Patient Education Management™

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

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IN THIS ISSUE

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Get patient point of view when creating written materials

Choose review method and selection process to put plan in place

Most patient education managers agree that having written materials reviewed by the potential users of the pieces is a good idea. Yet such review is not always a part of the process unless a plan has been set in place.

There are two issues to consider when creating a formal review process for educational materials. The first is to determine how the review process will occur, and the second is to decide on the selection process of reviewers.

How patients and family members are incorporated into the process often depends on the system set in place for writing new teaching materials.

At Cincinnati (OH) Children's Hospital Medical Center, all requests to write a handout are submitted to the clinical content committee, a multidisciplinary committee that meets once a month. If it's a new topic, the author is given permission to write the piece, says **Jennifer Willoughby**, RN, BSN, the committee chairperson.

EXECUTIVE SUMMARY

How do you make educational materials useful to patients and their family members? Institutions that follow the philosophy of patient- and family-centered care have found the best way is to make users a part of the process for creating teaching tools.
In the April 2009 issue of *Patient Education Management*, we consider how best to incorporate patients and family members into the review team.

Once the piece is completed, the author submits it to the patient education council at the unit level, which is responsible for making sure the content is evidence-based. If the council approves the copy, it is passed on to a clinical content liaison, who reviews the editorial style of the piece.

To get feedback from consumers, the liaison now hands the written material to a parent who has been trained for the review process, and he or she completes a form. The liaison and parent each have one week to review the content before it goes to the clinical content committee for implementation, says Willoughby.

Historically, families always have been involved in material review at Seattle (WA) Children's Hospital. Yet the process was not formal.

Now, a team of volunteers from the Family Consultant Program at the children's hospital has been assembled. Health educators will distribute the pieces created by clinicians to families for review. These family members use a form for the review. **(To learn how this form was created and what information is gathered, see article on pp. 39.)**

"Our target goal is to have families review one out of every 10 new health education pieces that clinicians create. Our goal is for randomly selected pieces to be reviewed by seven to 10 families," explains **Devora E. Chavez**, MA, MPH, CHES, coordinator for family-centered care at Seattle Children's.

Larger, more complex pieces will have more in-depth family review through focus groups. For example, last fall Chavez worked with health educators to organize three family focus groups to get input on what should and should not be included in standardized admission packets that families receive when they first arrive at the hospital.

Selecting reviewers

For patient education managers to know if written materials will benefit a particular patient group, the reviewers must fit a health care institution's demographics. Chavez worked with **Chris Hanssmann**, MPH, CHES, a health educator at Seattle Children's to create a reviewer profile. The ideal mix includes families of varying literacy levels and English-language proficiency. Also, parents selected as reviewers should reflect a range of experiences with respect to their child's situation and issues, such as chronic versus acute illness.

"We are also hoping to balance the degree to which families are familiar with our hospital and health education materials," says Chavez.

As time goes on, the institution will use interpreters and translated surveys to get responses to health education materials from families that speak a variety of languages other than English. "This will help us to identify problems and validate that our approach of translating English materials is an effective strategy," says Hanssmann.

According to Chavez, families are still being recruited for the review of health care materials, because the perfect balance has not yet been achieved.

Reviewers for patient handouts created by

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clinicians at Cincinnati Children's Hospital were selected from the community.

"We contacted churches, day care centers and people we knew, trying to get a different mix of parents who were interested in reviewing patient education. We got about 30 volunteers," says **Joan Morgan**, MSHA, MBA, RN, the education consultant for Patient/Family Education Center for Professional Excellence/Education at Cincinnati Children's.

Each family reviewer is paired with a member of the content committee and assigned a total of three topic areas. The reviewers are not familiar with the topics they are given. Patient education managers wanted the reviewers to act as first learners of the info.

All volunteers participated in a two-hour orientation in a computer lab. During this time, they met with their partner to learn how to complete the online review form. Dummy e-mail accounts were established for participants to practice.

Everyone participating at Cincinnati Children's must have access to a computer and understand how to send e-mail messages with attachments, says Morgan.

Family involvement in the review process is more likely if barriers are reduced, says Chavez. If families are expected to be available by phone at a certain time to discuss material or travel to the hospital to respond to questions, they are less likely to participate. E-mail or mail is easiest for busy families who need flexibility and a generous time-period to respond, explains Chavez.

The use of patient and family reviewers helps ensure that written materials are user-friendly in their final format. In addition, it helps improve writing overall. Morgan says a comment from a parent stating "I had no idea what you wanted me to do" really impacts an author.

They realize the material they are writing to teach the parent is missing the mark, says Morgan. ■

Strategically developed form is key to review

Review sample forms, determine best way to get info

When the process for using family members to review educational materials was formalized at Seattle (WA) Children's Hospital, an old survey used informally was revamped.

"The purpose of the form, currently and in the past, has been to get information about how well materials work from a family's perspective. However, we found the older form did not address all the issues we wanted to know regarding our health education materials," says **Chris Hanssmann**, MPH, CHES, a health educator at Seattle Children's.

For example, the old form had a question that asked families if they knew who to call after reading the material. The new version asks whether families know what to do after reading the flyer.

The change is to provide more insight into whether the main messages are clear to families.

"Among other things, we're interested in getting a sense of families' reaction to the 'now what?' that comes after looking at educational materials," explains Hanssmann.

They also want families to give their impres-

EXECUTIVE SUMMARY

To determine if the educational point of a written piece is clear to readers, the review forms must ask the right questions. Learn how one institution created its form and is testing it to determine if it achieves its purpose.

sion of what the main messages of the material are to see if it matches the intended learning objectives.

In addition, they wanted to make sure the review form included a way to assess whether educational materials communicate to patients and families the institution's commitment to family-centered care. That's why a question was added about whether families felt the material included them as part of their child's care team.

Health educators at Seattle Children's Hospital collaborated on the form. To guide the process, they collected forms from a variety of other health care institutions. This helped them see how others were obtaining feedback from families. Then the educators listed the areas in which they wanted to gather detailed information. These areas were based on health education theory about plain language, logical structure, and use of visual images, among other factors.

Questions solicit the following information: whether the flyer or material answered the family's questions; whether families know what to do after reading it; whether it's written in words they understand; and whether it includes them as part of their child's care team.

In addition, families are asked to name the main things they learned from the material and whether the length was about right. A variety of responses help to analyze the visual images in the material, to determine if families liked and understood them, whether they fit with the topic, and whether they made the material easier to read.

Now that the form is complete, it is being pre-tested with families to see if the questions make sense to people and capture the appropriate information.

This is accomplished by using the form on a small scale in the evaluation of health care materials. Family members are then asked their experiences of completing the form to find out whether there were any difficult or confusing questions.

"We will also be analyzing the completed forms to see whether there are certain questions that people are not completing or if there are other sticking points or irregularities. At that point, we will make any revisions that are necessary based on our analysis and information from families and begin to use the form more broadly," says Hanssmann. ■

Managing the process of online teaching inventory

Weeding, rewriting process results in good quality

Tracking 12,000 educational documents through the process of creating an online catalog could be a nightmare. That's why **Susan Kanack**, BSN, RN, patient education coordinator at ProHealth Care in Waukesha, WI, set up a system to keep the project manageable. She developed a spreadsheet that follows each document through the editing phase, design phase, and uploading onto the web site.

"The spreadsheet was created to keep work organized, because I was beginning to drown in the paper, literally. Determining what phase each document was in was getting too difficult, so this makes it easier to know where I am," says Kanack.

In addition, it keeps her director apprised of the progress and the number of hours she has devoted to editing copy, putting each piece in the ProHealth Care educational template, and uploading it. By February 2009, Kanack had already logged a total of 1,277.5 hours of work on the project, which equals 32 weeks.

The project was initiated almost three years ago when the health care system, which consists of two hospitals and 27 clinics, decided to centralize its large inventory of patient education materials. In this way, all health care professionals would have access to the handouts generated by each department.

Because the catalog is part of the public web site, consumers also can access all the educational pieces at prohealthcare.org. Consumer access fits with the patient- and family-centered care philosophy ProHealth is adopting.

"It allows the consumer or the patient to pull

EXECUTIVE SUMMARY

The job of creating an online catalog of patient education handouts can become disorganized. A system to track the progress of each piece through the system is vital.

information when they need it without relying on a nurse or doctor to hand it to them. If they lose the document or if caregivers at home want to know what was given by the physician, they can access it, as well. It's a lot more patient-centered, and it fits with our goals," says Kanack.

To begin the project, a steering committee was formed to create standards that would ensure all written materials were consistent, had a brand identity, print quality, and were easy to read. In addition, the steering committee got buy-in at the organizational level to centralize the inventory of patient education materials and distribute them electronically.

A committee of about 30 subject matter experts was also assembled to go through the boxes of materials collected, discarding the outdated pieces and using the remaining handouts as references to generate new ProHealth teaching sheets. Those in leadership within each department, such as cardiology and respiratory therapy, assigned individuals the task of writing handouts. All had patient care duties, so they worked during their nonproductive time. It has taken about a year and a half for this work to be completed.

Once the subject matter experts come to a consensus, the material is e-mailed to Kanack, who completes the editing according to the standards established by the steering committee. The rewrites are a time of negotiation between Kanack and the content experts. Once the content of the handout is agreed upon by all parties, it moves to the design phase.

Sustaining ongoing support

Kanack says she has tried to make the process user-friendly, so all staff members will remain invested in a centralized patient education system.

"I want to be sure that while we have standards, I am not too rigid, at least in the initial stages, because I don't want people to be turned off to the system and try to subvert it," she explains.

After allowing a year and a half for the writing process, launch dates have been established for each topic. Initially, it was thought that once the catalog was reasonably complete, it would be unveiled, but those involved in the process soon realized it may be a long time before results were seen. Departments that sorted through materials swiftly and got their work completed were placed at the top of the list of launch dates, with cardiology first.

While each subject category has a launch date, Kanack says she is the bottleneck. As the patient education coordinator for the entire system, the editing, design, and uploading all fall to her. Depending on the subject matter, she averages about 10 pieces a day, but if the material is complex, often only three or four pieces are edited.

To help the content experts write clear, concise copy, they were offered a class. It was not mandatory, but Kanack says she may require anyone writing educational copy in the future to take the class, because writing health-literate material is a learned skilled. The content experts also received a worksheet that had prompts to guide their progress and to get them started and help them identify the pertinent facts.

Once writing is completed, the rest of the work falls to Kanack. She formats the material according to an established template, so all the handouts would have the same look. Her assistant sometimes helps with this task when not working on her primary duties. Once the documents are in a PDF format, she uploads them to the consumer site, assigning search terms and tagging them. This takes about a minute per document.

Once the catalog is completed with all patient education materials available online, requests for new handouts will follow the same process. The author of the handout will need to check the catalog to make sure there is nothing currently available on the topic before writing begins. The piece will have to be submitted electronically, and Kanack hopes to have a software program in place to manage the editing process. Currently, the editing exchanges take place via e-mail, but Kanack wants to work with content experts on an internal web site where changes can be viewed and recommendations made.

The catalog is expected to be completed in June 2009. ■

SOURCE

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Family council can help make materials readable

Revamping written handout distribution

Written materials should be family friendly, but oversight can be difficult when institutions have a decentralized patient education program. How is this accomplished when each department determines what material is handed out to patients? Staff at Vanderbilt University Hospital and Clinics in Nashville, TN, are currently working on this process.

The first step is to make sure all documents in the system are written at a fifth-grade reading level. Therefore, experts are in the process of reviewing all written copy distributed. The informed consent documents were just completed and endorsed by the medical board. All patient education materials used within departments also will be rewritten.

The appropriate experts are selected for each writing task. The first draft of the consent forms was written by a quality consultant in the Center for Clinical Improvement. That draft was then reviewed by health literacy expert, **Sunil Kripalani,** MD, assistant director for the Vanderbilt Program on Clear Communication.

Once rewritten at fifth-grade level, documents go through an editorial process that includes a reading by the Patient and Family Advisory Council. To determine if the council members understand the material, they must teach back the content of each rewritten piece. This step helps to provide the patient perspective.

"The council is very committed to patient safety, and health literacy is a huge patient safety issue," says **Terrell Smith**, MSN, RN, director of Patient/Family Centered Care at the health care institution.

Materials are divided between the pediatric hospital advisory council, adult hospital advisory council, and the advisory council that serves the clinics.

This revision process will help create a central inventory of educational materials, so department heads will know what is being distributed throughout the system. Smith says that now, handouts on the treatment of diseases and other conditions can contain conflicting information, because each department is responsible for gathering its teaching materials.

For example, a patient who visits the diabetes clinic could receive a handout on the disease that has different instructions on when to call the doctor than the pamphlets used by staff in the internal medicine department.

To better meet patient and family members' educational needs, a health information center is planned as part of a new critical care tower that is being constructed. This center will be a clearing house for patient education materials, as well as patient education policy. A patient education coordinator will be hired to run the center.

"The reason we want to do all this is because we need to standardize how written materials look on our campus, as well as the reading level," explains Smith. ■

SOURCE

For more information on the process for revamping patient education at Vanderbilt University Hospital and Clinics or using the council to evaluate reading materials, contact:

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EXECUTIVE SUMMARY

Project to revise written materials to improve health literacy. Consumer viewpoint was obtained by including the patient and family advisory council in the editing lineup.

'Senior Sensitivity' training helps staff understand

Participants simulate vision and hearing loss

Before they start their job managing the care of senior members, case managers at Senior Care

Action Network (SCAN) Health Plan try to sort pills while wearing heavy gloves, strain to understand a speaker whose voice is muffled, and fill out a medical information form while wearing special glasses that simulate vision loss.

It's all a part of the Long Beach, CA-based Medicare Advantage Plan's Senior Sensitivity program to help employees feel, see, and hear what common physical and cognitive changes that occur with aging actually feel like and understand how much loss seniors experience as they age.

The health plan requires the Senior Sensitivity training for all of its employees, including board members, says **Sherry Stanislaw**, senior vice president at the health plan.

"The training is a good complement to the clinical training of the nurses and social workers, because they literally get to be in the shoes of the seniors. It helps our staff understand the challenges that their clients face in their everyday life and in adhering to their treatment plan," says **Lisa Roth**, MS, gerontology, director of independent living power and geriatric health management and monitoring.

For instance, during the training, Roth had to walk around with popcorn in her shoes to experience the pain of neuropathy or arthritis in a senior's feet.

"This class helps our case managers understand the problems that members face so they can work with them on strategies that keep them safe at home and out of the hospital. If the senior's eyesight or hearing is limited, the case managers know how to overcome the barriers," Roth says.

The health plan started its Senior Sensitivity training about five years ago.

"The program is based on experiential learning. We use tools to accelerate aging and help the participants understand how seniors may struggle with everyday activities as well as the challenges they face as they maneuver through the health care system," Stanislaw says.

Tools include vision loss glasses that simulate glaucoma, cataracts, and other eye diseases.

In one exercise, the participants are asked to put on the glasses and a pair of bulky gloves and try to open a pill bottle filled with small candies, and then sort the candies according to color.

"This exercise helps the participants understand how seniors struggle when they have arthritis or have lost dexterity in their hands and at the same time have impaired vision," Stanislaw says.

It's a real "ah-ha" moment for many case managers, who often suggest that members who are on multiple medications fill the compartments in a pill box with their medications for each day of the week, says **Kelly Giardina**, MS, gerontology, manager of geriatric health management and monitoring.

"It was hard to fill the box while we had gloves on. Another challenge was trying to separate pills by color while wearing glasses to simulate vision loss. It helps the case managers consider if they are being realistic to expect seniors to fill their pill box. From our perspective, it's easy to think they could use a pill box, but if they have a deficit, it could prevent them from implementing the plan. Typically, they need to have someone set up the pill box for them," she adds.

The participants have to fill out a standard medical information form, similar to the kind used in physician offices, and fill it out with their left hands (to simulate impairments caused by a stroke) and while wearing the vision-altering glasses.

They must write down what they hear on a tape where the speaker's voice is muffled.

"During the classes, we talk about common hearing loss problems, which are common in the senior population. Many seniors can hear vowels but lose their ability to hear consonants, particularly on the end of words. When we play the tape, the participants are straining to hear and understand, and most of them get most of the words wrong," she says.

The program also deals with psychological losses that occur as people age. The participants have to write down the three most treasured things they have — family members, jobs, etc. The facilitator walks through the room and starts snatching things away from the participants.

"It's amazing how people react when the facilitator takes away the things that are important to them," she says.

A memory loss exercise gives participants a list of items that they have to remember.

"At the same time we are doing these exercises, we also remind participants that you can never stereotype seniors. Not every older adult experiences all these losses. A lot of it is individual," she says.

The trainers give the class tips on how to compensate for the disabilities during their interaction with members. The case managers at SCAN range in age from the very young to those who are almost seniors themselves. Some have experience working with patients face to face but others have only telephonic case management experience, Roth says.

"Without the experience of a deficit yourself, it's

hard to understand what seniors face in the real world and to come up with unique ways to help members be adherent. The classes give them the feel of having a deficit and serve as a good reminder to put ourselves in the situation of the seniors," she adds.

Part of the initial case management assessment is to gather information that helps the case manager understand any challenges the member may face, Roth says. "We ask about their vision, their hearing, and other functional aspects to assess some of the potential challenges the member has, so we don't assume that the member can do things or understand things when they can't," she adds.

The case managers learn to adjust their pace and their volume as they interact with members, Giardina says.

"They stop and confirm that the member understands what they are saying and can repeat it back. It is a matter of adjusting interactions to compensate for whatever deficits the member may have," she says.

The case managers are trained to look for signs of deficits and vary the services they provide based on the different needs of their clients, Roth says.

For instance, if someone is visually impaired, the case managers may send them information in large print or provide an audio resource for the information.

"As a result of the program, the case managers work with the physicians to get the members a large-print copy of the medical questionnaire and send it to the members ahead of time.

"The case managers in our geriatric health management program always work on preparing the members for their doctors visits, helping them gather the information the doctor needs, and empowering them to make their doctor visits successful," she says.

As a backup to help overcome hearing and memory deficits, after the case managers talk to members, they send out a letter recapping what they have gone over during the telephone call, Giardina says. "We do this because many of our members have trouble hearing, and it gives them the information in writing that they can take to their doctors," she adds.

The health plan uses risk stratification software to identify high-risk members based on their diagnoses and prior medical encounters.

When a member is determined to be at risk for hospitalization, the health plan's outreach staff contact them to find out if they are interested in enrolling in the case management program.

The case management program also receives referrals from physicians and from members who learn about the program and want to participate.

The case managers work with the members to help them manage their health care and adhere to the treatment plan. In addition to their extensive assessment, the case managers have information generated from encounter data with the physician medical group and hospitals.

"They have a picture of the patient before they call them. This puts us in a good position to come up with a plan to help the members manage their chronic conditions and live as independently as possible," Roth says.

The case managers use motivational interviewing techniques to determine the members' willingness to make changes and help them set short and long-term goals.

In addition to requiring Senior Sensitivity classes for its staff, the health plan has offered customized training to contracted providers to help them understand the challenges that the senior members face. For instance, during the training, the staff at physician offices spend a lot of time trying to fill out the patient registration form while using equipment that simulates deficits.

In Arizona, the health plan recently partnered with Dependable Medical Transportation Services to train more than seasoned van drivers about the challenges that seniors face.

SCAN has given classes to elementary school children to help them learn to better understand their grandparents.

"We talk to the kids about communicating with their grandparents and teach them techniques like being face to face when they talk, so the seniors can hear them and pick up on both visual and audio cues. It's all a matter of understanding the other person's challenges," Stanislaw says.

*(For more information, contact **Lisa Roth**, MS, gerontology, director of independent living power and geriatric health management and monitoring, e-mail: lroth@scanhealthplan.com.)* ■

Medical group CMs coordinate care

Patients to get care they need to avoid readmissions

At Sharp Community Medical Group, case managers work in a variety of settings to

make sure that patients are getting the care they need in a timely manner and to ensure continuity of care as patients move through the continuum.

The San Diego-based IPA has in-house case managers who provide post-acute and complex case management as well as case managers who work with the hospitalists in local hospitals.

The physician group's disease case managers provide disease management to patients with diabetes, congestive heart failure, chronic kidney disease, and chronic obstructive pulmonary disease.

"We have case managers throughout the continuum to make sure the patients are getting the care they need to prevent readmissions," says **Karla Ascencio**, RN, director of health services for Sharp Community Medical Group.

John Jenrette, MD, the medical group's chief medical officer and CEO, is a firm believer in case management, says **Patti Derouin-Genel**, RN, manager for Sharp Community Medical Group

"Dr. Jenrette feels that nurses have a vital role in coordinating care. This is a very forward-thinking company regarding the benefits of a strong case management program," says Derouin-Genel.

The physician practice has recently developed a case management program in local skilled nursing facilities. That program is staffed by three nurses and two clinical resource coordinators.

The nurses attend case conferences and conduct telephonic review, following the patients through physical therapy, occupational therapy, and speech therapy. They track the number of days to ensure that the stay meets Medicare requirements and follow the patients through any post-discharge care.

"It's a nice continuum. The patients are followed by the hospitalist team and the ambulatory care managers at Sharp Community Medical Group's offices as well as a skilled nursing team. We provide case management at every level of care," Ascencio says.

If a patient who is part of the Sharp system goes to an out-of-network facility, a case manager travels to the facility and manages the patient's care until he or she is stable enough to be transferred to a Sharp facility.

The case managers in the Sharp Community Medical Group refer patients to each other as needed. For instance, if a patient in the hospital has diabetes and isn't already in Sharp's chronic disease management program, the hospitalist case manager refers them.

The inpatient case managers refer eligible patients to case managers within the medical group who provide post-acute case management, complex catastrophic case management, and disease management.

"We integrate all our case management efforts including the chronic disease management program, the telephonic case managers who follow the patients after discharge, and the hospital-based case managers," Ascencio says.

The medical group's clinical resource coordinators call each patient within 48 hours of discharge to ensure that all their needs have been met. This equals about 650 post-discharge calls a month.

They ask several critical questions, depending on the patient's particular situation. These include: Have you made a follow-up appointment? Did you fill your medication prescription? Did your durable medical equipment arrive?

If the patient has questions about medication or wound care or what appears to be a clinical manifestation, the call is immediately referred to one of Sharp's acute care managers who follows up with the patient and contacts the primary care physician or the home health or equipment agency as needed.

If the patients haven't made an appointment for a follow-up visit, the clinical resource coordinators help them do so.

"Ensuring that patients have a follow-up visit with their primary care providers is vital to our success. Many patients who see their primary care doctor after discharge end up back in the hospital," Ascencio says. ■

A small-scale wellness program got big results

Because the average UPS driver walks four and one-half miles a day, you'd think it would be difficult to convince them to come in early for a two-mile warm-up walk, but they do. This is just one example of how the company's Petaluma, CA, facility succeeded in changing the lifestyles of its workers.

Two years ago, the facility's rate for DART (days away from work, restricted work activity, or job transfer) was 10.3 for every 100 full-time employees, 2,000 hours a year. Something had to be done. A group of managers and drivers "brainstormed," says **Josh Young**, the facility's center manager, who oversees 200 employees.

"We knew we needed to come up with

something different to reduce the number of injuries. We asked, 'What can we do as a group that is different than our day-to-day regimen?'" says Young, who sits on the group's safety committee supporting drivers' safety and health initiatives.

The group's three-pronged answer: a walking club, a nutrition program, and yoga classes. At first, only one or two drivers participated, but the number grew steadily, due mainly to word-of-mouth recommendations from co-workers. Injury rates, on the other hand, started to drop. The DART rate is now 4.2 for every 100 full-time employees.

The goal is to make drivers "industrial athletes" who are fit enough to do the heavy manual labor required for the job. To reach this accomplishment, drivers first need to answer the question: "Why should I do this?" says Young. The answer differs for every employee, he says, and might be "so I can play with my kids when I get home" or "so I can lose weight."

"The hardest part is taking that initial step. We showed them the benefits that they can walk away with. Then we went mostly on word of mouth," he says. Outside wellness experts were hired to talk about nutrition, and a yoga teacher held classes in the early mornings. When the classes became too crowded for the space, a group of drivers arranged to meet at the yoga studio before work.

One driver now rides his bike from his house to the gym, then rides the bike to work, and then works his shift. Another driver weighed more than 400 pounds and was counseled on better eating habits, which resulted in significant weight loss. "He is another example of someone who has 'caught the bug,'" says Young. "Another of our drivers [has] quit smoking for six months. We have a lot of inspiring stories." ■

Let employees decide how to be safer and healthier

Workers ID root causes of accidents

Instead of management telling UPS employees how to improve their health and safety, the company's 12,000 frontline employees, who sit on more than 3,000 "comprehensive health and safety process" committees, decide that for themselves.

"UPS drivers move about 16 million packages a day. It's a very physical job. There's no such thing as a virtual package," says **Dan McMackin**, spokesman for UPS. "Everything people order on the Internet has to be delivered by somebody and picked up and carried."

The employees are the ones who investigate accidents to find out the root causes behind what happened. For example, they discovered that most back injuries occurred later in the afternoon when drivers are fatigued and fail to follow the correct lifting procedures.

"Committee members focused their efforts on making drivers aware that safe work methods are crucial, especially as the day wears on," says McMackin.

Each driver who has had an injury, no matter how minor, is given a refresher in the techniques taught in the company's internally developed UPS Safe Work Methods training course.

Beginning in 2008, each committee was required to nominate one person as a wellness champion, who is given wellness materials from corporate headquarters. The wellness champion leads the group with current health topics and points employees in the right direction to access health care resources. "It's a huge investment in time and resources and funds; we have to pay these people an hourly rate while they are doing all this and not getting their productive work done. But it pays back tenfold because you've got healthier, happier people coming to work," says McMackin.

Re-injury rate cut to 6%

Each month, the committees focus on a different topic, such as stretching, heart health, or nutrition, says **Mary Breen**, RN, COHN-S, CCM, corporate occupational health manager of UPS.

Recently, the committees looked at their most frequent injuries, on and off the job. "In the workers' compensation arena, we've narrowed it down to knee, back, and shoulder injuries, and in the disability area, musculoskeletal injuries," says Breen. "So, we knew a lot of our injury cost was due to those injuries, and also reinjuries, with the next one being more severe."

A 30-minute education program was developed by corporate occupational health, to teach injured employees how to do the proper job setup. The company's 22% re-injury rate was cut to 6% after only nine months.

The wellness champion is charged with

investigating the root causes of injuries. "But we have reduced our injury frequency over 60% over the last five years, so they have a lot less to investigate," says Breen. "We have seen a 10% reduction in back, knee, and shoulder injuries for our full-time employees in 2008 compared to 2007 with this initiative. We are hoping to see a decrease in the increase of our health care costs."

Successes are shared

Last year, disease management coaches were added to reach out to workers to prevent and treat chronic conditions. "We started off with the four big ones: coronary artery disease, diabetes, asthma, and chronic obstructive pulmonary disorder. People can go in themselves and get a nutrition coach," says Breen.

A quit-smoking program is free for the majority of employees. All employees can also access a companywide employee assistance program with six free therapy visits.

This year, health risk assessment data are being used to identify the number of employees with risk factors. "That is a brand new product this year. You can look at how many are at low, moderate, and high risk, and you can actually put a financial number to that," says Breen.

Successes are shared via the company's best practices health and safety department, which consists of about 60 occupational health nurses nationwide. "They can send in presentations that are put on our internal web site, such as the success they have seen with a stroke program, a walking program, or a blood pressure program," says Breen. ■

CNE instructions/objectives

Nurses and other patient education professionals participate in this continuing education program by reading the issue, using the provided references for further research, and studying the questions at the end of the issue.

Participants should select what they believe to be the correct answers, then refer to the list of correct answers to test their knowledge. To clarify confusion surrounding any questions answered incorrectly, please consult the source material. After completing this activity each semester, you must complete the evaluation form provided and return it in the reply envelope provided in order to receive a credit letter. When your evaluation is received, a credit letter will be mailed to you.

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** patient education programs based on existing programs from other facilities. ■

COMING IN FUTURE MONTHS

- Using technology to improve patient education
- Best practice for selecting vendors
- Education's role in demand management
- Web sites that enhance teaching
- Using volunteers to improve health literacy

CNE Questions

13. It's a good idea to create a profile for the selection of patient and family members to take part in a formal educational material review process. Traits identified might include which of the following?
    A. Varying literacy levels.
    B. Use of facilities to manage chronic illness.
    C. Use of services for acute illness.
    D. All of the above.

14. The evaluation form used by Seattle (WA) Children's Hospital to aid consumers in evaluating educational materials seeks to determine what reviewers think the main messages are to determine if they match the intended learning objectives.
    A. True
    B. False

15. Steps for creating an online catalog of patient education materials at ProHealth Care in Waukesha, WI, include which of the following?
    A. Hiring a team of proof readers.
    B. Identifying subject matter experts.
    C. Establishing standards for handouts.
    D. Answer B & C.

16. Family involvement in the review process is more likely if barriers are reduced. Which of the following is a more convenient way for family reviewers to take part in evaluating educational materials?
    A. Participating in a conference call.
    B. Attending a committee meeting.
    C. Responding via e-mail or mail.
    D. All of the above.

Answers: 13. D; 14. A; 15. D; 16. C.