AMERICAN HEALTH CONSULTANTS®

Patient Education Management™

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

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New guidelines recommend lipoprotein profiles for all cholesterol screenings

Accuracy key to patients' health

There's a hierarchy to good cholesterol screening based on the accuracy of measurement, says **Russell Luepker**, MD, MS, professor and head of the division of epidemiology at the school of public health at the University of Minnesota in Minneapolis.

A person is most likely to get an accurate measurement when a large medical or hospital laboratory is involved. The next best location is a physician's office if there is a machine available for an accurate screening and good quality control is maintained. It is the most difficult to obtain quality control in field settings, such as shopping malls.

EXECUTIVE SUMMARY

In June, *Patient Education Management* launched a new series on health screenings with an article on prostate cancer screenings. The July issue focused on blood pressure screenings. In this issue, we look at cholesterol screenings and how the new clinical practice guidelines on the prevention and management of high cholesterol in adults impact future screening efforts. According to the report, research shows that aggressive measures to reduce elevated low-density lipoprotein levels is vital.

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Clustering appointments increases efficiency

Group appointments can be an efficient way to meet the needs of patients with a chronic disease such as diabetes. Rather than repeat instructions on self-management throughout the day, patients can come as a group for education, support, and noninvasive medical interventions 91

Domestic violence often goes overlooked

To prevent or stop domestic violence in a community, friends and family members need to be educated on how they can help. Also, potential victims need to know what resources are available and how they can escape a violent environment. October is Domestic Violence Awareness Month, set aside for special educational events to increase awareness 93

Committee writes the ABCs on domestic violence

To meet the requirement of state laws, a committee at Baptist Health Systems of South Florida in Miami created curriculum for staff education on domestic violence. Individual team members researched each topic, and the content was edited as a group. As a result, staff now have guidance on how to recognize domestic violence cases and intervene 94

Focus on Pediatrics **insert**

Cards and book aid grieving children

A workshop sponsored by the James Cancer Hospital in Columbus, OH, taught children who had lost loved ones to cancer how to create art and poetry for cards that would comfort grieving children. A book also was created by the children's program director so parents could write messages of love to their sons and daughters before they die 1

More education on eye health and safety needed

Parents need to learn about the appropriate schedule for eye exams according to Prevent Blindness America in Schaumburg, IL. They also need to know how to prevent eye injuries and identify eye problems. September has been set aside to increase awareness 2

COMING IN FUTURE ISSUES

- Strategies for improving documentation
- Program profiles for specific ethnic populations
- Designing educational web pieces for kids
- Personalizing education to better meet needs
- Best methods for introducing new programs

"What the Adult Treatment Panel (ATP) III recommended, the fasting screening, rarely occurs in field settings because most don't schedule appointments and things like that," says Luepker, who was a member of the ATP III panel that recently revised the cholesterol guidelines for the National Cholesterol Education Program. The program is coordinated by the National Heart, Lung, and Blood Institute in Bethesda, MD. To do a complete lipoprotein profile, a person has to be fasting for nine to 12 hours in order to calculate low-density lipoprotein (LDL), or "bad cholesterol."

An alternative strategy recommended by the ATP III panel for a nonfasting patient is to measure total cholesterol and high-density lipoprotein (HDL) cholesterol. If people were above 200 mg/dL for total cholesterol and below 40 mg/dL for HDL cholesterol, then additional follow-up would be required, says Luepker.

A number of companies make small home devices to measure cholesterol, but experts find the results questionable because of the devices' variability and their inability to provide accurate measurements. Another factor that impacts results is the skills of the person doing the self-test. It's easy to make a mistake, says Luepker.

The trouble with many field settings and self-tests is that there is no connection for follow-up care. "A cholesterol level number in and of itself isn't enough," says Luepker.

The guidelines the ATP III panel released in May advise healthy adults age 20 and older to have a lipoprotein profile once every five years. This profile measures levels of LDL, total cholesterol, HDL, and triglycerides.

The panel defines optimal LDL as 100 mg/dL and high LDL as 160-189 mg/dL and a desirable total cholesterol level as 200 mg/dL with 240 mg/dL as high. Low HDL now is defined as being less than 40 mg/dL; previously, it was defined as 35 mg/dL. An HDL level of 60 mg/dL or more is considered protective against heart disease because this lipoprotein helps remove cholesterol from the blood and prevent fatty buildup in the arteries.

May require additional testing

The new guidelines issued by the National Cholesterol Education Program will mean some revisions in the guidelines for public lipid testing and counseling created at Deborah Heart and Lung Center in Browns Mills, NJ.

"I will need to revise our guidelines to reflect the

new recommendations about major risk factors and goals. Also, we will seriously consider testing for LDL cholesterol along with the other cholesterol levels since the initial approach is to lower LDL levels according to the risk category of the individual," says **Nell Kapeghian**, MSN, RN, patient care services programs director at Deborah.

For example, Deborah's counseling guidelines recommend that people with high cholesterol reduce intake of saturated fat to less than 10% of total calories, while the new ATP III guidelines have lowered that figure to less than 7% of calories. Counselors also recommended that those at high risk for coronary events based on cholesterol levels reduce their daily cholesterol intake to no more than an average of 300 mg. The new guidelines, however, lowered that number to 200 mg a day.

Screenings planned with care

Deborah Heart and Lung Center does not often conduct public screenings because of the cost, which runs about $10 per person. When one is planned, however, cost vs. benefit to the hospital and the community is carefully scrutinized. The screenings Deborah does provide are very popular, says Kapeghian.

A pharmaceutical company funded one large screening Deborah conducted at the Philadelphia convention center at a three-day event called the NBC-10 Fit Fest. People registered on the day of the event and were given an appointment time; therefore, they were not required to fast, and only total cholesterol and HDL were measured. "We scheduled one person per phlebotomist every 15 minutes," says Kapeghian. They had two machines and two phlebotomists for the event.

The facility conducted a small screening at a local Spanish-speaking church, arranged as a thank-you to the minister who is on-call at Deborah for Spanish-speaking patients who ask to see a member of the clergy. People were not required to register in advance, but it was announced that those who intended to be tested should fast.

The third screening the Deborah Heart and Lung Center conducted was at a health fair on campus. "We did require that people call to register ahead of time and asked that they fast," says Kapeghian.

At all screening events, registered nurses are on hand to counsel participants. General written information about how to lower cholesterol is given to each participant while those with abnormal levels receive more specific information during the counseling time. "A short history is taken during the counseling after the testing for those who have abnormal results," says Kapeghian. This determines if other health factors put them at greater risk for a coronary event, such as lack of exercise, being overweight, diabetes, or high blood pressure.

The general message about cholesterol is relatively simple, says Luepker. "Cholesterol is involved in the disease process of heart attacks and strokes. The higher the blood cholesterol, the more likely you are to have those events," he says.

Everyone should be encouraged to eat a diet low in saturated fat with lots of fruits and vegetables, lean meat, fish, and poultry. However, the report from the expert panel recommends that people with elevated cholesterol eat a more therapeutic diet that rigorously restricts fat intake. If the more restrictive diet doesn't have the desired effect after a few months, the report recommends placing the person on medications.

The new clinical practice guidelines on the prevention and management of high cholesterol in adults were developed because new and better research studies revealed that the old guidelines were outdated. "It is very clear that lowering cholesterol through drugs and / or diet for people who have had a heart attack already reduces future events and prolongs life. It also became apparent through a number of studies that the higher levels for treatment that were advocated in the previous report may not have been the best policy," says Luepker. The panel found that studies show lowering the LDL level can reduce the short-term risk for heart disease by as much as 40%.

The National Heart, Lung, and Blood Institute predicts that the new guidelines will expand the number of Americans being treated for high cholesterol. Dietary treatment should increase from 52 million to about 65 million, and those on

SOURCES

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cholesterol-lowering drugs should jump from 13 million to about 36 million.

"One of the messages of the new report is to treat more patients at lower levels to begin with than was recommended six or seven years ago because there are studies that show that it is beneficial," says Luepker. ■

Reader Question

On-line support: Should you or shouldn't you?

Some are successes, but caution is required

Question: "Has your institution created any on-line support groups? If not, do you refer patients to existing on-line support groups? When referring to these support groups sponsored by hospitals or health care systems, how do you evaluate them? Have you had much interest in on-line support groups by patients? What are the advantages and disadvantages of going on-line for support?"

Answer: "We created an on-line version of each of our support groups," says **Deborah Pfaffenhauser**, RN, MSN, director of consumer health education at Bayhealth Medical Center in Dover, DE. The catalyst behind the on-line support groups was the desire to provide community services over the Internet. The groups are set up in bulletin-board fashion, where someone posts a question and others provide input. However, there has not been much traffic on any of them to date.

To encourage their use, Pfaffenhauser had the facilitator of some of the regular sister support groups start a line of conversation, thinking that people may not want to post the first message, but the tactic did not help. This summer, she plans to do a marketing blitz to employees as well as the community to see if publicity increases traffic.

Currently, the on-line support groups have no moderators, but as traffic increases, Pfaffenhauser hopes to have the appropriate educator monitor the site. For example, the cancer educator would monitor the on-line cancer support groups.

The Anderson Network, a group of volunteers of current and former cancer patients who offer support to others living through the diagnosis and treatment of cancer, created an on-line support group at Houston-based MD Anderson Cancer Center as a listserv. The volunteers used the listserv method because they couldn't create a chat group in real time due to the institution's Internet security. People who come across the listserv on the cancer center's web site can subscribe via e-mail. **(For information on creating an on-line support group in real time, see article on p. 90.)**

"As moderator, I read all the e-mail messages on the listserv, and if there is a question that is not being answered, then I answer it. Our group is fairly knowledgeable about use of the Internet, so I don't say a lot to them. They are fairly self-monitoring," says **Linda Jones**, moderator of the Anderson Network listserv.

Although there has not been much of a problem with incorrect information being provided on-line, there is a policy in place to handle the problem. Jones would intercede with a statement about MD Anderson policy on the issue or refer interested parties to a web site that has correct information.

Anyone signing up for the listserv receives an automated letter explaining the rules of participation. Advertising is not tolerated, and if a person persists, he or she is removed from the listserv.

Set criteria for referral

Although USC/Norris Comprehensive Cancer Center and Hospital in Los Angeles does not sponsor on-line support groups, patients are referred to these groups. "In evaluating which groups that we refer to, we look at the organization that the group is sponsored by and who the facilitator is. We only refer to groups that are led by a professional," says **Carol Marcusen**, LCSW, director of social services and patient education.

Patients who have participated in chat rooms or support groups that are not led by professionals have received invalid information and have had problems with people who monopolize the group and have their own agendas, says Marcusen.

Any on-line support group listed as a referral should be sponsored by a reputable organization and led by a well-credentialed health professional, agrees **Mary Szczepanik**, MS, BSN, RN, manager of cancer education, support, and outreach for Grant/Riverside Methodist Hospital in Columbus, OH.

For example, a reputable institution for cancer support groups would be one that is a National

SOURCES

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Cancer Institute-designated Comprehensive Cancer Center. For an on-line cancer support group moderator, she recommends selecting a group led by a psychologist, psychiatrist, advanced practice nurse, or licensed social worker; all involved should have strong oncology experience. "Their credentials should be available on-line," she says.

Before referring a person to an on-line support group, she would make sure it had policies and procedures that covered such issues as how a person who is suicidal is handled on-line, what is done when someone makes statements or asks questions that indicate he or she is in a life-threatening medical condition, or how complaints about specific physicians, hospitals, or health care providers are handled.

"We provide one-on-one counseling over the phone, and since we have general and disease-specific live support groups, we funnel people into those. We rarely get questions about on-line support groups," says Szczepanik. Of the 600-700 calls received monthly on the information line, only one or two are requests for information about on-line support groups, she says.

"There are numerous on-line support groups on the web currently, but I have been very leery of recommending them to patients because I do not have enough time to frequent the groups myself and/or to assess the information that is shared within the group," says **Barbara Petersen**, RN, BSN, patient education coordinator at Great Plains Regional Medical Center in North Platte, NE.

One disadvantage of an on-line support group is that the trust and rapport built when two people who share a chronic illness, injury, or other life-altering event meet in person cannot be duplicated. Often the casual conversation that occurs as members enter the room before a support group meeting or walk to their cars afterward is more productive than the structured conversation, says Petersen.

On-line support groups are difficult to regulate and it is easy for people to misrepresent themselves. "Some of the ideas shared can be unproven or debatable issues and advice which can really lead someone astray," says Petersen. Also, people trying to make a "fast buck" prey on desperate people looking for a cure or alternative treatment. While she acknowledges that many on-line support groups have protection measures, such as passwords or registration methods, not all do.

The advantages of on-line support groups are that people do not have to leave home to attend. This can be especially advantageous for caregivers, says Pfaffenhauser. These on-line groups also are beneficial when there is limited space available for meetings. With on-line support groups, there is no limit to the number you can offer, she says.

Another advantage is anonymity, says Petersen. "The major advantage of an on-line support group is that someone can maintain their confidentiality when the patient does not wish to reveal to members of a community their illness or other reason for attending a support group," she says. ■

Promote your patient education events

If your organization is sponsoring a future event pertinent to patient education managers, send us the information at least two months prior to the scheduled date, and we will help you get the word out. Details should include event title, theme and purpose, dates and times, and cost. Information can be sent via e-mail to Susan Cort Johnson, Editor, *Patient Education Management*, e-mail: suscortjohn@onemain.com. Or mail information to: P.O. Box 64, Westwood, CA 96137. ■

On-line education, support is winning combination

Meet the needs of all patients

The on-line support group for cancer patients organized by the James Cancer Hospital and Solove Research Institute in Columbus, OH, is like any other support group that meets in person except that it is one dimensional, says **Pat Schmitt**, MA, CRC, program director for comprehensive oncology rehabilitation.

The group meets once a month, has a facilitator, guest speaker, and handouts with more detailed information frequently is available for participants to download. To participate, people contact the web master via e-mail to obtain a password and instructions before logging on at the designated time.

"One of the reasons we started the on-line group is because we realized that traditional support groups are not for everybody anymore. We were trying to very deliberately expand the menu of options that we were providing to our patients," says Schmitt, who acts as the group's facilitator.

To determine what people would want in an on-line support group the institute conducted a survey in the outpatient ambulatory area, which has a high volume of patients, so it's easy to collect data. Patients who were interested in trying an on-line support group said that they wanted it to be educational as well as supportive.

Therefore, the project team decided the group should be professionally facilitated rather than set up as a bulletin board or open chat. They also determined that an expert on the featured topic should be invited as a guest speaker. "Because this is offered by our institution, we wanted to bring a level of clinical expertise to it," says Schmitt.

People can choose when they want to participate based on whether the topic being covered meets their specific personal issues. Those with a password are sent an e-mail reminder. The information about the support group and the monthly topic also is on the James Cancer Hospital web site.

Some patients log onto the support group on a monthly basis because they like the contact with other people. Others like the anonymity of the Internet environment. Some of the topics covered, such as dealing with changes in sexuality and intimacy, work really well on-line, says Schmitt. "Some of the questions people wouldn't feel comfortable asking in person with a lot of other people around — they have no hesitation asking on-line," she explains.

Older adults are participating in the on-line support group, and the health care facility is pleased since this has been a patient group the hospital has had a hard time serving in the past. That's because older adults don't like to come back to the hospital in the evenings to access a class, clinic, or traditional support group, says Schmitt.

In addition, the on-line support group is one resource that the 30%-40% of patients who live out of the area can take advantage of once they leave the hospital. It's convenient for chemotherapy patients who need to conserve their energy as well.

The most people who have participated in the on-line support group at one time have been 12. The general attendance is between eight to 10 people with a few regulars and several one-time only participants, which fits with the support group's design. The cutoff point for the number of participants would be 15 because high numbers reduce the amount of time people actually have to communicate, says Schmitt.

Facilitation a challenge

To facilitate the communication process Schmitt monitors the text, trying to ensure that people who ask questions receive a response and cutting off people when appropriate by typing something such as, "We have had many questions from Ian, let's hear from Sally." She often takes notes to keep track of who is participating.

Sometimes a participant will type in several questions in rapid succession, so she will select the question she thinks will be of interest to most people and then asks the guest speaker to answer it. If time permits the other questions are answered later.

Often the guest speaker needs help getting used to the on-line chat environment. Therefore, Schmitt has the physician, dietitian, or other member of the health care team who is speaking arrive 30 minutes early to practice. She will then spend about 20 minutes chatting via the computer with the guest speaker so that he or she can see how long it takes to type answers, how long it takes for entered text to show up on the screen, and what it is like to be reading and thinking of answers simultaneously.

To make sure the session runs smoothly, Schmitt will send e-mail messages to everyone who has a password asking them to submit their questions in

SOURCE

For more information about facilitating an on-line support group, contact:

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advance. Then she will conduct an interview with the speaker for the first 20 minutes so that all the common questions are addressed.

The physician or other guest speaker is given the questions in advance so that they can prepare brief answers. In this way, during the group session, all the participants aren't entering text at the same time barraging the speaker with a flood of questions that don't have a proper flow. Also, it cuts the amount of time when the screen is blank as the speaker types in the answers to questions.

"It is helpful to have as much structure as you can bring to the format because discussion goes really, really fast," says Schmitt. Once the speaker has had time to present the topic, Schmitt opens the discussion up for questions that pertain to information that has been covered.

While practice makes perfect, many challenges have had to be addressed in order for the on-line support group to run smoothly. For example, the firewall that protects the hospital's computer network system from hackers could not be removed to create the support group; therefore,the sessions take place off campus. The hospital had to contract with a company, and the group sessions are run from this site.

Another challenge has been finding enough generic topics to present to the general cancer group. Topics covered have included work-related issues, symptom management, and nutrition.

Also, people who participate are asking that the sessions be more frequent. "We are thinking about holding the sessions more than once a month. From the feedback we get from our participants it is too infrequent. If you are using an on-line modality on a frequent basis, a month seems like a really long time to go before you connect with people again," says Schmitt. ■

Clustering appointments increases efficiency

Patients get more bang for the buck

Group appointments or group visits have become an effective method of delivering care at many institutions. Depending on the mix of providers, group appointments can combine educational, medical, psychological, and supportive care, says **Andrew Bertagnolli**, PhD, project manager for group appointments and chronic pain at regional health education, Kaiser Permanente Northern California in Oakland.

At Kaiser, group appointments have been used to meet the needs of chronic disease patients such as those with asthma, diabetes, congestive heart failure, or hypertension. "Kaiser has found them to be very helpful. They have worked when they are well thought-out, have clear goals, and staff have a clear vision of what their role is," says Bertagnolli. Group appointments have improved health care utilization, quality of life, and patient and provider satisfaction, he says.

Staff at the Diabetes Care Center at the University of Washington Medical Center in Seattle finds group visits beneficial as well. They have initiated them when the teaching in one-on-one appointments is repetitive or patients have to wait months to obtain a personal appointment.

"We started doing group insulin pump appointments simply because we found that you repeat yourself over and over again, and people in a group situation can learn from each other. We also found that it was cost-effective and emotionally supportive," says **Dori Khakpour**, RD, CD, CDE, nutrition and education coordinator at the Diabetes Care Center.

The groups at each health care facility are designed to fit the needs of the institution. At Kaiser, all groups have a physician and a health educator or behavioral medicine specialist, such as a psychologist or social worker, as leaders. They co-lead either the structured group model or facilitated group model.

The structured group model has a planned curriculum and low physician involvement. Usually a health educator covers lots of educational material, and a physician pulls people from the group one by one during the teaching to do a private assessment.

In facilitated groups, there is a high degree of physician and patient interaction, and the assessment is a group process. For example, the physician may do diabetic foot exams. Although there is

a key message, education is given as needed. "The facilitated group is more efficient because it doesn't duplicate the one-on-one office visits. Also, in the facilitated group physicians can use each patient as a teaching point for the next," says Bertagnolli.

Clustering patients

There are also two formats for the groups at Kaiser. A drop-in group meets at a set time each week and patients come as needed. This type works well for diagnoses that cause distress when symptoms are not controlled such as asthma, heart disease, or irritable bowel syndrome, says Bertagnolli.

For example, people having problems with congestive heart failure symptoms would come to the group and a physician would provide a medical assessment and perhaps adjust their medication. A psychologist, meanwhile, would be on hand to assess depression and anxiety problems and treat them.

"One of the main strengths of the drop-in group is that if you offer it weekly, there is frequent access and for some medical conditions that saves going to the emergency department or urgent care," says Bertagnolli.

The closed group clusters patients who meet at a particular time and date and no new patients are added once the group has about 15 members. This type is good for people with chronic diseases who do not experience stressful symptoms, such as diabetes or hypertension. Group participants can all be from one provider or referred from throughout the medical center. **(To learn how to determine what to consider when establishing group appointments, see article, right.)**

The group visits at the Diabetes Care Center at the University of Washington Medical Center focus on education. In addition to appointments that start people on the insulin pump, group visits are initiated to teach carbohydrate counting and basic nutrition. "The group visits have worked very well in terms of being able to see people in a timely fashion. There is almost a two-month wait to see a nutritionist," says Khakpour.

Patient service representatives make the appointment for five to seven patients, giving them the choice of waiting for a one-on-one session or being seen in a group. To work with a group of people simultaneously, Khakpour has them fill out a form when they come to the 90-minute appointment. It contains such information as the type of diabetes they have, how long they have had it, what diabetes medications their physician subscribed, and their normal exercise routine.

The sessions are conducted in a room with a large table, so she places the forms in front of her, directly across from each patient in order to individualize her teaching. The first 45 minutes of the session is education, while the last half is interactive exercises to reinforce the teaching.

The only downside to the group visits is that it doubles the amount of time spent charting, says Khakpour. Usually she sees about six patients in one day, but with the group visits, the amount doubles.

Confidentiality can be an issue as well, says Bertagnolli. Tell the patients not to share anything in the group they don't feel comfortable sharing and to let the group leaders know they need a private consultation at the end of the session if they have an issue they can't share. "Generally, people don't mind sharing if it is relevant to the reason they are there," he says. ■

SOURCES

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Take steps to ensure group visits are successful

Start with chronic patient groups

When deciding whether a group appointment would be beneficial, first identify the population you want to address, keeping in mind that chronic conditions respond best to group care, advises **Andrew Bertagnolli**, PhD. Bertagnolli is project manager for group appointments and chronic pain at regional health education for Kaiser Permanente Northern California in Oakland. Conditions that require a high degree

of patient involvement in disease management are also good candidates for group visits, such as diabetes and asthma.

Next, determine the goals for the group and what you wish to accomplish. For example, for a diabetes group, the goals might be to increase knowledge and education, improve clinical management, and reinforce behavioral life change skills.

Once goals are set, it's time to decide what clinical interventions you want to offer. It may be appropriate to offer nutrition counseling or medication counseling and adjustment. The goals and interventions will help determine who best can meet those needs.

To determine whether the group would work best as a closed membership or drop-in, review the condition. Is there a need for ready access? Is the level of subjective distress when symptoms are out of control high or low? If it is low, you may not get the participation in a drop-in group that would make it worthwhile and a closed group might be best.

"Once you have decided on the population you want to target, your goals, the interventions you want to provide, staffing decisions, and group structure, it's time to consider logistics," says Bertagnolli. Does your facility have a large enough room available for the group visits? It's important to have clerical support as well, someone to contact people and introduce them to the concept of group appointments, schedule patients for the group appointments, pull charts, and make sure educational materials are stocked in the room.

Finally, you'll need to determine how to measure whether you are meeting your goals. For example, to determine if patients were learning to manage their asthma, Bertagnolli checked computer data at Kaiser to see how many prescriptions for preventative medications group participants had filled vs. rescue medications. "A lot of people were overutilizing their rescue medications and not really taking their preventative, so I wanted to switch that around and I saw that happening," he says. ■

Domestic violence often goes overlooked

Time to focus on improvements

October is Domestic Violence Awareness Month, a national observance designed to create an avenue for community awareness about the issue and to honor women who have been injured or killed as a result of domestic violence. It provides an opportunity to remember the victims of domestic violence and think about what can be done differently, says **Rita Smith**, media director for the National Coalition Against Domestic Violence in Denver.

There are many ways to increase awareness about domestic violence. The clothesline project is a popular event where victims and / or their family members of domestic violence create T-shirts to hang on a line. Often the T-shirts have a photo of the victim scanned onto them with information about her life and what happened to her or a poem. "It gives a human feel to the damage that is done by violence," says Smith.

Some communities organize walks that bring people together talking about the issues. In addition to raising awareness, these events provide opportunities to distribute information, but educational materials should be tailored to fit the needs of the community, says Smith. They would include resources that are available in the community, what people should do if they know someone who is a victim of domestic violence, and information for victims.

"The best way to get materials is to connect with a shelter in your area. We have material available, but it is more generic and doesn't have particular local information in it," says Smith. Patient education managers who need local contacts should call the National Coalition office in Denver.

Local information is important because battered women often remain in a violent environment due to lack of resources, according to the coalition. Many have dependent children, are not employed outside the home, and have no access to cash or bank accounts.

Social issues also keep them bound in conditions that are bad for their physical and mental health. For example, some women have become isolated from friends and family members by a jealous possessive abuser. Other women isolate themselves to hide the abuse. Women often rationalize the behavior of the abuser attributing it to stress, alcohol, or other factors.

To escape the violence, women need information about local support services. The National Coalition Against Domestic Violence recommends

SOURCES

For more information about Domestic Violence Awareness Month or domestic violence in general, contact:

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making information available in the following categories:

• **Crisis intervention:**

— crisis hotlines and emergency residential facilities;

— medical services and transportation networks.

• **Emotional support:**

— self-help support groups;

— assertiveness training;

— parenting skills courses.

• **Advocacy and legal assistance:**

— financial support;

— access to custody of children;

— restraining orders;

— public assistance benefits.

• **Supportive services.**

— housing and safe accommodations;

— child care;

— access to community services.

"Local shelters would know the community, so your event could be tailored to what is currently happening, what kinds of things are working and what is not, and where the resources are outside the actual physical shelter because sometimes other kinds of support systems are needed," says Smith. ■

Committee writes the ABCs on domestic violence

Requirement reveals unmet need

To create a staff training program on domestic violence, Baptist Health Systems of South Florida in Miami created a curriculum committee. It consisted of staff from many disciplines, some who frequently interact with victims of domestic violence, such as emergency department physicians and nurses, and those who don't, such as representatives from the education department.

The committee was assembled in response to a mandate by the Florida State Legislature, which requires all licensed health care professionals to have one hour of domestic violence education annually. "We created the curriculum in response to the requirement, but as we wrote it, we realized that there was a great need. We heard a lot of stories as we researched the topic that sensitized a lot of people on the committee," says **Helen Slaven**, MS, corporate director of organization development at Baptist Health Systems of South Florida. She worked in the education department when she participated on the committee six years ago.

The legislature provided an outline of the information that needed to be included in the curriculum and the committee used it as a framework. Each committee member took a section of the outline to research and write. For example, one person researched statistics to provide facts and figures on the prevalence of domestic violence.

"My input was to coordinate committee members and make sure the pieces fit together," says Slaven. The committee had to take the narrative pages created by its members and compile a training manual, so a lot of editing was done as the project progressed. There was 20 times more material accumulated than could be covered in an hour class so choices had to be made.

What concerned the committee was how to effectively address everyone. It was easy for the legislature to mandate an hour of education, but trainers couldn't assume that everyone was at the same level of understanding. "We decided to include lots of information so that trainers would be able to use the materials as they saw fit based on the group they were going to deliver the information to," says Slaven.

Once the curriculum began to take shape, the committee gathered as a group and looked at the copy projected on a wall for the final editing. "It was a wonderful experience because everyone taught everyone else along the way," says Slaven.

Curriculum covers many aspects

The curriculum, titled *Domestic Violence: Breaking the Cycle,* covers the forms of domestic violence and provides a profile of the victim and the abuser. The training guide states: "In the health care setting, victims of domestic violence are most often identified by the injuries, signs, and symptoms for which they seek treatment. Acute signs and symptoms sustained by victims of domestic violence may include bruises, lacerations, concussions, and

SOURCES

For more information about creating a staff training program on domestic violence contact:

- **Leah Kinnard**, EdD, RN, Consultant, Creative HealthCare Management, Minneapolis. Telephone: (800) 728-7766. E-mail: leahjo@aol.com.
- **Education Department**, Baptist Health Systems of South Florida, 6200 S.W. 73 St., Miami, FL 33143-4989. Telephone: (305) 662-8139.

fractures. Chronic signs and symptoms include joint damage, partial loss of hearing or vision, scars from burns, bites, or knife wounds."

Also the curriculum provides guidelines for health care providers to routinely screen for domestic violence and assess suspected victims. These guidelines cover interview questions. For example, to uncover violence a health care professional may ask:

• Did someone cause these injuries? Who? Has it ever happened before?

• What do you fear the most?

To evaluate the extent of violence, the professional might ask:

• Have you ever been hit, punched, kicked, or hurt in any way before?

• Are you afraid it will happen again? Were you afraid to come here today?

To determine safety, the health care worker might ask:

• Have you wished you could leave? What has prevented it?

• Do you have a safe way to get home from here and a safe place to stay?

Details on documenting, intervening, and reporting domestic violence are covered as well as providing information about making referrals for a victim of domestic violence. The material is available as a self-study guide or as a training manual to be used to conduct a class. Currently, Baptist Health Systems of South Florida uses the self-study guide.

To enhance both formats, a video was created as an introduction. On the videotape, physicians, nurses, and a psychologist discuss their experiences in working with and living with domestic violence.

"The purpose of the videotape is to help people understand that victims of domestic violence may be working and walking right beside them. The video is not laden with content, its intent is to engage the observer emotionally to want to learn how to keep this from happening," says **Leah Kinnard**, EdD, RN, a consultant with Creative HealthCare Management in Minneapolis and formerly the director of education at Baptist.

The project was a well thought-out comprehensive approach, says Kinnard.

[Editor's Note: The video and curriculum, Domestic Violence: Breaking the Cycles, created by the Baptist Health Systems of South Florida is available from the Florida Hospital Association for $259 for members and $525 for nonmembers. To order, contact their Orlando office: Florida Hospital Association, Orlando Office, 307 Park Lake Circle, Orlando, FL 32803. P.O. Box 531107, Orlando, FL 32853-1107. Telephone: (407) 841-6230. Fax: (407) 422-5948.] ■

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Editorial Questions

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Health care education conference planned

The dates for the 2001 Health Care Education Institute sponsored by the Philadelphia-based Health Care Education Association (HCEA) are set for Oct. 4-6. The conference will be held at The Holiday Inn City Centre in Chicago. The theme this year is "Managing the Whirlwind of Health Care Education," and will include sessions on such issues as accreditation, compliance, technology, research, outcomes, management strategies, and leadership skills.

The cost of the conference is $395 for HCEA members and $465 for nonmembers before Sept. 14. After that date, the registration cost to members is $445 and $515 for nonmembers. One-day registration is available for $240 before Sept. 14, and $260 after that date. A pre-conference activity will take place at Northwestern Memorial Hospital Oct. 4 and costs $65. For more information about the 2001 Health Care Education Institute contact: HCEA, 1211 Locust St., Philadelphia, PA 19107. Telephone: (888) 298-3861. Fax: (215) 545-8197. E-mail: ken.Cleveland@rmpinc.com. ■

CE/CME Questions

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.

5. According to the new cholesterol guidelines issued by the National Cholesterol Education Program, healthy adults age 20 and above should have a lipoprotein profile once every five years. This would include which of the following?
   A. Measuring total cholesterol.
   B. Measuring levels of LDL.
   C. Measuring levels of HDL.
   D. All of the above.

6. The advantages of on-line support groups include which of the following?
   A. There are no space restrictions.
   B. People don't have to leave home.
   C. Advice can be freely given.
   D. A & B

7. Group appointments work best for chronic disease patients such as those with asthma, diabetes, congestive heart failure, or hypertension.
   A. True
   B. False

8. Curriculum for staff training on domestic violence should include which of the following components?
   A. Guidelines for assessment.
   B. Information on documentation and reporting.
   C. Details on intervention.
   D. All of the above.

Focus on Pediatrics
PATIENT EDUCATION MANAGEMENT'S MONTHLY SUPPLEMENT

Cards and book aid grieving children

Kids write sentiments for kids

Ever try to find a bereavement card written specifically for a child? **Pauline King**, MS, RN, CS, director for children programming and psychosocial clinical nurse specialist at the James Cancer Hospital and Solove Research Institute in Columbus, OH, looked for such cards to accompany the basket with a plant, stuffed animal, and Mylar balloons she sent to children she knew who had lost a parent or loved one. She couldn't find one, so she created the Comfort Card Workshop and solicited participants from her Good Grief and Beyond Support Group, where children come to honor lost family members they want to keep alive in their memories. "I thought what better people to do art and write sentiments for kids then kids who have already been through it," says King.

The three workshops that have been offered were held at the Columbus Museum of Art where poets, artists, and art therapists worked with the children to illicit sentiments appropriate for the cards. The artist took the children on a tour of the museum and asked them what they thought the artists were trying to make people feel by their choice of colors in various paintings.

The poet helped them remember what it was like to be in a similar situation and write what they would have liked to have heard when their loved one died. "Kids write different bereavement cards than adults do," says King. Kids wrote: "After this, I hope you get a life full of hot chocolate"; "When you are feeling blue, ask someone to hug you"; "People you love never really leave, they leave pieces of themselves for you to find at any time"; "I wish you a bird's song."

The card project was gave children who had gone through a traumatic experience the opportunity to help others in that same situation, says King.

Another aid for grieving children King created is the *Little Book of Love.* She encourages parents to complete the book for their children, whether they have a terminal illness or not. "Even though I work with kids who have parents with a serious and possible terminal illness the reality is that life is fragile. I could have a car crash on the way to work," says King. Therefore, she created the book that contains information she would want her son to have if she should die. It explains how much she loves and adores him, nothing more, she says.

The book is sectioned into topics with envelopes in which parents can put the information along with photos and other mementos. Topics include: Reasons I love you so much; Applause, applause, things you do that I admire; Hopes and dreams I have for you; Things I want you to know about me. "Most people don't have time to write an autobiography. This is just about love and you could probably finish it in one hour," says King.

King is hoping to publish several of the Comfort Cards and the *Little Book of Love.* Revenues from sales will help supplement funds for her bereavement programs for children, she says.

The support group is for children who have completed the Kids Can Cope, Too program, which is a six-week course that teaches children about grief at the beginning of the diagnosis of a loved one.

Good Grief and Beyond helps these children honor their loved one on a monthly basis. This is especially helpful the first year when there is a series of first anniversaries, such as the child's first birthday without their mother.

Although the comfort cards have not yet been published she has put them to good use by creating a card quilt. The quilt is made up of little doors or flaps with the card face on it. When the door is opened, the message is read inside. On the left hand side of the card is the name of the

SOURCE

For more information about the cards and booklet created to help children work through grief, contact:

- **Pauline King**, MS, RN, CS, Director for Children Programming and Psychosocial Clinical Nurse Specialist, James Cancer Hospital and Solove Research Institute, 300 W. 10th Ave., Room 004, Columbus, OH 43210. Telephone: (614) 293-4138. E-mail: king-4@medctr. osu.edu.

child, their age, and a definition of what their parent died of.

"The kids in Good Grief and Beyond will be able to read the cards and affirm what they are feeling. They will know that they are not alone," says King. ■

More education on eye health and safety needed

Children don't get eye exams

September is Children's Eye Health and Safety Month, an important health issue that needs to be promoted throughout the year. According to the health observance's sponsoring organization, Prevent Blindness America based in Schaumburg, IL, almost 80% of preschool-age children never get an eye exam, and many back-to-school physicals fail to screen for common eye disorders.

The organization recommends that children have their first eye exam shortly after birth with a second exam at 6 months. The next eye exam should occur before children enter school at age 4 or 5 and continue periodically throughout the school years.

"During Children's Eye Health and Safety Month, we hope to educate people about the common causes of children's eye injury and vision problems and encourage vision screening at an early age," says **Betsy VanDie**, media relations director for Prevent Blindness America.

What does the public need to know? In addition to an increased awareness of the need for eye exams for children, they need to know the common causes of eye injury and vision problems, says VanDie. According to Prevent Blindness America, the frequency and severity of at least 90% of children's eye injuries could be reduced if people were more aware of the dangers and hazards that caused the injuries and provided better supervision for children.

Prevent Blindness America lists the most common causes of eye injuries as:

- misuse or altering of toys.
- falls in the home involving beds, stairs, tables, and toys;
- misuse of items such as home repair and yard care products, kitchen utensils, silverware, pens and pencils;
- accidental exposure to household and cleaning products such as detergents, paints, pesticides, glues and adhesives;
- automobile accidents.

There are several symptoms that indicate a serious eye injury has occurred that requires immediate medical attention. These include pain or vision problems, abnormal pupil size or shape, blood in the clear portion of the eye and one eye that sticks out in comparison to the other.

Complete fact sheets on children's eye safety that can be distributed at eye screenings, health fairs, or other events are available through Prevent Blindness America. **(See contact information in the source box, below.)**

While parents, teachers, and other adults who work with children need to know the signs of possible eye trouble, they also need to be aware that some potentially serious problems have no symptoms. "Sometimes a child complains of headaches which is a symptom, but some eye disorders have no symptoms, and those are often the more dangerous disorders if not treated," says VanDie.

For example, amblyopia is a condition where the vision in one eye is reduced because it did not receive adequate use during early childhood. It is usually caused by eye misalignment or differences in image quality between eyes. Yet if not diagnosed and treated the weak eye could become useless.

Other disorders include strabismus, which occurs when one eye does not aim directly at the object where the other eye is aimed, myopia, or nearsightedness, and hyperopia, or farsightedness. There are signs to detect these disorders. For example, for strabismus, the eyes would appear to be crossed or misaligned.

Symptoms of vision problems might include holding items close to eyes, squinting eyelids, complaints that eyes itch, burn or feel scratchy, and dizziness, headaches, or nausea after doing close-up work. Education doesn't have to be aimed at adults only, says VanDie. "We have a whole range of publications that have been developed especially for kids," she says. Prevent Blindness America may be contacted for a catalogue listing all publications and videos. ■

SOURCE

For more information about children's eye health and safety, contact:

- **Betsy VanDie**, Media Relations Director, Prevent Blindness America, 500 E. Remington Road, Schaumburg, IL 60173. Telephone: (800) 331-2020. Web site: www.preventblindness.org.