephone triage.

- Job Satisfaction, Organizational Commitment and Organizational Instability Among Telephone Triage Registered Nurses. The speaker for this presentation will be **Kristin Hardy Wicking, MSN, RN** (Palomar College and Scripps Memorial Hospital). She will present definitions, methodology, and correlation findings of a study examining the key concepts of job satisfaction, organizational commitment, and organizational instability.

**Concurrent Session**

The second research-focused presentation will be a concurrent session. Ambulatory Care Nursing Quality Indicator: AAACN Pilot Survey. The speaker for this presentation will be **Peg Mastal, PhD, MSN, RN** (Health Services for Children with Special Needs, Inc.). She will review the results of the AAACN Member Survey on the proposed American Nurses Association quality indicators for community-based non-acute care distributed during the 2000 Annual Conference. The implications of the pilot survey results for future AAACN activities will be explored.

**Special Session**

The final session features invited speaker **Judi Henry, MS, RN** (Kaiser Permanente, Wheat Ridge Medical Office). She will be discussing Ambulatory Care Staffing: A Search for the Right Model. This session will highlight the challenge of providing the right quality and quantity of nursing support staff in an ambulatory care setting. The discussion will include the conceptual framework for developing a staffing model, tools to benchmark staffing models to national and regional data, and sources for current and ongoing information regarding staffing in ambulatory care.

In addition to the research focused sessions, Practice Evaluation and Research Committee members invite you to join them at the Networking Lunch on Friday, March 30, 2001. Members will be available to offer consultation, advice, and guidance to AAACN members interested in or currently developing research or practice evaluation outcomes projects.

**Let us know...**

The Practice Evaluation and Research Committee would also like to hear from AAACN members about areas of interest for future research programs; projects and areas you would like to see addressed by AAACN. We look forward to seeing you at the conference and hearing your ideas.

**Regina C. Phillips, MSN, RN**
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Cancer Pain

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Given the many known barriers to optimal pain management, it is tempting for a nurse to give up and go along with the status quo. But to do so is to abandon a basic professional tenet - the nurse as patient advocate.

Changing Attitudes

Why haven’t pain-related practice behaviors changed? While scientific documentation has yet to conclusively answer this question, it is speculated that many variables are at play.

Changing Attitudes

Why haven’t pain-related practice behaviors changed? While scientific documentation has yet to conclusively answer this question, it is speculated that many variables are at play.

Health care professionals often lack current knowledge about pain management (Jacox et al., 1994; Miaskowski, 2000; McMillan, Tittle, Hagan, Laughlin, & Tabler, 2000a).

Also, lack of organizational accountability for pain management is commonly cited: traditional institutional structures and policies have been at odds with optimal pain management (Hollen, Hollen, & Stolte, 2000). Physicians’ response (or lack of) to nurses’ assessments of pain likely play a significant role in nurses’ efforts to advocate for changes in pain management strategies (Maes, 2000). And finally, regulatory statutes do not consistently support the contemporary approach to addressing pain (Joranson et al., 2000).

The continued mismanagement of cancer pain is ultimately linked to the dilemma of how to change attitudes - attitudes of health care professionals, attitudes of people who have the pain, and attitudes of family members and caregivers. One thing is clear: we do have at our disposal the knowledge and tools to manage the vast majority of cancer-related pain.

Cancer Pain and Ambulatory Care Settings

The current cancer care delivery system is largely based in ambulatory settings. It is estimated that about 90% of all cancer-related services occur in such settings as hospital-based clinics and treatment centers; physician and nurse-practitioner offices; and patients’ homes.

Despite the commonplace use of sophisticated technology in cancer care – particularly in actual cancer treatment modalities – most of cancer care involves managing the sequelae of cancer itself and cancer treatment-related side effects and toxicities (Hewitt & Simone, 1999). In short, most cancer care falls within the nursing domain. The logic then follows that nurses in ambulatory care settings are in fact providing the vast majority of cancer care services.

Role of the Ambulatory Care Nurse

Given the many known barriers to optimal pain management, it is tempting for a nurse to give up and go along with the status quo. But to do so is to abandon a basic professional tenet - the nurse as patient advocate.

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January/February - 2001 - Volume 23 Number 1 12
There are several simple interventions any nurse can pursue to work toward the optimal management of pain:

**Accept accountability for addressing the problem of pain.** Even though the appropriate management of pain has yet to be uniformly codified in nurse practice acts, several professional nursing organizations, including the American Nurses Association, the American Association of Critical Care Nurses, and the Oncology Nursing Society recognize the essential role of the nurse in advocating for and providing optimal management of pain.

Put simply, each and every nurse who encounters people at risk for pain must accept accountability for addressing the essential human need for comfort.

Gordon and Berry (2000) suggest eight steps to implementing pain practice changes at an organizational level:

1. Develop an interdisciplinary workgroup.
2. Analyze current pain management practices.
3. Articulate and implement a standard of practice.
4. Establish accountability for pain management.
5. Provide information about pharmacologic and nonpharmacologic interventions.
6. Promise patients a quick response to their reports of pain.
7. Provide staff education.
8. Continually evaluate and work to improve pain management.

**Raise the index of suspicion.** The prevalence of pain in people with cancer dictates that every cancer care provider presumes that a person with cancer (or a cancer history) is more likely to have pain than not. Patients reluctantly initiate pain-related discussions, they expect to have pain, and often assume that cancer pain cannot be relieved without compromising mental clarity or risking other debilitating side effects (Corizzo, Baker, & Henkelmann, 2000). It’s up to the nurse to open the discussion and counter patients’ misconceptions about pain and its management.

Learn and apply pain assessment skills. Successful pain management depends on accurate and systematic assessment (McMillan, Tittle, Hagan, Laughlin, & Tabler, 2000b). The first element in accurate assessment is believing the patient’s report of his/her pain. Davies and McVicar (2000a) suggest the proper assessment of pain includes the 10 parameters highlighted in Table 1.

**Management - It’s not rocket science.** The AHCPR Guidelines offer relatively straightforward pain management strategies (Jacox et al., 1994). Analgesics are given on an “around-the-clock” schedule that maintains a plasma level sufficient to control pain. Short-acting medications can be used on an “as needed” basis to manage pain that occurs between scheduled doses. Most pain can be managed with oral analgesics combined with adjuvant medications and nonpharmacological pain management strategies.

An important strategy will be to incorporate pain management into the operations of cancer care settings. Georgesen (2000) offers a clinical pathway for outpatient cancer pain management that could be adapted in other ambulatory care settings.

**Help the patient develop and use effective self-advocacy skills.** Barriers to appropriate and optimal pain management are unlikely to disappear in the near future. Pain expert C. Stratton Hill suggests “Significant change regarding pain control may depend on empowering patients to demand adequate pain treatment” (1995, p. 1881). Therefore, patients and families must be empowered to be effective self-advocates. Effective self-care and self-advocacy are especially important, as much of cancer care occurs in patients’ homes, outside the purview of the cancer care team.

**Establish a partnership with the patient and family based on the agreed-upon goal of achieving a pain-free state, then work together to reach that goal.** A most basic strategy that any nurse can employ is to let people at risk for pain problems know that they do not need to endure pain – that cancer doesn’t have to hurt. Helping patients and families find informational resources geared to lay readers that explain cancer pain and its management is an easy, first step. [Note: the authors’ book, *Cancer Doesn’t Have to Hurt*, Haylock & Curtiss, 1997, is one such resource.] The Wisconsin Cancer Pain Initiative, the American Cancer Society, and the National Institute of Health all offer good resources developed especially for lay readers.

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**Table 1.** Pain Assessment Parameters

<table>
<thead>
<tr>
<th></th>
<th>Physical source of the patient’s pain</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>The patient’s mood</td>
</tr>
<tr>
<td>2</td>
<td>The patient’s expectations of pain</td>
</tr>
<tr>
<td>3</td>
<td>Available support from family and friends</td>
</tr>
<tr>
<td>4</td>
<td>Alterations in function as a result of pain</td>
</tr>
<tr>
<td>5</td>
<td>The patient’s perception of severity of pain</td>
</tr>
<tr>
<td>6</td>
<td>The patient’s fears and anxieties</td>
</tr>
<tr>
<td>7</td>
<td>The coping strategies the patient uses to manage pain, fears, and anxieties</td>
</tr>
<tr>
<td>8</td>
<td>Perceived response of the family</td>
</tr>
<tr>
<td>9</td>
<td>Impact of pain on the patient’s lifestyle</td>
</tr>
</tbody>
</table>

Adapted from Davies and McVicar, 2000a.
Conclusion

There is an increasing acknowledgement that cancer-related pain can and should be managed. On the other hand, we are a long way from achieving the desired endpoint where the existence of pain is the exception rather than the expected.

Optimal management of cancer pain is not dependent on the discovery of new drugs or new technologies. For the most part, cancer-related pain can be easily managed with the armament and skills currently at hand.

Nurses can and must assume patient advocacy roles on behalf of individual patients and groups of patients. There are many expert guides - recognized experts who are involved in identifying standards of care, and who give us clear instruction through credible, scientific publications to help us address the pain-related issues more effectively. But what has been missing to date is a collaboration of nurses from all cancer care settings who advocate for this most elemental of human needs. Nurses can wait for grassroots advocacy groups to demand the care patients deserve - and it will come eventually - or they can take a proactive position and work with patients and their advocates to achieve the goal of complete relief of cancer-related pain.

References


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Yes, we’re a medical and teaching wonder, but our most powerful results are
Assessing Pain in Older Adults

WHY: Studies on pain in older adults (65 years of age and older) have demonstrated that 25%-45% of community dwelling older people have chronic pain. In addition, 45%-85% of nursing home residents also report pain that is often left untreated. Although there is minimal research that strictly focuses on pain in older adults, studies with younger participants have elucidated associations between pain and depression. Increased pain has further resulted in decreased socialization, impaired ambulation, and increased health care utilization and costs. Older adults are reluctant to report pain; therefore, nurses need to be proactive in screening for and assessing pain.

BEST TOOL: No objective measure or biological marker of pain exists. Simply worded questions and tools which can be easily understood are the most effective, as older adults frequently encounter numerous factors including sensory deficits and cognitive impairments. Subjective tools such as the Visual Analog Scale (VAS) and the Faces Scale are highly effective in assessing pain in older adults. The VAS is a straight horizontal 100 mm line anchored with “no pain” on the left end and “worst possible pain” or “pain as bad as it could possibly be” on the right. Older adults are simply asked to choose a position on the line that represents their pain. The Faces Scale depicts facial expression on a scale of 0-6, with 0=smile, and 6=crying grimace. Older patients should choose a face that represents how the pain makes them feel.

TARGET POPULATION: Both the VAS and the Faces Scale are used with older adults. Studies have shown that 86% of nursing home residents could complete at least one of these pain scales.

VALIDITY/RELIABILITY: Studies, which have compared simple pain intensity measures, have demonstrated high reliability and validity using the VAS and Faces Scales with older adults.

STRENGTHS AND LIMITATIONS: These simple, yet effective pain assessment tools are easy to administer and provide a method to evaluate not only the presence of pain, but also the effectiveness of treatment. However, these assessment tools should not replace extensive medical history taking and physical exams which may lead to the determination of etiologies of pain.

MORE ON THE TOPIC:
INSTRUMENT:

1. [Faces Scale]

2. [Visual Analogue Scales]

Source for scales: Reprinted from PAIN, Vol 41, no 2, pp 1391-50, with permission from Elsevier Science.
1. Faces Scale  2. Visual Analogue Scales
New Pain Management Standards
continued from page 1

managing pain in a very different way that will result in better outcomes for patients. Key nursing associations as well as health care organizations will work together to develop the tools needed to meet this new standard of care.

Areas that are affected are:
• Ambulatory care
• Behavioral health care
• Home care
• Healthcare networks
• Hospitals
• Long-term care networks
• Long-term care pharmacies

JCAHO’s standards for pain management will increase the visibility of this critical component of patient care and encourage changes in practice. As pain management standards are applied in ambulatory settings, the principles of adequate pain management will prevail. These guidelines have been developed by the Agency for Healthcare Policy and Research (AHCPR), the American Society of Pain Management Nurses (ASPMN), and the World Health Organization (WHO).

The goal of these new standards is to support:
• The rights of patients to appropriate assessment and management of pain
• The acknowledgment of pain as a major factor affecting patient care outcomes
• The need for ongoing pain competencies for clinical providers and staff
• The identification of “red flags” in pain assessment
• The establishment of policies and procedures for pharmacologic interventions
• The promotion of data collection on the pain management process
• The support of symptom management in discharge planning (Kowal, 1999)

Ambulatory Care Nurse’s Role

Pain management is dependent on incorporating ambulatory care nurses as key members of the interdisciplinary team. The organizational structure and standards for the practice of ambulatory care nursing provide a mechanism for monitoring accountability, establishing communication, and defining quality patient outcomes (AAACN Administration & Practice Standards, 2000). As professional nursing seeks to maximize the patient’s state of health and wellness, pain management will play a critical role.

Efforts Intensify

The code of quality pain management was systematically created and refined by experts. Professional organizations such as ASPMN have written practice standards for nurses. Currently ASPMN is moving the vision of quality pain management to a higher level with the following goals:
• Apply the clinical knowledge with incorporated competencies into the nursing and provider roles
• Support the patient with pain as the expert
• Systematically assess pain
• Use combination therapies to balance the pain management treatment perspective
• Individualize pain treatment and “red flag” negative pain experiences
• Communicate the pain experience across geographic lines
• Identify the barriers to quality pain management and educate with research-based information

Legally and ethically, higher pain management standards will drive practice changes.

An important precedent was set in 1999 when Oregon’s State Medical Board disciplined a doctor for nonrelief of pain. Oregon has since mandated quality pain management in patient care.

In 2000, the American Bar Association held a symposium in San Diego, CA, on the legal implications of unrelieved pain. A jury in North Carolina brought a $15 million judgment against a long-term care facility for withholding adequate pain medications (Henry James v. Hillhaven Corporation, 1999).

Ambulatory nursing must recognize patient rights and value the person experiencing the pain by providing quality pain care. Specifically, pain must be identified and treated promptly.

In pain management, the standard is the patient’s self-report, the process is measurement and assessment, and the quality is defined by patient outcomes. (See related article, “Documenting Pain” on page 5.) The availability and utilization of ongoing education for all the players will affect disease state treatment (American Pain Society Quality of Care Committee, 1995). As they become educated, providers will accept the defined pain principles. They will also accept that patients are the pain experts. This is in keeping with JCAHO’s model that promotes the patient’s right to pain management. The impact on practice will clearly change clinical care and improve the “picture of pain.”

Conclusion

Uncontrolled pain costs the public a major toll in human, economic, and psychosocial terms. All patients have the right to expert pain diagnosis and pain management. JCAHO has activated a quality pain process and created an official mandate to change practice. The benefits achieved will redefine patient outcomes in the future.

References

continued on page 18
Overview of JCAHO Pain Management Standards

The Joint Commission views pain management as an integral component of care. To that end, it has expanded the scope of its pain management standards, which have been endorsed by the American Pain Society (APS), to cover all pain scenarios in accredited health care organizations rather than limiting the scope to end-of-life care.

Focal points to consider in complying with the new Pain Management Standards:

Patient Rights (RI)
Recognize the right of individuals to appropriate assessment and management of pain in the patient bill of rights, service standards, and/or mission of the organization.

Assessment of Patients (PE)
Assess the existence of pain and, if so, the nature and intensity of pain in all patients according to the policies/procedures of the organization. The orientation of patient care providers includes competency assessment and education in pain assessment and management.

Care of Patients (TX)
The organization’s policy assures a uniform interdisciplinary approach to pain assessment and management across all settings and patient populations. Pain reported by the patient that is not within the scope of the practice setting will be referred to an appropriate provider. Standardized procedures and practice guidelines are adopted to address patients’ needs and support the appropriate prescribing or ordering of effective pain medication. The effectiveness of referrals and interventions is monitored.

Patient Education (PF)
Education materials are developed to facilitate patients’ understanding of pain, involve them in the treatment plan, and provide them with specific knowledge and skills to meet their ongoing health care needs. When assessing patients’ learning needs, staff should consider such variables as patients’ beliefs and values; literacy; educational level and language; barriers to learning and motivations; physical and cognitive limitations; and the financial implications of care choices.

Continuum of Care (CC)
A collaborative, interdisciplinary team approach and open lines of communication related to symptom management, pain management strategies and their effectiveness or barriers, serve to support the continuum of care.

Improving Organization Performance (PI)
The performance improvement plan addresses the organization’s ongoing measurement priorities, including assessment and measurement of appropriateness and effectiveness of pain management. Baseline performance indicators for pain management are measured using patient interviews, satisfaction surveys and/or medical record reviews. These indicators are measured at regular intervals to assess ongoing performance improvement.

If you have questions, contact Standards Interpretation at (630) 792-5900 or www.jcaho.org.
Three years ago, we brought to you the role of the parish nurse in ambulatory settings and the holistic approach to delivery of health care (Viewpoint, March/April, 1998). This past fall we had the opportunity to represent the Carle Foundation Hospital, Urbana, IL, and the University of Illinois College of Nursing in Champaign-Urbana by attending a 5-day curriculum content program for coordinators who are delivering or plan to deliver a Basic Parish Nurse Preparation Program. It is with this in mind that we share with you our thoughts and experiences and invite you to join us in looking to the future for the role that nurses in congregational settings can play in community health care delivery.

History

Parish nurse programs are growing nationwide. In the 1970s, Rev. Granger Westberg began exploring the link between the church and medical communities. He believed that conventional medicine – by overlooking the relationship between spiritual well-being and physical health – deprived patients of complete care.

This medical clinic model using physicians proved too expensive in the congregational setting and nurses were identified as the “glue between the faith and medical communities.” The first parish nurse project was piloted by Lutheran General Hospital, Park Ridge, IL, now the Advocate Health System in Chicago. This system also supports the International Parish Nurse Resource Center. Surveys from the center show that the programs are developing nationwide, reporting numbers of more than 25,000 parish nurses.

Preparation

A core curriculum for parish nurse preparation, which is the outcome of the Third Invitational Educational Colloquium in Parish Nurse Education held April 27-29, 2000, is now being promoted. This ongoing project continues to be developed through a collaborative working arrangement which includes The International Parish Nurse Resource Center, Advocate Health Care, Loyola University, and Marcella Niehoff School of Nursing (all in Chicago, IL); and Marquette University College of Nursing in Milwaukee, WI.

This curriculum shares the philosophy of parish nursing as a specialty practice and professional model of health ministry. It is distinguished by the following beliefs:

- Parish nursing reclaims the historic roots of health and healing found in many religious traditions.
- Spiritual dimension is central to nursing practice and holds the belief that all people must be treated with respect and dignity.
- The parish nurse understands health to be a dynamic process.
- The focus of practice is the faith community.
- The parish nurse collaborates with the pastoral staff and congregations as a source of health and healing.

Curriculum development suggests a specific order of content modules and a required minimum of time.
allocated for each. Allocated CEs for most basic preparation courses is recommended at 35 contact hours. Many universities and colleges are also offering parish nurse preparation programs in both their BSN and master’s level programs. Partnering with a 4-year institution is important as the parish nurse movement continues to grow in both scope and impact in the community setting.

The strongest model for the delivery of a parish nurse’s basic preparation course is a collaborative model between a service provider who sponsors a parish nurse program and an educational institution. This builds on the resources of both while encouraging the college of nursing faculty to be more aware of parish nursing curricula components. Parish nursing then becomes a part of the community setting supported by both acute health care providers and community agencies who provide support services to congregations at the request of the parish nurse.

Currently, there is no professional certification for parish nurses. The American Nurses Association in Washington, DC, recognizes parish nursing as a specialty. The Health Ministry Association, Huntington Beach, CA, has supported standards for parish nursing as proposed in the Standards for Parish Nursing document. (Scope and Standards of Parish Nursing Practice [1998], American Nurses Association, and Health Ministries Association, Inc.)

The Basic Parish Nurse Curriculum offered by the International Parish Nurse Resource Center in Chicago uses the term “dimension” to reflect the work of parish nurses in their congregations and communities. These dimensions may be expanded or contracted depending on community needs, resources, and professional expertise. They are described as:

1. Integrator of Faith and Health
2. Spiritual Caregiver
3. Health Promoter
4. Counselor
5. Advocate
6. Educator
7. Care Coordinator
8. Community Resource Agent

### Table 1. Benefits of Parish Nurse Programs

**Institutions**
- Community Service Initiative
- Hospital + Physicians + Community = Continuity of Care
- Good image building for health care organizations
- Assist in identifying individual’s needs
- Laboratory of the future for all ages

**Communities**
- Healthier and more informed community population
- Individuals assuming responsibility for own health care
- Involvement of existing community resources for the good of the whole
- Prudent use of resources
- Provide wellness and health information to community populations

**Churches**
- Church mission includes healing
- Attracts new members
- Involves current members in stewardship
- Meets needs of community members whose needs are not being met (for example, elderly homebound)
- Provides gathering place for both churched and nonchurched

**Healthy Goals**

The literature continues to support the health care industry in producing and using progressively sophisticated technology, yet facts prove that most of the world’s health problems cannot be totally addressed this way. The mission of a church is health and salvation and interfaces with all ages and socioeconomic groups from birth to death. As a congregation, people want to be able to be proud of their ability to improve the health of their communities. Therefore, they all have a stake in the future.

Table 1 was developed to show the benefits gained by each entity when parish nursing is seen as an additional ministry. This diagram was used successfully to promote an acute care facility’s sponsorship of such a parish nurse program.

**Lessons Learned: One Community Program**

A parish nurse program was initiated by Carle Foundation Hospital in Illinois in the fall of 1997 with the goal of having 80 nurses complete the 40-hour CE approved course in 3 years. By fall 2000, 184 nurses representing 108 congregations (including an Islamic mosque) have taken the class.

One of the components of the program’s success has been the unique scheduling of the class itself. As most nurses work every other weekend, classes are held over three weekends spread out over several
weeks. Participants meet on Friday evenings, all day on Saturdays, and both days on the third and final weekend.

Since the majority of the nurses will volunteer their time as parish nurses, they are able to attend class and still maintain their work commitments. By meeting on the weekend the all-important bonding or retreat like atmosphere is maintained; a necessary element for such a course.

Nurses by nature like to “get things done” and by spreading out the weekends, they are able to get the course content synthesized and the classes completed in a relatively short time.

The two quotes from participants most often heard during the course are: “This is what I went to nursing school for,” and “I’ve been doing this for years in my church. I just never knew there was a name for it.”

This parish nurse program is truly community based, as the nurses come from a variety of health care settings. The largest group of nurses who have taken the course come from ambulatory care. The community has two large multispecialty physician clinics, one university supported student health service, and one community-funded clinic for the medically underserved. The dimension of nurse as referral agent is probably one of the most popular and eye-opening segments in the course. Everyone tends to get used to their own niche or work comfort zone and participants are always amazed to learn about the plethora of services available in their own community.

**Ongoing Support**

Carle Foundation Hospital supports the parish nurse program by offering bimonthly sharing sessions, bimonthly CE offerings, and an annual individual meeting with the program coordinator. In addition, the hospital offers liability protection for each parish nurse at no cost.

The hospital also publishes a monthly newsletter, Blessings, which has proven to be a great way to keep in contact with the 184 nurses who have completed the program. Each issue includes “Volunteer Opportunities,” “Educational Opportunities,” and other “Helpful Information” such as a prayer list for individual nurses, shared programs to use in their own churches, and short stories of sharing and successes.

Since the Carle health system also has a managed care product with a senior insurance plan, the parish nurse program is extremely helpful in reaching many of the members as they deliver preventive care and monitoring of chronic care to the congregation.

The budget for the parish nurse program is approximately 3% of Carle’s total community outreach budget. Other benefactors also come forward to help some of the small churches in rural communities send nurses to the annual Westburg Symposium in Chicago or they sponsor other program activities.

**Conclusion**

Who would have thought parish nurses could have such an impact on the health of a community? Yet that is exactly the stories that are reported.

Because parish nursing focuses on wellness and disease prevention; moves from clinician-centered care to patient-involved care; and uses a holistic approach to health care (body, mind, spirit), it could spur revolutionary changes in the country’s health.

At the Carle program, comments from nurses like “Parish nursing is the best thing I have done in my 34 years of nursing” or “Taking this class has been a life changing event for me,” have sparked great excitement for the future. In fact, Carle Foundation Hospital has made parish nursing a priority in their emphasis on community outreach for rural east central Illinois. Their initiative and ongoing support, along with similar backing from many organizations across the country, is the root of the parish nurse movement, which can only grow and flourish in the future into a health ministry that promotes love and healing for all ages.

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**Editor’s Note:** Sandra Reifsteck is a AAACN past president. She spent over 28 years at Carle Clinic Association and was instrumental in bringing the parish nurse program to the Carle organization where it is currently sponsored and underwritten by Carle Foundation Hospital. She also serves on adjunct faculty at the University of Illinois College of Nursing, an educational collaborator for the program.

Faith Roberts conducts two training programs annually in Illinois. She also conducts continued education for all the nurses who are trained in the Carle program. Faith is a frequent speaker at regional and national meetings on the topics of spirituality, parish nursing, and trends in health care.

For more information on parish nursing, visit the Web site www.parishnurse.org.
AAACN Election Results

The AAACN Nominating Committee is pleased to announce the results of the election for new officers conducted in December 2000. There were 254 members (18%) who returned the ballots and elected the following:

**President-Elect (2001-2002)**
Candia Baker Laughlin, MS, RN, Cm

**Board of Directors (2001-2004)**
Deborah Conway, MSN, RN
Regina C. Phillips, MSN, RN
Beth Ann Swan, PhD, CRNP

**Nominating Committee (2001-2003)**
Karen Griffin, MSN, RN, CNA
Susan Paschke, MSN, RN, Cm, CNA

**Bylaws Approval**
Yes: 248
No: 3
No vote: 3

On behalf of the Board of Directors and the members of AAACN we congratulate the new officers and wish them every success as they join the current Board of Directors, leading our organization into the future.

The overwhelming acceptance of the bylaws as revised has important implications for AAACN. By approving these bylaws, the members have ensured that AAACN is in an advantageous position, able to create new opportunities for action as we advance into the new millennium.

ANCC Drops BSN as Certification Exam Requirement

Good news for ambulatory care nurses interested in becoming certified! The American Nurses Credentialing Center (ANCC), which administers the only modular certification examination in ambulatory care nursing, has announced that a BSN is no longer required to take this exam.

In July 2000, the American Academy of Ambulatory Care Nursing (AAACN), which collaborated with ANCC to develop the exam, requested ANCC to reconsider the BSN eligibility criterion based on input received from several members. AAACN is very pleased with this decision!

When the ambulatory care nursing certification exam was first developed, ANCC required a BSN for nurses who did not hold a core certification in another area. However, nurses who held a core certification, whether or not they had a BSN, could take the exam. AAACN felt the BSN eligibility criterion was confusing and sent a conflicting message.

The AAACN Board has discussed the BSN criterion for certification numerous times. **While we support the BSN as the entry level into the profession, we also realize there are many nurses practicing in ambulatory care who do not hold this degree.** Certification is a practice based credential, not an entry into nursing credential. Since the ambulatory certification exam is the only credential that exemplifies expertise in ambulatory care nursing, we believe it is essential that all registered nurses in ambulatory care be eligible to take this exam.

AAACN applauds ANCC’s decision to drop the BSN requirement. We hope that now there will be many more ambulatory care nurses who join the ranks of those nurses who have taken the plunge and become certified.

For more information about the exam, contact ANCC at (800) 284-CERT(2378) or visit [nursingworld.com](http://nursingworld.com). AAACN offers the following excellent resources to help you study for the exam:

- Certification Review Course, April 2, 2001 – held in conjunction with the AAACN Annual Conference in Nashville, TN, March 29-April 1, 2001
- Certification Review Course Syllabus
- Self-Assessment Manual – includes 200 practice test questions
- Examination Preparation Guide – contains information about the exam and study tips
- AAACN Ambulatory Care Nursing Administration and Practice Standards
- Core Curriculum for Ambulatory Care Nursing – this new text will debut at the 2001 AAACN Conference and will be available for purchase after the conference.

For more information or to place your order, contact AAACN at (800) AMB-NURS, or visit the Web site at [www.AAACN.org](http://www.AAACN.org).
E-Commerce: From Novice To Connectivity

Maureen T. Power, RN, MPH

The 2001 AAACN preconference, E-Commerce: From Novice to Connectivity, will present both basic Web technology and information on assessing today's telecommunications systems.

Expert speakers will share their knowledge about America's migration to Web-enhanced services. They will identify organizational roadblocks commonly observed in e-commerce services, describe industry benchmarks, and help participants understand what patients and consumers are seeking from the health care industry.

New-age technology will be addressed from three perspectives, represented by organizations identified as leaders in their specialties. E Surg, a conference sponsor, is a young e-commerce company targeting physician practices and ambulatory care facilities. Presenter Mike Sweeney, E Surg vice president of business development, will target Web terminology, evolution of the technology, the impact of e-commerce in today's marketplace, and the need for migration from "brick and mortar" to the Web.

Robert F. Priddy, director of marketing, and Maurice J. Pitkofsky, product consultant, both of iMcKesson Access Health Services will discuss the evolution of nurse triage to expansion of Web and Internet related services. The last speaker, Byron Battles, president of Battles Group LLC will provide a consultant's perspective on where to begin, how to identify resources, and organizational development of e-commerce services.

The Urgency of Keeping Pace

The Internet is the key to maintaining and growing business relationships in today's virtual marketplace. Delays in implementing aggressive e-commerce or e-business strategies could be costly as more customers want (and expect) goods and services over the Internet.

This preconference will be extremely valuable to those who work for an organization with multiple systems and locations or new mergers pending. Participants will learn important elements to include in a telecommunications assessment to help integrate facilities and systems and expand business opportunities to Web-enhanced services.

Content will be directed to audience members wishing to gain a better understanding of how Web services, e-commerce, and revenue generation affect professionals at all levels.

This preconference is appropriate for people who work for an organization with a sophisticated or basic call center, for those relying on operators from another department to handle customer calls, and for those at a stand-alone facility seeking ways to improve operations. The preconference will also:

- Provide information on current terminology and on the options available for Web-enhanced call center services. This will help participants learn how to better communicate with technical support staff and vendors.
- Offer details on what the competition is doing, not just in health care but also in other businesses.
- Identify industry benchmarks which health care providers need to match in order to meet customer expectations for quality service.

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Conference to Feature Research And Clinical Practice Sessions

Regina C. Phillips, MSN, RN

The 2001 Program Planning Committee is proud to announce the sessions sponsored by the Practice Evaluation and Research Committee for the 26th Annual Conference in Nashville, TN. Continuing the AAACN tradition of offering sessions highlighting practice evaluation and research data, the 2001 conference will offer three research-focused sessions:

Theatre of Innovation

The first research session will be the Theatre of Innovation highlighting Telehealth Nursing Practice. This session will consist of the following three concurrent presentations:

- Use of Protocols and Guidelines by Telephone Advice Nurses. The speaker for this presentation will be Helen P. Leavy, PhD, MSN (University of New Mexico Health Sciences Call Center). She will discuss the results of data analyzed for correlation between triage disposition and ER acuity, triage diagnosis, and ER diagnosis and for correlation among frequency of telephone triage and ER usage and insurance type. Participants will be able to identify the common clinical endpoints of callers continued on page 11
An outstanding professional organization such as AAACN needs volunteers to help it succeed and provides to those volunteers tremendously enriching opportunities. Working with your peers to advance and influence ambulatory care practice is an investment in your own leadership development, in your expertise in the specialty, and in your development of a network of peers that continues to give back to you over time. The AAACN Board of Directors and the current leadership of all committees and Special Interest Groups (SIGs) would like to invite you to join them. Here are opportunities for you to consider:

- Annual Conference Planning Committee
- Research Committee
- Nominating Committee (elected)
- Web Site Advisory Committee
- Special Interest Group Steering Committee (chairs of SIGs)

(For more detailed information on these groups and for names and addresses of chairpersons and members, refer to your Membership Directory.)

You may also want to consider running for elected office. You are welcome to contact any of the current listed members or officers about their experiences.

Inside this issue of Viewpoint, you will find a “Willingness to Serve” form. Please complete it, expressing your interests, and return it to the National Office (see address in box at the top of this page) at your earliest convenience. We look forward to hearing from you.

Moderators Needed

Volunteers are needed at the 2001 AAACN Annual Conference in Nashville, TN, March 29 - April 1, 2001, to moderate concurrent sessions.

If you are planning to attend the conference, this is a great way to get involved and at the same time help AAACN. Moderating a session is an excellent way to enhance your conference experience.

If you are interested, please contact the AAACN National Office at (800) AMB-Nurs or via e-mail at aaacn@ajj.com