AMERICAN HEALTH CONSULTANTS

Patient Education Management™

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

March 2002 • Volume 9, Number 3 • Pages 25-36

IN THIS ISSUE

In This Issue **continued on next page**

Persistence pays off when fixing the pieces to the continuum of care puzzle

Consider it a work in progress

Delivering and documenting patient education across the continuum of care is a challenge at many health care facilities. It is something that's always going to be a work in progress, says **Kay M.B. Thiemann**, MBA, administrator at the Mayo Clinic Section of Patient Education, Patient Education Center in Rochester, MN. "At Mayo, our role is to do the best we can with the resources we have. We teach staff how to do good patient education and we will teach them again and keep coming back and improving as we go," she says.

Good patient education is provided across the continuum of care in many ways. There are educators at Mayo assigned to clinical areas who work with health care providers to create a patient education plan that meets the needs of both inpatient

EXECUTIVE SUMMARY

Patient education across the continuum of care is often a struggle for managers. An especially difficult task is providing effective patient education in outpatient areas and documenting it. In our cover story this month, we look at some of the ways health care facilities are providing patient education across the continuum, including outpatient areas.

In This Issue **continued from page 25**

COMING IN FUTURE ISSUES

- Using technology to improve disease self-management
- Teaching staff good assessment techniques
- Designing educational web pages for kids
- Examining Joint Commission patient education standards one by one
- Specialty service providing health care information for travelers

and outpatient providers.

The method used is similar to the direct patient teaching process where a patient's learning needs are assessed, then a plan is developed and implemented, and followed by an evaluation, says Thiemann. "We do an assessment to determine what providers need to deliver good patient education, we write a plan, we implement the plan and get staff up to speed, then we look back to see if we made the mark or not," she explains.

For example, if during the assessment the educator determines that clinic staff need assistance with documentation of patient education, he or she would write into the plan that a certain percentage of time in 2002 would be devoted to staff development.

Chart audits available

Both inpatient and outpatient services document on the same patient and family education flow sheet, which is kept with the patient's chart. To help clinical areas improve documentation, the education department provides chart audits for those who request it. "We give the leadership of the department the chart audit report and compliance is up to them," says Thiemann.

There are usually five to seven strategic objectives per patient education plan for a clinical area. In addition to staff development, the objectives might include the development of patient education materials or the development of a class.

Educators assigned to work with providers spend time in their clinical areas attending practice meetings and meeting with staff to listen to their concerns and inform them of available patient education services.

Staff awareness of patient education services is important. To meet the educational needs of expectant mothers, Sacred Heart Medical Center in Spokane, WA, developed teaching material, *Precious Journey Notebook*, that covers a woman's educational needs throughout her pregnancy, says **Sherry Maughan**, RN, women's services director. The notebooks are distributed to physician's offices where they are given to patients when they are 20 weeks into their pregnancy.

When a patient is given the notebook, a postcard is sent to Sacred Heart with the patient's name and contact information. That name is entered into a database, and at about 36 weeks of pregnancy, the couple is invited to the hospital for a pre-admit visit. **(To learn more about the notebook, see article on p. 28.)**

Slowly, providers are taking advantage of this educational service. When the booklets were first distributed, about 30% of maternity patients were coming to Sacred Heart for pre-admit visits. Last year, the number rose to 56% — a good jump since some of the women have already had babies and may not feel a visit is necessary, says Maughan.

In-sync education

The notebook, along with the education expectant mothers receive at the physicians office, provides the educational foundation that is built during the hospital stay. Education is reinforced again with postpartum follow-up calls.

"The notebook has helped standardize the information the patients are getting. They aren't being told one thing by nurses in the outpatient clinics and something different by inpatient nurses. We provide a set of very consistent education direction," says Maughan.

In situations where there are care teams or clinical practice groups that cross from inpatient to outpatient and include home health, education can be very strong, says **Zeena Engelke**, RN, MS, patient education manager at the University of Wisconsin Hospital and Clinics in Madison.

"There is a better understanding of what is taught there and, as a result, even if the documentation is more fragmented, there is a mutual understanding of what has occurred. Therefore, it is easier to carry on the education from that point rather than starting from zero," she says. For example, at the University of Wisconsin, the preoperative education for women having breast surgery is conducted in the learning center and augmented by inpatient or outpatient surgical staff and home health.

Build on previous training

In the clinic setting, it is important to have a clear picture of what the patient has been taught at previous visits so that staff can quickly reassess learning needs and move into new teaching to achieve new outcomes, says Engelke. For this type of teaching to take place in outpatient settings, outcomes of past teaching must be documented. For example, if the patient was taught to use a glucose meter and draw up and give insulin on a timely basis at his or her last appointment, the health care provider would know where to begin teaching at the next visit.

SOURCES

For more information about providing patient education across the continuum of care, contact:

- **Zeena Engelke**, RN, MS, Patient Education Manager, 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.
- **Sherry Maughan**, RN, Women's Services Director, Sacred Heart Medical Center, P.O. Box 2555, Spokane, WA 92200. Telephone: (509) 474-3713. E-mail: MaughanS@shmc.org.
- **Kay M.B. Thiemann**, MBA, Administrator, Section of Patient Education, Patient Education Center, Siebens SL, Mayo Clinic, 200 First St., S.W., Rochester, MN 55905. Telephone: (507) 538-1122. E-mail: thiemann.kay@mayo.edu.

A documentation tool is used in University of Wisconsin Clinics to track outpatient education; however, if the visit is not primarily focused on teaching, it's impractical to use it for every visit, says Engelke. Therefore, a stamp also can be used on history and physical notes to document barriers to learning, what has been taught, what teaching methods were used such as handouts or discussion, and the learner's response.

Set up a referral system

When a topic is too complicated or too much time is needed to provide adequate education, a referral system can help. At Mayo, providers are encouraged to send the patient to the patient education center for a one-on-one educational consult or enroll him or her in one of the classes that are offered. "We have printed referral cards and some clinical areas can electronically order a class or an education consult for their patient. However, it is up to the provider [to decide]," says Thiemann.

The education department at Mayo develops educational strategies for the providers so they feel more confident in their patient education delivery. The department also provides teaching tools such as print materials and videos to help providers educate their patients in addition to providing classes and one-on-one teaching consults. They just implemented patient education grand rounds and on kick-off day, over 200 health care providers attended. The topic was learning-needs assessment, says Thiemann. **(For more information on teaching staff to teach, see article on p. 30.)** ■

One book standardizes and consolidates teaching

Unity in inpatient, outpatient settings

Expectant mothers often are given lots of information — a pamphlet at one physician visit, a handout at another. To help bring this information all together, Women's Services at Sacred Heart Medical Center in Spokane, WA, created a booklet titled *Our Precious Journey*.

In addition to providing one resource, the booklet helped ensure that the education patients received was the same in both inpatient and outpatient areas. It also provided education in a timely manner. For example, one section covered community resources such as childbirth education classes, where to buy used baby clothing, and the location of support groups for mothers of multiple births, says **Sherry Maughan**, RN, women's services director.

A committee of three wrote the booklet after gathering similar materials from other health care facilities to use as examples. Each chapter was presented to physicians for feedback and patients reviewed it when the booklet was complete. "We didn't include patients until we were almost done with the notebook because we wanted them to be able to see the full scope of it," says Maughan.

The booklet contains several tabs that identify the sections. There is a diary for patients to track their physician visits and keep vital statistics about the baby. One section is for the information given to patients by the physician. Another section covers the pregnancy between 12 and 32 weeks discussing diet and nutrition, test evaluations, medications they should avoid, and the things they should be thinking about and planning for.

A section on labor talks about determining when the time is right to go to the hospital and what will happen upon arrival. A special section is specific to expectant mothers who will have a cesarean birth. A birth-to-home section discusses what new moms can expect in the postpartum period. The final section covers postpartum instructions for the care of the baby at home. It includes information on nutrition, when to call the doctor, caring for other children and a spouse in the process, and what moms need to do to take care of themselves. ■

Reach out and teach with kiosks

Build your own for less

Kiosks as a patient teaching tool have been around for a while. However, staff at the New Mexico Veterans Affairs (VA) Health Care System in Albuquerque found the cost prohibitive when considering this technology. The cost for a custom-built kiosk is about $40,000 a unit, yet the ready-made kiosks' content is not always satisfactory.

To remedy this problem, the staff decided to make their own kiosks by enlisting the services of a cabinetmaker, purchasing computers, and having staff create content using PowerPoint software. The cost is about $4,500 per unit.

There were several important factors that contributed to the decision to use kiosks. Most patients now have some familiarity with computers or can at least use a track ball to follow a simple lesson on a computer screen. Also, the VA has been teaching the use of PowerPoint software for many years, and many staff people know how to use the program and create content.

"Because information is constantly changing, if you have to have someone change the content for you, the unit becomes obsolete very quickly," says **Dale Kennedy**, MA, chief of staff development at the VA facility.

From an educational delivery perspective, kiosks complement the goal of the VA, which is to engage patients as active agents in their own health care. "The lessons on the kiosks are self-care-oriented, such as carbohydrate counting or medication refills. The entire approach is self-management, and that is how care is going in the VA system," says **Carol Maller**, RN, MS, CHES, patient education coordinator.

The lessons also deliver a message in an alternate medium rather than written text or video, which is important because patients have different learning styles. They are filled with visuals and graphics using pictures to communicate rather than text. "We felt that if we provided a visual lesson in addition to print material, we would appeal to different learning styles. The different messages complement each other," says Maller.

Currently, four programs are up and running

SOURCES

For more information on creating kiosks, contact:

- **Dale Kennedy**, MA, Chief of Staff Development, New Mexico VA Health Care System, 1501 San Pedro Drive, S.E., Albuquerque, NM 87108. Telephone: (505) 265-1711, ext. 2427. E-mail: dale.kennedy@med.va.gov.
- **Carol Maller**, RN, MS, CHES, Patient Education Coordinator, New Mexico VA Health Care System, 1501 San Pedro Drive, S.E., Albuquerque, NM 87108. Telephone: (505) 265-1711, ext. 4656. E-mail: carol.maller@med.va.gov.
- **Bill Frahm**, owner/cabinetmaker, Sunray Custom Wood Working, Albuquerque, NM. Telephone: (505) 344-4180.

on a pilot kiosk in the learning center. They include the lesson on carbohydrate counting for diabetes patients developed by a dietitian, a lesson on how to get medications refilled, and a lesson on stroke medication developed by a pharmacist. A fourth lesson on emergency preparedness was developed after the Sept. 11 terrorist attacks and was reviewed by the emergency coordinator at the hospital.

Clinicians develop most lessons; however, several volunteers with PowerPoint skills are able to take brochures and other print materials and create programs for the kiosks. They also take written copy from clinicians who are not PowerPoint-proficient and create the kiosk lessons. The edit review team, which is supervised by the hospital-wide patient education committee, approves the content for most of the lessons.

As kiosks are placed in areas throughout the hospital, lessons will be tailored to fit the patients' educational needs. "I want staff to get invested in the kiosk lessons and customize and individualize them for their patient populations," says Maller. In addition to the learning center, a kiosk will be placed in the women's clinic, the subspecialty area that includes cardiology and neurology, the mental health clinic, and the primary care clinic.

To determine where to place the kiosks Maller attended a meeting with outpatient clinic nurse managers to demonstrate the kiosk. Those who expressed interest will receive a kiosk.

"The biggest challenge is always space. We would like to put them in various clinic waiting rooms, but people don't have room for a trash can, much less something the size of a desk," says Kennedy.

Cabinet design is desk-like but enclosed so all patients see is the flat-screen monitor and the track ball to operate the system. An ordinary PC is inside as well as speakers. Background music plays as patients operate the system.

The cabinetmaker designed the kiosks to certain specifications so that they fit through hospital doors. Because they are on casters, they can be moved throughout the medical center. They also are consistent with the look of the other hospital furnishings and are wheelchair-accessible. **(For information on the cabinetmaker, see source box, left.)**

When a kiosk is located in a clinic, staff will refer patients to it while they wait to see their physician. For example, if the patient is on several medications, staff would suggest he or she review the lesson on medication refills. A directory on the kiosk not only shows patients where various clinical areas are located, it provides directions to the learning center where they can obtain more detailed information about their health care concerns.

Volunteers play an important role in the installation and upkeep of programs on the kiosk. **Curtis Heckel**, MA, picks up the lessons once they are approved and inserts them on the master program and loads it onto the kiosk. "I have a master disk that is a Zip drive; because when you put PowerPoint programs on a disk, it fills fast. I make certain that everything is working on the zip disk from the addition and then upload it onto the kiosk, which takes about 15-20 minutes," says Heckel.

Part of Heckel's volunteer work is to teach other volunteers how to upload programs and teach them how to write PowerPoint programs

Guest columnists welcome

Do you have any insights into persisting problems in patient education or new ideas that have improved patient education? If so, we invite you to share them with readers of *Patient Education Management* as a guest columnist. If you would like to be a guest columnist, please contact Susan Cort Johnson, Editor, at (530) 256-2749. E-mail: suscortjohn@onemain.com. ■

from written copy. "This project would never have gotten where it is without the support of volunteers," says Maller. ■

Teaching skills every staff educator should master

Patient assessment most important

While health care staff frequently are called upon to educate patients, they don't always have the skills to do an effective job. That's why many facilities create inservices, self-learning packets, and other tools that teach staff to teach.

For example, at Grant/Riverside Methodist Hospital, nurses can obtain teaching skills by attending four 30-minute inservices for nursing contact hours. The inservices are offered several times. In October, learning assessment was scheduled six times and in November teaching strategies were offered six times, says **Mary Szczepanik**, MS, BSN, RN, manager of the cancer education, support, and outreach department in Columbus, OH.

Three criteria are key

What skills do all staff need to learn? "The most important skill is to adequately assess the patient," says Szczepanik. This includes a patient's readiness to learn, learning needs, and possible barriers to learning such as hearing loss or inability to speak English.

Szczepanik uses the situational leadership model when teaching staff to evaluate learning readiness, which allows the teacher to determine how ready the patient is to learn based on three criteria:

- willingness and ability to take responsibility for the task;
- recent education and experience in the specific task to be done;
- ability to set realistic goals.

When the teachers receive negative results in assessing these criteria, they must be prepared to use a lot of supervision in their teaching. They may simply give the patient one specific thing to do, making sure the patient is clear on what that task is and how to do it, says Szczepanik.

To assess learning needs, staff must be taught to determine what the patient knows, what is misunderstood, and what he or she needs to know to meet the goals of patient and family education, such as informed consent or self-care skills, says **Fran London**, MS, RN, a health education specialist at The Emily Center at Phoenix Children's Hospital.

Determining the patient teaching strategy, or how to individualize the teaching, is another basic step that staff should master. Staff must learn to determine what type of teaching tools, what method of teaching would work best, and what information should be taught first, says London. **(To learn how to evaluate the patient teaching skills of staff, see article on p. 31.)**

If teaching adults, staff should understand adult principles of learning, says **Leah Kinnaird**, EdD, RN, consultant, Creative HealthCare Management in Minneapolis. Adults will have a wealth of experience with which they can relate new information helping with retention, but they need to immediately apply it. "Adults need awards just as much as children, if not more so," she says.

Teaching works best if a climate for learning is established as well, says Kinnaird. This includes both the physical and psychological environment.

EXECUTIVE SUMMARY

In the first part of an article series on teaching patients, *Patient Education Management* asks experts what staff need to know to be effective teachers. This piece provides an overview of the components of good teaching. Articles in future issues will examine these skills in detail. For example, one future piece will discuss how to effectively assess a patient's readiness to learn covering the steps and techniques involved.

SOURCES

For more information about training staff to teach, contact:

- **Leah Kinnaird**, EdD, RN, Consultant, Creative HealthCare Management, Minneapolis. Telephone: (800) 728-7766. E-mail: leahjo@aol.com.
- **Fran London**, MS, RN, Health Education Specialist, The Emily Center, Phoenix Children's Hospital, 909 E. Brill St., Phoenix, AZ 85006. Telephone: (602) 239-2820. E-mail: flondon@phxchildrens.com.
- **Mary Szczepanik**, MS, BSN, RN, Manager, Cancer Education, Support and Outreach, Grant/Riverside Methodist Hospital, 3535 Olentangy River Road, Columbus, OH 43214. Telephone: (614) 566-3280. E-mail: szczepm@ohiohealth.com.

"Often, this means sitting down with the learner if it is in a patient room, reducing distractions for yourself as well as for the patient, and having a demeanor that engages the patient in wanting to learn," she explains.

Body language says as much as the words used, warns Kinnaird. Rapport helps create an environment for teaching, so it is a good idea to develop it with a group or individual before teaching begins. **(Learn a few teaching tips in the article on p. 31.)**

Once a lesson has been taught staff need to know how to evaluate the learning to determine what the learner understands, what he or she can apply, what behaviors are changed as a result of the teaching, and what still needs to be taught, says London.

The importance of documenting the assessment, teaching, and learning evaluation so that the information is shared with health care providers over the continuum of care needs to be stressed. Information on the most effective teaching methods for the patient as well as what he or she knows and still needs to learn should be included in the documentation process, says London.

Staff should be taught that they are accountable for adherence to the Joint Commission standards for patient teaching, and that documentation is proof of that adherence. Documentation of teaching also is important for legal protection as well, says Szczepanik. ■

Every interaction is opportunity to teach

Conversation is a learning opportunity

Most patient and family education is done within the context of casual conversation; therefore, employees should be taught how to use conversation to assess learning needs, teach, and evaluate learning, says **Fran London**, MS, RN, a health education specialist at The Emily Center of Phoenix Children's Hospital.

"They need to recognize how learners are always providing information about what worries them, what bothers them, what they know, and what they need to know. They need to pick up on those cues and teach from there," she says.

Effectiveness as a teaching method depends on the individual situation. Teaching can take place through explanation, verbal exchange, demonstration, experiential, and behavioral strategies, says **Mary Szczepanik**, MS, BSN, RN, manager of cancer education, support, and outreach at Columbus, OH-based Grant/Riverside Methodist Hospital. "While explanation is the easiest, it's probably the least effective for a [new patient] when the patient has to perform a complex task independently, like care of a central venous catheter at home," she says.

When patients don't seem to be getting a concept, its time for a staff member to more thoroughly assess the learner's abilities and needs to better individualize the teaching, says London. "This skill takes practice and experience to perfect. Staff need to identify challenges and barriers clearly to figure out how to work around them," she says. Role-playing or actual cases can be used to teach this skill to staff.

Staff members become better teachers when they recognize that every interaction with a patient or family member is part of the teaching process — whether assessment, teaching, or evaluation of understanding, says London. Find out what their priorities are and individualize the teaching to their abilities and needs, she advises.

Although health care workers complain that they don't have time to teach every interaction is actually an opportunity to teach. "It is not a question of needing more time, but paying attention to the learner and the learner's needs in the time you have. This is patient-centered care, rather than task-centered care," says London. ■

Reader Question

Are your staff competent teachers?

Evaluate through observation

Question: How do you determine if your staff are competent teachers? What criteria do you use to evaluate them and what method? Is this part of their evaluation for job competency? Do you provide inservices that train staff to teach?

Answer: Staff competency related to educating patients is evaluated by the manager's observations, says **Diane Moyer**, MS, RN, CDE, program

manager for consumer health education at The Ohio State University Medical Center in Columbus. Opportunities for staff to gain information on teaching are provided through inservices and continuing education opportunities related to particular disease processes. Patient education also is part of orientation.

"There are teaching guides available on the intranet system so staff can review and refresh their knowledge about key aspects to be taught on a particular topic or area," says Moyer.

Patient education competencies are part of nursing staff, nutrition, and pharmacy staff competencies, and are evaluated by managers each year as part of the annual performance review process at the University of Washington Medical Center in Seattle. Observation is the typical method of evaluation; however, some staff members are very active in resource, committee, or systems development for the medical center. These activities may also be included in their performance review, says **Cezanne Garcia**, MPH, CHES, manager of patient and family education services.

Tip cards designed help new staff

"Our RN1 orientation includes a session on patient education, but it focuses more on accessing resources. However, it underscores some of the key teaching principles," says Garcia. Clinical staff also are given tip cards that have optimal strategies for patient education effectiveness in one-on-one encounters.

These tip cards are distributed to new staff when they receive their ID badge for the hospital. They are laminated cards the same size as the ID badge and punched so they can be worn with it. One side of the card has documentation tips that include:

- Baseline learning needs assessment.
- What was taught and why.
- How teaching was done.
- Outcome.

Documentation tips also advise staff to use action verbs to document how the patient demonstrated:

- Knowledge — identifies; defines; lists.
- Comprehension — describes; explains; gives examples.
- Skill — demonstrates; uses; practices.

The other side of the card has tips for quality education. They instruct staff to:

- Determine what information is most relevant to your patient.
- Limit your main points to three or less.
- Get the patient to talk about what you said.
- Make sure written materials provide an opportunity for interaction, such as questions or checklists.
- Be sure your visuals / pictures are clear and simple.

The effectiveness of the card has not yet been evaluated, but tip cards used for other types of services haven't been shown to be effective, notes Garcia.

During nursing orientation at Great Plains Regional Medical Center in North Platte, NE, the patient education coordinator gives an overview of Joint Commission standards, explains why staff teach, and provides tips on how and what to teach.

"I am not part of all-employee orientation yet, but foresee this in the near future with the development of some new programs," says **Barbara Petersen**, RN, patient education coordinator. Patient education is included in many job descriptions at the medical center, although there is not a competency per se for patient education.

The patient education committee decided to assess the education needs of staff because they were hearing feedback from clinical areas that staff did not know how to teach and had no training, although it was something they did each day. The assessment was informal with committee representatives asking staff in their area questions about patient education, says Petersen.

The committee found that staff wanted to know how to build rapport with patients, how to verbally teach from a handout rather than just giving the patient the information, how to determine patient learning styles, and how to document better.

To address the concerns of the employees, a speaker was brought in to teach on patient education. There was a fair response to the speaker, but with staff shortages, it's difficult for people to get away for a half- or full-day conference. Petersen is considering using e-mail to distribute teaching tips to staff. "Our facility relies heavily on e-mail, so I feel this may be a good avenue to pursue," she says. She also is considering learning packets on teaching that staff could complete for continuing education units.

On-line education is an effective way to get information to staff about patient teaching, says **Virginia Forbes**, MSN, RNC, program director for patient and family education at New York-Presbyterian Hospital in New York City. The hospital's intranet, referred to as "Infonet," serves as the cornerstone of the patient and family education program. "It provides an avenue

SOURCES

For more information on evaluating staff patient education, contact:

- **Virginia Forbes**, MSN, RNC, Program Director, Patient and Family Education, New York-Presbyterian Hospital, 525 E. 68th St. Whitney 102, New York, NY 10021. Telephone: (212) 746-4094. E-mail: vforbes@nyp.org.
- **Cezanne Garcia**, MPH, CHES, Manager, Patient and Family Education Services, University of Washington Medical Center, 1959 Pacific St., N.E., Box 358126, Seattle, WA 98195. Telephone: (206) 598-8424. E-mail: ccgarcia@u.washington.edu.
- **Diane Moyer**, MS, RN, CDE, Program Manager, Consumer Health Education and Wellness, The Ohio State University Medical Center, Department of Consumer & Corporate Health Education & Wellness, 1375 Perry St., 5th FL, Columbus, OH 43210. Telephone: (614) 293-3191. E-mail: moyer-1@medctr.osu.edu.
- **Barbara Petersen**, RN, Patient Education Coordinator, Great Plains Regional Medical Center, 601 W. Leota, North Platte, NE 69101. Telephone: (308) 535-8640. E-mail: petersenb@mail.gprmc.com.

for communicating with the thousands of employees in this 2,200-bed hospital. Regular updates, articles, and patient education resources are placed on the *Patient Education Webzine*, an on-line magazine," she says.

Currently an on-line continuing education program is being developed to increase staff knowledge and competency. Staff will be able to access the interactive program through the Infonet, and upon satisfactory completion of the program, obtain continuing education credit.

More traditional methods also are used to educate staff on teaching techniques. A handbook for patient and family education is available in each department, which has guidelines for assessing learning needs, teaching patients, and other subjects. Unit-based conferences are provided as needed and guidelines for effective patient and family teaching are covered during orientation, says Forbes.

Knowing how to teach is important, because professional staff are annually evaluated regarding their competency in patient/family education as part of their performance appraisal at New York-Presbyterian Hospital. In nursing, it is the responsibility of the nurse manager in collaboration with the nursing education instructor to determine if the staff member meets the standard.

An appraisal form helps managers consider and measure areas relative to patient teaching such as nurses' collaboration in the plan of care, meeting age-specific competency requirements, assessing patient needs and establishing priorities, communicating information, and providing education to staff on patient and family care-related problems. The overall criterion is: "Provides continuity of care through patient/family education and planning."

Dietitians, physical therapy, and social work departments evaluate competency on an ongoing basis. "This competency evaluates the staff's ability to assess educational needs, barriers, learning-style preferences; provide needed teaching; and assess learning outcomes," says Forbes. ■

Fair atmosphere promotes complementary therapy

Patients get hands-on experience

When the advisory board for complementary and alternative medicine (CAM) at Craig Hospital in Englewood, CO, looked for new ways to educate patients and staff about these types of modalities, they decided to try a health fair.

"One of our main goals is to educate staff and patients about CAM modalities, and we thought one of the ways we could do that was to put together a health fair that would be educational and experiential as well," says **Terry Chase**, ND, RN, patient and family education program coordinator. The nonprofit rehabilitation facility specializes in the care, treatment, disability management, and research for patients with spinal cord or traumatic brain injury.

To provide education and experience, several modalities were selected that could be presented in a variety of ways, including hands-on interaction and demonstration. However, participation in several activities, such as reflexology and massage, was limited to staff only. The patients watched because a physician's order was needed for them to participate in those modalities because of their injuries.

The three-hour fair was kicked off with a qigong demonstration in which attendees could participate. Also, the inhouse 24-hour relaxation station called The C.A.R.E. Channel was available for viewing. The closed-circuit channel provides nature images and instrumental music to create a healing environment. **(For information on The C.A.R.E. Channel, see source box on p. 34.)**

Music therapy was provided by a group of harpists that is part of a program called "Music for

SOURCES

For more information about setting up a health fair that features complementary therapies, contact:

- **Terry Chase**, ND, RN, Patient and Family Education Program Coordinator, Craig Hospital, 3425 S. Clarkson St., Englewood, CO 80110. Telephone: (303) 789-8211. E-mail: TMChase@CraigHospital.org.

For information about The C.A.R.E. Channel, contact:

- **Healing HealthCare Systems Inc**., 100 W. Grove St., Suite 175, Reno, NV 89509. Telephone: (800) 348-0799 or (775) 827-0300. Web: www.healinghealth.com.

Healing." The musicians traveled throughout the health care facility visiting bed-bound patients.

Several booths were set up in the patient education area to provide exposure to several other modalities. The vice president of nursing, who is certified in aromatherapy, had a table with samples, informational materials, and aromatherapy recipes. She mixed aromatherapy sprays and lotions for people to take home with them that were tailored to a specific need, such as easing stress.

A booth featured an array of healthy snacks for people to try. These included energy bars, health shakes, and nutritious breads donated by vendors. Another vendor distributed bottles of water. A distributor of magnet therapy products displayed various items that had magnets imbedded in them, such as neck straps. People could try them out at the booth.

A couple of reflexologists took sign-ups for 10-minute reflexology treatments, and a massage therapist provided neck and shoulder massages.

A Chi machine was perhaps the most unusual modality presented at the fair. This device is used while lying on the floor. People place their feet on top of the machine and it moves side to side, rolling their lower limbs. "It was one of those on-the-edge things, but also very well received," says Chase. It initiated a lot of conversation between health care professionals about the contraindications for their patients at the facility.

This is the type of awareness and discussion Chase hoped to create by offering exposure to a variety of complementary therapy modalities. She wants educational efforts to make the providers aware of various therapies so they will be better informed and know what is right for their patients and what might not be helpful. "My goal is to educate people so they are informed and have some experience or exposure and also reduce the fear factor," says Chase.

Board members and/or staff recommended the vendors, and complementary therapy practitioners were invited to participate in the health fair to ensure credibility. The hours were from 11:30 a.m. to 2:30 p.m., so the event would take place during lunch with a little overlap on either side. It was scheduled to not conflict with therapy time.

Word of the event got out to staff through the CAM advisory board. Also, flyers were distributed and the health fair was posted on the inhouse TV station. Chase placed reminders in patient's rooms. It was held in the patient education area so it would be difficult to miss. "The patient education area is a central place for patients and families, so they are in and out a lot," says Chase.

About 300 people attended, and because the facility only has 80 patients at any one time, most of those who came were staff. The area was so crowded that it was difficult for patients, who are in wheelchairs, to move around.

To remedy the problem, the next fair will be organized in time blocks for "patients only," says Chase. She also hopes to give patients flyers or coupons of some sort so that they can obtain a physician's order in advance to participate in some of the activities. This will give patients the opportunity to experience some of the modalities, she says.

Those who attended the September 2000 health fair had chances to win donated door prizes, such as massage gift certificates, bread coupons from the bread store, and aromatherapy lotions. There were a total of 20 gifts donated. "It was really a lot of fun, so we are thinking of doing it again this fall," says Chase. ■

CDC updates web site on bioterrorism

During the anthrax scare in October 2001, The Centers for Disease Control and Prevention (CDC) in Atlanta had 9.1 million hits on its web site. There was such demand for credible information from the public and health care sectors, the CDC recently updated its web site on bioterrorism

(www.bt.cdc.gov). The redesigned site is the official federal site for medical professionals to reference when providing information to the public. It has up-to-date and accurate information on health threats arising from exposure to biological, chemical, or radiological weapons of mass destruction.

The CDC also operates a hotline that provides information for public health preparedness and emergency response. The hotline is available Monday through Friday, 8 a.m. to 10 p.m. ET; Saturday and Sunday, 10 a.m. to 8 p.m. Telephone: (888) 246-2675 (English) and (888) 246-2857 (Spanish). ▼

Web site helps ID bioterror agents

A new web site funded by the Agency for Healthcare Research and Quality (AHRQ) in Rockville, MD, is designed to teach physicians and nurses how to diagnose and treat rare infections and exposures to bioterrorist agents.

Designed by researchers in the Center for Disaster Preparedness at the University of Alabama at Birmingham (UAB) under contract from AHRQ, the site is the first of its kind to offer free continuing education credits in bioterrorism preparedness to clinicians. It currently offers five on-line courses through the UAB Office of Continuing Medical Education for emergency department clinicians, including physicians, nurses, radiologists, pathologists, and infection control practitioners. The web site address is www.bioterrorism.uab.edu.

"This web site is an important new tool to help doctors and nurses identify rare infections that also could be potential bioterrorist threats," says AHRQ director **John M. Eisenberg**, MD. "The evidence-based information will help frontline clinicians in our nation's hospitals be better prepared in the event of another bioterrorist event." ▼

New study: Hospitalists help reduce costs, LOS

A new study from the *Journal of the American Medical Association* contends that the use of hospitalists in acute care facilities helps "improve inpatient efficiency without harmful effects on quality or patient satisfaction."[1]

Correction

In the January issue of *Patient Education Management,* in our cover story on preparing an emergency response to a bioterrorist attack, we stated that staff in the learning center at Northwestern Memorial Hospital in Chicago provide callers with resources because staff members are not qualified to field specific questions. "Ask a Nurse" is not one of the resources on the list, as was mentioned in the article. Northwestern does not have an "Ask a Nurse" program nor does it have a listing for one. ■

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.

Subscription rates: U.S.A., one year (12 issues), $399. Outside U.S., add $30 per year, total prepaid in U.S. funds. Two to nine additional copies, $319 per year; 10-20 additional copies, $239 per year; for more than 20, call (800) 688-2421. Missing issues will be fulfilled by customer service free of charge when contacted within one month of the missing issue date. **Back issues**, when available, are $67 each. (GST registration number R128870672.)

This continuing education offering is sponsored by American Health Consultants®, which is accredited as a provider of continuing education in nursing by the American Nurses Credentialing Center's Commission on Accreditation. Provider approved by the California Board of Registered Nursing, provider number CEP 10864, for approximately 18 nursing contact hours.

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.

Editor: **Susan Cort Johnson**, (530) 256-2749.
Vice President/Group Publisher: **Brenda Mooney**, (404) 262-5403, (brenda.mooney@ahcpub.com).
Editorial Group Head: **Coles McKagen**, (404) 262-5420, (coles.mckagen@ahcpub.com).
Managing Editor: **Kevin New**, (404) 262-5467, (kevin.new@ahcpub.com).
Production Editor: **Nancy McCreary**.

THOMSON
AMERICAN HEALTH CONSULTANTS

Editorial Questions

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

CE Questions

CE subscribers: *Please save your monthly issues in order to take the two semester tests in June and December. A Scantron form will be inserted in those issues, but the questions will not be repeated.*

9. To improve patient education across the continuum of care, the Mayo Clinic in Rochester, MN, has instituted which of the following programs?
   A. Educators assigned to clinical areas
   B. Referral system for educational center
   C. Patient education grand rounds
   D. All of the above
10. One effective method for determining the patient education competency of staff at health care institutions is observation.
   A. True
   B. False
11. Teaching skills that staff should learn include which of the following?
   A. Assessing readiness to learn and learning needs
   B. Determining best method for teaching patient
   C. Evaluating teaching outcomes
   D. All of the above
12. When making use of backpacks to carry school supplies, which of the following do children and their parents need to know?
   A. Bigger is better
   B. Pack heaviest items close to the spine
   C. Carry weight on hips, not shoulders
   D. B and C

The report examined data from studies conducted between 1996 and September 2001 that compared hospitalist care with a control group in terms of resource use and other factors. According to the report, "most studies found that implementation of hospitalist programs was associated with significant reductions in resource use, usually measured as hospital costs (average decrease, 13.4%) or average length of stay (average decrease 16.6%)." Some of the studies also found improved clinical outcomes as well, but the researchers noted that "these results were inconsistent."

Reference

1. Wachter RM, Goldman L. The hospitalist movement five years later. *JAMA* 2002; 287:487-494. ■

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

For a better back, take off the pack

Injuries occur early in life

Although many unhealthful habits children develop won't cause problems until they reach adulthood, some are having an earlier impact. Injuries and health problems caused by carrying backpacks stuffed with books and school supplies as well as long hours at the computer are two of them. "In the last two years, we see that by age 14, 7% of children have back pain that causes them some kind of discomfort in their daily living," says **Scott Bautch**, DC, president of the American Chiropractic Association's Occupational Health Council in Arlington, VA, and a chiropractor in private practice in Wausau, WI.

One cause of the problem is that children are carrying 30%-40% of their body weight in backpacks. Usually it is because they purchase enormous backpacks. Therefore, parents and children need to learn bigger is not always better. Children 8 years old and younger should never carry more than between 5% and 10% of their body weight in a backpack, says Bautch. Once children reach puberty, they can carry up to 15% of their body weight.

"The average textbook weighs six pounds," says Bautch. Therefore, it is important for parents, children, and teachers to work together so books do not have to be hauled back and forth between home and school every day. In addition to content, packing is important. The heaviest items should be placed close to the spine and those light items away from the spine.

Often, children will stuff their coat into the backpack before their books, which are the heaviest items, because the pack isn't well padded. That's where the selection process based on design comes into place. With a good backpack, most of the weight is carried on the hips. When selecting a mountaineering backpack, people are instructed to slide three fingers underneath the shoulder strap — to prove that the weight is not on the shoulders, says Bautch.

When the backpack is too heavy or the weight is distributed incorrectly, children have a tendency to fall down more easily, injuring themselves. "People will start to lean forward unless the weight is carried below their center of gravity. If the weight is carried high on their back or above their belly button, they will lean forward because they have to balance themselves," says Bautch. When the weight is on their hips, people stand up straighter to keep their balance.

Computers also a culprit

In addition to backpacks, long hours on the computer have become a problem. Most computer stations are made for adults. It is rare when a home computer is adapted to a child, says Bautch. "To fit, they will sit on the leg or hip and imbalance themselves and cause different postures," he says.

Parents should adapt the computer station to the child by placing pillows on the chair and putting a beanbag chair on the floor for the child's feet. Adjusting a chair to fit a child will not work because the workstation will still be too high, says Bautch.

The ergonomics of the workstation are not the only problem when children use computers. Often, they spend too much time surfing the Internet or playing computer games. "Sitting in one position and not moving around causes back problems and joint development problems," says Bautch. Parents need to set computer time limits for their children and also make sure that children schedule time to move around.

Rather than let children develop bad habits when it comes to the use of backpacks and computers, he advises that adults teach them the proper way to use these tools in the first place. ■

SOURCE

For more information about teaching children how to safely use backpacks and computers, contact:

- **Scott Bautch**, DC, President of the Occupational Health Council, American Chiropractic Association, 1701 Clarendon Blvd., Arlington, VA 22209. Telephone: (800) 986-4636. Web site: www.amerchiro.org.

Educational program focuses on cardiac patients

Checklist follows patient

To address the needs of 35% of its pediatric patients who have heart problems and its cardiac surgeons, Phoenix Children's Hospital created a comprehensive cardiac program. Education is a key part of this program.

Teaching begins by providing families with a drawing of a normal heart and another of their child's heart to help them understand the defect. "At some point, they are given a picture of how we have corrected it with the surgery as well," says **Vina Holloway**, BSN, RN, manager of the pediatric intensive care unit (ICU) and manager of the Children's Heart Center at Phoenix Children's Hospital. Parents also are connected with the hospital's learning center where they can obtain detailed information.

After the procedure, nurses follow a checklist for education beginning with basic information. Nurses use the checklist as a guideline tailoring the education to each family. For example, if the child is going to have a feeding tube at home, parents would receive information on that while other families would not. "Nurses may cover one thing one day, and five days later have to repeat it, but at least they have the checklist that shows what has been covered and how much comprehension there was," says Holloway.

When the children are transferred from the pediatric ICU to the general pediatric area the checklist goes with them. At discharge, a copy is sent to the surgeon's office so staff know what teaching has been done. The teaching protocols were developed in conjunction with the cardiovascular surgeon to make sure that inpatient and outpatient education is the same.

Prior to the surgery, families are given a comprehensive hospital tour by the child life department when they come in for lab work. At that time, families meet some of the nurses they will be in contact with during their child's hospital stay. "We always have people available on the cardiac unit to explain to families what is going to happen and to answer all the questions they have," says Holloway.

Families also meet with a social worker who specializes in cardiac patients. At that time, arrangements for any special needs they may have are made. If families are traveling to the medical center from an outlying area, housing is arranged. Links to other families who have gone through the experience and can give support also are made if the family wants the connection. Cab vouchers are given if needed. "We do anything to ease the stress the first few days," explains Holloway.

All nurses who come in contact with the children are educated about the heart defects and how to handle the children and the parents pre-operatively, post-operatively, and to prepare them for discharge.

Multidisciplinary planning

The program was designed by a multidisciplinary group that included nutrition, respiratory, pharmacy, social work, child life, nursing, the medical and nursing directors of the pediatric ICU, a cardiac surgeon, and a parent of a cardiac patient. As the group developed objectives, people were pulled in to help them meet the goals set. For example, the group worked with the education department when it saw the need for more intense education for the nurses who come in contact with cardiac patients.

When the group is working on special projects, it meets twice a month; otherwise, regular meetings are held monthly. Families are given surveys to determine what they liked and disliked about the program to promote ongoing improvement. A patient and family support group run by child life, and social work is provides the committee feedback.

Because families have a great deal of anxiety before their child's surgery, it is difficult to do much teaching ahead of time. Therefore, a handout was developed with information that families will need to know when they go home. Often, parents ask the same questions over and over or have a blank look on their faces during educational sessions because they are so overwhelmed, says Holloway. Therefore, nurses are encouraged to start education as soon as possible and constantly review what has already been covered. ■

SOURCE

For more information about the comprehensive cardiac program at Phoenix Children's Hospital, contact:

- **Vina Holloway**, BSN, RN, Manager, Pediatric Intensive Care Unit/Manager Children's Heart Center at Phoenix Children's Hospital, Phoenix Children's Hospital, 1111 E. McDowell Road, Phoenix, AZ 85006. Telephone: (602) 239-3949.