AMERICAN HEALTH CONSULTANTS®

Patient Education Management™

For Nurse Managers, Education Directors, Case Managers, Discharge Planners

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IN THIS ISSUE

In This Issue **continued on next page**

Patients can have active role in successful chronic pain management programs

Strategy stresses transition from patient to person

There are many reasons for chronic pain. It can be the result of an injury that never healed properly or caused by a health problem such as arthritis, lupus, or migraine headaches.

According to the Baltimore-based American Pain Foundation, one in six U.S. adults suffer from arthritis, and two-thirds of American adults will have back pain during their lifetime. More than 25 million suffer from migraines. As a result of pain, one in

EXECUTIVE SUMMARY

Symptoms caused by medical conditions can greatly impact the quality of life for patients. Often they suffer in silence thinking that nothing can be done; yet frequently, patients can be taught ways to manage their symptoms. In part two of a series on education's impact on symptom management, *Patient Education Management* addresses chronic pain. More than 50 million Americans suffer from chronic pain, according to the Baltimore-based American Pain Foundation. To better control chronic pain, those who experience it must be taught to become active participants in their pain management. Next month, *PEM* will cover educational methods for helping patients manage shortness of breath.

In This Issue **continued from page 25**

COMING IN FUTURE ISSUES

- What does the future of patient education look like?
- Prevention strategies for acid reflux disease
- How to overcome language barriers when teaching
- Strategies for National Headache Awareness Week
- Outreach strategies to curb domestic violence

three adults lose more than 20 hours of sleep each month, and lost workdays account for more than $50 million a year.

Although acute pain, which can be controlled by medications, surgery, or treatment, and has a beginning and an end, chronic pain is ongoing. Most people who have headaches take an aspirin and it goes away. Imagine having a headache that never leaves and you must live with it the rest of your life, says **Penney Cowan**, founder and executive director of the American Chronic Pain Association in Rocklin, CA.

If a person does not experience pain relief three to six months after an injury, it is highly unlikely they will ever experience full pain relief, says **B. Eliot Cole**, MD, MPA, the administrator for the national pain databank of the American Academy of Pain Management in Sonora, CA.

Patient acceptance key to recovery

The person with chronic pain must accept some of the responsibility for their own recovery and maintaining their wellness, says Cowan. "That magical pill that will take all the pain away doesn't exist. People have to learn with the help of the medical community and the best medical care possible to find a means that they can actually live with the chronic pain and that is possible," she says. Cole agrees. People with chronic pain must learn to cope, function, and manage their pain, he says.

If chronic pain is left unmanaged, the person experiencing the symptoms slowly deteriorates. Often they withdraw, isolate themselves, and just give up. "There are a number of people with chronic pain who feel that life is not worth living," says Cowan.

Pain and suffering go hand and hand. Suffering can lead to desperation, despair, depression, and suicidal thinking. Also, chronic pain can interfere with activities of daily living. People become physically weakened from doing nothing and are unable to shop for groceries or cook a meal, says Cole.

People who experience chronic pain need to be thoroughly evaluated by a medical professional so that they know that the cause of the pain is not life-threatening and won't bring immediate harm, says Cowan.

Medical evaluation helps to uncover a means of managing the pain whether through medications or another technique — such as yoga — that can lower the pain intensity and improve

the performance of activities of daily living, says Cole. "The therapies would depend on what kind of pain the person is experiencing. The diagnosis is critical. You first have to pin down why someone is hurting. The underlying pain problem would determine the therapy," he explains. For example, stretching techniques such as yoga, Tai Chi, or swimming would help with muscle spasms and muscle tightness and help to keep people limber.

Get patients involved

To gain pain management skills, it's best to attend a multidisciplinary pain management program; however, such programs are difficult to find and can be expensive, says Cowan. "To be a part of the treatment team and assume some responsibilities for patients' wellness, people need to learn certain skills, and that is where a good multidisciplinary team management program comes in," she explains.

When a pain management program is not available, the person can work with a physician, physical therapist, and people knowledgeable about complementary therapies to devise a management plan.

Pain management skills might include eating a nutritious diet and exercising to maintain optimum overall health, reducing everyday stress, recognizing emotions that will cause pain flare-ups and dealing with them in a timely manner, and learning skills such as biofeedback.

Patients experiencing pain need to be accurate observers of their condition, and as best they can communicate what they experience to the health care provider, says Cole. This includes learning the descriptive vocabulary for pain so they can describe it with terms such as tingling, stabbing, prickling, or burning. They also need to learn to rate the intensity on a pain scale and notice the correlation between what they are doing and their pain level over a 24-hour cycle. "If there is going to be a change in the treatment, it can reflect what is clinically going on," explains Cole.

However, when pain is chronic, it's important for a person to accept the pain once he or she has been thoroughly evaluated by the medical community. "When pain is chronic, people must move from the patient role and become a person again," says Cowan. The role of patient brings with it the expectation that someone is going to take care of them and fix them, she explains.

Cowan went through a pain management program 21 years ago and still applies the basic skills she learned in the program, along with many other techniques garnered through daily living in order to remain a person rather than a patient. When pain is intense, she has found that certain relaxation skills help redirect her thoughts to something she can control rather than the pain in her body.

For example, during biofeedback sessions she learned a breath relaxation technique in which she imagines air filling her lungs. She visualizes it entering her body as soft, puffy clouds going into her lungs. During this visualization process, she cannot think about her pain because people have a one-track mind, says Cowan. "The technique allows my muscles to relax a little bit; and as we relax, our muscles' blood flow is restored and the pain can quite often be reduced. That is one of the skills I use," she says.

To help chronic pain sufferers become persons not patients, Cowan founded the American Chronic Pain Association which provides training for support group facilitators and offers workbooks

SOURCES AND RESOURCES

For more information on teaching people to manage chronic pain, contact:

- **B. Eliot Cole**, MD, MPA, Administrator, National Pain Databank, American Academy of Pain Management, 13947 Mono Way #A, Sonora, CA 95370. Telephone: (209) 533-9744. Fax: (209) 533-9750. Web: www.aapainmanage.org.
- **Penney Cowan**, Founder and Executive Director, American Chronic Pain Association, P.O. Box 850, Rocklin, CA 95677-0900. Telephone: (916) 632-0922. Fax: (916) 632-3208. Web: www.theacpa.org. The first year membership in the association is $30 and includes a 200-page workbook titled *From Patient to Person,* a quarterly newsletter, and a 10% discount on other materials. For an additional $7, people can purchase the facilitator guide, which gives them information on how to get a support group started.

The following organizations also can provide information on chronic pain management:

- **American Academy of Pain Medicine**, 4700 W. Lake, Glenview, IL 60025. Telephone: (847) 375-4731. Fax: (847) 375-6331. Web: www.painmed.org.
- **The American Pain Foundation**, 111 S. Calvert St., Suite 2700, Baltimore, MD 21202. Telephone: (410) 444-9200. Web: www.painfoundation.org.
- **The American Pain Society**, 4700 W. Lake Ave., Glenview, IL 60025. (847) 375-4715. Fax: (877) 734-8758 (Toll free). Web: www.ampainsoc.org.

that teach coping skills that the groups use. Ongoing support is important, she says, because people have difficulty following an appropriate preventive strategy, even after participating in a chronic pain management program. **(For more information on this support program, see box, p. 27.)**

For example, participants know if they don't do their stretching exercise every day, the muscles will lose the tone they worked so hard to achieve. Or, if they ignore signs of stress, the pain will become so intense it will be difficult to gain control, yet it is difficult to stay disciplined. "What individuals need is that continuing positive reinforcement," says Cowan.

When people are told to live with chronic pain it feels like the end of the world, yet they can control certain aspects of pain control, such as their stress levels. Although people with chronic pain have no control over certain things that may increase the pain, such as changes in the weather, they can control how they will respond to them, says Cowan. ■

Staff's pain management education must be priority

Ensure compliance with new JCAHO standards

With a survey of the Oakbrook Terrace, IL-based Joint Commission on Accreditation of Healthcare Organizations scheduled for April 2001, staff education on pain management became a high priority at Mercy Hospital in Iowa City, IA.

That's because this year, compliance with the Joint Commission's new pain standards will be assessed.

Therefore, a pain assessment workgroup was assembled to create a staff education program that would bring everyone up to speed on how pain is addressed throughout the organization. "My role was in determining resources and the outline for the program," says **Mary McCarthy**, RN, C, CDE, BSN, patient education coordinator at Mercy Hospital. Other group members were from home health, inpatient and outpatient areas, and pharmacy.

The one-hour training sessions took place in January with makeup sessions in February. They consisted of a brief pain management history that included mention of the efforts of the Agency for Healthcare Research and Quality (AHRQ) in Rockville, MD, which created clinical practice guidelines on pain. Also discussed was media coverage of pain management within health care settings so that staff would be aware of the information consumers received.

Training tailored to organization's policies

Curriculum includes what the hospital has in place systemwide. "We adopted a zero to 10 pain scale in the mid-1990s after a workgroup looked at the [AHRQ] clinical practice guidelines on pain," says McCarthy. In 1998, the health care facility also included in its policy the use of alternative comfort measures for pain, such as relaxation methods and music. This occurred when it looked at its policies and procedures on pain in preparation for a survey by the Chicago-based American College of Surgeons.

"We also talk about barriers to assessment for pain, and have a handout on cultural differences and how to evaluate the cognitively impaired patient," she says. Age-appropriate resources for patient education are discussed, as are all the various forms for the documentation of pain assessment and management.

During the training session, staff view a 16-minute video, "Pain Management: The 5th Vital Sign," produced by Envision Inc. in Nashville, TN. **(For information on this resource and others, see box, p. 29.)**

Class participants then are invited to play a game. The game, based on a popular TV show, is titled "Who Wants to be the Millionaire of Pain Management." Contestants are given a question with four possible answers; and once during their turn, they can call a friend (who is someone attending the class), ask the audience, or have two of the wrong answers removed just like the TV version.

One of the simpler questions is: "A reliable indicator of the patient's pain is: A. the patient's vital signs; B. what the patient's wife says; C. the patient's report of pain; or D. the physician's progress notes." (Answer: C)

"This is a housewide program, so we made it global. We also wanted people to know that pain is being addressed throughout the organization," says McCarthy.

The approach to staff training taken by the New Mexico Veterans Affairs (VA) Health Care System in Albuquerque is slightly different, however. We went with a department-based rather

SOURCES AND RESOURCES

For more information on educating staff about pain management, contact:

- **Carol Maller**, MS, RN, CHES, Patient Education Coordinator, New Mexico VA Health Care System, 1501 San Pedro Drive S.E., Albuquerque, NM 87108. Telephone: (505) 265-1711, ext. 4656. Fax: (505) 256-2870. E-mail: Carol.Maller@med.va.gov.
- **Mary McCarthy**, RN, C, CDE, BSN, Patient Education Coordinator, Mercy Hospital, 500 E. Market St., Iowa City, IA 52245. Telephone: (319) 339-3662. E-mail: mary.mccarthy@mercyic.org.

Resources for staff education:

- **Pain as the 5th Vital Sign Toolkit.** To review a copy of the booklet produced by the Department of Veterans Affairs, visit the Internet site. Web: www.va.gov/OAA/docs/residentresources/Pain5thVitalSign/PainToolkit_Oct2000.doc.
- **Pain Management: The 5th Vital Sign.** This 16-minute video is produced by Envision Inc., 1111 16th Ave. S., Nashville, TN 37212. Telephone: (615) 321-5066. Fax: (615) 321-5119. The staff education video and an accompanying patient education version are sold as a package along with a self-learning packet. The cost is $450, plus $13 shipping and handling. For a free preview of the video, call Envision or visit their Web site: www.envisioninc.net.

than systemwide approach, says **Carol Maller**, MS, RN, CHES, patient education coordinator. For example, instruction on pain management for health care providers was incorporated into grand rounds, and a weeklong pain seminar is now an annual event. During this year's seminar, in order to help meet Joint Commission pain management standards, the chief medical officer canceled clinics for an hour every morning so that providers would be relieved of patient care responsibilities and could attend. Experts in pain management from around the nation were the scheduled speakers.

In an effort to aid the health care institutions within the VA system, a national coordinating committee for pain management strategies was created. One workgroup within the committee created a resource manual titled "Pain as the 5th Vital Sign Toolkit," for use by Veterans Health Administration managers and staff.

The toolkit offers guidelines for the completion of comprehensive pain assessments, and content includes the following sections:

• **Barriers to pain screening and assessment** — this section covers barriers for practitioners, patients, and the health care system.

• **The pain screening process** — this section describes use of the numeric pain scale, provides answers to questions patients frequently asked, and discusses when to screen, document, and interpret pain scores.

• **Comprehensive pain assessment** — this is a comprehensive "how-to" guide featuring interview suggestions and documentation.

• **Education and resource information** — this section includes policy, contact persons within the VA, samples for electronic and paper documentation, pain assessment tools, and templates.

• **Related JCAHO standards —** the American Pain Society based in Glenview, IL, first proposed pain as the fifth vital sign, says Maller. The Department of Veteran Affairs embraced that proposal and mandated the assessment of pain as the fifth vital sign in March 1999.

In addition to the toolkit, the committee groups helped create many tools for staff education, including a Microsoft PowerPoint program and discussion guide on basic pain management, and a pharmacy Internet education series.

Complying with the Joint Commission's pain management standards is a large endeavor, says Maller. "It has to be integrated throughout the entire medical center. I have a policy for my patient education program at the medical center, and I have to revise it so it includes pain management. It has to appear everywhere." ■

Noise biggest culprit in hearing loss

Simple solutions minimize or prevent damage

Prevention education should include keeping ears healthy. Although the majority of patient presentations are noise-induced, some simple measures could shield the ear. Wearing earplugs or earmuffs while in a noisy working environment or engaged in a recreational activity, chore, or hobby that encompasses loud noise could prevent damage to the ear, says **Kathleen Yaremchuk**, MD, vice chair of the department of otolaryngology — head and neck surgery at the Henry Ford Hospital in Detroit. Yaremchuk is a member of the subcommittee for the Medical Aspects of Hearing Loss for the American Academy of Otolaryngology in Alexandria, VA.

EXECUTIVE SUMMARY

There are many barriers to education, and hearing loss is one of them. In the first of a series of articles that address learning barriers, we discuss how education can prevent the problem of hearing loss in the first place. It focuses on what patients need to know to protect their hearing for better quality of life. A complementary article provides tips on teaching the hearing impaired. It focuses on steps educators should take to ensure that patients understood the lesson in spite of the impairment.

People hear because sound waves travel through the air into the ear opening through the ear canal to the eardrum. As the eardrum vibrates, the sound travels to the small bones of the middle ear, which transmits them to the nerves in the inner ear. The vibrations create nerve impulses that go directly to the brain so that the sound can be interpreted. Hearing loss from noise occurs when the nerve endings in the inner ear are destroyed.

"The hearing damage that we sustain because of noise is cumulative, so it is over a lifetime," explains Yaremchuk. A person may have worked in a factory where loud machinery was present, been in the military where firearms were used, and have a woodworking shop set up in the basement at home with electric saws. All those activities create a person's total exposure or life history. That's why it is important for people to protect their ears when using a snow blower, lawn mower, or chain saw and even while sitting in the stands at a rock concert or auto race, she adds.

Single incidents, such as a firecracker or gun going off near the ear, can cause damage as well. When the ear rings, it is a sign that the person has sustained a concussion to their ear, says Yaremchuk. According to the American Academy of Otolaryngology, noise may be harmful under the following conditions:

- A person has to shout to be heard.
- The noise hurts their ears.
- They have difficulty hearing several hours after exposure to the noise.
- They experience ringing in their ears.

"There are different increments of sound with sound measured in decibels. When we talk about safety, there is individual susceptibility to noise," says Yaremchuk. However, the longer a person is exposed to loud noise, the more damaging it can be. According to experts, continuous exposure to sound at 85 decibels is dangerous. Lawn mowers, shop tools, and truck traffic have a decibel level of 90; chain saws and snowmobiles are about 100 decibels; auto horns and loud rock concerts are 115 decibels; and jet engines and gun muzzle blasts are 140 decibels.

Get a baseline

Anyone who's occupationally or nonoccupationally exposed to loud noise should have a hearing test, advises Yaremchuk. This will create a baseline from which a person can measure their hearing in regular testing to make sure they are not allowing further damage to occur. The frequency of hearing tests depends on what the baseline shows, but if loss is indicated, the tests usually are recommended every one or two years.

People usually experience warning signs of hearing loss during conversations. They can't hear when someone is talking and frequently have to ask the person to repeat what was said. Also, they notice that people tap them on the shoulder to get their attention before speaking because they don't hear otherwise. "It is a lot easier to know that you are losing your sight. You pick up the newspaper and you can't read it, but when you lose your hearing, you don't know what you are missing. For the majority of people, it is gradual," says Yaremchuk.

Hearing loss is like standing in water up to the chin with 80% of the body covered, she says. The person is OK; but if the water rises two or three more inches, he or she is in trouble. It is the same with hearing loss. All of a sudden, people notice that they can't hear, and think that the loss has occurred only during the past year. Yet it probably has happened over 30 or 40 years and has just gotten to the point where conversational speech is difficult to hear, says Yaremchuk.

People lose their connection to others when they can't hear because they can't communicate. "Quality of life is very important and shouldn't be underestimated. When people are unable to hear on a telephone, it is very problematic," says Yaremchuk. Therefore, communication is the key reason to get a hearing aid. If people with hearing loss work or are involved in lots of social activities, then a hearing aid is important. However, if they are older, live by themselves, turn the TV or radio up as loud as they want, and don't go out much, then a hearing aid is of little benefit, says Yaremchuk.

The best scenario is for people to make a habit

SOURCE

For more information on preventing hearing loss, contact:

- **Kathleen Yaremchuk**, MD, Vice Chair, Department of Otolaryngology — Head and Neck Surgery Henry Ford Hospital, Member Subcommittee for the Medical Aspects of Hearing Loss, American Academy of Otolaryngology — Head and Neck Surgery Inc., One Prince St., Alexandria, VA 22314, Telephone: (703) 836-4444. Web: www.entnet.org.

of reaching for the earplugs or earmuffs when around loud noise. "It is just like if you are in a car, you wear a seat belt, and if you are going somewhere where there will be noise, have earplugs with you," says Yaremchuk. ■

Tips for teaching patients with hearing loss

Learn to recognize common signs

Hearing always should be assessed, because hearing difficulty is a barrier to education. To assess for hearing loss, simply ask learners if they have trouble hearing, advises **Fran London**, MS, RN, health education specialist at The Emily Center at Phoenix Children's Hospital. Also, ask learners if they wear a hearing aid or if people seem to be mumbling or don't speak clearly.

Signs of hearing loss can be assessed by observation as well, says London. She suggests learners look for the following signs that could signal hearing loss:

- The patient prefers the volume on the TV or radio louder than others.
- The patient consistently asks the speaker to repeat information.
- The patient has difficulty following the conversation and understanding words.
- The patient avoids using the telephone.
- The patient gives answers that are unrelated to the questions posed.
- The patient doesn't seem to hear people speak unless they are looking at the speaker.

Have plenty of resources available to teach patients who are hard of hearing, says **Allison M. Reid**, MS, RNC, an educator at St. Francis Hospital and Health Center in Blue Island, IL. St. Francis has picture boards that educators can point to, as well as slates available to write on. In addition, listening devices and telephone amplifiers are available from the speech pathology department. If the person is completely deaf and knows sign language, an interpreter is contacted.

Other visual tools that can aid in teaching the hearing impaired include posters, models, videotapes, and written materials. "The learner may be able to use your stethoscope to hear better. Put the bell near the source of the sound," adds London.

When teaching patients who have difficulty hearing, select a quiet area or shut the door. If the learner is wearing a hearing aid, make sure the battery works, then sit or stand at the same level as the learner and within four feet, says London. If the learner has a good ear, sit within three to six feet of it.

Educators should face the learner and make sure their mouth is never covered with their hand. They should speak slowly, in short, clear sentences in their normal voice or in a slightly lower pitch without dropping their voice at the end of the sentence.

Have the patient frequently repeat or demonstrate what was taught, says Reid. That's the best way to make sure a patient who is hard of hearing has understood the lesson. "We always identify someone who is hard of hearing with a placket in their room so staff will know to make the necessary adjustments in their teaching." ■

SOURCES AND RESOURCES

For more information on teaching people with hearing loss, contact:

- **Fran London**, MS, RN, Health Education Specialist, The Emily Center, Phoenix Children's Hospital, 909 E. Brill St., Phoenix, AZ 85006. Telephone: (602) 239-2820. Fax: (602) 239-4670. E-mail: flondon@phxchildrens.com.

The teaching tips offered by London in this article and others can be found in her book, *No Time To Teach? A Nurse's Guide to Patient and Family Education*. Philadelphia: Lippincott Williams & Wilkins; 1999. ISBN 0-781701644-6. For more information or to order, call toll-free: (800) 638-3030. Web: www.lww.com. The cost of the book is $31.95.

- **Allison M. Reid**, MS, RNC, Educator, St. Francis Hospital & Health Center, 12935 S. Gregory Ave., Blue Island, IL 60406. Telephone: (708) 597-2000 ext. 5854. Fax: (708) 597-1381. E-mail: allison_reid@ssmhcs.com.

Give old muscle movements new options

Feldenkrais Method helps break bad habits

People usually try the Feldenkrais Method because they are experiencing pain and discomfort, says **Alice Brydges**, a certified movement therapist and Feldenkrais practitioner in San Francisco. That's how she was introduced to the therapy that harnesses the intelligence of the central nervous system through movement and guided attention.

As a dancer, she kept injuring herself over and over again. "I would recover from the injury for a while, but it always came back. I explored every therapy known to man, yet I couldn't stop hurting myself," says Brydges. Then she attended an Awareness Through Movement class that taught the Feldenkrais Method.

As she lay on the floor, following the instructor's verbal directions for movement that included a lot of turning her head one direction while looking in the opposite direction, she thought that it wasn't doing much good. However, when she stood, she felt like she was in a different person's body. The pain was gone and it never came back. The experience prompted her to train as a practitioner.

Now she works with people who are often as frustrated as she was. They are drawn to her Awareness Through Movement class or private sessions called Functional Integration for a variety of reasons. Women who've had mastectomies and are experiencing restrictive movements in their arms are interested in the Feldenkrais Method, as are professional athletes and dancers who want to learn how to move better. A bass guitar player who hurts his back each time he plays can show his body new options by using this method.

Learn new, more natural movements

It's easy to develop habit patterns for movement. The Feldenkrais Method helps people become aware of habitual body positions and movements that can cause problems. Also, it helps them learn new ways of moving that might be more natural for their body. "You move in a way that is familiar and you can't get out of that rut, but the nervous system is intelligent and it doesn't take a lot to learn something else," says Brydges. The Feldenkrais Method introduces so many options, the ruts begin to smooth out and the person is no longer committed to moving only one way, she explains.

During her classes, Brydges verbally guides participants through various choreographed movements. She does not demonstrate because the therapy is individual and people aren't supposed to force their body into a position, which they might do if following the example of a teacher. For example, if the directions are to roll to the side, participants should only roll as far as is comfortable.

There are thousands of choreographed sequences in the Feldenkrais Method, and some are based on human developmental patterns, such as crawling, rolling, rolling to sit, and hand-eye coordination. "Most of the lessons are done lying down, and the reason for that is our anti-gravity muscles that hold us upright are very firmly entrenched in our nervous system and our movement pattern," says Brydges. Lying down takes the person out of the field of gravity, allowing other muscle groups to be accessed.

Although classes are more affordable than a session with a practitioner, generally $7 to $10 vs. $60 to $100, individual consultations are an option. During the individual session, a person would be asked to sit or lie on a low, wide padded table. The practitioner will observe as the person does some movements on the table and standing on their own; then the practitioner may move the person noting areas of strain and movement difficulty. During an individual session, the practitioner would verbally guide the person through some intriguing movement sequences that would indicate problem movements in their body and give them more options for movement, says Brydges.

Moshe Feldenkrais developed the Feldenkrais Method in the early 1950s. After being crippled,

SOURCE

To learn more about the Feldenkrais Method, contact:

- **Alice Brydges**, Certified Feldenkrais Practitioner and Movement Therapist. Telephone: (415) 664-8113. E-mail: abrydges@onebox.com. Web: www.senseyourself.com.

Brydges has created a cassette tape series with an instructional booklet for breast cancer survivors. The series is called *Unbound! Gentle Movement Lessons for Breast Cancer Survivors*. It costs $59.95 and is available on her Web site.

he used his background in science to teach himself how to walk again by studying human movement. Now practitioners learn his methods to aid others who are injured, are in chronic pain, or want to learn to move better.

The best way to find a practitioner is through the Feldenkrais Guild of North America. They have a directory on their Web site (www.feldenkrais.com). If a practitioner is not available, instructional audiotapes can be used, says Brydges. **(For a list of resources, see source box, p. 32.)** People often find it helpful to either repeat the movements at a class or on their own. It helps remind the body of the new options for movement so it won't go back to old, familiar ways, says Brydges.

(Editor's Note: A selection of audiotapes for beginners as well as people who have taken an Awareness Through Movement Class can be ordered through Feldenkrais Resources, 830 Bancroft Way, Suite 112, Berkeley, CA 94710. Telephone: (800) 765-1907. Fax: (510) 540-7683. E-mail: feldenres@aol.com. Web: www.feldenkrais-resources.com.) ■

Reader Questions

Referrals ensure continuum of care

Packets outline available support services

Question: "What process do you have in place for referring patients from an acute-care setting to an educational program such as asthma, diabetes, or heart disease? What mechanism is in place to assess for educational needs that might result in a referral to a program or center, and what criteria is the referral based upon? Is the referral mechanism in place only in an inpatient setting, or can it also be initiated from the emergency department? If yes, how?"

Answer: The system at Akron (OH) General Medical Center is quite simple. Patients admitted to the hospital with a chronic disease such as asthma, diabetes, or congestive heart failure are given a teaching packet that has a list of support services. A nurse goes over the information with all but the asthma patients who receive the teaching from the respiratory therapist.

In all cases, the educator strongly encourages them to attend an outpatient class, but does not make a formal referral, says **Billie M. Foley**, RN, MSEd, patient education coordinator at the medical center.

Patients who are admitted to Jackson Memorial Hospital in Miami with a chronic disease also receive a standard educational package. However, the materials are considered a "starter" to education, explains **Peggy McLoughlin**, RN, JD, chronic disease manager at the health care facility.

For further education, the inpatient case manager enrolls the patient in a group class, such as diabetes self-management, and refers the patient to the disease state case manager. Classes are available at primary care sites in the north and south ends of the county and at the hospital's main campus with two sites offering education in Spanish as well as English.

"Once a patient is referred to our disease management program, the disease state case manager does a risk screening of the patient and assigns the patient to either a low, medium, or high-risk category. The criteria vary by disease, but the main categories are clinical, adherence, and psychosocial risk factors," says McLoughlin. The overall risk level of the patient governs the frequency of interactions with the case manager. High-risk patients receive intensive one-on-one education from the disease state case manager.

An example of the process is as follows:

- Patient admitted to hospital with a diagnosis of diabetes.
- Patient placed on a clinical pathway.
- Patient followed inhouse by inpatient case manager.
- Patient referred to the appropriate disease state case manager who follows the patient after discharge.
- Patient screened for risk level at primary care site.
- Patient's level of risk determines the frequency of interactions with the disease state case manager.

"The goal of the disease state case manager is to work with the primary care provider to maximize medical therapy and provide the patient with the skills necessary for self-management of the disease," explains McLoughlin. As the patient develops the skills to manage the disease on their own, their risk level is reassessed.

When a person is admitted to Grant/Riverside Methodist Hospitals with a diagnosis of diabetes the patient receives an automatic consult with a diabetes educator. If a patient has asthma and has

SOURCES

For more information on designing a process for the continuum of education, contact:

- **Billie M. Foley**, RN, MSEd, Patient Education Coordinator, Akron General Medical Center, 400 Wabash Ave., Akron, OH 44307. Telephone: (330) 344-6325. E-mail: bfoley@agmc.org.
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a new breathing treatment prescribed by the physician, a respiratory therapist comes to teach. Similarly, cardiac rehab provides an educator for heart patients.

In each case, the educator talks to the patient about the benefits and support of an educational outpatient program pertinent to management of their chronic disease. If the patient is interested, a referral is made, says **BJ Hansen**, BSN, patient education coordinator at the health care system in Columbus, OH.

Create statewide network for out-of-towners

Because many of the heart patients are from outside the Columbus area, a list of rehab programs throughout the state of Ohio is maintained. "We have a list of all the cardiac rehab programs in the state of Ohio we give to the patient, and we try to get them to a cardiac rehab program in their area if they are willing to go," says Hansen.

Within their own system, they have a heart disease management clinic and a Coumadin clinic for heart patients. For asthma management, there is an asthma clinic/pulmonary rehab program, and for diabetes patients, outpatient classes are available with a case managed program available for HMO members.

Specialists automatically visit patients with heart problems or a diabetes diagnosis when they are admitted to Provena Mercy Center in Aurora, IL. During the education session, cardiac rehab nurses teach the heart patient and explain the health care systems' cardiac rehab program. They set up a time for the patient to begin the program after discharge, explains **Rita Smith**, MSN, RN, education coordinator.

"For patients with diabetes, the dietitian sees the patient and refers them to the diabetes support group that meets once a month. Also, they are given my name and number so they may come in as an outpatient for further education sessions on managing their diabetes at home," says Smith.

To make sure asthma or diabetes patients who come to the emergency department at Jackson Memorial Hospital don't slip through the cracks, case managers intercept them. "They initiate education and give the patient a 'starter' education packet. They will also determine where the patient receives their primary care, and make an appointment to the appropriate class," says McLoughlin. The names of the patients are forwarded to the disease state managers who conduct the classes and follow the patients in the primary care centers. ■

Better Sleep Month tackles a national problem

Educate public on healthy sleep habits

America is a sleep-deprived nation. According to research by the Alexandria, VA-based Better Sleep Council, work and family responsibilities frequently rob Americans of the sleep they need. Both men and women work full time and often have a three- to four-hour commute. Almost half have dependent children or an elderly adult at home, so their duties don't end when they punch the time clock. Americans have added about 158 hours a month to their annual work and commute time since 1969.

Sleep is needed for physical and mental well-being and critical for maximum performance. Therefore, to raise awareness about the impact sleep deprivation has on health and help Americans improve their sleep habits, the Better Sleep Council declared May Better Sleep Month. "There are lots of different angles health care facilities can

EXECUTIVE SUMMARY

Do you want to provide education to the public on pertinent health issues? Take advantage of the nationally designated health months, weeks, or days. Sponsoring organizations are ready to supply ideas and sometimes even educational materials. To help you in your efforts, *Patient Education Management* will give you a heads-up on a nationally designated health awareness date in every issue. This month, we begin the service with information on Better Sleep Month designated for May.

take to educate the public. You can look at your facility's demographics and approach sleep from that perspective," suggests **Andrea Herman**, director of the Better Sleep Council.

Sleep deprivation affects all types of people

People who struggle with sleep deprivation include parents of newborns, the elderly, college students, shift workers, and working moms. Other educational angles that can be addressed during Better Sleep Month are environmental factors that hamper sleep and sleeping disorders.

Following is a list of topics that can be addressed during a brown bag luncheon or other community educational event:

- **Restorative sleep.**

A good night's sleep is not always equivalent to eight hours. Sleep must be restful and uninterrupted to be restorative. Provide tips on how to get a good night's sleep such as avoiding caffeine, alcohol, and tobacco products late in the day, says Herman. Developing a sleep ritual for bedtime provides cues for the body to begin slowing down. Establishing regular sleep hours helps, as well.

- **Importance of sleep environment.**

The atmosphere in which a person sleeps can either be conducive to sleep or a deterrent. People sleep best in a dark room because light is a time cue for day which signals wakefulness in the brain. Noise can disrupt sleep as well, especially if it is loud or sudden. The steady, low hum of the air conditioner or a fan can help block out noises and is soothing, according to the Better Sleep Council. People sleep best when the room is 60° to 65° F, and when they are sleeping on a mattress that provides firm support and allows them to move around easily.

- **Sleep problems and aging.**

Poor sleep is not part of the aging process. However, aging-associated health problems such as arthritis and heart disease, can impact sleep. Also, drugs used to treat medical conditions can interrupt sleep.

In addition, sleep patterns change as people age. The body's circadian rhythms, or biological clock, advance a few hours, causing seniors to feel sleepy earlier at night and to wake earlier in the morning. Seniors should make adjustments in their sleep habits when those changes occur.

Lifestyle can improve sleep patterns

Other lifestyle habits that can ensure a better night sleep include moderate exercise, spending time outdoors during the day, and avoiding food

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SOURCE

For more information on creating educational outreach programs for Better Sleep Month in May, contact:

- **Andrea Herman**, Director, Better Sleep Council, 501 Wythe St., Alexandria, VA 22314. Telephone: (703) 683-8371. Web: www.bettersleep.org.

and beverages with caffeine. Seniors should know that naps are not the answer to daytime drowsiness and can contribute to difficulty sleeping at night. Naps should be limited to 30 minutes or eliminated altogether.

- **Teens need for sleep.**

Teens, parents, and school officials need to know that teens require more sleep than children just a few years younger. Homework, extracurricular activities, or after-school jobs should not prevent them from getting eight to nine hours sleep a night. Another culprit for lack of sleep is a change in sleep patterns during puberty. Teens are more alert later in the day, but often must start school very early. Lack of sleep can contribute to poor grades, traffic accidents, and moodiness. Good sleep tips for teens include making sleep a priority, catching up on sleep when necessary, and creating a good sleep environment to ensure restful sleep.

See health professional for sleep disorders

- **Addressing sleep disorders.**

When a sleep disorder is the cause of sleep deprivation the best solution to the problem is to see a physician. The main symptoms of sleep apnea are persistent loud snoring at night and daytime sleepiness. Other sleep disorders include insomnia — trouble falling asleep, staying asleep, or getting back to sleep; narcolepsy — a condition where people fall asleep uncontrollably during the day; and restless legs syndrome — a tingling sensation in the legs.

"There are lots of ways of breaking down your audience. There are childhood sleep issues, the angle of the woman trying to get it all done, and the unique needs of shift workers who are working against their biological clocks," says Herman. She suggests patient education managers planning an outreach program for Better Sleep Month look for ideas and information on the council's Web site (www.bettersleep.org).

Most people who are having trouble sleeping blame stress; yet if they are taught to do a self-analysis, they might be able to find ways to get a better night's sleep, says Herman. ■

CE objectives

After reading *Patient Education Management*, health professionals will be able to:

- identify management, clinical, educational, and financial issues relevant to patient education;
- explain how those issues impact health care educators and patients;
- describe practical ways to solve problems that care providers commonly encounter in their daily activities;
- develop or adapt patient education programs based on existing programs from other facilities. ■

Focus on Pediatrics
PATIENT EDUCATION MANAGEMENT'S MONTHLY SUPPLEMENT

Violence prevention goal of educational program

Start young to avoid intervention mode

Violence is a public health problem, says **Andrea Iger**, LCSW, MPH, director of the violence prevention program at the Connecticut Children's Medical Center Injury Prevention Center in Hartford. "It affects people's well-being. It is a stress issue and physical issue whether a person is a bystander, victim, or perpetrator," she explains. It also can be expensive, with people involved in violent acts incurring huge medical bills and lost time from work.

The focus of the center is to identify ways to prevent violence and it focuses on four areas — interpersonal violence, child abuse, domestic violence, and youth suicide.

To prevent interpersonal violence, the center works with the public school system and has implemented a curriculum for first-graders called *Second Step — A Violence Prevention Curriculum*. **(For information on this program, see source box, p. 2.)** The program focuses on empathy development, problem solving, impulse control, and anger management.

"We are trying to help first-graders learn these interpersonal skills that will help them prevent violence in their life as they get older," says Iger. The center staff not only teach the children, but the teachers as well so they can continue to reinforce the lessons learned. To prevent violence, it is important to start young before kids are already violent. Otherwise, it is intervention rather than prevention, Iger adds.

In addition, parents are invited to come to the school to observe and participate. Letters usually are sent home with the children at the beginning of the program and before each unit, inviting parents to attend or contact their child's teacher, principal, or the violence prevention curriculum instructor with questions. "The school is our access point, but we need the parent to support what the children are learning in the classroom in order for them to practice their skills at home and in school," says Iger. If the parents give their children instructions that contradict the violence prevention curriculum, the kids will do what the parents say, she explains.

Iger currently is working on obtaining a grant to see if the same curriculum is as effective with fourth- through sixth-graders. It has been proven effective in grades first through third but many believe that by the time children reach middle school, they have established their way of coping with issues such as violent confrontations. "Our program is not just educational. Our goal is to link the programs we do with research in either the way they are implemented, an evaluation of the process, or an evaluation of the results and how they affect the knowledge and behavior changes in the people that receive the information," explains Iger.

Using a variety of prevention methods

In an effort to stop domestic violence, the center is conducting a study in which parents are interviewed at pediatric visits or after delivering a baby at a local hospital to determine if their medical provider screened for domestic violence. If the study reveals that the screening does not occur as often as it should or clinicians are being judgmental in deciding whom to screen, recommendations for improvement will be made.

Domestic violence also is addressed in the center's support of the Violence Intervention Project for Children in Hartford. The city's program provides counselors who are dispatched by the police when they go to the scene of the crime and find that a child witnessed violence. The counselors provide support to the parents and children, educating them about post-traumatic stress disorder. The crime might be a domestic dispute, burglary, or assault.

Although the Injury Prevention Center does not have curriculum that addresses youth suicide, Iger is a member of the Connecticut Youth Suicide Advisory Board, which is part of the state's child protection agency. The board advises the agency on training and grants pertaining to youth suicide prevention.

The violence prevention program also is part of the Greater Hartford Violence Prevention

SOURCE

For more information on the Violence Prevention Program, contact:

- **The Violence Prevention Program**, Connecticut Children's Medical Center, Injury Prevention Center, 282 Washington St., Hartford, CT 06106. Telephone: (860) 545-9988. Fax: (860) 545-9975.

Coalition, a group of organizations that focus on violence prevention but have varied purposes. Some target domestic violence, some gun violence, others sexual assault. The goal is to bring these groups together for statewide educational efforts. In the 18 months since it was formed the group has held a legislative workshop teaching people how to use the process to stop violence.

It also hosted a safe night out program for middle school kids. To help end gun violence, the coalition organized an event that included the viewing of a national documentary, a discussion by a panel of experts on the topic, and a candlelight vigil attended by many legislators who gave speeches.

The events were quite varied, with one for kids, one for community, and another helping people understand that they have a voice, says Iger. "A lot of what we are trying to do is encourage people to get more involved in whatever it might be that they have an interest in," she says.

At the Injury Prevention center, the focus is to identify ways to prevent violence or ways to prevent unintentional injury. "We come at the topic in different ways with our programs," says Iger.

[Editor's note: The Seattle-based Committee for Children created Second Step-A Violence Prevention Curriculum. The Second Step 1-3 kit and staff training videos cost $414. The curriculum without training materials costs $269. For more information or to order contact: Committee for Children, 2203 Airport Way S., Suite 500, Seattle, WA 98134. Telephone: (800) 634-4449 or (206) 343-1223. Fax: (206) 343-1445. Web: www.cfchildren.org.] ■

Dispel myths on safe diving practices

Several myths hamper education on safe diving, says **Ron Gilbert**, JD, chairman of the Foundation for Aquatic Injury Prevention in Detroit. One is that everyone knows what shallow water is and won't dive into water that is less than five feet deep. However, to most people, shallow means anything from 18 inches to four feet deep. Making sure that people understand the importance of depth when diving is a vital point of education, says Gilbert.

When people are taught to dive, they usually are around the age of seven, when a depth of three or four feet is adequate for their height. "Few, if any of them, are taught that once they become teen-agers, it is unsafe to dive into such depths of water," says Gilbert.

Many people dive into shallow water without being injured, even if they hit their head on the bottom. Yet more than 1,000 people each year sustain spinal cord injuries. Just because one person is lucky and doesn't sustain an injury doesn't make it safe.

People must become aware that there are complex laws of physics involved in diving, says Gilbert. "Once a person's body leaves the deck or diving area, it is completely out of control and for an average recreational swimmer, there is nothing that can be done to change their trajectory or entry speed at that point," he explains.

Another problem with diving is that most think a clean dive with no splash or ripple is an ideal dive. Yet for the average recreational swimmer, this is not an example to follow. "Clean" dives should be left to the trained, skilled divers to help prevent striking one's head on the bottom.

Although health care professionals tend to think that everyone knows they can suffer spinal cord injury from diving into shallow water, that is not true. Many people have hit the bottom; however, many have never suffered injury and don't believe that they ever will. Prevention education might prompt swimmers to check the depth of the water before diving or think twice about attempting a dive that could cause them to hit their head on the bottom, says Gilbert. ■

SOURCE

For more information about education on diving safety, contact:

- **Ron Gilbert**, JD, Chairman, Foundation for Aquatic Injury Prevention, 1310 Ford Building, Detroit, MI 48226-3901. (800) 342-0330. E-mail: ron@aquaticisf.org. Web: www.aquaticisf.org.