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Patient Education Management™

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

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IN THIS ISSUE

In This Issue **continued on next page**

JCAHO asks: 'Is your patient education thorough?'

Documentation, interviews, materials are proof

Don't expect the same old survey when the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), in Oakbrook Terrace, IL, pays you a visit. Patient education managers are telling their colleagues to prepare for more staff and patient interviews and expect surveyors to look for evidence of patient teaching in a variety of places.

In a survey, there are many ways to determine if patient education standards are being met, according to **Carol Mooney**, RN, MSN, associate director for JCAHO's standards interpretation group.

To evaluate patient education efforts at a health

EXECUTIVE SUMMARY

Forget what the survey by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) was like in the past, say patient education managers who recently have been surveyed. There will be no formal interview of the patient education committee. Instead, surveyors will seek out rank-and-file employees to determine if they know the process of educating a patient and if the policies and procedures are being followed. In this issue of *Patient Education Management*, we talked to managers who recently went through the survey process to see what advice they might have for preparing for a JCAHO survey.

In This Issue **continued from cover page**

COMING IN FUTURE ISSUES

- The pros and cons of using one form for documentation
- Tailoring education to culturally specific groups
- Group appointments, a wave of the future?
- Incorporating herbal instruction into medication teaching
- The pros and cons of answering the call for conference presentations

care facility, surveyors look at educational materials, signs, and other informational items posted to educate the patient, medical records, physician progress notes, policy and procedure, and patient rights and responsibilities. Also, they interview patients and staff to validate that the process is followed.

Cross-checking provides a clear picture. There may be documentation of interdisciplinary communication and teamwork on patient education, but an interview with a patient or staff member may contradict what was written, says Mooney. Surveyors may find evidence in other areas, indicating the standard is not being met.

How do health care institutions reveal evidence of patient education in all the areas a surveyor might scrutinize? To find out, *Patient Education Management* asked several who were recently surveyed.

Interviews with staff involved in the day-to-day care provide a lot of information. That is why it is important for patient education managers not only to make sure that policies and procedures for meeting patient education standards are in place, but that staff are aware of the policy and how the institution meets the standards, says **Karen Peterson**, RN, MSN, patient education coordinator at All Saints Healthcare in Racine, WI.

To make sure staff understood how they were meeting patient education standards in ambulatory care areas, Peterson educated them on the assessment and teaching process in that setting before the health care facility was surveyed in December 2001.

Patients fill out a history form that includes questions about cultural and educational issues. Physicians then provide the main patient assessment and record their education in the progress notes. "Before this education effort, if someone would have walked in and asked how we do patient education, staff probably would have given them a blank stare. I helped them understand how they were meeting the standards," says Peterson.

To educate staff throughout the institution, an employee handbook was published that highlighted areas of the chapters on patient education standards that were important for staff to know. Helping to define how staff met the standards was important, she adds.

Joint Commission surveyors interviewed patients and staff on more than 20 units at Jackson Health System in Miami. In preparation for anticipated interviews, the hospital gave employees tips on complying with the standards and included

questions and answers in the employee newsletter. They also did mock interviews every week for a year where an internal survey team asked staff questions based on the standards.

During the March 2002 Joint Commission survey, surveyors asked staff how they got patient education materials approved and what the process was, recalls **Sharon Sweeting**, MS, RD, LD, CDE, patient and family education coordinator at Jackson Health System. The staff preparation proved worth the effort because they knew that clinical educators distributed materials approved by the patient education committee to units, service areas, and clinics. They also knew that the hospital had many patient education materials on the Internet, and patients could access the information on their own, she reports.

At Southwest Washington Medical Center in Vancouver, surveyors asked staff if patients were asked about over-the-counter medication use including herbal medications and if patients were educated accordingly. They also asked how patient's pain was assessed when the patient was unable to speak or if he or she was an infant or small child, according to **Cindy Eling**, RN, **Donna Bashwiner**, RN, and **Christine Bolger**, RN, three nurses from the quality department that accompanied the JCAHO survey team in January.

In preparation, staff were trained to answer such questions about patient care and treatment during mock surveys. They also were required to complete chart audits so they could see what was expected and what was missing when documenting patient education, says **Mary Paeth**, MBA, RD, patient/community education coordinator at Southwest Washington Medical Center.

The education department also conducted chart audits and rewarded staff for documenting patient education. In addition, they used a *Jeopardy* game show-style format in a skills-fair setting to ask JCAHO questions and review answers. **(For information on using rewards to improve documentation, see *Patient Education Management*, May 2002, p. 57. To learn more about *Jeopardy*-style games to teach Joint Commission standards, see *PEM*, May 2002, p. 55.)**

The search for evidence

To conduct patient and family interviews at Jackson Health System, the surveyor met with the patient care team and asked them to present the case. The cases sometimes were selected by staff, and other times the surveyors randomly pulled charts. A frequent question asked of patients was: "Were you taught how to take care of yourself? And if you were, what was the most important thing you learned?"

While patient and staff interviews seem to be an important piece of the current survey process, remember that evidence of patient education must be found in many components. Therefore, the use of forms can provide evidence that standards are being met.

At Jackson Health System, the use of patient education protocols has helped to provide evidence of interdisciplinary team planning and documentation. The forms have educational content down the left of the page and resources for teaching across the top. The 54 diagnoses-specific forms were created for standardization to ensure that everyone covered the same information, says Sweeting. They have been well received by the Joint Commission.

A one-page interdisciplinary documentation form provides evidence of communication at Southwest Washington Medical Center, says Paeth. However, according to Mooney, while there must be evidence that there is interdisciplinary coordination and collaboration, documentation does not have to be on one form.

"Nursing might be the primary discipline over patient care, but there must be evidence that other disciplines are part of the education and nobody

SOURCES

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works in isolation," she explains. For example, if a registered dietitian instructs a patient, there needs to be evidence that the nurses caring for the patient know what the patient was taught.

"What we heard over and over is 'Where can I find the story of the patient?' They didn't say that we had to have a multidisciplinary form; they just asked to see the story of the patient," says Sweeting.

Because documentation was not in one place, the education department developed a new tab for education in the inpatient record where any forms that have education in the title are to be kept, including the education summary, patient education protocols, and clinical pathways with an education component. While the system had not yet been implemented at the time of the survey, the fact that it was ready to put into place satisfied the survey team.

Materials can be used as evidence of the education process as well. A handout at Jackson Health System shows the integration of patient safety with patient education. *Five Steps to Safer Health Care,* published by the Agency for Healthcare Research and Quality in Rockville, MD, is available for every patient. It includes such information as "Make sure you understand what will happen if you need surgery," and "Talk with your doctor about options."

The Patient Bill of Rights, written at a fourth- or fifth-grade literacy level, is posted throughout the hospital, says Sweeting.

A *TV Guide/Patient Handbook* at Southwest Washington Medical Center contains general information on patient safety and patient rights and responsibilities. "We use that as our general information. Specific information, based on patient condition and treatment, is handled individually," says Paeth.

It also is important to have evidence of real-life outcome measures to show the value of patient education, says Sweeting. When a surveyor asked her how she was able to justify patient education in terms of outcome measures, Sweeting was able to tell him about a diabetes self-management program the hospital created that was adopted as an HMO member benefit. "We showed them that we could decrease the amount of emergency department visits their clients would have if they went through the program. The surveyor wanted real-life outcome measures, not clinical academic measures," she says. ■

Reader Question

No need to scrimp when budget is tight

Managers offer innovative methods

Question: "When your budget is small, it is difficult to build a good variety of resources for patient education. How do you make sure staff have the tools they need to teach patients when your budget is tight? What have been some of your most innovative methods for inexpensively obtaining or creating patient education resources?"

Answer: Identify priority educational needs requiring materials, and focus on purchasing information on those first, advises **Annette Mercurio**, MPH, CHES, director of patient, family, and community education at City of Hope National Medical Center in Duarte, CA. To determine top needs, review data on the most common diagnoses at your health care facility, most common tests and procedures performed, and the results of patient and staff needs assessments.

Once the most pertinent educational needs have been pinpointed, review what is available on those topics and identify one or two of the best pieces to keep on hand. "Given that connecting patients with resources is what we love, patient educators sometimes adopt 'the-more-the-better' attitude regarding materials," Mercurio explains. However, purchasing several pamphlets to distribute on each topic can be expensive.

An inexpensive way to supplement materials on hand is to provide patients with a handout listing other print and on-line resources. In fact, the range of resources available to staff also can be expanded by helping patient care areas bookmark reliable web sites with educational materials that can be printed on demand. "While staff may be better supported with hard copies of materials that they frequently use, Internet-based resources can expand resource options for less commonly addressed topics," she says.

Building a patient education library can be difficult when you are a small, rural hospital (37 beds), says **Loretta Glaze**, RN, education/QI coordinator at Samaritan North Lincoln Hospital in Lincoln City, OR. To stay within budget, she looks for sources of free patient educational materials,

such as drug companies and national organizations. For example, insulin companies have pamphlets on diabetes, as does the Alexandria, VA-based American Diabetes Association. The Centers for Disease Control and Prevention in Atlanta has pamphlets on hepatitis B and C.

Grant money is another means for bolstering a meager patient education budget, says Glaze. She works with the hospital's public relations and foundation departments supplying information needed to secure a grant once they have done the legwork to find it.

While pharmaceutical companies are good resources for free materials, they always need to be screened for product bias. But there are lots of excellent materials that do not promote products, says Mercurio. In addition, pharmaceutical representatives also may be receptive to requests for unrestricted educational grants to support patient education efforts, including the purchase of materials, she says.

Print on demand

Asking for donations is a good idea, says **Laurel D. Spooner**, education coordinator for Winter Haven (FL) Hospital. When asked, the hospital's volunteer auxiliary donated funds to cover the cost of implementing Micromedex Carenotes, a software program that generates patient education handouts. Since that time, they have donated money to upgrade to the intranet version and for the annual subscription renewal, she reports.

The education department at Great Plains Regional Medical Center in North Platte, NE, purchased Savenotes from Micromedex, which enables hospital staff to make their own documents or alter the Micromedex documents to fit their needs. "It's a great resource. We can customize the documents, create our own, and they are not a storage problem because they are printed as needed," says **Barb Petersen**, RN, patient education coordinator at the medical center.

Having patient education handouts in the hospital's computer system so they can be printed as needed not only saves money and storage space but saves time because managers don't have to keep the floors stocked with materials, says **Gwen Thoma**, EdD, RN, CAN, BC, director of educational services at Southeast Missouri Hospital in Cape Girardeau. In addition, computer-generated handouts make it easier to prompt education. "We have arranged to have many of our handouts on tests and procedures run off automatically when the test or procedure is ordered," says Thoma.

Before the computer system was in place, Thoma produced handouts that could be reproduced on a copy machine. To make them look attractive, she purchased cream-colored paper and had the health care facility's three-color logo printed on it. She then ran the handouts through the copier and supplied the patient care areas as needed. "Expensive booklets don't always have to be purchased if you are willing to spend a little time and develop your own content," she says.

To reduce staff time when creating in-house materials, get samples from other facilities and find out what others have done that works, suggests Petersen. To have access to such information, join a networking group or patient education listserv. "I am in a personal network of patient education staff within my area that I have compiled telephone numbers for and contacts on my own," she says.

Petersen also belongs to the Nebraska Iowa Patient Education Council that meets quarterly to discuss conferences, new issues, and share documents. Although the distance to the meeting place prohibits her from regularly attending, members are willing to share what they learned at a meeting.

Many of the institutions that are represented in these networking meetings have the technology and funds to produce quality videos and often will

SOURCES

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sell them at cost or for a small profit, says Petersen.

There also are inexpensive teaching tools that can be tailored to the needs of patients. For example, audiotapes can be developed and duplicated at a relatively low cost. Also, consider creating flipcharts for teaching by developing a PowerPoint presentation and printing pages on a color printer, says Mercurio. ■

Learning center perfect for community outreach

Mall location reaches with timely health topics

A lack of space at the medical center for ancillary programs is one reason the learning center for Saint Francis Medical Center in Grand Island, NE, ended up at the local mall. The fact that 3.2 million people visit the mall annually, making it possible for the medical center to reach a larger population made the off-campus location even more enticing.

"We thought we would draw from a bigger area, not just our immediate city, but rural Nebraska, exposing more people to some of the services we have at our medical center through Wellness Works at the mall," says **Doreen Foland**, RD, manager of Wellness Works Por Su Salud (For Your Health).

The name is meant to attract Spanish-speaking people; in fact, two of the center's goals are to serve the Hispanic population and target women's health. One staff member was a physician in Colombia, and although she is not licensed to practice in the United States, she can teach classes.

This physician runs a diabetes and heart club, which holds biweekly meetings with the first hour taught in Spanish and the second in English. The focus is on helping people with questions or problems and to steer them into the hospital system as much as possible. "We are trying to address those two health topics with the Hispanic population because that is a big problem in our area," said Foland.

There are many features at Wellness Works that are designed to draw consumers who visit the mall. For example, the reading center is set up like a living room with easy chairs so people can come in and learn about health topics while they wait for friends or family to shop. There are no checkout privileges, so people must read the books and view the videos on premise.

However, there are a variety of pamphlets on popular health topics such as diabetes, cholesterol, nutrition, exercise, and smoking cessation that people can take with them. Brochures that promote a particular health awareness month often are featured during that time span.

Cooking demonstrations on nutritional topics frequently are conducted in the kitchen at Wellness Works, which is located near the entrance so that the smell of cooking might draw people in. A couple of cooking demonstrations usually are scheduled during the day, with one on Saturday as well.

They cover such topics as heart-healthy food and desserts, cooking on the run, and how to use herbs in place of sodium. Once, the staff held a tea talk discussing the benefits of different types of tea such as green or black, and those in attendance tried the different types.

Explaining Wellness Works

While the smell of cooking near the entrance and other design features may help attract consumers, lots of advertising is what draws customers, says Foland. "A lot of people had never heard of a center like this and didn't know what to expect. It could have been a clinic for low-income people as far as they knew," she explains. Radio and newspaper ads as well as contact with social groups and organizations have helped people learn what the resource center is all about and how they might use it.

In addition to the kitchen and reading room, Wellness Works has a computer center. The three computers that are available for public use are connected to the center's web site (www.wellnessworksonline.org), which has health features and links to other health web sites that have been approved by a panel of physicians at Saint Francis Medical Center. A firewall keeps consumers from accessing other Internet sites.

The health works center has an interactive learning environment with models of the various parts of the body and a skeleton for those who prefer hands-on learning. An educational center that can seat from 30-50 people and can be petitioned off is used for lectures by health care professionals is available. Lectures usually are scheduled for Thursday evening and focus on the health topic of the month, such as colorectal cancer during colorectal cancer awareness month.

The educational center also is used on Wednesday morning for a program called Lap and Learn that targets mall walkers. "We try to

SOURCE

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gear the topics to the retired age group, talking about topics like eating healthy, medication interaction, or keeping your brain active as you get older," says Foland. During the first Wednesday of each month, blood pressure screenings are conducted.

On occasion, other screenings are scheduled at Wellness Works if physicians from the medical center think it would be a good tool for diagnosis. "About every three months, we will have cholesterol or glucose screening for a small fee to cover lab work," says Foland. A knee and hip pain seminar also is scheduled twice a month.

In addition to Foland, who is a dietitian, and the physician from Colombia, the center is staffed with RNs and one LPN. It is open from 10 a.m. to 8 p.m. weekdays, opening one hour earlier on Wednesday mornings for Lap and Learn. On weekends, Wellness Works is open on Saturday from 10 a.m. to 3 p.m. and on Sunday from 1 p.m. to 5 p.m.

"The mall is open 70 hours a week, and we are required by our lease agreement to be open 60 hours a week," says Foland. ■

Resources for healthy aging

Here are resources for Healthy Aging Month from Educational Television Network that can be ordered on-line at www.healthyaging.net or by calling (610) 793-0979:

- **Book:** *Healthy Aging: Inspirational Letters from Americans.* Cost $24.95
- **Brochure:** *Healthy Aging: It's Never Too Late!* A 16-page brochure that discusses the issues of growing older. Single copy free, plus $1.50 shipping and handling. Pack of 20 brochures $9.95, plus $1.50 shipping and handling.
- **Educational Kit:** *Healthy Aging Discussion Guide.* Tool for conducting a seminar. Cost: $49.95.
- **Videos:**
  — *Healthy Aging: Redefining America.* Inspirational profiles of middle-aged Americans planning for what lies ahead. Cost $19.95.
  — *A Question of Choice: Our Nation's Health. How Diet and Fitness Can Help Prevent Heart Disease.* Cost $19.95.
  — *Our Nation's Health: Healthy Aging.* Dispels myths of aging by profiling older adults. Cost $19.95; with educational kit, $49.95.
- **Workshop Kit:** *Healthy Aging: Write from the Heart.* Materials to conduct a creative writing workshop for older adults. ■

It's never too late to improve health

Campaign highlights positive aspects of aging

September is Healthy Aging Month, part of an ongoing national campaign to broaden awareness about the positive aspects of aging. The campaign also is designed to prompt health care professionals to inspire older Americans to improve their physical, mental, social, and financial health.

"The underlying theme is that it is never too late to get started to achieve a better quality of life. The month is a point during the year we created to draw attention to the issues of older adults," says **Carolyn Worthington**, president of the Education Television Network in Unionville, PA.

The Education Television Network has produced several specials on aging that show why it is never too late. One focused on a study that looked at a group of 90-year-olds who were confined to wheel chairs or walkers because they had no muscle mass. These individuals began lifting small weights to build their muscle mass and eventually were able to walk unassisted. The point of the special is that when the elderly don't use their muscles, they atrophy. Part of the campaign is to encourage people to look at different options to improve their health, reports Worthington.

A national contest promoted by the Education Television Network asked seniors for their secret for healthy aging and resulted in 10,000 letters from around the country. Many wrote about the importance of mental wellness through social support systems. "Most people who lived long lives were surrounded by others. People cherish their solitude at times, but the people who aged successfully generally had someone around them, whether it was a family member or friend," she says.

SOURCES

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Seniors also mentioned in the letters the importance of keeping their minds sharp. Often seniors accomplished this by watching game shows such *Jeopardy* or playing Bingo. More and more, older Americans are using computers as well to exercise their minds and increase communication with others. The winning contest entries were published in a book and often are used by health care professionals to promote their own contest or encourage letter writing during Healthy Aging Month.

Last year, **Kelly Nichols**, MSW, assistant program director for Lourdes Behavioral Health Center in Paducah, KY, displayed the book of contest entries at a booth in the lobby of the health care facility where she worked. Someone staffing the booth explained the letter-writing process and many people started writing about their life experiences or words of wisdom gleaned with aging. Others determined to take it a step further and create journals for their grandchildren.

For her lobby display, Nichols also used the Healthy Aging Kit produced by the Education Television Network that includes a video and brochures. The video ran continually, drawing a lot of attention from people who weren't used to seeing seniors in their 70s running marathons. **(For information on promotional aids for Healthy Aging Month, see resource list, p. 67.)**

The letter-writing book was used on the geriatric psychiatric unit during group-therapy sessions. "We used the book with group therapy to get people to focus on the healthy aspects of aging," says Nichols.

The ideas from the Healthy Aging Month promotions work all year long, says **Crystal Young**, RN, BSN, health education coordinator with Southern Illinois Healthcare Senior Membership Program in Carbondale. She frequently holds group discussions on the various aspects of healthy aging that include physical, mental, and social wellness, as well as financial fitness. "People share what has worked for them and what hasn't. I find it is successful, especially in smaller groups because people really open up," she says.

In commemoration of Healthy Aging Month, Young held an ice cream social where everyone discussed the myths of aging and drew pictures of what they thought was old such as someone in a rocker. "We will probably do the ice cream social again this year," she reports.

There are multitudes of ways to promote Healthy Aging Month, says Worthington. Run a contest on the secrets of healthy aging, plan a seminar, host a healthy aging night with an inspirational movie or motivational speaker, or design a bulletin board with the myths of aging, she suggests.

"We encourage health care providers to use the concept that September is Healthy Aging Month and then tailor ideas to fit their own needs," says Worthington. ■

Education makes travel good for your health

Don't leave home without facts and information

During summer months, many people make travel plans. They book flights and hotel rooms and create lists of things they will need to do before they go or pack, such as finding a neighbor to water the yard or the perfect wardrobe for the tropics. Most forget to include medical preparations to protect their health on that list.

What people need to know about staying healthy while traveling depends on where they are going, says **Abinash Virk**, MD, director of the Mayo Travel and Geographic Medicine Clinic in Rochester, MN. This clinic helps travelers with medical preparations before a trip and treats those who acquire an illness while traveling. It also provides infectious disease evaluations for immigrants, refugees, and internationally adopted children.

"Europe is not a high-risk situation in terms of health hazards, so people only need to consider simple things like deep-vein thrombosis prevention (a problem that can arise on long flights)," she says. "However, people traveling to Mexico, Africa,

Make immunizations first on travel prep list

Up-to-date record important

People planning on traveling outside the United States need to see their doctor up to six months before their departure to determine which immunizations they will need. Many vaccinations consist of a series of shots and require time for immunity to build. For example, hepatitis B immunity is acquired by a series of three inoculations given over a period of six months.

Following is a list of immunizations that might be appropriate for protection against infectious diseases prevalent in many developing countries, according to the Mayo Travel and Geographic Medicine Clinic in Rochester, MN. They include:

- diphtheria;
- diphtheria/pertussis/tetanus;
- hepatitis A;
- imunoglobulin for hepatitis A;
- hepatitis B;
- *Haemophilus influenzae* type B;
- influenza A/B;
- Japanese encephalitis;
- meningococcal;
- mumps, measles, and rubella;
- polio (live and attenuated);
- Pneumovax;
- rabies;
- typhoid;
- varicella;
- yellow fever. ■

Asia, or Latin America have a slightly higher risk of getting diarrhea or picking up a disease depending on where they are going, what they are doing, and how long they are going to stay there."

A specialist in travel medicine not always is necessary if staff members at a medical center are able to evaluate a patient's medical needs for travel and address educational issues.

The first step in travel preparations for healthy people is to identify their vaccination status and make sure they are up to date with routine vaccines. Many diseases that are no longer common in the United States still are common in other countries. They also need to find out what travel-related vaccines they will need, says Virk.

For example, if people are going to a destination where they may contract typhoid, they would need a vaccination. "There are a whole host of vaccines that one may need specifically for certain types of travel," she says. **(For a list of vaccines that may be needed before traveling, see article, left.)**

It's important that people learn about the country they plan to visit, including the health risks that they may encounter. Education about food and water precautions and personal hygiene such as hand washing is important. The two most common infectious disease problems when traveling to foreign countries are travelers' diarrhea and respiratory illness, says Virk. **(For a list of web sites with traveler's health information, see p. 70.)**

Mosquito-borne illnesses such as malaria and dengue fever can be a problem in some areas, and travelers must take precautions before they go. Travelers need to carry along insect repellent and know how to use it correctly. Taking the necessary precautions to prevent contracting malaria is extremely important because the disease has a high mortality rate, she says.

In addition to learning about the proper immunizations, knowing what types of food to avoid, what to drink, and about protection from insect bites, which are the major topics. According to Virk, there is a lot of other information that could be important depending on the destination and activities planned. For example, how to prevent and treat sunburn or what to do if bitten by a jellyfish, she says.

Most people who die outside the United States are killed in automobile accidents, says Virk. Therefore, it is important to be aware of such health hazards as poor driving practices and take precautions such as securing safe transportation.

Traveling with health problems

People preparing to travel with medical problems have more to do to prepare for than the healthier traveler does. However, preparation can be simple or very complicated depending on the underlying medical problems, says Virk. For example, with people who have asthma, a physician might go through an algorithm of how they should handle an acute attack. Preparing a heart or liver transplant patient for a trip to Indonesia is more complicated, for they have to be taught how to keep from picking up a disease and how to monitor their drugs while away, she explains.

"People on blood thinners planning to travel

Contacts for travelers' health information

Upfront preparation helps with prevention

There are several web sites with traveler's health information that provide details on how to prepare for visits to various countries. They are helpful as a resource for travelers and for health care professionals helping their patients prepare for a trip.

Web sites with traveler's health information include the following:

- **www.istm.org — International Society of Travel Medicine.** This site provides a travel clinic directory.
- **www.mayo.edu/travel-clinic/services.htm — Mayo Travel and Geographic Medicine Clinic.** This site provides information on the types of medical evaluations people need before traveling to determine which immunizations and medications are needed as well as educational needs.
- **www.cdc.gov/travel/index.htm — National Center for Infectious Diseases Traveler's Health.** This site has health information on specific destinations, outbreak alerts, information about specific diseases that can affect travelers, vaccination recommendations, information on how to avoid illness from food and water, and tips for travelers with special needs.
- **www.travel.state.gov — U.S. State Department Consular Information and Travel Advisories.** People can find consular information sheets, health conditions, and crime and security information on this site. ■

for two months need to learn how to access medical care while in another country so they can have their blood thinner monitored," says Virk.

Everyone should make sure they fill prescriptions so they don't run out of their medication while traveling. A good precaution is to take a typewritten copy of the prescription along. Those needing to carry such medical items as insulin syringes should obtain a letter from their physician that explains why these items are needed. They also should make sure that medical items are properly labeled, says Virk. Otherwise, they could be confiscated at border crossings or at airport security checks.

Anyone returning from an extended trip overseas needs to visit a physician or travel clinic to determine if he or she has been exposed to any diseases, such as tuberculosis. Depending on the type of exposure, certain tests might have to be done.

"The average traveler going for a week or two doesn't need a return follow-up," says Virk. However, those who develop symptoms such as fever, chills, and a headache after returning from a trip need to see a physician right away and make sure they report what part of the world they visited while the medical history is being taken. Without this information, a physician could label the illness influenza, and it could be malaria, which can be life-threatening.

"As part of the education in the travel clinic, we tell patients that upon their return, if they need to see a physician, to be sure to tell him or her that they were somewhere where they could have picked up something unusual," says Virk. ■

SOURCE

For more information about educating patients about including health preparations in their travel plans, contact:

- **Abinash Virk**, MD, Director, Mayo Travel and Geographic Medicine Clinic, Rochester, MN. Telephone: (507) 255-8459. Web site: www.mayo.edu/travel-clinic/services.htm.

Develop a 'magnetic' personality to prevent pain

Therapy often used for aches, sprains, chronic pain

While most physicians may not be telling patients with minor aches, pains, strains, and sprains to tape a static magnet to the region of pain and call in the morning, many of their patients are doing just that, especially athletic people experiencing sports-related injuries.

For these types of injuries, it is no different than taking a couple Advil or putting ice on the injury, says **Milt Hammerly**, MD, director of integrated medicine at Catholic Health Initiative in Denver.

"It is very benign, noninvasive, safe therapy," Hammerly says. Magnetic therapy also is good for

SOURCE

For more information about magnetic therapy and its appropriate use, contact:

- **Milt Hammerly**, MD, Director, Integrated Medicine, Catholic Health Initiative, Denver. Telephone: (303) 778-5818. E-mail: MiltHammerly@Chi-National.org.

treating chronic pain.

It is important that people know what they are treating when using magnets for the treatment can mask the symptoms of an underlying condition, such as metastatic prostate cancer to the spine. "Anyone with chronic symptoms needs to have an adequate work-up and diagnosis to know what he or she is treating," he says.

How they work

It is thought that the magnets help with minor aches and strains by enhancing blood flow because the ionic or charged particles of the blood respond to the magnetic field. The reduction of inflammation is a slightly different process, says Hammerly. It appears that part of the inflammatory process is white blood cells being attracted to a charge imbalance in the area of the injury. "By overriding that charge imbalance with the presence of the external magnetic field, it actually decreases the migration of the white cells to the area of injury and thereby decreases the whole inflammatory response," he explains.

With chronic pain, the nervous system seems to be working abnormally, and anything can trigger the nerves — even weather changes. Small nerve fibers continuously are firing and depolarizing in a vicious cycle. "With that kind of pain, an external magnetic field has been shown to block the depolarization and the pain impulse," Hammerly explains.

In practice, he finds that some people have great results from magnetic therapy and others have no response at all. "I wish we were sophisticated enough to be able to predict in advance who would respond and who wouldn't, but we aren't there yet," says Hammerly. It does work often enough to make it worthwhile for patients with chronic pain and sprains, strains, and aches to try. He recommends that people order magnets from a company that offers a 60- to 90-day money-back guarantee in case the therapy does not work for them.

How they're used

Magnets often are designed into a product such as belts, wraps, or mattress pads but can be purchased separately and taped onto the area of discomfort. Magnets to be used as part of therapy are designed with strength measured in

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Editorial Questions

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CE Questions

CE subscribers: Please use the enclosed Scantron to submit your answers for the January-June 2002 CE test and return the Scantron and CE Survey in the enclosed envelope.

21. To evaluate patient education efforts at a health care facility, surveyors look at which of the following?
A. Informational items posted
B. Policy and procedure
C. Medical records
D. All of the above

22. Which of the following are good ways for managers to stretch a tight budget for patient educational materials?
A. Obtain free materials from pharmaceutical companies.
B. Use Internet resources.
C. Don't let patients take pamphlets home.
D. A & B

23. When preparing to travel to developing countries, patients should visit their physician at least six months in advance to begin vaccinations.
A. True
B. False

24. When attempting to eradicate head lice, garments and bedding should always be washed in hot water.
A. True
B. False

gauss. A typical strength for magnets is from 400-4,000 gauss. Weaker magnets are not very effective, and stronger magnets can cause problems, says Hammerly.

People who have pacemakers or any electrically driven medical device should not use magnetic therapy. Pregnant women should not use it on the abdomen, for some research suggests that it could cause developmental changes, says Hammerly. Also, it should not be used as a cancer treatment because it is just as likely to be stimulated as it is to be inhabited, he says.

While there are some people who specialize in magnetic therapy, he doesn't recommend them. "They don't seem to be giving any better advice to their patients than what they can get on their own. Some of the advice is misguided and inappropriate," says Hammerly. ■

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

Just say no: To fireworks?

There is no safe way for home fireworks displays

Although "Just say no" is part of an anti-drug campaign, **Betsy Vandie**, media relations director for Prevent Blindness America in Schaumburg, IL, would like more parents to adopt that same response when their children ask for fireworks.

That's because there is no safe way for nonprofessionals to use fireworks, she says. Data from the United States Eye Injury Registry shows that bystanders are more often injured by fireworks than those who are setting them off; 44% of those injured each year are children ages 19 and younger. The greatest number of eye injuries is associated with rockets.

Handheld sparklers are the second-highest cause of fireworks injuries. "You see children playing with sparklers, chasing each other around the yard, and they could blind each other that way. It is a lack of information on the part of people. They don't realize how dangerous sparklers are," says Vandie. According to Prevent Blindness America, sparklers can heat up to 1,800°F, which is hot enough to melt gold.

To get the word out, Prevent Blindness America has made July Fireworks Safety Month with an emphasis on education from July 1 through July 4. Most Americans associate fireworks with celebrating and don't understand the danger, she says. Therefore, this is a time to increase awareness.

According to statistics gathered from the U.S. Product Safety Commission, there were 11,000 injuries treated in hospital emergency departments in the year 2000. The data do not take into account all the injuries that were self-treated or treated by private physicians, says Vandie.

Anyone who sustains an eye injury needs to seek medical help. "It may seem like an invisible injury to the layman but the cornea could be damaged," she explains. Following are eight action steps suggested by Prevent Blindness America that parents could follow when their child sustains an eye injury from fireworks:

- **Seek immediate medical attention, even if the injury seems minor.** Seemingly mildly damaged areas can worsen and end in serious vision loss, even blindness, which might not have happened if treatment had occurred right away.
- **Stay calm.** Do not panic; keep the child as calm as possible.
- **Do not let the child rub the eye.** If any eye tissue is torn, rubbing might push out the eye's contents and cause more damage. Rubbing the eye is an automatic response to pain so take the child's hand from his or her face.
- **Do not rinse the eye, for this can be more damaging than rubbing.**
- **Shield the eye from pressure.** Tape or secure the bottom of a foam cup, milk carton, or similar shield against the bones surrounding the eye: brow, cheek, and bridge of the nose.
- **Avoid giving aspirin or ibuprofen (or other nonsteroidal anti-inflammatory drugs) to try to reduce the pain.** They thin the blood and might increase bleeding. Acetaminophen is the best over-the-counter drug to give the child, yet nonprescription painkillers won't be of much help. It is best to go straight to the emergency department rather than take the time to obtain painkillers.
- **Do not apply ointment or any medication to the injured area because it is probably not sterile and ointments can make the eye area slippery.** Ointments applied to the eye area could slow the physician's examination at a time when every second counts.
- **Above all, do not let your child play with fireworks and do not use them yourself.** Keep family members away from anyone using fireworks.

"People should be aware that there are dangers even at a professional display, but of course that is less risky than setting fireworks off on their own," says Vandie. ■

SOURCE

For more information about preventing fireworks injuries or Fireworks Safety Month, contact:

- **Betsy Vandie**, Media Relations Director, Prevent Blindness America, 500 E. Remington Road, Schaumburg, IL 60173-6611. Telephone: (800) 331-2020. Web site: www.preventblindness.org.

Many myths surround head lice eradication

No need for house-cleaning frenzy

When children return from summer camp, parents expect a suitcase full of dirty laundry, rolls of film to be developed, and lots of stories about the adventure. Many times the children return with something parents don't expect — a case of head lice.

When this happens, there usually is chaos in the household for several weeks. Mom strips beds daily to wash the sheets, items from camp that might be contaminated are bagged and left on the porch for five weeks, and children have their head scrubbed with a special lice shampoo.

The frenzy is caused by misinformation that has been passed from neighbor to neighbor and relative to relative. It's similar to the telephone game where a message is passed along, and after several links it is a different message. Incorrect advice causes frustration, paranoia, and desperation, says **Dan Sheridan**, a telephone counselor at the National Pediculosis Association in Needham, MA.

"People believe that the lice are everywhere, like when they have an infestation of fleas," he says. "However, lice don't jump or fly. They only live on human heads because they are a parasitic creature." Studies have shown that lice die in about 24 hours if they are not on a head, Sheridan adds.

The best way to rid of lice is to get a good comb and work on nit removal from the child's hair. Lice are spread when a child has direct contact of the head or hair with an infested individual. They also are spread if a child shares personal articles such as hats, towels, brushes, helmets, and hair ties with an infested individual.

Lice may spread to pillows, headrests, or similar items that are touched by a child's head when infested as well. The best way to remove lice or fallen hairs with attached nits from upholstered furniture, rugs, stuffed animals and cars is by vacuuming, says Sheridan.

To remove lice from pillows, sheets, jackets, and hats, place the item in the dryer for half an hour on high heat, he says. Parents tend to wear themselves out washing items all the time, and it isn't necessary. If the item isn't dirty it can simply be placed in the dryer.

Children are more likely to get head lice than adults because they share personal items and play together. The risks of transmission can be managed more easily if children have their own sports equipment, such as bicycle helmets, and other personal items such as towels for swimming. "Tell kids not to share personal items, but don't make them phobic," advises Sheridan.

If a child has head lice over and over again, it is probably because parents have succeeded in lowering the infestation but not eradicating it completely. They comb the nits until they can't see anything and their child is no longer itching. Two weeks goes by and they have another case of head lice. "There probably were eggs in the hair that were not removed. It takes seven to 10 days for the eggs to hatch," says Sheridan.

Once hatched, lice can survive on a human host for about 30 days. The female louse will lay between three and five eggs per day, and it takes about seven to 10 days for a louse to become mature and lay eggs.

To make sure that a case of lice has been eradicated, parents need to continue combing their child's hair to remove eggs that have not yet hatched for at least a week after they think the lice are gone, says Sheridan. "If parents are thorough and use a good comb, they have really good odds of getting every egg out before it hatches. Parents should keep combing every day until they have gone a week without seeing any bugs or eggs."

Many parents want to use lice shampoo in addition to nit removal. Those who do use such products should do their homework first, advises Sheridan. "There are segments of the population that are very sensitive to these chemicals. They can cause skin irritation and touch off asthma, and overtreatment can cause serious health risks."

The best prevention and control method for head lice is regular screenings. Parents should check their children for head lice before they go off to summer camp so they won't infect others. Then parents should check children when they return. "It's a good idea to check children a couple times a year, particularly at those times when large numbers of kids are getting together at summer camp," says Sheridan. ■

SOURCE

For more information about the detection and control of head lice, contact:

- **Dan Sheridan**, Telephone Counselor, National Pediculosis Association, 50 Kearney Road, Needham, MA 02494. Telephone: (781) 449-6487. E-mail: npa@headlice.org. Web site: www.headlice.org.

BIOTERRORISM WATCH
Preparing for and responding to biological, chemical and nuclear disasters

They don't call it bio***terror*** for nothing: Fear is the foe when anthrax spores are found within hospital walls

'We feel we were able to ward off a panic . . .'

Clinicians nationwide were beset with hoax powder scares last year at the height of the anthrax attacks, but at one hospital, the threat turned out to be real. Positive cultures for *Bacillus anthracis* were found within hospital walls, setting off a wave of anxiety that threatened to descend into panic.

"There was a mounting level of anxiety among our health care workers," said **Maureen Schultz**, RN, infection control coordinator at Veterans Affairs (VA) Medical Center in Washington, DC. "It had to be dealt with before we could work out any other aspect of the situation."

The events began to unfold last October, when it was discovered that the anthrax letter sent to Sen. Tom Daschle (D-SD) might have contaminated other federal buildings through cross-contamination of mail processed at the Brentwood postal building in Washington, DC.

"It was several days before the contamination was discovered, and by that time, several downstream facilities, including our VA hospital, were contaminated," she said recently in Salt Lake City at the annual meeting of the Society for Healthcare Epidemiology of America (SHEA).[1] In light of the situation, it was recommended that mailrooms in federal buildings be cultured for anthrax.

"One of the things we found frustrating was that we were not given any guidance as to how we should screen the mail," Schultz said. "So we [took] cotton swabs and ran each swab over an approximately 10 to 50 square inch area."

Four of 34 environmental swabs taken in the hospital mailroom grew *B. anthracis*, with colony counts varying from one to 11. The anthrax was found on a canvas mail tote, a cardboard box that had been mailed, on the top of a mailroom speaker, and on a canvas mail cart.

The fear factor

"Even before the contamination was discovered, [we] decided to take some action because of the growing concern among our employees," she said. "So [we] convened a group from the emergency response team, infection control, safety, and public affairs."

The focus of the response was to determine risk level, provide prophylaxis as needed, decontaminate the environment, and get accurate information to all 1,700 health care workers, patients, and visitors, Schultz said. In order to reduce the high level of anxiety, a series of educational sessions were held, information was posted on the hospital web page, press releases were distributed, and printed materials were given to staff, patients, and families. In addition, a series of "town-hall" meetings was held to fully air the concerns of employees.

"These were informal sessions that we had in our auditorium where many health care workers could come and interact on an informal basis," Schultz said.

The risk to hospital workers was determined to

This supplement was written by Gary Evans, editor of *Hospital Infection Control.* Telephone: (706) 742-2515. E-mail: gary.evans@ahcpub.com.

be low, and only eight staff members were started on prophylactic antibiotics. Those included five mailroom employees who were encouraged to take full 60-day regimens. Another three workers, considered at lower risk, were given 10-day regimens due to possible contact with contaminated mail. The mailroom and surrounding area were decontaminated by an outside contractor.

Overall, some 500 health care workers attended the education sessions, and each town-hall meeting drew more than 200 staff members. With the colony counts low and the contamination limited, the decision was made to limit prophylaxis to only the eight aforementioned employees. That approach was not well received by other health care workers who feared they could have been unknowingly exposed.

"We refused treatment to all other employees, and initially, this created a lot of anxiety among the health care workers, particularly in these large town-hall meetings," Schultz said. "They were demanding ciprofloxacin or doxycycline in case they had come in contact with something contaminated. But we did hold firm on this, and we did not provide prophylaxis to any other employees."

Still, at the SHEA meeting, the Centers for Disease Control and Prevention (CDC) conceded that many of its initial assumptions about anthrax turned out to be false, including the perception that mail handlers were not at risk for inhalational anthrax. Given that acknowledgment, *Bioterrorism Watch* asked Schultz if she would now reconsider the decision to limit antibiotic prophylaxis to a few workers. "Based on the information we have now, no. I don't think we would change that decision." There really was no evidence that any widespread contamination had occurred, she added.

A total of 34 workers reported to the occupational health service for clinical evaluation, but there were no reports of staff refusing to work, and patient care was not interrupted. The initial level of fear and anxiety among many of the workers eased off under the continuous education and communication effort.

"We feel we were able to ward off a panic situation by the actions that we took," she said.

NYC hospital faces similar situation

A similar contamination incident was feared at Memorial Sloan Kettering Institute, a 431-bed cancer center in New York City. Some 1,200 health care workers at Sloan Kettering work in the same building as Gov. George Pataki's Manhattan office, which was reported to be the target of anthrax mailing. On Oct. 17, possible anthrax (positive by polymerase chain reaction test) was discovered in the governor's office. Pataki and staff vacated their part of the building, and infection control staff and hospital administration at Sloan Kettering developed a response plan to protect their workers.

The hospital employees worked on 10 floors of the 40-story building, including three floors that shared an air-ventilation system with the governor's offices. The response was honed to focus on mailroom staff and some 250 employees who worked on the three floors with shared air. With incomplete information on the scope of potential contamination of Pataki's offices, hospital clinicians decided to perform nasal cultures on the employees on the three floors, **Janet Eagan**, RN, an infection control professional at Sloan Kettering reported at the SHEA conference.[2] All of the 245 cultures taken were negative.

"I think the nasal swabs were more to allay fear," she said. "We wanted to do something that was proactive."

Public health investigators first used the nasal swab approach after the first anthrax case in Florida, but the CDC would later advise against routine use of the practice. The reliability of the swabs came into question, in part, because even those exposed may test negative as the nose clears of spores. At a Nov. 1, 2002, press briefing, the CDC advised against using nasal swabs "as a nonspecific probe to determine whether anthrax has ever been present in an environment."

Of course, clinicians at Sloan Kettering were dealing with a situation before that clarification was issued, but even then there were doubts about the wisdom of swabbing the workers.

"By the time we agreed to do the nasal swabs, I was kicking myself, thinking what on earth are we going to do with this information," **Ken Sepkowitz**, MD, epidemiologist at the hospital told SHEA attendees. "The nasal swabs was a screw-up, but with the information we had . . ."

With all the swabs negative, no antibiotics were administered. Additional efforts were needed to reassure the "worried well" that they were not at risk. Personnel from infection control, safety, security, and social work all met with the staff. Building management conducted an independent environmental survey of the building.

"E-mails went to all staff that all 245 employees tested had negative results," Eagan said.

"Communication is key. We believe that by having a hands-on approach — actually being there meeting with staff — prevented panic in employees that were very vulnerable."

Then word came that the original specimen from the governor's office had been found culture negative on retesting. The hospital had been through an intense false alarm drill, but overall had met the challenge, Eagan said.

"Decisions were made using incomplete information at a time-sensitive pace," she said. "Staff responded in a positive manner to the high visibility of administrative leadership, infectious disease, and infection control in numerous educational sessions and e-mail alerts."

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2. Eagan J, Martin K, Prager L, et al. Infection control response to potential anthrax contamination of building with hospital workers. Abstract 130. Presented at the annual conference for the Society for Health Care Epidemiology of America. Salt Lake City; April 6-9, 2002. ■

APIC: Smallpox plan uses outdated infection control

Designating patient facilities a mistake

The Centers for Disease Control and Prevention (CDC) has based its smallpox bioterrorism response plan on "outdated concepts," and entire sections need to be revised to reflect current epidemiologic strategies, the nation's leading group of infection control experts warned.

The Association for Professionals in Infection Control and Epidemiology (APIC) commented on the *CDC Interim Smallpox Response Plan and Guidelines*, which has been released as something of a work in progress.

"In general, we are concerned that the draft guidelines appear to be based on outdated strategies used to control this disease decades ago and do not appropriately integrate those infection control strategies and environmental controls utilized in our hospitals today," the APIC letter stated.

The CDC response plan calls for investigators to rapidly immunize a "ring" around the first cases. The ring concept uses isolation of confirmed and suspected smallpox cases followed by contact tracing, vaccination, and close surveillance of contacts. The ring approach was used to successfully eradicate smallpox from the world in 1980. But the ring concept was effective when the demographics of smallpox were very different, when few were infected, and the vast majority of people already were immune.

As part of the ring response, vaccine would be administered to people involved in the direct medical care, public health evaluation, or transportation of confirmed or suspected smallpox patients.

"Vaccination, like any preventive strategy, is more effective if given prior to exposure," APIC argued. "If health care workers are not immunized prior to case identification, these individuals [especially emergency department staff, direct caregivers, and laundry personnel] should be vaccinated immediately upon documentation of a case in their community. It is crucial that we not wait for a case to present in the facility before taking preventative action."

In addition, it may not be possible to distinguish between febrile response to vaccine or actual exposure in health care workers, APIC warned.

"Approximately 20% of vaccinated employees will develop fever and not be able to work if vaccine is given in response to a suspect or confirmed case," the association stated. "We need to develop strategies for dealing with staffing shortages whether they are due to febrile reaction to vaccination, true infection / disease, or refusal to care for patients in a smallpox emergency."

'Misuse of resources'

APIC also questioned the CDC concept of a "Type C isolation facility" for smallpox patients. As proposed, the sites would be facilities that are at least 100 yards from any other occupied building, or those that have nonshared air-ventilation systems with filtered exhaust.

"We believe it would be a misuse of resources to design, build / retrofit, and maintain a designated facility that is not integrated with the existing health care system," APIC stated. "Using alternative structures rather than enhancing the current infrastructure is not a wise use of our limited resources."

Instead, existing facilities could substantially

benefit from dedicating resources to ensuring appropriate air handling and ventilation systems for existing clinics, emergency departments, and isolation rooms. "This would provide the added benefit of controlling more likely exposures to infectious droplet nuclei [tuberculosis, disseminated zoster, chicken pox, measles, etc.] in addition to minimizing or eliminating the likelihood of intrafacility transmission of smallpox," APIC stated.

The association expressed concern that health care delivery might be compromised in separate Type C facilities, particularly if they are not designed to provide services such as intensive care, ventilator support, dialysis, and laboratory resources. Rather then designate facilities for smallpox patients, each hospital should be prepared in advance to activate its program when the first case is identified, APIC argued.

"There needs to be a predetermined area [building or wing, etc.] that meets the 'Type C' facility requirements for isolation," APIC noted. "Part of a facility's planning would include a determination regarding the number of patients that could be housed in the designated area."

Some of the cleaning and disinfection recommendations in the document are out of date with current sterilization principles and practices. That includes "fogging" rooms to disinfect environmental surfaces, the association charged.

"CDC has not recommended the fogging of rooms for many years," APIC stated. "We strongly suggest the deletion of any archaic references to fogging." ■

Stanford sets the standard for bioterrorism planning

A separate piece: Stand-alone plan advised

It's not enough merely to update the bioterrorism component of your current disaster preparedness plan, experts say; you must create a detailed bioterrorism response plan that stands on its own.

That's precisely the philosophy behind the Stanford (CA) Hospital and Clinics (SHC) & Lucile Packard Children's Hospital (LPCH) Bioterrorism Response Preparedness Plan, which is gaining widespread recognition as a model for such plans. In fact, several Kaiser Permanente facilities in California already have adopted the plan.

"You need a separate [bioterrorism] plan," asserts **Eric A. Weiss**, MD, assistant professor of emergency medicine at Stanford, associate director of trauma at Stanford Hospital, and chairman of the disaster committee and bioterrorism task force. "During most disasters, for instance, you don't rely on the microbiology lab to identify pathogens. Also, infectious disease and infection control staff take on a major, heightened role."

In disasters such as an earthquake, Weiss notes, you generally don't have to worry about the quarantine of patients or the spread of infectious agents. Similarly, you may not have to put on protective clothing or worry about cross-contamination of existing patients who may be immunosuppressed.

A bioterrorism plan had been in place prior to 2001, Weiss says, "but it was really just a skeleton plan — not very comprehensive. It was part of a larger disaster preparedness plan, but a plan to deal with mass casualties from bioterrorism is very different."

When you have a major disaster such as the collapse of the World Trade Center, Weiss notes, local health care providers are likely to come to the hospital and offer to chip in and help wherever they can.

"But what happens when the word goes out that patients are walking around with smallpox?" he asks. "Are providers going to want to stream down to the hospital and potentially infect themselves and their families? You need a response plan to address the safety of health care providers, so they will feel comfortable and want to show up for work."

To create such a plan, the Bioterrorism Planning Task Force was formed, incorporating personnel from 30 or more different departments at both facilities. Those departments include infectious diseases, infection control, emergency medicine, pediatrics, critical care, intensive care units, nursing and hospital administration, dermatology, psychology, social services, and environmental health and safety.

"We began putting the plan together when we identified the fact that the current plan was not adequate," notes Weiss. "We accelerated our activities after Sept. 11. After Sept. 11, *everybody* wanted to be part of it."

[Editor's note: The bioterrorism plan is available on the Stanford web site at www.stanfordhospital.com.] ■