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Patient Education Management™

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September 2001 • Volume 8, Number 9 • Pages 97-108

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Glucose screenings ID patients who may not be aware they have diabetes

Marginal levels signal warning about lifestyle choices

One of the advantages of screening for diabetes is the opportunity to increase awareness about the chronic disease. The Alexandria, VA-based American Diabetes Association (ADA) estimates that 16 million Americans have diabetes, but about 5 million of them don't know it.

"There are so many people who walk around with diabetes and have damage done to their bodies because they don't realize they have the disease. Often they have no signs and symptoms, or what signs and symptoms they do have develop so

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, and August covered cholesterol screening. In this issue, we look at blood glucose screenings. Many health care facilities find that screenings increase diabetes awareness and often detect a need for physician intervention early in the development of the disease. Yet the American Diabetes Association voiced concerns about community screenings in its 2001 clinical practice recommendations.

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COMING IN FUTURE ISSUES

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gradually that they are unaware," says **Cindy Farricker**, MS, RD, CD, a registered dietitian at the Diabetes Care Center at the University of Washington Medical Center (UWMC) in Seattle.

The goal of public screenings conducted by UWMC is to not only uncover people with high glucose levels, such as 300 mg/dl, who need to see their physician and learn how to control their diabetes, but identify people who are at risk for type II diabetes and who could potentially develop it within the next year or two, explains **Dori Khakpour**, RD, CD, CDE, nutrition and education coordinator at the Diabetes Care Center.

"The positive aspect of glucose screening is to identify patients who are asymptomatic and have lower elevations in their blood sugars that will allow simpler diabetes management regimes and will have better outcomes. It's a lot easier to treat a blood sugar of 129 mg/dl than someone with a fasting glucose test of 400 mg/dl," says **Amparo Gonzalez**, RN, CDE, director of the Specialty Center for Diabetes Care at Saint Joseph's Hospital of Atlanta.

These diabetes educators are fully aware that the ADA no longer endorses community screenings due to the lack of scientific evidence proving them effective. One of the problems with community screenings cited in the organization's 2001 clinical practice recommendations for diabetes screening is that there is not appropriate follow-up testing and care for those with high glucose levels. Additionally, says the ADA, there's no way to ensure repeat testing for those who screen negative but have glucose levels high enough to indicate that they could be at risk for diabetes.

The educators also acknowledge that there are drawbacks to diabetes screening. The downside of glucose screening is that people get a false sense of security because they were tested and their blood sugar was good after fasting, says Farricker.

Other drawbacks are that there's limited time to conduct patient teaching and it's difficult to ensure that patients pursued the appropriate medical follow-up, says **Janet Hale**, RN, manager of the Health Information Center of University of Missouri Health Care in Columbia.

In spite of the drawbacks and the concerns voiced by the ADA, many health care institutions have programs in place for glucose screening that they find effective. To help make them successful, they have set in place steps for education and as much follow-up as possible. What they all have in common is they ensure patients understand that

screenings are not for the purpose of diagnosing diabetes but to determine if those screened are at risk. If they have an elevated glucose level, they would be referred for further testing, says Hale**. (For more information on follow-up see article on p. 100.)**

Create a plan

At the Health Information Center, which is located in a mall setting, a glucose screening is available once a month on a walk-in basis. A newspaper ad encourages people who are over the age of 40, overweight, or have a family history of diabetes to have a glucose test periodically. It explains that the test is best done two hours after eating a well-balanced meal.

The center averages 40-50 people a month for this screening, and most are over the age of 50. On average, two or three new people are identified with high blood sugar each month. "We get two kinds of people, those with a diagnosis of diabetes who want to compare our glucose readings with their own and those individuals who may be at risk for diabetes and want to be screened," says Hale.

A consent form people fill out before the screening asks several questions, such as their family history pertaining to diabetes, to see if they are at high risk for developing the chronic disease. The form is used to initiate education specific to each person being screened during the time it takes for the machine to determine his or her glucose level.

For example, if they have a family history of diabetes, they would be told the importance of being tested on a regular basis even if their glucose is within a normal range so that they might catch the onset of diabetes early. According to ADA guidelines, high-risk individuals should be evaluated at three-year intervals beginning at age 45.

Hale doesn't try to cram too much information into the short amount of time there is for teaching. "If you try to teach people more than three things, they won't remember them anyway. If I can drive three points home, I have been successful," says Hale.

While Provena Mercy Center in Aurora, IL, no longer conducts community screenings for diabetes, it does provide free glucose screenings by appointment twice a month from 8:30 a.m. to noon. "I do a risk assessment over the phone when setting up appointments for screening, but even if they are not at risk for diabetes, I let them schedule an appointment because this is a service to the community," says **Rita Smith**, MSN, RN, coordinator of clinical education at the health care facility.

The ADA identifies high risk factors as a family history of diabetes, obesity, habitual physical inactivity, members of certain race/ethnic groups such as African-Americans and Hispanic-Americans, and people with signs of insulin resistance or conditions associated with insulin resistance.

Smith always asks participants if they have questions because often they come to be screened after someone they know is diagnosed with diabetes. This provides a chance to dispel any myths they may have about diabetes. She also discusses the two types of diabetes (Types I and II) and symptoms by providing a pamphlet to reinforce the teaching. She also provides tips on prevention of diabetes. For example, if the person being screened is overweight, she suggests that they try to stay at a normal weight, get adequate exercise, and eat a balanced diet to help prevent diabetes.

At the Specialty Center for Diabetes Care at Saint Joseph's Hospital, people can walk in for a free glucose screening. Center staff, however, also conduct screenings at corporations, churches, and other community venues when asked. When people test positive for diabetes, Gonzalez takes them to a private area near the screening site and provides five to 10 minutes of basic education. She also

SOURCES

For more information about glucose screenings, contact:

- **American Diabetes Association**, 1701 N. Beauregard St., Alexandria, VA 22311. Telephone: (800) 342-2383.
- **Cindy Farricker**, MS, RD, CD, Registered Dietitian, and **Dori Khakpour**, RD, CD, CDE, Nutrition and Education Coordinator, Diabetes Care Center, UWMC Box 356176, 1959 Pacific St., Seattle, WA 98105. Telephone: (206) 598-4882. Fax: (206) 598-4976.
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gives them a booklet with the basics of diabetes.

It's impossible to adequately educate people at that moment because many are in a state of disbelief. The goal is to get them to understand their need for follow-up and further education, says Gonzalez. Diabetes education takes at least 10-12 hours, she explains.

When doing community screenings, it is important to make sure people have enough education to prompt them to follow up with their physician if their blood glucose is elevated, says Khakpour. Because the Diabetes Care Center has a multitude of information sheets on specific and general diabetes topics, people can get answers to most of their questions, she says. ■

Follow-up important for those who test positive

High glucose levels need proper diagnosis

Follow-up is key to successful glucose screenings for diabetes. Although resources may prohibit health care institutions from contacting patients directly to make sure they have seen a physician after an elevated glucose test, it's possible to provide resources for patients.

"If patients have a high glucose level, I tell them to get further testing from their physician, and if they are diagnosed with diabetes, they can come back for one-on-one teaching," says **Rita Smith**, MSN, RN, coordinator of clinical education at Provena Mercy Center in Aurora, IL. Those with abnormally high blood sugars are escorted to the emergency department so they can receive immediate treatment.

Most of the people screened have a physician, but if they don't, Smith refers them to a local clinic that provides service on a sliding payment scale. She also makes sure they are aware that Provena Mercy Center has a diabetes support group that is education-based. At each monthly meeting, a different diabetes topic is covered and a team of health care professionals attend, such as a dietitian, pharmacist, and nurse, to answer patients' questions.

During community screenings conducted by the Specialty Center for Diabetes Care at Saint Joseph's Hospital of Atlanta, information sheets on people who test positive are set aside for follow-up. "When I get back to my office, I make a note to call those people a week later," says **Amparo Gonzalez**, RN, CDE, center director. At that time, she checks to see if they have made an appointment to see their physician.

When people who are screened do not have access to health care, they are referred to either the county hospital, which has an excellent diabetes program, or one of its satellite clinics. Gonzalez has assembled a list of resources in order to make referrals for all patients who may have diabetes — whether or not they have health care insurance. "Because Atlanta has a growing foreign population, there are many clinics serving these populations in their own languages with sliding-scale payment, and we keep track of that information," she says. ■

Adopt the less-is-more principle of communication

Teach staff simple writing and speaking skills

Staff aren't likely to strive for good health communication until they recognize that there's a problem, says **Sandra Cornett**, RN, PhD, director of The Ohio State University Health Literacy Project in Columbus. "When educating health care professionals, first help them understand there is a health literacy problem and its extent," she advises.

An adult literacy survey conducted by the government in 1993 determined that 21% of U.S. adults read at a fifth-grade level and 26% read at an eighth-grade reading level. Add those figures, and you will find that 47% of the adult population reads at a basic level.

In addition to alerting professionals about the health literacy problem, they need to know that most written materials are done at a level too difficult for many Americans to read and understand. "There is a mismatch between the public's reading level and the level different health materials are written at," explains Cornett.

Once they understand these facts, you can identify the elements in a written piece that make it easy to read, so when they write educational materials or select published materials they can choose what is best for the patient. The more syllables there are in the words and the more words there are in a sentence, the higher the reading level, says Cornett.

Easy-to-read materials are written in the active

voice, concepts are well-defined, and important information is highlighted with bullets. The need to know information must be obvious because people who don't read well will miss the point if a lot of nonessential information is included in the text, says Cornett.

The content must flow logically as well. For example, if the material covers a surgical procedure, it should first explain how to get ready for the procedure, continue with information on what happens during the procedure, and end with what to expect following the procedure.

To draw attention to essential information, use techniques like bold type or boxes around key points. Headings and subheadings help people quickly find the information they need. For example, a heading might read: "When to call your doctor," and then list five signs and symptoms that warrant a call. "Information sheets should look like a recipe card, not a novel," says Cornett.

In addition to text, consider the layout as well, advises **Zeena Engelke**, RN, MS, clinical nurse specialist for nursing staff development at the University of Wisconsin Hospital and Clinics in Madison. "We need to look beyond the words and be sure there is sufficient white space, skillful use of lists or charts, and appropriate graphics. Too often we are focused on counting three-syllable words and miss the point about ease of presentation," she explains. **(For more information on the elements of easy-to-read materials, see article on p. 102.)**

All levels of communication affected

Communication is much more than the written word, and health care professionals must be aware of the words and phrases they choose to explain medical concepts to ensure that patients understand their instructions. A good exercise during staff instruction on health literacy is to give class participants a list of words commonly used by medical professionals and have them choose an alternate word or sentence that is more readily understood, advises Cornett. For example, rather than using the term anti-inflammatory, the health care professional might say "a drug that will prevent redness, swelling, and all the signs and symptoms of infection."

Cornett often advises health care professionals to tape a conversation they have with a patient when providing instructions so they can hear how they answered questions and explained concepts. Most patients won't mind if told why the conversation is being recorded.

Videos and other nonwritten methods of communication should frequently be used when low health literacy is suspected. "I watch for cues that might indicate literacy concerns. If I have an individual that I know or suspect is illiterate, I rely more heavily on verbal instructions, videotapes, audiotapes, and other nonwritten methodologies," says Engelke.

Cues to a person's literacy level includes the kind of words they use, their use of language in general, and whether they have reading materials around. For example, "Did the person bring a book to read in the waiting room?" says Cornett.

During staff training on health literacy use lots of hands-on activities, advises Cornett. Role playing is a good way to practice plain communication with patients. There are also many exercises for sharpening material selection skills. "An exercise you can do with students is to give them brochures at various reading levels and ask them to select materials for different types of patients," she says. After teaching them to write in easy-to-read language, you also can give them a paragraph that is written at a 12th-grade level and have them rewrite it at a fifth-grade level.

It is important to set a standard at your facility so that staff know that a particular reading level is required. At the University of Wisconsin Hospital and Clinics, staff are encouraged to select or create materials that are no greater than an eighth-grade reading level. To aid staff, the health care facility has an author's guide to reinforce its standard and provide strategies for decreasing reading level. **(For a list of resources to aid in educating staff on health literacy, see p. 102.)**

"Likely, the most important help comes when we edit and work directly with staff to help them bring down the reading levels," says Engelke.

SOURCES

For more information about teaching staff about clear health communication, contact:

- **Sandra Cornett**, RN, PhD, Director, The Ohio State University Health Literacy Project, Office of Health Sciences, AHEC, 218 Meiling Hall, 370 W. 9th Ave., Columbus OH 43210-1238. Telephone: (614) 292-0716. Fax: (614) 688-4041. E-mail: cornett.3@osu.edu.
- **Zeena Engelke**, RN, MS, Clinical Nurse Specialist, Nursing Staff Development, University of Wisconsin Hospital and Clinics, 3330 University Ave., Suite 300, Madison, WI 53705. Telephone: (608) 263-8734. E-mail: zk.engelke@hosp.wisc.edu.

Simple steps to sure-fire materials

At the University of New England Health Literacy Center in Biddeford, ME, a checklist for creating easy-to-read materials was assembled to help health care professionals improve communication skills. Following are some of the tips offered on the list:

• **Appearance/appeal.**

Appearance is important. Written material should look easy to read and also be appealing and attractive. All the design elements, including text layout and pictures, work together to attract attention.

A good layout should include the following:

— ample white space, generous margins, short line length;

— balance between white space, words, and illustrations;

— highly visible section titles;

— key points emphasized with such techniques as boxes, bold letters, different typeface, and increased font size;

— upper- and lowercase letters in 12-14 point serif typeface;

— Illustrations that reinforce key points located close to the appropriate text that are suitable for the target audience and have captions when needed.

• **Organization.**

When good organization skills are used, the structure and sequence of the text makes it easy for readers to grasp the message quickly. Well-organized materials should include:

— key messages or actions a person should take located up front;

— three to five major points that are "need to know" information;

— information that is sequenced and written in a logical way;

— sections that are short, visually distinct, and appropriately labeled.

• **Writing Style.**

The author should use strong, clear, concrete nouns and verbs that create visual images the reader will remember. Well-written materials have the following attributes:

— conversational style writing with friendly tone and use of pronouns;

— technical jargon eliminated from text unless necessary and when used an explanation is provided;

— concrete examples are used to improve understanding, and common words and analogies explain difficult concepts;

— words and sentences are short and simple but not choppy, and important information is clear.

(Editor's note: For more information, contact: AHEC Health Literacy Center, University of New England, 11 Hills Beach Road, Biddeford, ME 04005.) ■

Resources for teaching staff health literacy

The following materials can be used for staff education:

• ***An Author's Guide.***

The guidelines for patient education written materials used at the University of Utah Health Sciences Center in Salt Lake City can be found on the institution's web site (www.med.utah.edu/ pated/authors/). The guide has literacy facts, readability testing, a substitute word list, and information on clear writing.

• **Health Literacy Introductory Kit.**

The Chicago-based American Medical Association (AMA) created a health literacy kit that contains a video*, Low Health Literacy: You Can't Tell by Looking;* a health literacy report; fact sheets on health literacy; and a discussion guide. The cost of the kit is $25 (AMA members, $15). For more information or to order, contact: American Medical Association, Clinical and Public Health Practice & Outcomes, 515 N. State St., 8th Floor, Chicago, IL 60610. Telephone: (312) 464-5563.

• **Plain English Network.**

The Plain English Network (www.plainlanguage.gov) is a government web site that provides information on how to write in plain language. There are plenty of before-and-after documents illustrating the use of plain language on the site. ■

Network for cancer control targets African-Americans

Goal is to eliminate disparity

Efforts are under way in two states to eliminate disparity in cancer death rates between African-Americans and Caucasians.

This problem has led five universities in Alabama and Mississippi to form a network with federal, state, and local agencies to provide better education about cancer and early detection.

SOURCES

For more information about the Deep South Network for Cancer Control, contact:

- **Lydia Cheney**, MEd, CHES, Cancer Education Specialist, University of Alabama at Birmingham Comprehensive Cancer Center, LNB 1001, 1530 3rd Ave. S., Birmingham, AL 35294-0001. Telephone: (205) 934-5772. Fax: (205) 975-9666. E-mail: Lydia.Cheney@ccc.uab.edu.
- **Claudia M. Hardy**, MPA, Program Manager, Deep South Network for Cancer Control, University of Alabama at Birmingham Comprehensive Cancer Center, LNB 1001, 1530 3rd Ave. S., Birmingham, AL 35294-0001. Telephone: (205) 975-5454. Fax: (205) 975-9666. E-mail: Claudia.Hardy@ccc.uab.edu.

The Deep South Network for Cancer Control was funded by a $5.2 million grant from the Bethesda, MD-based National Cancer Institute (NCI) in April 2000. The network targets African-Americans in underserved areas by using men and women from the various communities as peer counselors or advisors after they have completed an eight-week training program. The community health advisors know the available local resources and are able to help their neighbors navigate the system. They offer advice, assistance, and provide an action plan.

"They assist women in getting the screening and services they need, and they will often do the actual work that is required to initiate the screening," says **Claudia M. Hardy**, MPA, program manager for the Deep South Network at the University of Alabama at Birmingham.

The health advisors currently are educating women about the importance of early detection of breast and cervical cancer. The Centers for Disease Control and Prevention in Atlanta has a program in place that provides free breast and cervical cancer screenings. As other types of early cancer detection programs for the underserved become available, the health advisors also will help people in their communities take advantage of them.

One of the Deep South Network's top priorities is to train 600-700 community health advisors within the next five years. Other goals include promoting African-American participation in clinical trials and to encourage minority students to go into cancer research.

The universities involved in the network provide information on the clinical trials they are recruiting for so the community health advisors can be kept abreast of the various opportunities and advise the appropriate people in their communities. When the advisors recruit participants from their communities for the clinical trials, they often receive an incentive for referrals.

A part-time county leader, one who is well-respected and often sought for advice by his or her neighbors, recruits men and women for the community health advisor program. There are eleven rural counties and one urban county in Alabama and twenty rural counties and one urban county in Mississippi that are part of the network.

The role of education

To effectively change the health behavior of the African-Americans living in the Deep South, the community health advisors receive extensive training. For two months, they attend a weekly two-hour class. Local health care professionals, who follow curriculum created by the Deep South Network staff, teach the classes. Some of the topics covered include cancer awareness, breast health, breast cancer treatment options, cervical cancer, community resources, and lessons on recruiting people for cancer screening such as mammograms, or for clinical trials.

There are many obstacles to early detection of cancer within the African-American community that the health advisors must overcome to reach the people in their communities. "Fear is the No. 1 reason people are not screened. They are afraid that if they are screened, they will discover a diagnosis of cancer," says **Lydia Cheney**, MEd, CHES, cancer education specialist at the University of Alabama at Birmingham's Comprehensive Cancer Center and Deep South Network staff member.

Many believe that cancer is an automatic death sentence; so if they have it, they don't want to know. Therefore, education is a key component in helping people understand the value of early detection and treatment. To make sure that the community health advisors have the knowledge they need to teach people the steps for early cancer detection, they are given a pre- and post-training test.

Although the community advisory program covers an expansive area and is a large undertaking, several small pilot projects provided the facts needed to support its viability when the grant proposal was written. Also, the team consists of many health care professionals who have years of experience working with underserved communities.

To help determine the effectiveness of the Deep South Network for Cancer Control, the number of

women referred to the breast and cervical detection program to be screened are tracked. "County coordinators in each community help advisors keep a running list of the women they contact and refer to a health care program," says Hardy. ■

November designated as marrow awareness month

Stress donor registration, responsibility

November is National Marrow Awareness Month, an observance designed to increase the number of potential donors in the computerized registry maintained by the Minneapolis-based National Marrow Donor Program.

There are approximately 4.5 million people in the register (established in 1987), and about 12,500 transplants have been initiated since. About 3,000 people search the registry and 140 transplants are performed monthly.

"One would think that with 4.5 million donors and only 3,000 people searching the registry, there would be more transplants. Those numbers show how difficult it is to match a patient with a donor," says **Molly Ferris**, public relations specialist with the National Marrow Donor Program.

When a person is diagnosed with an inherited disorder or blood disease, such as leukemia, that could be cured with a transplant, physicians look at siblings first for a match. There's a 30% chance a sibling will match. The other 70% of the population must go to the registry to find a match. "After a sibling, the best chance of finding a match is someone within your own race or ethnic group," says Ferris.

The most important message for National Marrow Awareness Month is that people of all racial and ethnic groups should join the registry. Currently, African-Americans have the lowest percentage of matches. A second message that is equally important is that donors need to be committed. "We have people every day who are called to be donors, and they say they have decided they don't want to do it," says Ferris. When a person has a life-threatening disease, the donor is often the only hope for a cure.

People who want to be in the registry go to a donor center and have their tissue typed. The cost is usually $73 to cover the lab expenses, unless the center has matching funds available that brings the price down. The process takes about 15 minutes and consists of having blood drawn for the lab test and answering health history questions. Currently, all minorities, including Asian, Hispanic, African-Americans, and American Indians, can join the registry at no cost. The need for racial and ethnic diversity is so great the fees have been waived, says Ferris.

The antigens found on the surface of white blood cells and other body tissue are used to match donors and patients. Six out of six antigens are considered a perfect match, but transplants are done if the match is four or five out of six antigens as well.

Teach the details

Potential donors need to know that if their tissue type matches the patient, the transplant physician will decide on the type of transplant, which could be marrow or peripheral blood stem cells. In the traditional marrow method, the marrow containing the blood stem cells is taken from the donor's pelvic bone while he or she is under anesthesia. In the second method, the stem cells are taken from the peripheral blood similar to a blood donation and spun through a machine to harvest the stem cells. This type of donation requires the donor to take Filgrastim, a drug used to increase the release of stem cells from the bone marrow.

Donors also need to know what side effects they will experience during both procedures. "With the peripheral blood stem cell donation, the side effects come before the procedure, where with the traditional marrow method, they are afterward. There are side effects with both, but neither are a painful procedure," says Ferris. Most people complain of lower back pain following the marrow donation and experience stiffness up to a few weeks after the procedure. Those who undergo peripheral blood stem cell donation experience bone pain and muscle pain prior to the procedure, which is caused by the Filgrastim.

A person must be between the ages of 18 and 61 to be a donor and in good general health to reduce the risks for both the donor and patient. They cannot have a history of cancer or have any infectious diseases, serious back disorders, heart problems, or diabetes. Donors must be free of infections and medications that might hinder a patient's recovery, explains Ferris. Also, women who are pregnant are prohibited from donating because the marrow donation requires anesthesia and the peripheral blood stem cell donation requires injections of Filgrastim, both of which may be harmful to the fetus.

SOURCE

For more information about providing education on the marrow donor program, contact:

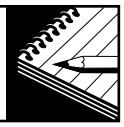
- **Molly Ferris**, Public Relations Specialist, National Marrow Donor Program, 3433 Broadway St. N.E., Suite 500, Minneapolis, MN 55413. Telephone: (800) 627-7692. Web site: www.marrow.org.

National Marrow Awareness Month is a good time to provide information for patients and staff as well as donors. "There are a lot of people who are eligible for transplantation that never get into the process. There are various reasons for that," says Ferris. Some physicians who do not have the latest information consider the transplant experimental or they tell African-Americans that they don't have a chance of finding a match. The National Marrow Donor Program has brochures available for both donors and patients to aid in the education process.

One of the best ways to get the word out is to host a luncheon where the donor and transplant recipient meet for the first time. "A year after the transplant, the donor and patient have an opportunity to meet if they desire, and some do it in a public manner which is very emotional. It is a great way to get across the message," says Ferris. To make arrangements, contact a transplant center in the region of your health care facility, she advises. If a meeting isn't possible, the center could help arrange to have either a transplant patient or donor come and speak. A list of centers can be found at www.marrow.org.

"People who need transplants do not have a chance without the donor, so it is important for people to realize that donors need to be committed, patients to know they need to search the registry, and doctors to get it started," says Ferris. ■

GUEST COLUMN



Blending business strategy with patient education

By **Kay M.B. Thiemann**, MBA,
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As resources in health care become tighter, programs often considered supplementary to a patient's care experience become "nice to haves" rather "need to haves." Most managers of patient education programs realize that when the purse strings are tight, their program may unfortunately fall into the former category. That's why it's imperative that program managers constantly assess their environment and offer a service that customers need and value. To maintain its viability, the service must have clear alignment with the parent organization's mission while efficiently utilizing resources.

How do managers do this? By formulating a business strategy. Strategy is a process that determines the direction a program needs to follow to fulfill its mission. Developing a clear strategy is important because it:

- Provides you with a sound basis for making decisions that will keep you focused.
- Helps you avoid being reactive to crisis situations, which often move you in the wrong direction.
- Leads to a common agreement on direction from all in your program.
- Saves time and effort.

Without strategy, managers often make decisions based on short-term rather than strategic objectives. Here are some simple steps when developing a strategy:

1. Assess your external and internal environment.

As program managers, our role is to continually benchmark with other organizations to assess the external environment. Defining the needs and wants of your internal environment — clients, complementary services, and other factors — is another component of the assessment.

2. Identify your primary customer.

Often the demand for services can be so great that organizations lose focus on whom they serve. Be specific in identifying your main customer, and the rest of your strategy will fall into place.

3. Evaluate your competitive position.

With the information from step one, develop a list of your internal and external strengths and limitations. In simpler terms, this is called a SWOT analysis (Strengths, Weaknesses, Opportunities, Threats).

4. Identify key planning areas.

Ask yourself what common themes or words appear when reviewing the assessment information and SWOT analysis. Select no more than five themes; these are your key planning areas.

5. Define your mission.

Your mission should succinctly articulate the concept of your organization, the nature of your business, why you exist, and whom you serve. A mission statement is an internal guide for all major decision makers so initiatives can be tested for compatibility with the mission.

6. Define your vision.

Your vision is your destination. A vision statement provides a motivational picture of where you are headed. The more succinct your vision statement, the clearer it is to get to your destination.

7. Develop strategic objectives.

Strategic objectives help drive you toward your vision. For each key planning area identified, develop one or two strategic objectives. Strategic objectives should be specific, measurable, attainable, realistic, and include a target date for completion.

8. Identify actions required to implement strategic objectives.

For each strategic objective, define your priorities, schedule, and resources needed.

A case in point: Mayo Clinic's experience

The section of patient education at Mayo Clinic recently underwent a strategic planning process and department reorganization using the process above. Our results were used to develop a business plan seeking additional funding and human resources.

To assess the internal environment, an external consultant conducted focus groups with more than 70 Mayo Clinic physicians, nurses, and other allied health staff, as well as patients, department staff, and internal suppliers (illustrators, writers, buyers, etc.). Information on the external environment was obtained by benchmarking with organizations such as Cleveland Clinic and Johns Hopkins Medical Center in Baltimore.

What we learned was that a solid foundation for delivering patient education was in place. However, enhancements were needed in several key areas (later identified as our key planning areas). Narrowing the focus of our service also was necessary to improve customer and staff satisfaction.

Identifying our primary customer was one of the most difficult parts of our strategic planning. In a patient education program, one would naturally assume the patient is the primary customer. Not true in our case! We identified the health care provider as our main customer. Our approach was to give health care providers the skills and materials necessary to educate patients "at the point of care," an approach that gained greater mileage with limited resources.

Next, our *SWOT analysis* clearly indicated that patient education was vital to the Mayo Clinic practice. However, many clients avoided using the department's services due to slow turnaround times for new patient education materials.

From here, *key planning areas* emerged:

- Be more proactive and strategic in working with clinical areas.
- Prove that patient education affects clinical outcomes via research.
- Develop patient education materials faster (more timely).
- Deliver patient education consistently among the clinical areas.
- Be flexible in meeting patients' unique needs and more easily accessible to health care providers.
- Provide financial and workload indicators to continually assess resource needs and demonstrate value to the parent organization.

Our mission, vision, and strategic objectives were developed. The mission provides a clear sense of direction, states why we exist, and identifies our primary customer. Our vision statement is concise, yet inspiring. Our strategic objectives are specific, measurable, attainable, realistic, and provide target completion dates. **(To learn what the mission, vision, and strategic objectives are, see article on p. 107.)**

Finally, our consulting services, patient services, and operational support teams began implementing the strategy by developing work plans for each strategic objective. Staff workload indicators and productivity measurements were established as a management tool to continually monitor utilization of resources and forecast demand for services.

Our business plan was strengthened by a solid strategy based on customer needs. The evidence? Our department doubled its staff and received a considerable increase in funding. We have achieved — and in many cases, surpassed — our strategic objectives. Overall service has improved, and customers and staff are noticing a difference. Blending business strategy with patient education showed our parent organization that our program is worth it — we are a "need to have" that is

simply part of good health care for patients.

Recommended reading

• Christensen J. *Formulating a Strategy. Healthcare Management Initiatives.* St. Cloud, MN; 1999. ■

Put mission, vision, and strategy into words

Following are the mission, vision, and strategic objectives created as part of the business strategy for patient education at the Mayo Clinic in Rochester, MN.

• **Mission**

The Section of Patient Education will proactively promote and facilitate the consistent application of outcome-based patient education for Mayo Clinic Rochester health care providers.

• **Vision**

Making a difference through patient education!

• **Strategic Objectives (per each planning area)**

— **Proactive Strategies/Clinical Outcomes**

1. To have proactive patient education plans established for at least five clinical areas by January 2001.

2. To have at least five new research projects of significance that evaluate patient education outcomes completed or in process by January 2002.

— **Timeliness**

1. To deliver planned print patient education projects within four months of a provider's request by January 2001.

2. To have rapid, limited support for unplanned provider requests for patient education materials by April 2000.

— **Consistency**

1. To have implemented an institutionwide policy for the consistent delivery and documentation of patient education by December 2002.

— **Flexibility and Accessibility**

1. To have patient education materials available on-line to providers by April 2000.

2. To have tested and evaluated at least three new media, technology, or delivery methods for the purpose of increasing flexibility and / or accessibility of patient education by January 2002.

— **Financial**

1. To have financial and productivity performance measures (workload indicators) in place for the Section by January 2000. ■

SOURCES

For more information about formulating a business strategy, contact:

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Patient Education Management™ (ISSN 1087-0296) is published monthly by American Health Consultants®, 3525 Piedmont Road, N.E., Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodical postage paid at Atlanta, GA 30304. POSTMASTER: Send address changes to **Patient Education Management**™, P.O. Box 740059, Atlanta, GA 30374.

Subscriber Information

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

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Opinions expressed are not necessarily those of this publication. Mention of products or services does not constitute endorsement. Clinical, legal, tax, and other comments are offered for general guidance only; professional counsel should be sought for specific situations.

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Editorial Questions

For questions or comments, call **Susan Cort Johnson** at (530) 256-2749.

CE/CME Questions

9. The purpose of many glucose screenings offered as a community service by health care institutions is to:
   A. increase awareness.
   B. uncover people who are asymptomatic.
   C. diagnose diabetes.
   D. both A and B
10. When teaching staff about good health communication, which of the following information should be included in the curriculum?
   A. Facts about the health literacy problem
   B. Tips on writing easy-to-read materials
   C. Examples of medical jargon patients don't understand
   D. all of the above
11. People who are considering joining the national registry for marrow donation, need to understand:
   A. there are two types of transplants.
   B. it's important that donors be committed.
   C. donors must be in good general health.
   D. all of the above
12. It's good to get input from parents when shaping patient education materials and programs because they have a unique perspective on the needs of family and children.
   A. true
   B. false

Strategic Planning Resources

Refer to these resources for more information on strategy development:

• Bryson J. *Strategic Planning for Public and Nonprofit Organizations: A Guide to Strengthening and Sustaining Organizational Achievement*. San Francisco: Jossey-Bass Publishers; 1995.
• Herzlinger R. *Market-Driven Health Care: Who Wins, Who Loses in the Transformation of America's Largest Service Industry*. Reading, MA: Addison-Wesley Publishing Company; 1997.
• Ohmae K. *The Mind of the Strategist: The Art of Japanese Business.* New York City: McGraw-Hill; 1982.
• Stevens G. *The Strategic Health Care Manager: Mastering Essential Leadership Skills*. San Francisco: Jossey-Bass Publishers; 1991.
• Thompson Jr. A., Strickland III A. *Strategy Formulation and Implementation: Tasks of the General Manager*. Plano, TX: Business Publications; 1986.
• Webster J, Reif W, Bracker J. The manager's guide to strategic planning tools and techniques. *Planning Review* 1989; 17(6):4-13. ■

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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

Make education a family affair

Don't bombard with information

When addressing the educational needs of parents with sick children, health care professionals frequently assume they know what is appropriate, yet often they miss the mark.

That's why it's important to get input from the population you serve, says **Kim Meighan**, RN, health information manager at The Hospital for Sick Children in Toronto. You might decide to produce a pamphlet, but the parents may need a video or audiotape instead, she explains.

At St. Jude Children's Research Hospital in Memphis, TN, parents help shape patient education because they have a unique perspective on the needs of family and children undergoing cancer treatment, says **Samuel L. Maceri**, RN, MPA, CNA, director of education and support of patient care services. "We are the content experts and they are the experience experts," he explains.

Parents can provide information on what needs to be communicated, when it needs to be communicated, how it needs to be communicated, and how much or how little information needs to be included. For example, parents have told the health care providers at St. Jude that when their child is first diagnosed with cancer, they don't want to be bombarded with information. Instead, they need time to get used to the diagnosis.

"Later, they go through a phase where they are hungry for information, and whatever manuals and books we can provide is hardly enough. We have to gear our educational efforts to their phases," says Maceri.

To help parents get information when they need it, St. Jude put into place a video-on-demand system, and they are producing educational videos for it. Also, they moved their cabinets of patient education materials out in the hallway and put a sign on it that instructs parents to take whatever information they wanted. "Nurses will continue to give parents information, but they can come by and rifle through the cabinet whenever they want to at their will, and the video on demand is the same idea," says Maceri.

In an effort to ensure that the distributed materials are parent-focused, The Hospital for Sick Children often does focus testing with parents when developing materials. For example, they currently are in the process of assessing what types of materials families who have children with brain tumors might need. To capture the information needs parents have at each stage of illness, they are interviewing three groups of parents. Those groups are parents who have a child who was just diagnosed with the brain tumor, those parents who have had the diagnosis from three months to a year, and parents whose child has been diagnosed for longer than a year.

While input on educational materials is valuable, parents can be used to improve education in many ways. At St. Jude, a panel of parents and cancer survivors spend time talking with the nursing staff about the experience of being a patient. The panel is part of an intensive pediatric oncology course all new nurses must participate in.

Parents sit on many committees at The Hospital for Sick Children, such as the pain management committee. "Parents are able to offer input in terms of the types of direction we should take in programming or educational materials," says Meighan.

Although a parent does not currently sit on the interdisciplinary patient education committee at St. Jude, it's been discussed, and a parent will soon be selected. A parent already has been selected to sit on the planning committee for the new family resource center. When the hospital remodeled its outpatient area, parents and children were asked for input in order to make the area as user-friendly and child-sensitive as possible.

Many of the article ideas and tips printed in *St. Jude Parents*, a family newsletter, comes from parents. For example, one parent suggested a piece about how to keep children from sharing germs in waiting areas.

"We take parent's concerns and put them in the newsletter, as well as the tips that they give us," says Maceri. Parent participation can be invaluable, he says, but the information that is used in the newsletter must carefully be evaluated, and

SOURCES

For more information about soliciting parent participation to improve patient education, contact:

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- **Kim Meighan**, RN, Health Information Manager, The Hospital for Sick Children, 555 University Ave., Toronto, Ontario, Canada M5G1X8. Telephone: (416) 813-6528. E-mail: Kimberley.meighan@sickkids.ca.

participants on committees and other projects must be selected with care.

The information provided for the newsletter must be clinically valid and not open to misinterpretation by other parents. Also, parents selected as committee members or speakers must be representative of families in general and have a true desire to provide valid information. "We contact the parents and talk with them to make sure they have the time and are available to work with us. Our concern is that they don't have an ax to grind or one particular point of view," says Maceri.

Nurses and physicians that have worked closely with the parents during their child's illness recommend those who are asked to participate. "They know who is involved and who is articulate," explains Maceri. ■

Obesity hikes risk for Type II diabetes in kids

Type II diabetes is referred to as "adult-onset" because it is most often diagnosed in people over the age of 40. Yet in recent years, children have been developing Type II diabetes as young as 8 years old.

"While there is a genetic potential, the rise seems to also correlate with the rise in obesity," says **Janice A. Greer**, RN, MS, CDE, an endocrine clinical nurse specialist at Phoenix Children's Hospital.

Excess weight does not cause diabetes; it increases the risk when a predisposition to diabetes exists. "Most of these kids are young and obese, so the prevention issue is really related to prevention of obesity," says **Kathy Murphy**, PhD, director of the Diabetes Center at Children's Hospital of Philadelphia.

Obesity is a growing health problem, and many factors contribute to its cause. Children are spending too many hours watching television or sitting in front of a computer playing games. In many families, both parents work, therefore, fast food is frequently on the dinner menu. In addition, highly processed foods laden with sugar and fat are being piled into the grocery cart rather than fresh fruits, vegetables, and whole-grain items.

Prevention of Type II diabetes in children must begin when they are toddlers, says Murphy. Children who are off the growth chart at 3 years old probably will end up at the Diabetes Center when they are 10 years old, she says.

While unhealthy eating and lack of exercise are two of the factors that contribute to obesity, a third is overeating, says Murphy. Portions at most restaurants and fast-food outlets are now super-sized.

To change this trend, families must change their lifestyle, says Greer. "We have attempted on several occasions to find a program that will help children who are obese lose weight, and it is frustrating because children cannot make wise decisions. It needs to be a family affair," she argues. Yet families have their own obesity and lifestyle issues, which makes it challenging. They must not only change their child's behavior, but also change their eating and exercise habits as well.

Knowledge about healthy choices is vital. It's OK for people to go to a fast-food stand on occasion, but rather than select the deep-fried chicken or fish sandwich with 25 or more grams of fat, they should select the grilled chicken sandwich which has 5 g of fat or the plain hamburger with 9 g of fat, says Greer. Families also must learn to limit the hours of TV they watch and replace them with exercise. The message that needs to get out is that entire families need to change their lifestyle, says Greer. ■

SOURCES

For more information about educating families on lifestyle change to prevent Type II diabetes, contact:

- **Janice A. Greer**, RN, MS, CDE, Endocrine Clinical Nurse Specialist, Phoenix Children's Hospital, 909 E. Brill, Phoenix, AZ 85006. Telephone: (602) 239-4844. E-mail: jgreer@phxchildrens.com.
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