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Patient Education Management™

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

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IN THIS ISSUE

How technology can transform your patient education department

Meaningful but simple changes through technology

Although it is sometimes difficult to abandon tried-and-true methods, even simple changes can improve patient education programs. Usually, there are warning signs that the current method isn't working. A solution doesn't have to be complicated. Sometimes, it starts small.

When it became a challenge to get consistency in the patient education manuals that were being created at the New Mexico Veterans Affairs (VA) Health Care System in Albuquerque, **Carol Maller**, RN, MS, CHES, patient education coordinator, began to contemplate automating the process so that they would

EXECUTIVE SUMMARY

Patient education managers always are looking for better ways to manage their department and programs. That's why they network with colleagues, attend conferences, and read publications that cover patient education. In this month's cover story, *Patient Education Management* asked managers to discuss the new directions they had taken and changes they had made in their programs and management styles. Some of these changes save time, others have an economic impact, some improve employee morale, and others help patients take a more active role in their health care.

***In This Issue* continued from cover**

***Focus on Pediatrics* insert**

COMING IN FUTURE ISSUES

- Informing patients about complementary medicine options
- Selecting facilitators for support groups
- Designing educational interventions in light of the nursing shortage
- Tailoring education to culturally specific groups
- Teaching patients to control pain

reflect a standard of care in keeping with the Joint Commission on Accreditation of Healthcare Organizations standards. To standardize the process, she hired a consultant to develop a macro, which is an electronic file that automatically generates certain text.

She wrote the manual with the consultant, leaving blank spaces in strategic places where the author would need to create copy unique to the program. For example, the evaluation and documentation process is the same for any patient education teaching so that is automatically generated on the macro. The developer would write such copy as the learner objective and the content of what the patient is to be taught. "Whenever a new manual is developed, all the author has to do is sit down with the file and plug in the missing pieces. The macro knows where to put the missing pieces," says Maller.

Each manual is a three-ring binder and all have tabs with identical sections. The first section has the goals and needs assessment; the second holds the patient outcomes; the third contains the educational resources; the fourth has information on community resources; and the fifth section covers documentation. "One of the major advantages is that when the manuals need to be updated, I just pull out my macro and do a couple editing changes. I can update it in a matter of minutes," she says.

Technology has impacted other facets of management as well. Distribution and oversight of more than 350 titles of patient education materials created in-house became extremely burdensome. "It was very labor-intensive to transport the materials around the medical center, and managing the inventory was time-consuming. I would get orders from staff on a daily basis," says Maller.

Therefore, she decided to automate this system as well. The medical center implemented a web-based system of handouts that had been pilot-tested at a VA hospital in Amarillo, TX. Providers can access the materials on the intranet, and patients also have access to them via the Internet. "All the updates are done on a regular basis by the company, and they offer three times as many titles as we had," she says.

The clearinghouse for print materials at M.D. Anderson Cancer Center in Houston also is no longer necessary. However, rather than using a web-based system, all in-house materials now are on-line and can be accessed on the intranet, says **Louise Villejo**, MPH, CHES, director of patient education. "It is convenient for the staff, and we can make changes in real time, we don't have to wait to

deplete an order. It's a cost savings because we don't have to have materials printed," she says. Also, affiliates of the cancer center around the country have access to the patient education database.

Now that the technology is available for electronic documentation, Maller no longer has to manage the 50 paper forms that formerly were used to document patient education. In addition, auditing the documentation of patient education has been simplified. "We can generate a report of the documentation being done across the medical center, and we can show that it is interdisciplinary. We have already run those reports for our upcoming Joint Commission survey," says Maller.

Catalysts for change

Time constraints often are the catalyst for change in programs. Now that tight staff schedules have made regular meetings of interdisciplinary patient education committees difficult to arrange, more communication takes place via e-mail, and there are fewer meetings, says Villejo.

About every two to three years, clinical staff in the various areas covered by committees are interviewed so the committee can assess the program and obtain feedback on which materials are being used. "Once we determine what a clinical area needs, we work individually or in small groups," she says. Often, just certain key people need to be involved, such as the clinical coordinator and the pharmacist or dietitian.

Evaluation of programs routinely is continued through patient and family assessments, and with materials on-line, it is easy to generate a report on handouts to determine the ones that are being used and the ones that aren't, says Villejo.

Annette Mercurio, MPH, CHES, director of patient, family, and community education for City of Hope National Medical Center in Duarte, CA, has found that it is easier to assess educational needs on a small-scale basis than by conducting a large, institutionalwide needs assessment. Now, when she does an assessment, she either focuses on a particular high-volume patient population with complex education needs, one particular medical area, or uses available data to assess needs, such as that generated by patient satisfaction surveys.

"If I have data indicating a problem, I do a performance improvement project vs. the really broad needs assessments that require a lot of time," she says. Mercurio realized she could look at data for smaller projects, make changes, and follow through in a shorter period of time, focusing realistically on something that could make a difference.

For example, to determine how to improve integration of patient education materials into practice and learn whether staff were using materials, the patient education department focused on one patient-care area. A staff survey was conducted that found that staff in this area thought materials were disorganized and they didn't have the handouts they needed such as those that explained tests that were ordered for patients. Therefore, this particular patient care area was focused on for a period of time until considerable improvement was seen. "I think this is more practical given the limited time we have to work with," says Mercurio.

Changing from one-on-one teaching to group instruction is improving staff morale because it helps caregivers make better use of their time, says **Barbara Petersen**, RN, patient education coordinator at Great Plains Regional Medical Center in North Platte, NE. The first program targeted was diabetes teaching. That's because the two diabetes educators, as well as dietitians, were saying the same thing to patients five times a day. "Now instead of taking a dietitian's time and nurse's time five times a day, it is being done once a week," she says.

Group teaching for total hip and knee surgery also is being implemented. Physical therapists at Great Plains just don't have time to see patients on an individual basis before surgery. "We will include case management and our pre-op nurses to get all three educational portions completed on the same day during one session," says Petersen.

Research articles have provided staff information on how to collect some data before beginning the pre-op teaching for total hip and knee patients that can be used to evaluate the effectiveness of the program once it has begun. After the program has been up and running for a while, they can collect the same data to see if there have been any measurable improvements, says Petersen.

To improve participation in educational activities as well as save resources, the New Mexico VA Health Care System is integrating its traditional group education classes into group clinic visits. Adult learners are more willing to participate in a group clinic than class, says Maller.

To fill a class, she has to schedule double the amount of participants because about half fail to show up. Also, it is costly to have staff come in to teach when only a few patients are present. However, staff already are at the clinic, she says.

"It integrates patient education into the clinical visit. You don't want education as a separate entity

SOURCES

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you want it integrated into every clinic visit so it is part of every encounter with a clinician," says Maller. In addition, this setting helps patients become more actively involved in their care.

Innovation not always necessary

Changes in patient education programs don't have to be based on innovative new methods of patient education or the latest technology to make sense. At City of Hope, the patient education department has been working on streamlining the materials given to new patients. It probably will save money and be more effective from an educational standpoint, says Mercurio.

In the past, all the patients received an expensive orientation booklet to all the services available at the health care facility, including the patient education resource center. A booklet similar to the desk services portfolio found in hotel rooms soon will be kept in a plastic folder in patient rooms on a permanent basis.

Great Plains ordered all its patient education materials from vendors until recently when staff began to generate handouts in-house. "It seems like we were spending so much money on external patient education materials, and staff really didn't like it. The satisfaction of the clinicians now is higher that we have started producing it here and it is available on-line," says Petersen.

When the idea was first suggested many said that the facility was not large enough to produce its own materials, and it would be too costly. However, Petersen worked with the public relations director to come up with a template so handouts would be standardized and have a disclaimer. "Patients, no matter what point of access, will get the same handout with the same format on-line, and it is accessible to everyone," says Petersen.

Sometimes patient education managers become use to a certain routine, but it isn't working. For example, Mercurio routinely had the library run a monthly search on patient education literature. The librarian would send a list of all the new articles that were published, and Mercurio would check off the ones that she wanted to read. However, when they reached her office, they would pile up and she would never find time to read them.

"Now, instead of having that search done every month, I wait until I am starting to work on a project or think about a project, like developing a patient orientation program, and I have the library do a literature search on that topic," she says.

There's always someway to do something better, says Mercurio. "If you don't have the answer to something, someone else may have a little different perspective on it and have figured out how to do it better," she says. ■

Incorporating herbs into meds education

How much information is just right?

Although herbal supplements are extremely popular, they are not always safe. Consumers need to know that taking ginseng, echinacea, and St. John's wort is not the same as taking a multivitamin in the morning.

Herbs, which are parts of a plant such as the flower, seed, or stem, are an alternative form of drug. Therefore, they can interfere with other medications, have adverse interactions with food, can cause a medical problem to occur, or worsen an existing condition, says **Ann Nawarskas**, PharmD, PA-C, a clinical specialist at the New Mexico Veterans Affairs (VA) Health Care System in Albuquerque.

"I have had patients with borderline blood pressure problems who take licorice or supplements with licorice that cause their blood pressure

to get worse," says Nawarskas. Before taking herbal supplements, patients need to consider their medical conditions, past surgical procedures, drugs they are taking, and dietary restrictions. **(To learn what patients need to know about taking herbal supplements before surgery, see article on p. 90.)**

They also need to have a clear understanding of what the herb will do. Although The Ohio State University Medical Center in Columbus does not provide patient education monographs on specific herbs and dietary supplements, the drug information center will provide specific information when patients or health care providers request it, says **Marva Tschampel**, RPh, a drug information pharmacist in the department of pharmacy. Information on supplements is not routinely made available to patients because it might encourage the use of herbs without scientific justification, she says.

When a request is made for information on an herbal supplement, Tschampel's favorite reference is the *Natural Medicines Comprehensive Database, Fourth Edition*, published by Therapeutic Research Faculty in Stockton, CA. This reference is available in hard copy and on the web at www.naturaldatabase.com.

It has a standardized format, which includes synonyms, scientific names, possible uses, safety, effectiveness, mechanism of action, adverse reactions, interactions with herbs and other dietary supplements, interactions with drugs, interactions with foods, interactions with lab tests, interactions with diseases or conditions, dosage, and administration. **(For more information on how to get a copy of the *Natural Medicines Comprehensive Database*, see sources box, right.)**

Communicate with the physician

"A general statement of the use of herbs and dietary supplements is provided to patients to encourage their communication with their doctors and nurses," says Tschampel. People always should discuss the herbal supplement with their health care provider before taking it, agrees Nawarskas. She recommends that people create a list of the current medications that they are on that include over-the-counter purchases as well as prescriptive medicines whether taken infrequently or regularly.

It's important for patients to discuss herbal supplements with their providers because there are potential herb-disease interactions, drug-herb interactions and herbal-food interactions that should be screened for, says Nawarskas. For example, St. John's wort can decrease the blood thinning effect of warfarin, which is prescribed to keep blood clots from forming. It also can reduce the effectiveness of some HIV drugs. "The herb increases the risk of developing drug resistance so the virus is no longer sensitive to the HIV medicine," she says.

Another important issue for patients to remember is that they may have an adverse or allergic reaction to herbal supplements. "People don't have to take herbs in large doses or long-term to have problems. In the last six months to a year, there has been more and more in the press about kava, which is used as a sleep agent and for anxiety. There have been reports of individuals who have gone into liver failure while taking it," says Nawarskas.

People who purchase herbal supplements need to know that there is no guarantee that the contents listed on a label are actually contained in the bottle. "In the United States, there are no laws that require any of the herbal supplement manufacturers to prove that their advertised product contains a certain amount of the ingredients advertised," she reports.

SOURCES

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- **National Nutritional Foods Association**, 3931 MacArthur Blvd., Suite 101, Newport Beach, CA 92660-3013. Telephone: (800) 966-6632 or (949) 622-6272. Web site: www.nnfa.org.
- **NSF International**, P.O. Box 13140, 789 W. Dixboro Road, Ann Arbor, MI 48113-0140. Telephone: (800) 673-6275 or (734)-769-8010. Web site: www.nsf.org.
- **U.S. Pharmacopoeia**, 12601 Twinbrook Parkway, Rockville, MD 20852. Telephone: (800) 822-8772 or (301) 881-0666. Web site: www.usp.org.
- ***Natural Medicines Comprehensive Database, Fourth Edition,*** published by Therapeutic Research Faculty, 3120 W. March Lane, P.O. Box 8190, Stockton, CA 95208. Telephone: (209) 472-2244. Web site: www.naturaldatabase.com.

Herbal supplements and surgery don't mix

Curb herbal remedy use before procedure

Some herbs and dietary supplements should be discontinued prior to surgery. The Ohio State University Medical Center has educational sheets that can be used to teach patients, says **Marva Tschampel**, RPh, a drug information pharmacist.

Patients are advised to stop taking herbal remedies at least two to three weeks before scheduled surgery. If there is not enough time, patients are asked to bring the herbs and other over-the-counter medicines they take to the hospital in their original containers. This gives the anesthesiologist an opportunity to see what ingredients they contain.

Some of the herbal products that may cause complications for people having surgery that the department of pharmacy singles out include:

- **Echinacea:** Can cause allergic reactions and decrease the effectiveness of drugs that suppress the immune system.
- **Ephedra:** Causes an irregular heartbeat when used with certain anesthetics. It also causes high blood pressure.
- **Feverfew:** Believed to interfere with blood clotting.
- **Garlic:** Increases the risk of bleeding.
- **Ginkgo biloba:** May reduce platelets, which are needed for blood to clot.
- **Ginseng:** Believed to cause episodes of high blood pressure and rapid beating of the heart. Can increase the risk of bleeding.
- **Kava:** Can increase the sedating effect of anesthetics.
- **St. John's wort:** Can prolong the sedating effects of anesthetic agents.
- **Valerian:** Increases the sedative effect of anesthetics. ■

Many factors can influence the product. The strength, purity, and effectiveness of a product depend on where the herb was grown, how it was stored, and how it was manufactured. An herb in a product may have been mixed with another crop or there may be only a trace of the herb in the product. Sometimes the product doesn't even contain the herb, says Nawarskas.

To make sure they are purchasing a quality product, consumers should look for the seal of approval from two agencies that offer verification programs for herbal products. These include the United States Pharmacopoeia (USP), based in Rockville, MD, and the National Nutritional Foods Association (NNFA) in Newport Beach, CA, working with NSF International in Ann Arbor, MI. These agencies test products to determine if they contain the herb on their labels and do random searches for quality assurance. However, only the companies that volunteer and pay a fee for this surveillance are monitored.

Participating manufacturers who are approved by the USP will have the dietary supplement verification program mark on the container label. Those approved by NNFA will have the good manufacturing practice seal of approval on the label.

While patients need to be educated about herbal supplements and how to use them safely, health care providers also need to be kept abreast of current information. Therefore, at The Ohio State University Medical Center, the Department of Pharmacy created a database for health care practitioners that can be accessed via the hospital intranet system. The database lists the adverse effects and drug interactions of a group of targeted herbal and dietary supplements that are selected on the basis of published articles in the medical literature, says Tschampel.

"Included in the patient history are questions regarding the use of herbs and dietary supplements. This list is matched to the database for potential adverse effects or drug interactions," says Tschampel. ■

Controlling menopause: One size doesn't fit all

Counseling reveals options to fit women's lifestyle

It is probably safe to say that no two women experience menopause in the same way. That's why **Debbie DeAngelo**, RN, BSN, a health educator at Hamot Health Connection, the women's center at Hamot Medical Center in Erie, PA, provides individual counseling about nutrition, vitamins, and hormone-replacement therapy to control symptoms.

EXECUTIVE SUMMARY

Last month, *Patient Education Management* began an article series on educating patients about symptom management with an article on cancer fatigue. This month, we look at menopause, discussing its signs and symptoms and the options women have for alleviating them to improve their quality of life. Hormone-replacement therapy is not the only option. The foods that women include in their daily diets can make a big difference as well as the vitamin supplements that they take. Women need to know their alternatives to make an informed decision.

"I don't believe that one size fits all for anything, whether it is vitamins, hormone-replacement therapy, or nutrition. I think it depends on women's lifestyle, their diet, family history, and their goals," she says.

Prior to a counseling appointment at Hamot Health Connection, women complete a health profile so that DeAngelo knows their family history, what their health screenings have revealed, their symptoms, and what they are using to control symptoms from vitamins to hormone-replacement therapy.

Clients vary in age. The age range for natural menopause is 45-55, with an average age of 51. If a woman begins going through menopause on the early side of the age spectrum, she will start having symptoms a few years in advance. In their late thirties or early forties, some women find that their menstrual periods change, they begin having vaginal dryness, hot flashes, or night sweats.

Another group of women begins experiencing menopausal symptoms in a matter of hours because of a hysterectomy in which their ovaries are removed, or in a matter of months because of chemotherapy or pelvic radiation. "These women struggle with the same symptoms but to a more severe degree because menopause has come on so fast their body doesn't have time for the hormones to transition over a period of years," says DeAngelo. **(For more information about handling sudden menopause, see editor's note at the end of this article.)**

For many women, changes in their menstrual cycle are the first signs of menopause. They will become irregular, lighter, shorter, heavier, longer, all across the board, she says. Other common signs include interrupted sleep, night sweats, or hot flashes. Some symptoms women don't associate with menopause. These include mood swings, mild anxiety or depression, cognitive changes such as short-term memory loss, or a drop in their sex drive.

"With natural menopause, what usually triggers those symptoms is the fact that a woman's hormone levels are fluctuating and declining at the same time, and that triggers some hormonal chaos," DeAngelo explains. However, a woman's body adjusts over a period of two to four years, and the symptoms level off.

When a woman first begins experiencing menopausal symptoms, a visit to her physician is in order. That's because women should not automatically assume that the symptoms are a sign of menopause, especially if they are experiencing them at an early age. They could be a sign of a thyroid dysfunction or some other health problem.

Quality-of-life issue

Menopause is not a medical problem; however, those who experience menopausal symptoms want to alleviate them to improve their quality of life, says DeAngelo. Therefore, she focuses on lifestyle counseling, first examining diet. "I determine if women are getting enough protein that is equally distributed throughout the day, because that makes a big difference with their mood, their energy level, and brain functioning," says DeAngelo

She also determines if women are eating enough fruits and vegetables. Women worry about taking vitamins to fortify their immune system and help with symptoms, but supplements won't help if they aren't getting adequate nutrition, says DeAngelo.

Other important dietary changes include incorporating omega-3 fatty acids and monounsaturated fats into their diet. The strategy is to improve cholesterol and provide symptomatic relief from menopause as well. She also may add soy products and flaxseed to the diet to help manage menopause symptoms, build bone density, and reduce cholesterol level. When estrogen levels drop, women can be at increased risk for a heart attack and osteoporosis.

DeAngelo always asks women to bring their supplements with them to the counseling appointment. Usually, they are taking all kinds of vitamins for a variety of reasons. They may have helped a friend or were recommended by a clerk in a health food store. "I try to get them on a vitamin regimen that is beneficial and safe," she says.

Most menopausal women want to see if lifestyle changes and natural techniques help before they consider hormone-replacement therapy. However,

SOURCE

For more information about counseling women on their options for managing menopausal symptoms, contact:

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she does go over the advantages and disadvantages of hormone-replacement therapy and the differences in the variety of products available. For example, estrogen is effective for relieving menopausal symptoms such as hot flashes and night sweats, and helps build bone density. However, it wouldn't be the best option for women with heart disease because it increases their risk of a heart attack, she says.

It's important that women understand all the options for management of menopausal symptoms. "If you give women alternatives and they know the consequences of their actions. that is the basis of an informed decision," says DeAngelo.

[Editor's note: Debbie DeAngelo went through menopause at the age of 26 following a hysterectomy due to ovarian cancer. In an effort to manage her menopause, she did a lot of research, experimented, and talked to other women. As a result, she was able to help herself and her patients and was prompted to write a book.

Sudden Menopause: Restoring Health & Emotional Well-Being, *published by Hunter House, is available in bookstores and on Amazon.com for $15.95 plus tax. It is written for women who experience unanticipated menopause due to hysterectomy, chemotherapy, pelvic radiation, premature ovarian failure, and anorexia.]* ■

Teaching only takes a minute if patient's ready

Watch and listen to clues

Got a minute? Sometimes that's all it takes to educate patients when they are receptive to teaching. Times like these often are referred to as teachable moments and are easy to recognize.

Practitioners can recognize a teachable moment by one of many cues, says **Fran London**, MS, RN, a health education specialist at Phoenix Children's Hospital. Cues include:

- **Questions:** The learner asks a question, such as "What's that pill for?"
- **Concern:** The learner expresses a concern. For example, he or she might say, "I'll never be able to do that!"
- **Lack of understanding:** The learner makes a statement that is incorrect such as, "I don't want morphine. I don't want to become a drug addict."

Educators often can tell by looking at people that they are ready to learn. The learners' eyes light up and their ears seem to perk up, says **Naomi Holtz**, RN, BSN, a health education specialist at St. Luke's Regional Medical Center in Sioux City, IA. "They are eager and able to absorb what you have to offer and may be more motivated than usual to change some of their unhealthy behaviors," she says.

When a nurse is caring for a patient at the bedside, he or she may ask a question, such as "Why are my feet swelling?" When patients ask questions, they are receptive to learning, and the nurse or health care provider can explain that their heart is not pumping like it should, so they have extra fluid in their system. At that point, they can be given some interventions that they can do to help with the problem. "It's good to give patients little, easily digestible bits of information and then, if possible, reinforce them frequently," she says.

What educators need to know is that when a teachable moment arises, they need to respond immediately, says London. If a learner has a question, answer it, or if a learner has a misperception, correct it, she advises. An educator may have to use a delaying tactic, such as giving the patient a handout to read and promising to return in 30 minutes to discuss it. However, acting on the teachable

SOURCES

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moment immediately in some way keeps the moment open, says London.

Many factors can create a teachable moment. It may be a symptom a patient is experiencing or an external experience. It can come in a classroom setting, the emergency department, a clinic, at the bedside, or during a formal teaching setting. For example, there may have been a fatal house fire in the neighborhood, so a person is very receptive to teaching about fire safety at that point, says Holtz.

"Once you recognize a teachable moment, you need to figure out how best to respond," says London. One consideration is how to individualize the presentation of the information to meet the needs of the learner. If a patient has poor eyesight or poor literacy skills, it would be inappropriate to respond with a handout, she says.

"You need to know your patients before you teach them," says **Theresa Towne**, RN, MSN, an inpatient educator at Bayhealth Medical Center in Dover, DE. At Bayhealth, an initial assessment is done when a patient is admitted to the hospital that includes barriers to learning, such as the inability to speak English and ways the patient prefers to learn.

It's always important to really listen to what the patient is saying. "Have a good ear as to what they really need to know," says Towne.

Often the learner tells you what he or she needs to know either directly or indirectly, she says. Learning needs can be assessed as well by evaluating the understanding the learner has of self-care skills such as medication or diet.

Although patients need to have their concerns and questions addressed, other education often can be tagged onto the teaching when appropriate. For example, St. Luke's has a teaching plan for patients with hepatitis C that covers such topics as medications, fatigue, and nutrition. However, the patient may be experiencing a lot of fatigue, and that is all he or she wants to discuss. In such cases, the educator can incorporate nutrition into the discussion about fatigue by explaining that if the patient eats the recommended healthy foods, some of their fatigue could be alleviated.

Whenever teaching takes place, whether it is an extended session or a teachable moment, it should be evaluated and documented. "Just because we said it, or gave a handout, there is no guarantee that the learner got it or got it right," says London. Educators should ask the learner to teach the information back to them or demonstrate the skill independently.

It may take several teaching sessions from

several different approaches before the learner understands. That's why all teaching, whether formal or informal, should be documented, says London. The purpose of documentation is to communicate the learner's status to the health care team so each can build on one another's progress and to have a record of the learner's informed consent and readiness for self-care, she explains.

It's important that educators never ignore a teachable moment. Instead of learning the information they are after, patients might learn the environment at the health care facility is not responsive to patients and the information is not available. Then when educators want to teach, they may find that patients are not ready to learn. Teaching could become a time consuming chore. "Taking advantage of teachable moments may both save time and improve outcomes," says London. ■

Oct. 10 set aside for depression screening

Screening day designed to increase awareness

The National Institute of Mental Health in Rockville, MD, reports that more than 17 million Americans develop depression each year, yet less than half are diagnosed and treated. There are many reasons why. Some people know something is wrong but don't know what it is. Others think they may be depressed, but they don't know where to turn. Many have difficulty bringing up the concept of mental health problems with their primary care physician. They want to talk about it but they don't know how, says **Joelle Reizes**, MA, director of special projects for Screening for Mental Health in Wellesley Hills, MA.

To help get the word out about the signs and symptoms of depression and help people who suffer from the illness seek treatment, Screening for Mental Health has designated Oct. 10, 2002, as National Depression Screening Day. On this day, psychiatric facilities across the country set up screening sites at local shopping malls, libraries, and other facilities to screen for depression. "People are interested in being screened for mental health issues. It is an opportunity to talk to a clinician for free that is the biggest draw," says Reizes.

The screening involves completing a form, listening to an educational presentation, and sitting down with a clinician for a few minutes for a one-on-one consultation. There are brochures and handouts on depression participants can pick up at the screening. All these materials, as well as a publicity guide and procedure manual, are available in a complete kit for $150 from Screening for Mental Health. **(See contact information, above.)**

SOURCE

For more information about screening for depression, contact:

- **Joelle Reizes**, MA, Director of Special Projects, Screening for Mental Health, One Washington St., Suite 304, Wellesley Hills, MA 02481. Telephone: (781) 239-0071. Web site: www.mentalhealthscreening.org.

The one-page screening form is designed to be easy to use and score, and addresses a range of commonly underdiagnosed disorders that often co-occur with depression. "What we have done is create one-stop shopping for the public when they are feeling symptoms that are often overlapping," says Reizes. These symptoms might be tension, feeling down, and feeling keyed up with all the symptoms interacting.

People are attracted to the screening with catchy promotions. For example, colorful balloons and a sign that reads 'Test your Mood' is very inviting. The most successful screening facilities are public sites such as shopping malls, and the least successful sites are psychiatric facilities. There are fewer stigmas in bringing it out in the open than making it private, says Reizes. "Making it private conveys the message that somehow we should be hush-hush and embarrassed. Bringing it out in the open as we would any other health issue removes the stigma," she explains. **(To learn how to screen in the physician office, see article on p. 95.)**

Teach signs of depression

It is important for the public to recognize signs of depression so that they can seek treatment or aid others in finding help. There are many signs and symptoms that could indicate a person is depressed. Feeling blue is not necessarily one of them. Sadness often is a normal reaction to a life situation but goes away after a few days. Clinical depression persists, and, if left untreated, can last for months or years.

According to Screening for Mental Health, symptoms include:

- persistent, sad, anxious, or empty mood;

• feelings of hopelessness or pessimism;
• feelings of guilt, worthlessness, or helplessness;
• loss of interest or pleasure in ordinary activities;
• decreased energy, a feeling of fatigue;
• difficulty concentrating or making decisions;
• restlessness or irritability;
• inability to sleep or oversleeping;
• changes in appetite or weight;
• unexplained aches and pains;
• thoughts of death or suicide.

Data collected from National Depression Screening Days, which were implemented in 1991, reveal that some people who have depression do not experience the classic symptoms of changes in sleep or appetite. Data from the screenings reveal that the most common symptoms are:

• difficulty doing things done in the past;
• feeling hopeless about the future;
• difficulty in making decision;
• feeling worthless and not needed;
• no longer enjoying once enjoyable activities.

There are four types of depression. Major depression is the most common, and people who experience it would have at least five of the major symptoms of depression. Dysthymia, a milder form of depression, is the second most common. People with dysthymia may only have two or three symptoms. Bipolar depression is the depressive phase of manic-depressive illness. Symptoms are similar to major depression. Seasonal affective disorder is a type of depression where symptoms occur in the winter months and diminish in spring and summer. It may be caused by a biochemical reaction from the absence of sunlight.

It is important for the general public to be aware of depression and the various types not only for their well-being but for the health of their family and friends. People who are depressed cannot simply "snap out of it" and need to seek medical intervention, says Reizes. People who suffer from depression can be treated with medication and psychotherapy.

Suicide is the most tragic outcome of depression, yet many people do not know how to intervene by helping their friend or family member seek psychiatric help. That's why there is a suicide-prevention component in the screening kit.

"Most people stand a better chance of surviving if they start to choke to death in a restaurant than if they are sitting in that same restaurant and tell their dining partner they want to take their own life," says Reizes. ■

Depression screening while you wait

Simple forms for a quick overview

While depression screening as a community outreach helps to uncover many people who suffer from depression but haven't been diagnosed, routine screening might be more beneficial, says **Joelle Reizes**, MA, director of special projects for Screening for Mental Health in Wellesley Hills, MA. That's why the organization has created a screening form for primary care use that can be

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CE Questions

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5. Patients indicate that they are ready to learn if they ask questions, express concern, or show lack of understanding.
A. True
B. False

6. Before taking an herbal supplement, consumers should consider:
A. Their medical conditions
B. Past surgical procedures
C. Dietary restrictions
D. All of the above

7. To help control menopausal symptoms such as hot flashes and night sweats, women should consider:
A. Trying dietary changes
B. Taking cold showers
C. Drinking more water
D. Sleeping sitting up

8. Parents should explain the purpose of a procedure to their child in the medical terminology health care professionals use.
A. True
B. False

Answers: 5. A; 6. D; 7. A; 8. B.

ordered free of charge.

They encourage physicians to have patients complete the form while in the waiting room. Any staff person could score it and place it in the patient's file for the physician to review. "If the score is negative, there is nothing more to do, but, if positive, depression could be the reason patients are experiencing their symptoms. Frequently, patients come to their physician with unexplained aches and pains that are caused by depression, she says.

Screening for Mental Health encourages physicians to try this method of uncovering depression by screening patients for one day. "It will provide a snapshot look at the level of depression in their existing practices," says Reizes. ■

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

Procedures are easier when parents tell the truth

Teach Mom and Dad to communicate at child's level

Communication is key to compliance for children during the treatment process, and parents have a big role. Teaching parents how to talk to their children during a medical encounter and preparing the child for the intervention can make a big difference.

"When talking with children, the goal should be to accurately communicate in a minimally threatening manner without increasing their stress level," says **Katie McFaull**, CCLS, a certified child-life specialist at the emergency department of Children's Healthcare of Atlanta.

For example, if a child has to have an IV and wants to know how it will feel, a parent should explain that all children are different. Some think that it feels like a pinch. Avoid telling the child that it won't hurt, advises McFaull. Parents should invite the child to tell them how he or she thinks it feels. If a nurse tells the child that it won't hurt, the parent should simply say, "Why don't you tell us how it feels," she says.

Also, parents should explain the purpose of a procedure such as an IV in terms a child can understand, such as: "The IV has a job. It will get medicine into your body faster to help you feel better quicker."

Parents should make sure their children understand the medical terminology being used as well. Young children are very concrete thinkers. Nurses might use such language as "put to sleep," "move you to the floor," or "stick." "When children can't think abstractly, which usually doesn't happen until school age, they think the nurse is going to put them on the floor," says McFaull.

If an accident was the reason a child was brought to the hospital, parents should explain that accidents happen every day, such as children falling off playground equipment. "Preschool children are very egocentric and can see the hospital as punishment for a past misbehavior," she says.

Avoiding confrontation

Preparing the child will help to avoid confrontation later. There are other ways to skirt an argument. One way is never to tag the word "OK" onto a sentence because children feel that they can refuse. For example, instead of saying "We need you to take your medicine now, OK?" parents might say, "Take your medicine now; you can take it slow or fast." A child feels more in control and is more likely to cooperate if he or she is given realistic choices, says McFaull.

Also, it's important for parents to keep from making promises that they might not be able to keep. For example, parents should never tell children that they can have something to drink following the procedure unless the physician has told them that will be possible.

Tension can be eased if children are given a job to do during the procedure such as holding their arm still, advises McFaull. That gives them self-esteem and confidence. It also provides a positive point of reinforcement. Parents can say, "You did a good job holding your arm still."

"Avoid saying 'good boy or girl,' because you don't want to label the children, but the behavior," she says.

How parents communicate with children does depend on their age. School-age children and teens can think abstractly. They understand that taking medicine by mouth will get rid of a headache. School-age children need more time to ask questions and understand what is happening. Teens may fear that physicians and parents are not being honest and open therefore communication is extremely important, says McFaull.

Families often rush children to the emergency department only to be asked to wait; therefore, it is

SOURCE

For more information on teaching parents how to communicate with their children, contact:

- **Katie McFaull**, CCLS, Certified Child Life Specialist, Children's Healthcare of Atlanta, SR Campus, Child Life Department, 1001 Johnson Ferry Road N.E., Atlanta, GA 30342. Telephone: (404) 250-2442. E-mail: katie.mcfaull@choa.org.

wise to come prepared. "All children fear strangers, new places, and being left alone, so if at all possible, parents should try to engage them in a familiar activity," she says.

If possible, on the way out the door, parents should grab a favorite toy or video game or an item that provides comfort and security such as a blanket, advises McFaull.

All children cope best when allowed to play, and it is a great way to distract them from pain. Bubbles, a coloring book, or card game all are good items to bring along, she says.

Parents should avoid talking about past experiences that involve negative connotations or information to pass the time. Often they reminisce about a visit to the emergency department when they were a child, which tends to frighten their child rather than provide comfort, says McFaull. ■

SIDS education saves 2,000 babies annually

Target parents, grandparents, and caregivers

Since the Back To Sleep campaign began in 1992, the rate of sudden infant death syndrome (SIDS) in the United States decreased by a total of 42%, according to numbers released by the Sudden Infant Death Syndrome Alliance in Baltimore. This campaign has taught parents to put their babies to sleep on their backs rather than their stomachs and other important prevention methods.

Educating new parents saves the lives of more than 2,000 babies each year. However, SIDS still is the leading cause of death in infants between 1 and 12 months old, so health care providers must be vigilant. "We like education to take place third trimester and also once the baby is born," says **Kathy Graham**, MSW, MHS, program coordinator for SIDS Alliance.

Discussion of SIDS during the third trimester can focus on the nursery and where the baby will sleep. After the baby is born, the focus might be how the baby will sleep. Providing a time to reinforce what was first taught refreshes parents' memories and helps them become aware of facts they missed the first time. What needs to be taught? Graham suggests the following information:

• **Back sleeping:** When putting babies to sleep, parents should place them on their backs. If infants fall asleep on their stomachs, parents should know to gently turn them onto their backs.

• **Bedding:** The baby's crib should have a firm, flat mattress, and no fluffy blankets or coverings. Pillows, sheepskins, or comforters should never be placed under the baby. Parents might consider using a sleeper or other sleep clothing as an alternative to blankets. Infants should never sleep on a waterbed, sofa, or with stuffed toys or pillows.

• **Head covering:** If babies' heads become covered during sleep, they are at an increased risk for SIDS because it causes re-breathing of stale air. Therefore, parents shouldn't place a blanket over a baby's face for protection from sun or weather while sleeping.

• **Smoking:** Women who smoke during pregnancy are three times more likely to have a SIDS baby. Passive smoke in a household after the baby's birth doubles the risk of SIDS.

• **Room temperature:** A baby's room should be at a temperature that feels comfortable to an adult. When babies become too warm, they fall into a deep sleep and are difficult to arouse.

It's important to explain to parents that some babies are possibly born with some sort of defect in the brain stem and they don't have an internal mechanism that tells them to turn their heads if they are re-breathing carbon dioxide, says Graham. "It is not only better that these infants are not face-down or on their stomach but that they are not around soft materials, so we stress no blankets or very light blankets," she says.

In spite of the education campaign initiated by the SIDS Alliance, there are some groups of people that need to be better educated on the topic. Grandparents are one of these groups. They were taught to put infants to sleep on their stomachs to prevent choking. Therefore, new parents need to be coached to educate their parents before soliciting their help as baby-sitters. Also, sleeping arrangements at grandparents' houses need to be evaluated.

A second group is day care providers. "If infants have gotten used to being placed on their backs and are placed on their stomachs in day care, they are at much higher risk for SIDS. We call them 'unaccustomed stomach-sleepers,'" says Graham. ■

SOURCE

For more information on preventing sudden infant death syndrome, contact:

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