AMERICAN HEALTH CONSULTANTS

Patient Education Management™

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

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IN THIS ISSUE

The dynamic duo of technology and care coordinators improves patient outcomes
At a network of Veterans Affairs health care facilities, many patients classified as high use, high risk, and high cost have been incorporated into a program that combines technology with care coordination. The technology and care coordinator are specific to each patient's health care needs and provide home monitoring and guidance to help patients learn better self-care . . . . . cover

Assessment, the foundation of good teaching
For effective teaching, patients must be assessed for their readiness to learn, barriers to learning, and learning needs. Often, details come out in conversation, prompted by open-ended questions. For example, patients and their families frequently provide information about lifestyle habits that help pinpoint learning needs. 40

Shortened LOS proves beneficial to teaching
While shortened hospital stays often make teaching in the inpatient setting difficult to complete, patients coming in for surgery might benefit from learning the steps that make for a better recovery in advance so they can begin putting them into practice. At Sacred Heart Medical Center in Spokane, WA, pre-op teaching for total-hip and total-knee patients helps them recover faster following surgery 42

Educational resources they can't refuse
Many patient education managers spend a great deal of time assembling and cataloging patient education materials for staff use. Yet, harried staff don't always use the information at hand

In This Issue **continued on next page**

Dynamic duo of technology and care coordinators improves patient outcomes

Coordinated care targets patients at risk

Some high-risk, high-use, high-cost patients within the VISN (Veterans Integrated Service Network) 8 Veteran Affairs (VA) medical system are using technology to better control their disease from home. With a dialogue box, or "buddy system," they answer a set of questions each day specific to their disease or multiple disease state to help them manage symptoms and learn better self-care techniques.

For example, overweight, diabetic patients might be asked if they weighed that day. If they push the "yes" button, the box would ask them to indicate their weight range. The collected data go into a web-based site where a care coordinator at a medical

EXECUTIVE SUMMARY

In an effort to learn best practices for home monitoring and care coordination of high-use, high-risk, and high-cost patients within VISN 8 health care system, a call for proposals was sent out. As a result, 24 ideas for demonstration programs came in and eight were selected to trial. All eight were successful at reducing use of medical resources and improving patients' health status, and are being implemented throughout the system.

In This Issue **continued from page 37**

when they teach the patient about a condition, procedure, or treatment even though they would greatly enhance the lesson. To make sure resources are being used, many facilities are placing materials on the intranet, assembling catalogues for quick reference, and conducting chart audits to uncover instances of underuse 43

Standardized formats for health screening
To help standardize screening methods and interpretation of results, staff at Martha Jefferson Hospital in Charlottesville, VA, created health-screening forms. These forms not only standardize the process; they provide information on health issues that should be targeted at the health care facility . . . 44

Pet therapy does more than break routine
Having a dog visit a patient seems like a nice social activity, something to break the routine, but health care facilities with a pet therapy program find the visits much more valuable. They can be used for physical therapy, such as having stroke victims pet the animal from their weakened side. They can also help patients with psychological disorders 46

Focus on Pediatrics **insert**

Child's signs of depression often differ from adults
The National Mental Health Association in Alexandria, VA, estimates that one-third of the children suffering from depression in the United States are never diagnosed and treated. Yet, childhood depression can lead to suicide and severe depression as an adult. That's why the organization has designated May 7 as Childhood Depression Awareness Day . . 1

Colposcope documents exam in child sexual abuse
Easing the trauma of physical exams for sexually abused children is the goal of many centers that provide these examinations. Using the colposcope helps to document exams, but does not always provide the evidence needed to keep children out of court 2

Inserted in this issue

— 2002 Reader Survey
— Health-screening forms
— Sample of hospital policy for pet therapy

COMING IN FUTURE ISSUES

■ Joint Commission's recent survey strategy on patient education

■ Teaching parents how to be safety seat-savvy

■ Specialty service providing health care information for travelers

■ Creating web sites to educate children

center can access and evaluate the information. The computer tags the answers with a green, yellow, or red flag. Red indicates a potentially serious problem, prompting the care coordinator to contact the patient; and if action is warranted, the patient's health care provider is notified.

More than 90% of the patients using the dialogue box feel more educated and knowledgeable about their disease state than they did prior to the use of this care coordination and technology approach, says **Marlis Meyer**, MA, program director for VISN 8 Community Care Coordination Services in Lake City, FL.

This and four other types of technology were up and running by June 2000 on a trial basis. Its purpose is to coordinate the care of patients with complex health problems, assess their condition at home, and intervene early in medical problems. "The technology gives us feedback on a regular basis in a way that we did not have before. By intervening earlier, we can make a difference in the quality of the patients' lives and in the use of medical resources," says Meyer.

The outcomes based on results from patients who have been in the system one year have been impressive. There has been a great improvement in patients' functional ability, which helps them stay independent longer. Patients with diabetes have reduced their hemoglobin A_{1C} level by 1.26 units, which is a significant reduction for this population and improves their medical condition. Blood pressure levels have also improved. More than 90% of the patients found the technology easy to use and about that same amount were highly satisfied.

The care coordination has also reduced the use of medical center resources. Consider the following outcomes:

- Hospital admissions dropped 63%.
- Emergency department visits dropped 40%.
- Surgeries dropped 64%.
- Prescriptions dropped 67%.

"These patients developed a better understanding of what medications they are taking and why. Therefore, they are better able to manage their medication regimen," reports Meyer.

The model combines care coordination with various technologies aimed at specific high-cost patients who generally cost the system $25,000 or more in prior years. It was first developed in 1998; and in 1999, requests for proposals within VISN 8 were issued, which include VA facilities in South Georgia, Florida, Puerto Rico, and the Virgin Islands.

Eight demonstration projects were selected that would best test care coordination and care management principles and the use of new technologies to assist in monitoring patients in their home. "[We had not seen] the combination of what we were doing we had not seen anywhere else — especially in the magnitude that we were doing it," says Meyer. They wanted to test the principles, see what would work best, and establish best practices, she explains.

In the beginning, care coordinators would review computer generated listings of high-cost patients and determine which patients matched their selection criteria. They would then contact the primary care provider and suggest that the patient become part of the program. If the physician agreed, then the patient was invited to participate. Now, providers refer and patients self-refer; if they meet the criteria, the patients become part of the program. Currently, there are close to 1,300 patients involved.

Different technologies for different needs

"We never believed that one size would fit all and felt very strongly that we needed to match the technology to the medical needs as well as the patient's needs," says Meyer. To help meet the patients' needs, the technology is simple and easy to use. Simplicity also makes for fewer difficulties once the technology is placed in the home, and there is less frustration as a result, she says.

One piece of equipment, a Polaroid-style camera, is used in the diabetes limb wound care program. Typically, diabetic patients with open wounds that aren't healing properly eventually must have the limb amputated. Also, they must frequently travel to the clinic to have their wound checked by their provider. Now they are taught to take photos of the wound and send them to their care coordinator (a wound care specialist) on a weekly basis in preaddressed envelopes via mail. If the wound is not healing properly, the care coordinator contacts the patient to see if the treatment protocol needs to be changed.

"We have reduced the time it takes for the wound to heal. Traditionally, it took from three to six months on average; now it takes from four to six weeks, and that is a big difference," says Meyer.

One of the reasons for the significant difference in healing time is that the patients begin to understand what the wounds look like when they are healing after discussing the pictures with their care coordinator. "They realize the wound doesn't look right sooner than they did before," she says.

A videophone is used to help educate patients with chronic disease in order to improve their self-care skills. For example, patients with chronic obstructive pulmonary disease are shown how to correctly use an inhaler if the care coordinator sees that the patient is using it incorrectly when demonstrated on the videophone. "With the videophone, care coordinators are trying to train and teach people how to use whatever device they need to use in order to follow their treatment plan," says Meyer.

This piece of technology also is used with the mental health population. While medical feedback on their condition is not important to the care coordinator, their emotional responses often are. "With the mental health group, seeing a patient's facial expressions is beneficial," says Meyer.

A video monitoring system has different types of medical monitoring capabilities, such as measuring blood pressures, as well as viewing capabilities. It is used less than the other instruments because it costs the most. However, the system is often placed in assisted-living facilities where several patients can make use of the system to maximize its use. With the visualization capabilities, care coordinators can make sure that patients are doing the monitoring correctly.

For example, if a patient's blood pressure readings don't look right, the care coordinator can watch to determine if he or she is putting the cuff on correctly or making another mistake. This technology has reduced hospitalization for this group of patients in an assisted-living setting by 67%.

Computers are used to connect mental health patients with each other as well as their care coordinator. Supervised chat rooms on the Internet with each patient connected by a camera and speaker so he or she can hear and see each other provide the connection. E-mail keeps care coordinators connected to the patients and up to date on their emotional state.

This technology works well for patients suffering from post-traumatic stress syndrome because they prefer not to be in closed settings with other

SOURCE

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people and therefore find it difficult to come to the clinic for treatment, says Meyer. Consequently, the patient's condition can escalate into critical mode, which could require hospitalization.

The e-mail contact helps those patients avoid acute episodes. For example, a patient was given new medications during a routine visit to the psychiatrist and started taking them when he got home. They soon made him agitated, so he e-mailed his care coordinator, who immediately contacted him. Once the issues were discussed, the care coordinator contacted the psychiatrist, who immediately changed the prescription and mailed it out to the patient.

For educational purposes, a series of mental illness informational web sites have been created for the mental health group.

As new technology is introduced, VISN 8 Community Care Coordination Services will explore these capabilities to continue improving patient care and help care coordinators work more efficiently as well as maximize use of existing resources. The program never was designed to replace the existing system or duplicate services but rather fill a gap. Care coordinators are not providers; they just make that patient to provider connection when needed without the clinic visit or hospitalization. Care coordinators are nurse practitioners, RNs, or social workers. Frequently, a nurse practitioner and social worker will work in tandem with patients to provide social as well as medical or mental health needs, says Meyer.

While this method of providing health care by combining technology with the oversight of care coordinators may not be appropriate for the entire health care system, it does work for a specific group of patients. "We believe there is a real role in health care for this way of managing patients. It keeps patients in the home, doesn't require as much structure or overhead as traditional care, is safer, and improves the patient's functional ability," says Meyer. ■

Assessment, the foundation of good teaching

Address barriers, personal needs for education

No matter the health care setting, good learning assessment techniques are essential because there's no time for a lengthy, involved assessment, says **Kathleen Fitzgerald**, MS, RN, CDE, a patient educator at Saint Joseph's Hospital Health Center in Syracuse, NY.

In addition, a good assessment will uncover whether the patient is motivated to learn, the barriers to learning, and what the patient needs to know, helping to keep teaching sessions on target. In the long run, this saves time, explains **Yvonne Brookes**, RN, patient education liaison at Baptist Health Systems of South Florida in Miami.

One of the first questions Brookes asks a patient who has been admitted to the hospital is: "What brought you here?" It not only helps develop rapport between patients and their teachers, but it can reveal their attitude about the situation and provide clues to whether they are motivated to learn. They may have been admitted because they were noncompliant, yet their answer reveals they take no responsibility for what has happened to them, or seem disinterested or angry, all of which indicates lack of motivation.

There are some key questions that can be asked to determine how motivated the patient is to learn, says Brookes. These include:

- What do you think has caused your problem?
- What do you think your illness will do to you?
- What kinds of treatment are you going to receive or would you like to receive?
- What are the most important results you hope to receive from your treatment?

"If they answer these questions, you know they will be motivated. They are like triggers to see how involved the patient is going to be," says Brookes.

When patients start asking the instructor questions during the assessment process, they are ready to learn, says **Teresa Towne**, RN, MSN, an inpatient educator at Bayhealth Medical Center in Dover, DE. Body language also is an indicator. If

EXECUTIVE SUMMARY

Last month, *Patient Education Management* asked experts what the components of good teaching were to launch an article series on how to teach staff to educate patients. In this issue, we examine the learning assessment in detail, discussing the best techniques for assessing readiness to learn and learning needs. We also cover barriers to learning and how to assess for them. Next month, we'll offer tips on how educators can evaluate the effectiveness of their teaching.

Stages of Change Theory

The Prochaska and DiClemente Stages of Change Theory[1] states that people go through five stages when making a change in behavior. The stages range from pre-contemplative with no plans to change to a maintenance stage where the person practices the desired behavior consistently. They include:

- **Pre-contemplation:** Not even thinking about change. People might be motivated to change by increasing their awareness of the problem behavior and providing information.
- **Contemplation:** Starting to think about a change. Ambivalence might be decreased by identifying pros and cons of change and giving patients support.
- **Preparation:** Planning for change, thinking of ways to change. Educators can identify rewards and help make action plans.
- **Action:** Actually making the change. To bring about change educators can help patients set short-term goals and provide support. Educators also can help patients solve problems as they arise.
- **Maintenance:** Continuing new behaviors, recovering from relapse. These patients need continued support, help with problem solving and recovery from lapses.

Reference

1. Prochaska J, Norcross J, DiClemente C. *Changing for Good: A Revolutionary Six-Stage Program for Overcoming Bad Habits and Moving Your Life Positively Forward.* New York City: Avon Books; 1994. ■

they are fidgety or look away a lot, it probably isn't the best time to teach, she says.

In the outpatient setting, patients usually are referred to educators by their physician to learn a particular skill or technique for managing a chronic illness or for disease prevention. At that time, it is important to be up front with the patients and ask if they are willing to learn, says Fitzgerald.

When patients say they are receptive to learning, she verbally verifies what they are agreeing to learn, such as giving insulin. Fitzgerald then observes their actions to see if they follow through. Often, it's a matter of helping them reduce barriers to learning, she says.

When people say they are willing to learn, yet seem to avoid the teaching or practicing the skill, Fitzgerald will ask them to tell her what is getting in the way to determine what they perceive as barriers. In the case of learning to use insulin, the process may be frightening to them. "Once I know that they are willing but scared, we can make a plan," she says.

Barriers inhibit learning readiness

Uncovering the barriers to learning is extremely important. Fitzgerald finds Prochaska's Stages of Change Theory very helpful when determining a patient's readiness to make a life change. The theory contends that there are stages of readiness that include pre-contemplation, contemplation, preparation, and action, and that change is a process that happens over time.

If a person is at the pre-contemplation stage and not even thinking about change, the educator might make the best use of time by helping the patient examine why he or she won't make a behavior change. In that way, the patient may move to the next stage when he or she begins to think about change. For example, if a smoker is not ready to quit, an educator can help him or her explore the reasons he or she isn't ready to stop.

"If the person is contemplating change, I can help them examine the pros and cons and remove some of those barriers so that the pros outweigh the cons. Often that helps us move forward much faster, says Fitzgerald. **(For information on this theory, see article, above left.)**

When patients are receptive to learning and barriers have been taken into account, the patient's learning needs can be met. Brookes cautions educators not to ask a lot of specific questions to

SOURCES

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identify barriers because they will surface during the general assessment. For example, if a patient has a family member interpret the conversation or has difficulty communicating in English there is a language barrier.

"Briefly look at the patient's story and determine what he or she needs to learn," says Brookes. It often helps to have family members provide a few details about a patient's typical behavior, responses, and daily living patterns.

It's important to keep in mind the goals of patient and family education, which is for the patient to be able to make informed decisions, develop basic self-care skills, recognize problems, and have their questions answered. "We aren't there to give a lecture, we want to meet the main goals of patient and family education whether in an inpatient or outpatient setting," says Brookes.

Part of the learning assessment at Bayhealth Medical Center includes asking the patients what they already know about their condition, then determining what it is they need to learn during their hospitalization. It also includes finding out the method of teaching best suited to the patient, says Towne. This can be done by naming several teaching methods, such as one-on-one instruction, audiovisual, written instruction, or group classes.

"If someone is an audiovisual learner, we have a research library where staff can check out videos, and we also have closed-circuit TV where videos can be viewed throughout the day," says Towne.

To determine the best method for teaching patients, have them think back to a time when they had to learn something and consider how they went about learning it, advises Brookes. In that way, patients can pinpoint the best method for teaching.

When patients have a lot to learn and a lot of lifestyle changes to make, it often helps to break the teaching down into manageable pieces while keeping the main goal in mind, says Fitzgerald. Also, it's important to provide equipment, a class, or support that will help make the changes easier. ■

Shortened LOS proves beneficial to teaching

Classes make system more efficient

As length of hospital stay for total-hip and total-knee surgery got shorter and shorter, there was no longer enough time to provide all the necessary education on the inpatient setting at Sacred Heart Medical Center in Spokane, WA. As a curriculum for outpatient teaching was developed, however, it became evident that some information delivered in advance could make for a better recovery.

To have any results from pre-op strengthening exercises, patients must learn and perform them several weeks in advance, explains **Kristine Becker**, RN, MHA, ONC, director of orthopedics at Sacred Heart. Also, it's better for patients to learn how to adapt their home so they have gotten rid of throw rugs and installed handrails where necessary and can be discharged to a safe environment.

During a two-year study, Becker discovered that total-hip surgery patients who attended the class were discharged a half-day sooner than those who did not. Also, 70% of those patients went home rather than to an interim facility, while only 54% of patients who did not attend the total hip class were able to go home after their discharge. Total-knee surgery patients attending the class had a 0.4 day shorter discharge than those who did not, which was close to half a day.

Staff on the units prefer to be assigned to patients who attend the class because they participate more fully in their recovery process, says Becker. In class, patients are given a rundown of what happens on the day of surgery from where they park when they arrive at the hospital to the sights and sounds they might expect when they awake following surgery. They also are told about the role they have in their care, such as communicating to the care team about pain so it can be effectively managed.

Physical therapy teaches patients pre-op strengthening exercises and about the precautions they need to take during their recovery process. All the information taught in the class also is given to patients in a three-ring binder and they are asked to bring it with them to the hospital. "We distributed these booklets throughout the continuum, so everyone is talking from the same booklet," says Becker. That includes the surgeon's office, home health, and the nursing homes.

For patients who have been to a class, much of the inpatient teaching is review. Also, they are in a better position to ask good questions because they have been thinking about the information they have been given, says Becker. Yet teaching during the hospital stay is tailored to meet the

SOURCE

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needs of every patient. For example, if patients have a lot of stairs in their home, the staff will work with them on climbing stairs.

Becoming better with time

There are some hospitals that cancel the surgery if patients don't attend the pre-op class, but Sacred Heart Medical Center is not one of them, says Becker. Instead, the orthopedic department has worked hard at trying to get patients to the class in a timely manner before surgery. At first, the scheduler at the surgeon's office was asked to do it, but time constraints caused the patients to fall through the cracks.

The orthopedic department took over the process. When a patient is scheduled for surgery, his or her name, address, and phone number is placed in the internal data system. This contact information is used to send a letter four weeks prior to their surgery letting the patient know a place in the class was reserved for him or her.

"We let them know their surgeon recommends they attend the class and that and other patients have found it very valuable. We ask them to call and confirm so we can put them on the valet parking list," says Becker.

How successful this method will be has yet to be determined because it was recently implemented. The prior method of telephoning patients was not successful because they often could not be reached, or when they returned the call the appropriate person in the orthopedic department was not available. Patients who miss the reserved class are given a call to see if they can be scheduled for a class at another date.

The total hip surgery class lasts about 1½ hours on Mondays while the total knee surgery class held on Tuesdays lasts about an hour. "It is free to the patient and is time-efficient. We have arranged free valet parking for convenience," says Becker. The class helps decrease the anxiety patients often have prior to surgery, she says.

Another challenge has been reaching patients who live 40-100 miles away and don't want to drive to Spokane for the class. Sacred Heart Medical Center produced a total knee surgery video to support patients in outlying areas. While it follows the content of the notebook, it is best for people to be in the class interacting with other patients who might have questions they had not thought of yet.

In the future, Becker hopes to be able to use interactive technology to connect patients in remote areas with the teachers and students in the classroom at Sacred Heart so that they can participate in the classes. ■

Reader Question

Educational resources they can't refuse

Provide easy access along with inventory list

Question: "How do you alert staff across the continuum of care to the patient education resources your health care facility has available and, more importantly, how do you get them to use those resources? What problems have you had in the past with lack of use, and what specifically have you done to overcome those problems? What problems are you now having in getting staff to make use of the resources available and what are you doing to address them?"

Answer: Like many health care facilities, Hamot Medical Center in Erie, PA, is in the process of placing its patient education materials on-line so staff will have easy access to it via an intranet site. This should make it easier for staff in all patient areas to access materials and ensure that the most current copy is in use. Also, the use of the intranet should provide savings in costs related to copying, storage, and distribution, says **Barbara Magee**, BSN, RN, patient education coordinator.

"In the past, we listed our educational materials on the computer system and placed copies of appropriate topics in hanging files on patient education carts in each department," explains Magee. However, the cart has proven to be inconvenient. When staff members need materials for teaching, the cart is often down the hall or in the conference room; they don't take the time to go find it. If they do take the time, in their haste, materials often are scattered and misplaced.

SOURCE

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In addition, each time patient education materials are revised, the new editions must be added to the cart and the old copies removed. Many outpatient areas only have room for a small selection of materials because of limited storage space.

While staff aren't able to download patient education materials from the intranet at Southeast Missouri Hospital in Cape Girardeau, they can access a database that lists all educational resources, including booklets, videos, and hospital-produced handouts. Staff learn about new materials approved for use from their department's patient education committee representative. Each department keeps an inventory of the approved materials they routinely use. "We feel accessibility to materials is the key to staff utilization," explains **Gwen Thoma**, EdD, RN, CNA, director of educational services.

To increase use of educational materials, chart audits are conducted twice a year during patient education committee meetings. "This gives the group a better realization of underutilization and makes them aware of the materials they might have used," says Thoma.

The learning center, which is part of the staff and patient education department at The Medical Center of Central Georgia in Macon, provides a centralized location for patient and family educational resources in all clinical areas. To make sure staff are aware of these resources, a patient education catalog is issued continuumwide yearly and also posted on the intranet, says **Clarissa Mercer**, RN, patient education coordinator. Educational resources and their access during and after learning center hours are also discussed at monthly nursing orientation and leadership meetings. Reminders about available resources are periodically sent to leadership such as directors, assistant directors, and department-based educators.

"We try to encourage staff use of the resources by accepting telephone and e-mail material requests and delivering materials to patient care areas when time permits," says Mercer. In addition, the department selects educational materials to support the institutions clinical pathways and develops population appropriate materials.

A Health Resource Center, which is open to the public, further supports the educational efforts of the staff by providing books, videos, audio tapes, journals, and reviewed web links directly to patients and their families. A new program, Library on Wheels, will bring resource materials directly into inpatient areas, such as the intensive care waiting room, the birthing center, and the cancer floor, says Mercer. ■

Standardized formats for health screenings

Programs increase awareness and prevention

By **Pamela Holden**, RN
Community Educator
Susan Winslow, RN, MSN, CNS
Director, Community Services
Martha Jefferson Hospital, Charlottesville, VA

Many hospitals, as part of their community outreach, conduct multiple health fairs and screenings. For nonprofit organizations, these special events provide an ideal opportunity to promote new services, conduct health education and establish positive outreach. They may consist of a single activity or a whole host of interventions at events such as an annual health fair.

People are naturally drawn to health fairs. They want to know "the numbers" that affect their lives. Health fairs are a valuable method to reach large numbers of individuals at one time.

Martha Jefferson Hospital is a top-100, nonprofit, community hospital located in central Virginia. As part of its commitment to community service, a number of health screening programs are offered throughout the year. These programs were created to help educate the public on health awareness and prevention, as well as

SOURCES

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provide on site screenings to assist in early detection. These health screenings also assist in identifying specific health care concerns and high-risk criteria that need to be addressed. The screening results help the hospital serve the community more efficiently and effectively.

Due to practitioner variability in screening result interpretation, inconsistency in clinical advice, and participant interest in receiving written results, the hospital instituted a process of standardizing the format for all community health screenings.

The need for the standardized health screening form was threefold: it assisted the department in improving educational strategies on risk behaviors; reduced the variance of individual practitioner interpretation; and incorporated recent patient confidentiality concerns. Each screening form has an area for demographic data, risk factor identification, results, and recommendations. A liability statement at the bottom of each form addresses the purpose of the screening, and the importance of the patient's responsibility for initiating any follow-up exams or treatments that may be necessary. **(See examples of the form inserted in this issue.)**

The process for creating the forms took approximately six months. Initially, information was gathered from the following sources: National Cancer Institute in Bethesda, MD; American Cancer Society in Atlanta; National Quality Advisory Committee in Salt Lake City; American College of Preventive Medicine in Washington, DC; Agency for Healthcare Research and Quality in Rockville, MD; Center for Disease Control and Prevention in Atlanta; National Breast Cancer Coalition in Washington, DC; American Academy of Dermatology in Schaumberg, IL; American Urological Association in Baltimore; American Diabetes Association in Alexandria, VA; American Heart Association in Dallas; National Heart, Lung and Institute in Bethesda, MD; and the National Osteoporosis Foundation in Washington, DC.

No specific criteria or standardization for screening forms was discovered. There were recommendations regarding who needs to be screened and how the screening is to be conducted, but apparently no specific information on form content or standards exists.

As a result of this investigation, the department of community services at Martha Jefferson Hospital decided to create its own standardized hospital screening forms. The committee drafted forms for each common screening activity, for a total of eight forms. These included clinical breast exams, skin cancer, prostate cancer, diabetes, bone density, peripheral vascular disease, blood pressure, and heart rhythms.

A rough draft was created for each screening. The form was then sent to a specialty physician for review and editing. The breast, skin, and prostate forms were also sent to the director of the cancer care center. After revisions, the forms were sent to the medical director, and the medical staff committee for review and approval. Legal counsel reviewed the liability statement at the bottom of the form. The vice president of administration and human resources also reviewed the liability statement. Once final reviews were made, the forms were copied and made available for use.

The forms are used at each screening event conducted by Martha Jefferson staff, as well as any individual screening that may occur (for example, random walk-in blood pressure checks). Each health care provider and the patient fill out the form, with the original to the patient and a copy for filing. It was decided that each section head physician and the litigation staff would review the forms annually to make sure they were updated and current.

The health-screening forms have been useful in tracking patient health findings in a consistent manner, while preserving confidentiality of data. The forms also provide a standardized way of recording information for statistical use, and are a good way of tracking data that may indicate any trends, or provide risk behavior criteria.

The information derived from the forms provides summary statistical data that will provide information as to what areas and health issues need to be explored and targeted in the future at other health screening events. These forms also are utilized by the hospital as an important documentation tool that helps address the liability issue involved in health screening events. The standardized health screening forms have assisted the community services department in

Audio conferences target disasters, medical disclosure

Have you missed one of American Health Consultants' (AHC) recent audio conferences? If so, two upcoming conference replays offer another opportunity to take advantage of excellent continuing education opportunities for your entire facility.

• **Disaster Response at Ground Zero: How NYU Downtown Hospital Handled Mass Casualties With All Systems Down**, originally held on Jan. 10, takes participants to the heart of the World Trade Center disaster on Sept. 11. Just a few blocks away from the crash site, NYU Downtown was cut off from crucial lifesaving supplies and power, even as hundreds of injured came through the ED doors. HazMat teams on the roof of the hospital had to vacuum all of the debris out of air ducts to maintain air quality and keep generators running. Physicians and nurses had to balance urgent care with proper documentation. Learn how to prepare your facility for the unthinkable. The replay will be available from 8:30 a.m. on Tuesday, April 16, to 5:30 p.m. on Wednesday, April 17. Current AHC subscribers pay $249, which includes free CME and CE credit. The cost is $299 for non-subscribers.

On April 23 and 24, **What to Say When Something Goes Wrong: Do the Right Thing When Trouble Strikes** also will be available for replay. This successful audio conference covers the major fear factors clinicians experience when confronting issues of medical disclosure. Learn benefits for patient and provider, as well as the risks of litigation and how to avoid costly legal battles. Free CE for your entire facility is included in the $249 fee for AHC subscribers.

To register for either one of these replays, contact American Health Consultants' customer service department at (800) 688-2421 or customerservice @ahcpub.com. ■

logging and tracking data and keeping this important information on file.

(Editor's note: Special thanks to Hallie Hegemier, MEd, business health specialist, who assisted with this project.) ■

Pet therapy does more than break routine

Visits help with psychiatric and therapeutic issues

When a program to evaluate geriatric patients with dementia was established on the behavioral health unit at Wausau (WI) Hospital, one of the problems the organizers had was to find enough therapies for cognitively compromised patients. Research uncovered such activities as reading the newspaper, showing pictures of old appliances, and showing historical pictures of people, places, and events.

These therapies worked quite well, but staff still were hard-pressed to come up with more activities. Then a consultant suggested pet therapy explaining that it worked well with geriatric patients. That's when staff logged onto the Internet and got information on the Flanders, NJ-based Therapy Dogs International and successfully implemented a pet therapy program, says **Chris Zaglifa**, MSW, CICSW, CADC, social worker and alcohol and drug counselor with Family Counseling Services in Wausau, WI. Zaglifa is a former employee of Wausau Hospital who helped implement the pet therapy program. **(For contact information for Therapy Dogs International, see source list, p. 47.)**

Having owners bring dogs trained to make hospital visits geriatric patients' rooms triggered long-term memory and proved to be a good reminiscing tool. The elderly would mourn the loss of their pets and jump from that association to the loss of important people in their lives and the loss of their mobility and functioning as they grieved. "I was especially impressed with the communication. People who could barely babble would begin talking, and you could see the joy in their face," says Zaglifa.

After pet therapy proved to be beneficial to geriatric patients, it was implemented on the psychiatric unit, in hospice, and then in rehabilitation as well. While the therapy dog is licensed to bring comfort to patients who are hospitalized and to make them feel better for at least a short while, the dogs can be used as a part of therapy, says Zaglifa. For example, a woman who was blinded as a result of a traumatic brain injury used a visit from one of the dogs to practice identifying things by touch. She would identify the dog's nose, ear, and tail.

One woman on the psychiatric unit suffered from depression and would not participate in any activities so her psychiatrist asked that a therapy

SOURCES

For more information about creating a pet therapy program, contact:

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- **Therapy Dogs International,** 88 Bartley Rd., Flanders, NJ 07836. Telephone: (973) 252-9800. E-mail: tdi@gti.net. Web: www.tdi-dog.org.

dog visit her. "She played with the dog and began talking about the pets she had in her life," says Zaglifa. The next day, she went for a walk with the dog and when she returned to the unit she went to the day room to watch football.

"Pet therapy reinforces the efforts the hospital makes to meet the needs of the patient. Not just in providing medical and clinical care, but the overall well-being of the patient. I think a therapy dog does that easily, it is a natural fit," says Zaglifa.

When the therapy dogs are scheduled to make a visit at New Mexico Veterans Affairs (VA) Health Care System in Albuquerque, the volunteers are given a list of clients submitted by the physical therapist or psychiatrist who works with the patients. Currently, a team of seven volunteers visits the VA four times a month, seeing patients on the spinal cord injury unit and rehabilitation unit during one visit. The volunteers then visit the patients on the restorative care unit and psychiatric unit next time, says **Michelle McKenzie**, MA, a therapeutic recreation specialist with the VA physical medicine and rehabilitation service and a pet therapy volunteer.

"The visits are scheduled in the evenings and on weekends because the volunteers are more accessible at that time and the patients are in other therapies during the day that would create a conflict," explains McKenzie, who oversees the visits and makes note of the patient's response. Part of the visit is social, but frequently there is a goal approach. For example, to help one patient who had a stroke, the volunteer was asked to approach from the left side so the patient would look to the left and try to pet the dog with his left hand, thus strengthening his weaker side.

To ensure that the dogs will be well behaved while in the health care facility, they are well trained and certified by a dog therapy group. Dogs are screened to make sure they are in good health and have an up-to-date veterinary record. They are also tested, says Zaglifa.

For example, the dogs are taken into a large room where people are walking around on crutches, with walkers, or in wheel chairs, and the handler will have the dog greet someone using an assistive device. While the dog is being petted, someone will go up behind the dog and drop a metal pan on the floor to see how the dog reacts. Dogs can attend special obedience classes in preparation. Dog handlers have a set of ground rules on how they are to conduct themselves, says Zaglifa.

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CE Questions

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

13. The combination of technology and care coordination improved outcomes for high-use, high-risk, and high-cost patients at the Veterans Affairs medical centers within VISN 8 for which of the following reasons?
A. Patients had frequent evaluation.
B. They learned better self-care techniques.
C. There was early intervention on medical problems.
D. All of the above

14. Asking patients why they were hospitalized can often provide clues to their motivation to learn and is a good learning assessment technique.
A. True
B. False

15. Sacred Heart Medical Center in Spokane, WA, found that some information delivered in advance to total hip and total knew surgery patients could make for a better recovery. Which of the following lessons is more beneficial before hospitalization?
A. Strengthening exercises
B. Tips to make the home safe following surgery
C. Menu choices during hospitalization
D. A & B

16. The signs and symptoms of childhood depression differ from adults. Which of the following symptoms indicate that the child may be depressed?
A. Aggressive behavior
B. Radical change in behavior
C. Physical complaints such as a stomach ache
D. All of the above

(To review the pet therapy policy at Wausau Hospital, see special insert in this issue.)

Therapy dogs at the VA medical center are not allowed in certain areas, such as sterile areas or where drugs are distributed. Volunteers are trained to read the signage and learn handwashing techniques because they are going from patient to patient, says McKenzie.

"There are so many different therapeutic values to pet therapy, but for the most part, you are hospitalized for a reason and it is not a good one so this gives patients some relief," says Zaglifa. ■

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. ■