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INSIDE

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Patient education graduates to a different group as boomers age

Detailed assessment key to tailoring teaching to elderly patients

The old adage is true now more than ever: We ain't getting any younger. According to the Census Bureau, the percentage of Americans age 65 and older has more than tripled since 1900. What's more, this segment of the overall population is getting older itself. In 1997, the 85-and-older age group was 31 times larger than this same age group in 1900, and the 75-84 age group was 16 times larger. Between the years 2010 and 2030, these population groups will burgeon further when the baby boomer generation reaches age 65.

Patient education must meet the learning needs of the growing population of elders. To do so, patient education managers will have to create programs specifically for the elderly, train staff to overcome barriers to education that worsen with age, and find new ways to provide access to information and services for this growing population.

In 1995, older people accounted for 40% of all hospital stays and 49% of all days of care in hospitals, according to the U.S. Department

EXECUTIVE SUMMARY

As the population gets older, the need for educational programs and teaching materials targeting elderly patients increases. Since 1900, the percentage of Americans age 65 and older has more than tripled, according to the U.S. Bureau of the Census. In 1997, those who reached age 65 had an average life expectancy of an additional 17.6 years. The special teaching needs of seniors include:

- the need for more complete learning assessments;
- the need for programs covering topics on aging;
- the need for information on accessing special services.

of Health and Human Services' Administration of Aging (AoA), in Washington DC. Most older Americans have at least one chronic condition and many have multiple conditions, according to the AoA. In 1994, the most frequently occurring conditions among the elderly were arthritis, hypertension, heart disease, and hearing impairments.

"The elderly need to know the same information as anyone else. The problem with teaching them is that they have more barriers. For example, they may have hearing or sight problems so they may need some material presented to them a different way," says **Berdelle Ingeman**, patient education coordinator at Rice Memorial Hospital in Willmar, MN.

Learning assessment vital

Completing a good learning assessment is vital to effectively teach the elderly, says Ingeman. For older patients, a learning assessment not only reveals what needs to be taught, but how they will best understand the information. The assessment should uncover physical or sensory changes that take place as we age, such as impaired mobility, hearing loss, or poor eyesight.

Personal losses also can affect learning, says Ingeman. These not only include the death of a spouse or other loved ones, but such lifestyle changes as retirement, moving from a house to an apartment, or not being able to drive anymore.

Finances, too, should be a part of the assessment because they often impact compliance, says Ingeman. "We need to assess their financial resources to determine if they have enough money for medications, food, shelter, and heat."

"The best thing that health care providers can do for elders is to get a very good assessment — including medical background, cultural background, and systems background. We need to know where these people live and what their support systems are like," says **Angela Stoops**, RN, vice president of education and work force development for AGE Institute, a nonprofit educational organization in Chambersburg, PA.

Although it is possible to list many general signs of aging, you should never generalize about a patient group, says Stoops. Each person is unique, and the assessment will make it possible to individualize the teaching, making it more effective.

The assessment doesn't need to be complicated, it just needs to be complete, agrees **Jennifer Browning**, MS, RN, CNS, CNP, gerontological clinical nurse specialist and adult nurse practitioner at The Ohio State University Medical Center in Columbus. Ask simple, straightforward questions, she advises. These might include:

- Do you have any problems with your memory?
- Do you have any vision or hearing problems?
- What losses have you had in the last six months?

While undergoing a complete assessment before teaching might take a little longer, it will save time, says Ingeman. "It is important for staff to realize that by knowing the person's special needs and completing the assessment, they will ultimately save time in the long run because they don't have to go back and re-teach the person later," she explains.

Overcoming barriers

Learning effective teaching techniques for the elderly is important for all health care providers who work with these patients. Because many seniors experience hearing loss, those who teach elderly patients should face them when talking and make sure there are no distractions in the room or background noises, says Ingeman. Large-print materials should be available to reinforce teaching.

It's sometimes difficult for the elderly to adjust to new restrictions and limitations brought on by aging, such as the fact that they are not as mobile as they use to be. "It's important to start right where they are and help them make the necessary adjustments in their life," says Ingeman. **(To learn about a community outreach class to help seniors adjust their lifestyle to the limitations of aging, see story, p. 3.)**

The special requirements of the elderly always must be taken into account when designing classes and other educational programs for them, says Browning. Make sure the class is held in a barrier-free environment, she advises. Classes should be held in rooms the elderly can get to easily, that accommodate wheel chairs, and have parking close by. Night vision often is a problem so hold sessions in the daytime, and avoid rush-hour traffic. Incontinence can be an issue too, so make sure that the restroom is located near the classroom and hold short sessions.

Feed them, and they will come

Site of senior outreach forum means easy access

The Fitness Forum, a community outreach program for seniors, draws crowds of 150 and more the third Thursday of the month. That's because the message is positive, says **Linda Mauger**, program manager for the Office of Geriatrics and Gerontology at The Ohio State University Health Sciences Center in Columbus.

"The program is being offered so that older adults can stay more in charge of their lives and age independently in a healthy manner over the long term," says Mauger. Topics covered have included financial planning, Medicare, and memory loss.

The educational sessions are held at the food court of a local mall that sponsors a senior walking program. The mall is located in a community with a large percentage of older adults. A continental breakfast is served at 8 a.m. with the hour-long presentation beginning at 8:45 a.m. Each presenter answers about 10 minutes of questions at the end of each session. The sessions are followed by a drawing from the merchants at the mall. "I believe that food and the drawing are great incentives," says Mauger.

SOURCE

For more information on Fitness Forum, contact:
Linda Mauger, Program Manager, Office of Geriatrics and Gerontology, The Ohio State University Health Sciences Center, S 2042 Davis Center, 480 West 9th Ave., Columbus, OH 43210. Telephone: (614) 293-8031. Fax: (614) 293-5612. E-mail: mauger.10@osu.edu.

Those who attend the Fitness Forum are given a notebook at the beginning of the nine-month lecture series that runs from September through May, following the university's academic calendar.

Each month, participants receive a chapter on the topic being covered to create a manual by the end of the lecture series. Also, they have an opportunity to pick up information on other topics of interest or resources in the community as they register.

Seniors who attend Fitness Forum are placed on a mailing list and receive a card in the mail announcing the upcoming topics for three months. Mauger obtained the original mailing list of prospective seniors from a local commission on aging.

"We started from day one with just amazing attendance. That mailing list of 250 has grown into 1,000 and each month the session is in the newspaper," says Mauger. ■

If possible, distribute a screening questionnaire before holding a session to determine what special concerns seniors have. Also, ask what they hope to get out of the class. Adults in general, and especially older adults, want to know that they are going to come away with new insight or knowledge.

It's best to be proactive in education, says Stoops. Help elders see aging as part of the natural life cycle instead of a negative, she says. That means providing access to information that helps people age well, including Web sites, books, articles and other publications.

"It is important for us as health care providers to provide access to services and systems," says Stoops.

(For Web site addresses and other resources, see source box at right. Also, see the following article about educational sessions to help seniors age well, p. 4.) ■

SOURCES

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Safety class has senior focus

Purpose is to make seniors more aware of limits

Educating seniors about the subtle changes that occur as people age is the focus of a community outreach course created by ENCARE (Emergency Nurses CARE), a nonprofit organization in Alexandria, VA.

The course, called Take Care, is aimed at people 55 and older. Its purpose is to reduce preventable injuries and deaths through lessons that increase awareness and promote healthy lifestyles. **(For information on how to implement this course at your institution, see resource box at the end of this article.)**

Susanne Heinzerling, RN, is a volunteer who teaches the course to seniors. Although she now works as a nurse practitioner for Mad River Valley Health Center in Weightsfield, VT, she worked 24 years in the emergency department. "I used to see a lot of injuries caused by household accidents," says Heinzerling.

That's why the slide lecture, which lasts about 45 minutes, covers ways to make the house safer for older adults by installing handrails on bathtubs and toilets. Another safety measure discussed is using night lights to keep from becoming disoriented when waking from a sound sleep to get to the bathroom.

Heinzerling presents the information in a positive manner, in hopes that seniors will acknowledge the changes that come with age to prevent serious injury. For example, many seniors won't use a cane even though it would help them become more stable on their feet.

Heinzerling shows them canes that are artistically beautiful. "I tell them that in Europe they are a sign of affluence," she says.

The course covers a wide range of safety and health issues, including:

• **Living alone.**

A senior living alone often has poor dietary habits. "They tend to live on tea and toast," says Heinzerling. The course provides information on how to improve eating habits by going to the local senior center for lunch or becoming a part of the local home meal delivery program.

• **Driving problems.**

Because seniors often have poor vision and slower reflexes, they need to be educated about changes in driving ability, says Heinzerling. "I have to remind people that with nighttime driving they have to use a little more caution," she explains.

Also, many seniors lose their ability to react quickly and some of their motor skills. For example, they may begin to make big, wide swing turns that make other drivers think they have the wrong blinker on so they pass on the wrong side.

• **Safety in walking.**

Crossing the street can be hazardous for senior citizens when they don't realize that they aren't as quick as they used to be. "They must be reminded of how quick the light turns and how traffic moves out," says Heinzerling. Also, seniors need to be more careful when walking in back of driveways and through parking lots. It's important that they watch for backup lights, because drivers look for other cars, not people, she explains.

• **Proper medication use.**

Many seniors take several medications, so the potential for suffering from the ill effects of mixing over-the-counter drugs with prescriptions is greater. Also, by not reporting all the medications they take to a physician, there is the possibility that two physicians might prescribe the same drug.

The course also explains that the potency of generic drugs varies according to the manufacturer. While the core of the medication is the same, the shell varies from company to company, says Heinzerling. Therefore, if the drug is purchased in one location once and another location the next time, it might be up to 20% stronger or 20% weaker than the previous dose, she explains. Many seniors are not aware of this, she adds.

• **Alcohol use.**

Some medications cannot be mixed with alcohol. Therefore, seniors need to be sure to read the labels of each prescription carefully, says Heinzerling. Also, it takes fewer drinks to impair driving ability as a person ages.

To get the word out about the program, Heinzerling, who attended a training course before becoming an instructor, contacts senior

SOURCE

For more information on Take Care, the senior safety class created by ENCARE, contact:

ENCARE, 205 S. Whiting St., Suite 403, Alexandria, VA 22304. Telephone: (703) 370-4050. Fax: (703) 370-4005. E-mail: encare@aol.com.

groups such as the senior center and local American Association of Retired Persons chapters. However, targeting seniors is a little different than the safety classes ENCARE designed for grade school children and teen-agers.

First of all, seniors aren't a captive audience, she explains. "A school kid is confined to the school room until the bell rings. With seniors, you don't want to interfere with their bingo games," says Heinzerling. **(For information on the safety classes designed for teens and grade school children, see *Focus on Pediatrics*, inserted in this issue.)** ■

Educational resources for working with elderly

• ***Exercise, A Guide from the National Institute on Aging***. This 100-page free guide is part of a national education campaign for keeping fit after 50. It focuses on four key exercise areas for improving health and ability: endurance, strength, balance, and flexibility. To order by telephone call: (800) 222-2225. E-mail: niainfo@access.digex.net.

• **The American Geriatrics Society**, 770 Lexington Ave., Suite 300, New York, NY 10021. Telephone: (212) 308-1414. Fax: (212) 832-8646. Web site: http://www.americangeriatrics.org. AGS, a professional organization of health care providers, conducts education programs for all health professionals to promote better understanding of the aging process. It also creates educational materials that address the health care concerns and needs of older people, their families, and caregivers.

• **The National Institute on Aging Information Center**, P.O. Box 8057, Gaithersburg, MD 20898-8057. Telephone: (800) 222-2225. Web site: http://www.nih.gov.

Web sites

• **http://www.caregiving.com.** Information on how to be prepared for the roll of caregiver. Caregivers are invited to write their insights, frustrations, angers, hopes, and dreams. Web site also has tips, resources and links.

• **http://www.eldernet.com.** A senior's guide to health, housing, legal, financial, retirement, lifestyle, and entertainment information on the Web.

• **http://elderweb.com.** ElderWeb is an on-line sourcebook with more than 4,000 links to non-commercial, on-line information about health, financing, housing, aging, and other issues related to the care of the frail elderly.

Reader Question

Develop system to get physicians on board

Develop rapport, then materials

Question: How do we get physicians to participate in our patient education efforts? What can be done when a physician is concerned that the patient is being given too much information? What do you do when a physician won't allow the patient to receive the standardized information for diagnosis-specific patient education?

Answer: Before putting a plan together to create patient education materials or a program, approach physicians for their input on how to solve the problem. "Show them where the problems are and bring them some facts and figures, whether it is readmissions or the results from patient satisfaction questionnaires," says **Mary Wolcott**, RN, MSN, patient education coordinator at Methodist Hospital in Omaha, NE. It's important to get the physicians' buy-in up front, she explains.

Wolcott works with the care manager nurses on the floor who are responsible for teaching and discharge planning. They, in turn, speak with the physicians to get their informal feedback on an idea. After physicians have given their informal approval, Wolcott creates a rough draft and has the care manager nurses approach the physicians again for suggestions.

When the material is complete, Wolcott sends it to all appropriate physicians for final approval. If it is a large group, she sends it to the department chair to see if he or she can approve it, or asks if she needs to send a copy to all the physicians.

It is also important to develop a close relationship with the medical staff director, says Wolcott. Often, the director can offer advice on whom to send the materials to for approval. "There have been times when the medical director has had me send the copy to physicians I probably wouldn't have sent it to. It is covering your bases. People want to be included. They want the opportunity for input," she explains.

At St. Joseph's Regional Medical Center in

South Bend, IN, the obstetrics department has a team of experts develop the curriculum or teaching plan before taking it to the physicians for input. "We have found that physicians are not going to sit at the table and help design curriculum. We need to develop it and then ask for their input," says **Jo Wells**, MS, community education coordinator at St. Joseph's. Once a rough draft is agreed upon, the teaching plan is completed and presented to the physicians and their office staff.

Making a luncheon appointment with a physician and stopping by the office with the lunch is a good way to get your ideas heard, says Wells. However, you have to be prepared and present your ideas in a clear, concise manner because physicians don't have much time.

"I have watched pharmaceutical reps and they can say a lot in 30 seconds. We have gotten very good at that ourselves," says Wells. **(For information on developing rapport with physicians, see article on p. 8.)**

Develop common ground

It is important to develop common ground and a system from which to work with physicians, says **Peg Harmon**, RN, BSN, patient education specialist at the Mayo Clinic in Rochester, MN. At Mayo, educators and physicians agree that the needs of the patient come first because that is the standard set by the clinic. "If education is important to patients and families, which it is, then certainly it is important to both educators and providers," says Harmon.

Once an organization has established a common vision, a partnering framework helps ensure that the patient and family will receive the appropriate resources throughout the continuum of care.

"It's important to have a system for support and communication for all those involved in patient education. At Mayo we have a liaison system that helps us stay connected to people doing patient education," says Harmon.

The medical director sends a letter to the division chair of each clinical practice area, asking him or her to name a physician liaison for patient and health education. **(To learn how to create a liaison system within your health care facility, see *Patient Education Management*, July 1998, pp. 85-87.)**

Each patient education specialist partners with several clinical practice areas to facilitate patient education. In addition to partnering with physicians, they maintain contacts with other disciplines including dietary, physical therapy, social services, and nursing leadership.

Any party can make contact concerning education issues, such as requests for materials or initiation of a patient education program. The specialists rely on their formal liaison relationships and procedures for review of all patient education materials. The liaison relationships are posted on the medical center's Intranet along with the database of patient education materials, says Harmon.

It is a good idea to establish a philosophy or mission statement on education that is understood by everyone who participates in the care of the patient, agrees Wells. This cuts down on a lot of the controversy about how much or how little information patients should be given.

In the OB department at St. Joseph's, for example, the philosophy is that patients need to be given nonbiased, factual information and then be allowed to make a choice. "We believe that consumers can make good informed choices when they are given nonbiased information and that is the philosophy from which we educate," says Wells. **(For information on what to do when a physician won't allow a patient to receive standardized information, see article p. 7.)** ■

SOURCES

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Handout for my patients? No way!

How to overcome physician resistance

What do you do if physicians won't allow their patients to receive the standardized information for diagnosis-specific patient education? Provide a method for the physician to create personalized instructions, advises **Mary Wolcott**, RN, MSN, patient education coordinator at Methodist Hospital in Omaha, NE.

Every physician can create what the hospital calls a personal order set, which are instructions for a specific diagnosis such as a lung infection. These instructions are entered into the computer, and physicians simply write instructions for the nurse to give the patient information from their personal order set.

When the nurse enters the doctor's name on the computer, a list of his or her personal order sets appear on the computer screen and the nurse prints off the correct one. "The physician has to order the special instructions. It is treated as a doctor's order," says Wolcott.

Certain policies for education have been established at Methodist Hospitals of Memphis (TN) that permit nurses to initiate certain education processes without a physician's order, says **Denise Thornton**, RN, MSN, CDE, patient education coordinator at the hospital system.

For example, if a patient is confused about a diet, the dietitian can be called to educate the patient without the doctor's permission. In the cancer care area, all breast cancer patients are referred to a program called Reach to Recovery following surgery. If a physician does not want a referral to take place, he or she needs to write an order, says Thornton.

Also, on many high-volume diagnoses, preprinted physician orders have been created. These orders might state that the patient will see a cardiac educator, receive education from a dietitian, and go to cardiac rehab, for example. The physician must sign the order to initiate the education process and at that time he or she can delete or change the information, says Thornton.

"We don't have any standardized orders, they are simply preprinted because that is almost the common practice of the physicians consistently with this particular diagnosis," explains Thornton.

While the obstetrics department at St. Joseph's Regional Medical Center in South Bend, IN, has standardized material, it is often tailored to what each physician wants his or her patient to know, says **Eileen Humes**, RN, BSN, LCCE, an obstetrics nurse. For example, each physician has an opinion on when a woman should come to the hospital when she is in labor.

If one physician does not want a standardized sheet given to a patient, speak to her in private to see how she would like the information given to the patient. By discussing the matter with the physician you might be able to persuade her, says **Jo Wells**, MS, community education coordinator at St. Joseph's.

Educators must try to move patients from a stage where they are no longer just contemplating a behavior change but willing to take action, the same often is true for physicians, says **Susan Karlins**, MPH, director of health education of Santa Clara Family Health Plan and Valley Health Plan in San Jose, CA.

A patient education manager might have to work with a physician to uncover the barrier and overcome it. "Maybe they have thought about it but aren't sure that it won't interfere with their communication. Or maybe they had a bad experience where misinformation was given to their patient. Patient education managers must figure out the barrier of an individual provider," says Karlins.

A small pilot study showing the benefits of a handout to the patients might help persuade physicians, says Wolcott. Several years ago, when physicians refused to let nurses give their patients medication instruction sheets because they were fearful that patients would be given the wrong one, Wolcott did a two-month trial study in the emergency department.

The nurses gave the patients instructions on any medication they were sent home with from the emergency department. "We tracked the patient satisfaction with the medication instructions and came up with 98%," she says.

Wolcott was able to show the medical director that patients were satisfied and there had been no problem with patients receiving the wrong sheet. The medical director gave her permission to have the medical education committee, which includes a physician from every department, review the sheets for approval.

Because the hospital uses a computer system that has 5,000 medication sheets, Wolcott selected the top 20 drugs to send to the committee for

Get physicians on your side

Show how patient education benefits them

One of the best ways to get physicians to support patient education is to show how it benefits them, says **Mary Wolcott**, RN, MSN, patient education coordinator at Methodist Hospital in Omaha, NE.

Find out what physicians keep repeating to their patients or areas where patients are noncompliant and create a handout for them, she advises. This helps to build rapport between the patient education department and physicians, she says.

Wolcott came to the aid of an orthopedic physician who would sit down with each patient and go over a set of exercises he wanted them to do after surgery, yet they never followed through. She offered to create a teaching sheet he could use to reinforce the lesson, explaining that when patients are in pain they often don't remember what they were taught. Now the physician is satisfied because the patients are more compliant.

Not only did patient education gain an ally, but the department was able to make the sheet available to other physicians. The care manager nurses on the floor who are responsible for teaching and discharge planning showed it to other physicians while they made their rounds to see if it might be beneficial for their patients. One by one they gained the support of each physician and the sheet was included in the total hip replacement surgery book when it was created.

"If you do something for physicians that will help them in their practice you'll get their support," says Wolcott.

It's important to spend time with physicians one-on-one, says **Jo Wells**, MS, community education coordinator for St. Joseph's Regional Medical Center in South Bend, IN. Educators in obstetrics talk with the physicians when they see them in the hallway at the hospital. They also make a special effort to talk with the nursing staff in the physicians' offices. ■

review, making others available on request.

"If you really focus on the patient satisfaction or patient's comments, it is persuasive," says Wolcott. ■

SOURCES

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It's on paper, but do they understand it?

Simple testing gets written handouts on target

Don't assume that the education materials your staff wrote for the average national level are right for your facility. The reading level of patients from area to area varies widely; therefore, many patient education managers are evaluating their patient groups.

"We assumed that our population would fit into that national average range [seventh- and eighth-grade reading level] so we kept writing right at that national average level," says **Kathy Ordelt**, RN, CRRN, CPN, patient and family education coordinator at Egleston-Scottish Rite Children's Healthcare System in Atlanta.

However, the hospital had never surveyed its population to be sure. Therefore, in 1998 staff in the education department decided to verify their hunch that the materials were written at the correct level. They purchased the Rapid Estimate of Adult Literacy in Medicine (REALM) test to

help determine the reading level of the hospital's patient population. **(For information on REALM see the resource box at the end of this article.)**

Educators at Medical University of South Carolina in Charleston also wanted to know the average reading level of the patients who were hospitalized, yet they had not made an estimate. With South Carolina trailing the nation in literacy, providing educational materials patients could understand had been an ongoing problem.

"Educators need to be a lot more creative and they need more time to teach when you have patients who can't read," says **Margaret M. Duffy**, EdD, RN, CNN, CCM, clinical educator at Medical University. The REALM test helped them determine that 47% of the patients who come to the emergency department are not able to read the handouts at the level they are written.

Assessing the reading level of your patient population provides valuable information, agrees **Carol Maller**, MS, RN, CHES, patient education coordinator at the Veterans Medical Center in Albuquerque, NM. She worked on a project where about 300 patients were interviewed to evaluate literacy skills and determine the overall reading level of the medical center's population. The Wide Range Achievement Test (WRAT) was used to evaluate literacy within the medical center's patient population. **(For more information on WRAT, see the resource box at the end of this article.)**

"We found that the average reading level of our patients was beginning seventh grade and that was valuable information as far as targeting print materials for the appropriate grade level," says Maller.

Some materials need rewrites

Often, such projects reveal that written materials must be rewritten at a lower grade level, says **Mary Jean Kotch**, BSN, CRRN, patient education coordinator at John Heinz Institute of Rehabilitation Medicine in Wilkes-Barre, PA. High-frequency, interdisciplinary patient education materials were evaluated using the SMOG readability scale, introduced by McLaughlin.

Explain survey purpose, reward participants

Test takes only 90 seconds

Getting people to participate in literacy surveys is surprisingly easy if they are approached in the right manner. Medical University of South Carolina conducted 110 interviews in the emergency department using the Rapid Estimate of Adult Literacy in Medicine (REALM) test. Although the emergency department can be a high-stress area, it was a successful location because an experienced nurse conducted the interviews. She knew how to pick patients who were not in much distress.

"[The nurse] found it took about 90 seconds to conduct the test. She would be working 12 hours and would work the interviews into her shift," explains **Margaret M. Duffy**, EdD, RN, CNN, CCM, a clinical educator at Medical University of South Carolina.

At Egleston-Scottish Rite Children's Healthcare System in Atlanta, a child life specialist intern conducted interviews using REALM with adults in waiting rooms of various areas including clinics, surgery, and the intensive care unit.

The intern would introduce herself, explain what child life was all about, then ask the parent to participate in a survey for the education department to help determine if the educational materials were written at a level that was understandable to most people, says **Kathy Ordelt**, RN, CRRN, CPN, patient and family education coordinator at the medical center.

"She explained that all they had to do was read a list of 66 words, which would take about five minutes," says Ordelt. Names were not taken. The only written information taken from the test sheet was the area where the interview was conducted.

Parents who participated in the survey received a Scottish Rite bag filled with handouts, a cup, pen, pencil and some magnets as a gift. "We let them know they would receive a thank you gift for agreeing to an interview. We also let them know that if they did not want to participate that would be fine," explains Ordelt. ■

During the nursing assessment, nurses ask patients what grade level they have completed. In reviewing more than 200 charts, the average grade level of these patients was 10.45, yet a handout on advance directives that all patients received was written at a 16th grade reading level.

Designing a project to assess the reading level of your patient population is not difficult. One drawback, however, is time. "Someone has to have the time to do the sampling," says Ordelt.

Following are the steps Ordelt and others took to assess the reading level of their patient population to improve written materials:

• **Determine patient sample.**

To verify that the average reading level of adults at Egleston-Scottish Rite was seventh- to eighth-grade level, people were interviewed in every department except the emergency department. "We thought that the area [emergency department] was too high-stress to ask people to take tests," says Ordelt. Candidates were approached in the waiting rooms of such areas as clinics, day surgery, and even intensive care units.

Staff at Medical University of South Carolina targeted the emergency department because 40% of those patients are admitted to the hospital and they determined that would give them a rough estimate of the reading level of the inpatient population. **(For information on how to get people to participate in a literacy survey, see article, p. 9.)**

• **Select an assessment tool.**

Before choosing a tool to assess the reading level of patients, Ordelt read several journal articles that discussed various methods. She wanted a tool that was inexpensive, easy to use, and did not take a lot of time to administer. She decided REALM fit those criteria.

Duffy was familiar with REALM, because she had taught several nurses to use the tool. "We debated on whether to have the nurses use the

SOURCES

For more information on assessing the reading level of your patient population, contact:

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REALM (Rapid Estimate of Adult Literacy in Medicine). This test consists of three separate lists of words that progress in difficulty. People are asked to read the lists to determine their reading level range. The kit costs $10 total. Address inquiries to: Terry C. Davis, PhD, Department of Medicine and Pediatrics, Louisiana State University Medical Center, 1501 Kings Hwy., Shreveport, LA 71130. Telephone: (318) 675-5318. Fax: (318) 675-4319. [Send no money, an invoice will be included with the order.]

WRAT (Wide Range Achievement Test). This test consists of three components reading, spelling, and arithmetic. It not only tests peoples ability to pronounce printed words but their ability to count, read number symbols, and do computation. A starter set costs $110.00 with additional aids available at varying prices. Scoring software, for example, is an additional $99.00. Shipping and handling is 10% of domestic orders. For additional information, or to order: Wide Range, 15 Ashley Place, Suite 1A, Wilmington, DE 19804-1314. Telephone: (800) 221-9728 or (302) 652-4990. Fax: (302) 652-1644.

COMING IN FUTURE MONTHS

- Effectively addressing suffering for the dying patient
- Bearing the burden of increasing regulations
- Good? Bad? Adequate? Evaluating program effectiveness
- Education through mobile mammography outreach
- The pros and cons of electronically documenting patient education

tool with each patient, but they have to do so much already," says Duffy. The tool is available to use with individual patients but it is not mandatory.

• **Find a person to survey patient groups.**

An emergency department nurse conducted the readability tests at Medical University of South Carolina. She selected patients to interview who were not heavily stressed, conducting about six interviews throughout each 12-hour shift. The nurse conducted a sampling of 110 patients.

At Scottish Rite, a child life specialist intern conducted the REALM tests. "We did a sampling of 50 adults and will repeat the sampling of 50 after the first of the year [in 1999]. We might do this every year," says Ordelt.

• **Make use of the information.**

As part of a performance improvement project, the patient education department at John Heinz Institute of Rehabilitation Medicine undertook the task of rewriting the advance directives brochure at a lower reading level. "The patient education department simplified the information and made a much more appealing brochure to read. We included pictures, increased the font size, and rewrote the copy to a 10.3 grade reading level," says Kotch. ■

Video bolsters chronic pulmonary teaching

Identify need for additional teaching

When chronic pulmonary patients were interviewed at Baptist Hospital of Miami to determine the reason for their re-admission, educators discovered that many patients did not fully understand the instructions they were given.

Many patients, for example, said they knew how to use their inhalers, yet when asked to demonstrate the technique could not do so correctly. When asked if they took their full course of antibiotics, patients said they took the medication until they felt better and then quit.

"We found a big knowledge deficit for patients," says **Tania Del Rey**, MSN, ARNP, assistant nurse manager on the pulmonary unit at Baptist Hospital. There was a lot of information for patients to learn and the health care team did not always have enough time during the hospital stay to go over the instructions again and again with slower learners.

To remedy this problem, the staff made a video to be viewed on the hospital's closed-circuit television (CCTV) system. Patients can watch the video over and over to learn the information and if they need additional instruction, the appropriate discipline can be notified. For example, if patients need specific instruction on medications, the pharmacist would instruct the patient one-on-one.

A nurse makes sure the patient watches the video at least once during the scheduled viewing times. Following the viewing of the video, a nurse returns to the patient's room to ask questions about the information to determine if additional teaching is needed in a certain area. Patients have the CCTV schedule and can watch the video again if they want.

A multidisciplinary committee created a video

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that involved every department that works with pulmonary patients, including social work, respiratory therapy, nutrition, and the chaplain's office. Staff who were often involved with the pulmonary patients after discharge also were included, such as pulmonary rehabilitation and home health.

The committee determined what information should be included in the video and Del Rey wrote the script. During the video, each discipline goes over the information that pertains to that area of expertise. For example, the nutritionist discusses the importance of a pulmonary diet and the pharmacist explains how to take medications and food and drug interactions. After the instruction in each area, patients are told to tell the nurse if they need more information so the nurse can contact that discipline.

In the beginning of the video, a pulmonary specialist discusses what patients should expect during their hospital stay. A nurse explains the function of the respiratory system, signs and symptoms patients need to report to the doctor after discharge, and the importance of complying with their treatment.

Booklet still to come

The video was produced by the media services department of another hospital in Miami that is affiliated with Baptist Hospital. This kept the cost down, says Del Rey. In the future, the committee plans to create a booklet to accompany the film.

The booklet will briefly describe the various disciplines that teach in the film and include outpatient phone numbers so patients can call each discipline if they need more information after they are at home.

Follow-up to determine the effectiveness of the video is also planned. Staff will ask patients the same questions they asked before creating the video. "We will also check the readmission rate to see if it has dropped since we implemented the film," says Del Rey. ■

SOURCE

For more information on creating a film for chronic pulmonary patients to reinforce teaching efforts, contact:

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CE objectives

After reading the January issue of *Patient Education Management*, the continuing education participant will be able to do the following:

1. Describe three ways to gain the support of physicians for patient education.
2. Name two methods for ascertaining the reading level of patient population.
3. Describe at least two barriers to educating older adults.
4. List two ways to prevent head injuries from bicycle accidents. ■