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

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An ounce of prevention avoids big problem with childhood pounds

Keys to success: Family involvement and interactive teaching

The need to address childhood obesity is often in the news because the numbers are staggering. According to the Center for Disease Control and Prevention (CDC), childhood obesity has more than tripled in the past 30 years. CDC data shows the prevalence of obesity among children aged 6-11 years increased from 6.5% in 1980 to 19.6% in 2008. In teens it increased from 5.0% to 18.1%.

In light of the statistics, many children's medical centers are putting into place programs to reverse the trend. Education is a strong component.

Cincinnati (OH) Children's Hospital Medical Center set in place an initiative to "reverse the trend of increasing childhood obesity through policy and initiatives incorporating specific programs to reach schools, private practices, and the community by June 30, 2015."

To accomplish the initiative the organization has focused on body mass index (BMI) screening education. A multidisciplinary committee developed a handout for families that educates them on what BMI means, why it's important, and what they can do to help their child stay healthy, says **Joan Morgan**, MSHA, MBA, RN, an education consultant for patient/family education at Cincinnati Children's Hospital. *[For a copy of the BMI Screening handout, see the online issue of* Patient Education Management. *Go to www.ahcmedia.com. On the right side of the page, select "Access*

Next month: Invaluable role of education in health literacy

In July, *Patient Education Management* will devote the entire issue to healthy literacy and the role patient education has in improving understanding and use of information for good health. We will cover making sure consent is informed and teaching techniques to mitigate low health literacy. We also will include resources for writing easy-to-read copy. Don't miss this special issue of *Patient Education Management*!

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Your Newsletters – Sign In." You will need your subscriber ID from your mailing label. For assistance, contact customer service at (800) 688-2421 or customerservice@ahcmedia.com.] The handout educates families on what BMI means, why it's important, and what they can do to help their child stay healthy. The patient education materials are available as handouts in each of the outpatient areas or can be printed off the patient/family education web page at www.cincinnatichildrens.org. *(Under "Health Topics," select "Your Child's Health." Under "Nutrition and Diet," select "More" and then "Body Mass Index.")*

A comprehensive pediatric wellness initiative at Florida Hospital for Children in Orlando, with the goal of giving kids the best chance of living to a healthy 100 years old, resulted in a program to address obesity called Healthy 100 Kids.

The program is for children ages 6-17 with a BMI of 85th percentile or above in children of the same age and sex. According to the CDC, overweight is defined as a BMI at or above the 85th percentile, and obesity is defined as above the 95th percentile.

Before designing the program, staff researched similar programs, according to **Kristen Duquaine**, MSN, MHA, RN, CDE, director of outpatient services and community health and wellness, which includes educational programming. They found the most successful programs were long-term. They also learned that programs with the best outcomes involved the families.

Although a pediatrician is part of the team, the program is not a medical model where children visit a physician every 3-6 months and see a nutritionist. It is a one-year program that includes 10 educational workshops and the weekly support of a health coach. *(For a more detailed description of this program see p. 63.)* Through literature searches and reading about successful programs, staff learned that they needed to engage children in something that was social, fun, and interactive to help them change behavior. Children don't want to be lectured on what not to do, she says, therefore lessons are positive. For example, during a workshop on how the body works, children learn the function of organs with the use of models and a felt board. The workshop focuses on how good food choices positively impact body organs, rather than the negative consequences of poor choices.

Interaction boosts confidence

Interactive teaching is key, says **Carolyn Landis**, PhD, a clinical psychologist at University Hospitals Rainbow Babies & Children's Hospital in Cleveland, OH, A program named "Healthy Kids, Healthy Weight" for children ages 4-18 with

EXECUTIVE SUMMARY

Childhood obesity has tripled in the past 30 years. In light of these statistics, many children's hospitals are dedicating staff and resources to childhood obesity to teach families how to have healthy lifestyles.

- Education addressing obesity can be part of hospital-wide initiatives.
- Programs need to include child and a parent or caregiver.
- Teaching works best when interactive and hands-on.

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EDITORIAL QUESTIONS

For questions or comments, call Susan Cort Johnson at (530) 256-2749.

Editor: **Susan Cort Johnson**, (530) 256-2749.
Executive Editor: **Joy Daughtery Dickinson** (229) 551-9195 (joy.dickinson@ahcmedia.com).
Production Editor: **Kristen Ramsey**.

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a BMI above the 85th percentile is taught in a participatory way at the children's hospital.

For example, during the behavioral component of a group session, children go through a handout on binge eating and discuss what might be their triggers. Strategies for addressing binge eating are covered such as eating regularly scheduled meals and snacks, and waiting 20 minutes before eating chips or cookies when the urge arises. Children make a list of things they might do during the 20 minutes they are waiting, such as taking a walk or calling a friend. During the nutrition portion, they might make a healthy snack.

"Our main goal is to increase the kids self efficacy because we find if you participate in the activity, you are more likely to find you can do it and feel confident that you can do it," Landis says. "You have done it; you haven't just heard about it." *(For a more detailed explanation of this program, see story, p. 64.)*

Offering a Healthy House

Hands-on education at Catawba Valley Medical Center (CVMC) in Hickory, NC, is provided in the rooms of a house on campus. Healthy House is a prevention and treatment program created by Vondell Clark, MD, who was a dietitian and returned to school to become a family physician. With a house as a classroom, families can be taught how to stock their pantry and refrigerator and how to do inexpensive activities that are physically active using items around the house. For example, the activities specialist will have families roll socks from dresser drawers into balls and have a "snowball" fight. *(For a more detailed description of this program see p. 65.)*

Education addressing childhood obesity is needed in Catawba County because 61% of adults and 40% of children are overweight or obese, says **Lynn Winkler**, MA, RD, LDN, the wellness coordinator for CVMC's Healthy House and the pediatric dietitian for the program. The teaching team, which includes Winkler, the physician who is the program director, and an activities specialist, adjust the teaching as they see what works and what doesn't. For example, initially families were taught individually, but now they are taught in a group setting for more dialogue and input.

Education is hands-on with few handouts. This strategy is to get families to take ownership of the concepts being taught, explains Winkler. Families have a notebook but it is used primarily to collect the recipes and activity tips, she adds.

All three programs mentioned are a year long, because good outcomes are linked with longevity. Landis says the statistics they are collecting for Healthy Kids/Healthy Weight show that improvements in BMI are related to the number of educational sessions attended. The more sessions attended, the better they do. *(To learn how to provide education as a community outreach program, see article on p. 65.)*

SOURCES

For more information about addressing childhood obesity through education, contact:

• **Kristen Duquaine**, MSN, MHA, RN, CDE, Director of Outpatient Services and Community Health and Wellness, Florida Hospital for Children, 601 E. Rollins St., Orlando. FL 32803. E-mail: kristin.duquaine@flhosp.org.
• **Carolyn Landis**, PhD, Clinical Psychologist, Associate Professor of Pediatrics, Division of Developmental/ Behavioral Pediatrics & Psychology, Rainbow Babies & Children's Hospital, University Hospitals Case Medical Center, WO Walker Center, Suite 3150, 105524 Euclid Ave., Cleveland, OH 44106-6038. Telephone: University Hospitals -- Healthy Kids/Healthy Weight at (216) 844-8447.
• **Joan Morgan**, MSHA, MBA, RN, Education Consultant, Patient/Family Education, Center for Professional Excellence/Education, Cincinnati Children's Hospital Medical Center, MLC 8006, 3333 Burnet Ave., Cincinnati, OH 45229-3039. Telephone: (513) 803-0031. E-mail: joan.morgan@cchmc.org. Web: www.cincinnatichildrens.org.
• **Lynn Winkler**, MA, RD, LDN, Wellness Coordinator/ Pediatric Dietitian, Healthy House, Catawba Valley Medical Center, 810 Fairgrove Church Road, Hickory, NC 28602-9617. E-mail: lwinkler@catawbavalleymc.org. ■

Healthy 100 Kids offers health coaches

Workshops address learning needs of families

Healthy 100 Kids at Florida Hospital for Children in Orlando is open to children ages 6-17 who have a body mass index (BMI) of 85th percentile or above in children of the same age and sex. One parent must be willing to participate with the child.

When a child is referred to the program, the child meets with a physician, child psychologist, dietitian, and exercise physiologist for an individual assessment. Children return for a reassessment every three months for one year.

To address main learning needs, families attend 10 workshops over a 3- to 6-month timeframe. There are nutrition, exercise, and behavioral topics. These include movement and its benefits, food choices, and body image and self-confidence. There are classes for parents separate from the children, then family workshops. One joint workshop covers meal preparation and family meals, and another is a grocery store tour.

"One of the things we are careful not to do in our program is label anything as bad or good. That sets up issues of guilt. We try to develop a more positive relationship with food, says **Kristen Duquaine**, MSN, MHA, RN, CDE, director of outpatient services and community health and wellness.

One member of the team is assigned as a health coach to each child and contacts him or her weekly by e-mail or telephone, whichever is preferred. They engage in goal setting and discuss any barriers that prevented the child from achieving a goal. Once the program is complete children will take part in a maintenance program lasting up to five years in which they return for an assessment every six months. However, if a child continues to need more regular support after a year, they can continue in the more intense program with the weekly goal setting and monitoring from health coaches.

Healthy 100 Kids was launched in June 2010, and data on the children enrolled in the program has not yet been evaluated. The program is funded through several partnerships such as a grant from the Orlando Magic Youth Foundation. This funding is necessary because there is little insurance reimbursement, says Duquaine. "Families who have very few resources are the ones who are at highest risk and need this program the most so it is accessible to them," she adds. ■

3 areas of education for Healthy Kids/Weight

Focus: Nutrition, exercise and behavior

Healthy Kids, Healthy Weight is a clinical research program at University Hospitals Rainbow Babies & Children's Hospital in Cleveland, OH. The program is open to children ages 4-18 with a body mass index (BMI) above the 85th percentile in children of the same age and sex.

Children older than age 7 participate in a 12-week family-based program. At least one parent must attend, but other family members can participate, such as the grandmother, if the child spends a lot of time in another household. Children are divided into two groups, ages 7-13 and ages 14 and above.

They learn about nutrition and exercise with the aid of lots of games. For example, one nutrition game is called "Food Label Frenzy." Children are divided into two teams, and each has a set of food labels. There is a buzzer on a table in the middle of the room. Questions are called out and the team with the correct answer sends out a runner with the label to hit the buzzer. Questions include: a food that is a good source of vitamin A, a food that is a good source of fiber, a food that is high in total fat, a food that is high in sodium, a food that is more than 500 calories a serving, a food that has more than three servings per container, and a food that is high in cholesterol. There also is a behavioral component addressing body image, teasing, emotional eating, binge eating, setting goals, monitoring food intake, and sleep duration.

During the exercise portion, children are exposed to different activities. Younger children participate in playground games such as relay races and versions of tag. Sometimes floor aerobics, dance, or yoga is included. The exercise session for older children is more of a group fitness workout with such exercise techniques as kickboxing, interval training, step aerobics, circuit training, and yoga. They play games as well. Both groups do strength training with weight-bearing exercises such as push-ups, squats, crunches, and lunges. Also, they use weights that are appropriate to their age and fitness level. With strength training the exercise physiologist focuses on form to make sure the children do the exercises correctly.

Families attend the education portion for 12 weeks, and they come to one class a week. They meet once a month for the remainder of the year.

A manual is followed for the education portion, since the program is a research project to gather knowledge about childhood obesity. An exercise physiologist, registered dietitian, behavioral specialist, and psychology assistant teach, explains **Carolyn Landis**, PhD, a clinical psychologist who has participated in the program for four years. It has been operational for six years.

The hospital funds the program except for the medical evaluation and labs at the time of enrollment, which is billed to insurance. At the time of the physical exam, the family meets with the dietitian, psychologist, and exercise physiologist.

A group of physicians created the program

based on literature and other existing programs at the time, says Landis. ■

House used for healthy lifestyle lessons

Families have hands-on learning

A house owned by the Catawba Valley Medical Center (CVMC) in Hickory, NC, which is a part of its campus, is the site of a prevention and treatment program to address childhood obesity. The program is called Healthy House.

The prevention program works with the Catawba County Head Start program to teach children age 3-5 about fitness and nutrition. The children are bussed to the house once a month for lessons. The curriculum is reinforced in the classroom by the teachers.

"The idea behind the prevention is to catch the kids before they are diagnosed with obesity and teach them healthy habits at a younger age," says **Lynn Winkler**, MA, RD, LDN, the wellness coordinator for CVMC's Healthy House and the pediatric dietitian for the program.

Interaction with the family takes place through a newsletter and attending the Head Start family meetings.

When the program starts each September, each child's height, weight, and blood pressure is measured. They are given a fitness test with parental permission. This is done once again each May before the end of school. Winkler says it is the third year they have done this tracking, but they still are analyzing the data. The objective information from teachers and parents is that the children are eating more fruits and vegetables and are able to verbalize what is being taught. They are more active and drinking less soda.

Children diagnosed as obese can be referred to Healthy House by a physician and enroll in a one-year program to learn how to change unhealthy habits. A family member is involved in the program.

Winkler conducts the nutrition part of the program in the kitchen where she can pull food from the refrigerator, cabinet, and pantry. The activity specialist has a garden, activity room, the garage, and a courtyard to teach participants how to be active. She has performed yoga and Zumba for the whole family, and she is starting a walking club. Also, Winkler has a map of the county and has placed activity stickers to show people parks, recreation centers, or YMCAs in their neighborhood.

The medical director meets with the child at the first appointment. The medical director works with the families on behavioral issues focusing on awareness of factors that contribute to obesity, such as the need for a person to take responsibility for his or her actions.

One-third of the program is funded by the hospital. A Duke Endowment Grant helps fund the treatment program, and a grant under the KB Reynolds Charitable Trust funds the prevention program. Both grant funders are based in North Carolina. ■

Class helps kids set goals for weight loss

Visual lessons, hands-on instruction educate

To help children struggling with a weight problem learn how much fat is in their favorite lunch; instructors at WHAM, a wellness, health, action, and motivation class at Arkansas Children's Hospital in Little Rock; weigh out caulk on a gram scale and put it in small take-out boxes. On the top of each box is a picture and name of the food item, such as a taco salad from Taco Bell.

The exercise triggers a lesson on how to make good choices when eating out, explains **Bethany Spillman**, MS, RD, LD, a pediatric clinical dietitian at Arkansas Children's Hospital and one of the class instructors.

This one-day free class is open to all overweight and obese children ages 6-18 in Arkansas and a family member. The class is one way the hospital is addressing childhood obesity. The hospital also has an obesity clinic for children in the 97th body mass index (BMI) percentile in children of the same age and sex. Families attending the class receive information about the clinic.

The key areas of education in WHAM include nutrition, physical activity, motivation, and goal

EXECUTIVE SUMMARY

WHAM (wellness, health, action, and motivation class) is a community outreach class for overweight children and their parents to provide education about nutrition, physical activity, motivation, and goal setting to help families develop a healthier lifestyle.

- Class helps children set realistic goals.
- It provides hands-on instruction.

setting. The overall goals of the program are for all children to eat at least five servings of fruits and vegetables each day; consume no more than 12 ounces of a sweetened drink per day; increase meals prepared and eaten at home to greater than five a week; increase physical activity to at least 30 minutes a day; and decrease screen time to less than two hours a day, which includes television, video games, and computers.

At the end of the class the instructor, who is a registered dietitian, helps participants set realistic, achievable goals. In a recent WHAM class, one child agreed to monitor portions, eat at the table, and wait 20 minutes before getting seconds. Another child wrote that he would eat healthier snacks and watch the nutrition facts. Also wrote that he would try to work out 30-60 minutes every day.

Families have the option to schedule 15-minute follow-up sessions with a registered dietitian every two weeks at the hospital to go over the goals and address what they are struggling with. There is a fee for the sessions.

Children can also participate in a free support program. An eight-week program run by the physical therapist from the obesity clinic called Champions Club focuses on activities, nutrition, goal setting, and working on challenges. The class is held on Thursdays in the fall and spring.

Lessons in the WHAM class are a mixture of computerized graphic presentations and activities. Usually 2-10 families attend, so the teaching is casual with lots of questions. Also families have an hour of activity at the recreation center, which is part of the obesity clinic. Children are taught how to use a resistance band, and they take it home. The exercise session begins with warm up walking/jogging around a track and stretching. Strengthening exercises with the band are conducted as well as simple calisthenics and aerobic movement exercises. The focus is on simple exercises, without a lot of equipment, that can be done at home.

They also receive handouts on the nutritional topics discussed and food and activity tracking sheets. When children come into the class they fill out a food and activity recall sheet for the day and also track how much time they have spent in front of a TV or computer screen. *[For a copy of a food and activity tracking form and family meal tracking form, see the online issue of* Patient Education Management. *For assistance, contact customer service at (800) 688-2421 or customerservice@ahcmedia.com.]* The main educational material used is found on web sites and is free to the general public. The web sites include information from the United States Department of Agriculture "My Pyramid.gov, Steps to a Healthier You" (www.mypyramid.gov), and information on "Portion Distortion" from the U.S. Department of Health and Human Services, National Institutes of Health (hp2010.nhlbihin.net/PORTION). A booklet named "We Can Parent" is also distributed, which provides information for parents about helping children lose weight. The material is produced by the Department of Health and Human Services. *("We Can" educational material can be downloaded for free from the government web site. For more details, see source box below.)*

Such activities can be enlightening. Families and children need education, says Spillman. Many are surprised by nutritional facts such as salads can be higher in fat than a hamburger when dressing is added.

SOURCE/RESOURCE

For more information about WHAM contact:

• **Bethany Spillman**, MS, RD, LD, Pediatric Clinical Dietitian, Arkansas Children's Hospital, One Children's Way, Little Rock, AR 72202-3591. E-mail: spillmanbd@archildrens.org.

• We Can! educational materials can be downloaded from the program web site at: http://www.nhlbi.nih.gov. In the "Public" section, select "Heart and Vascular Diseases," "Obesity and physical Activity, and "We Can! – A Way to Enhance Children's Activity and Nutrition." ■

Peer counseling doubles breastfeeding rates

Goal of free program: Boost rates

To improve breastfeeding initiation and its continued practice, administrators at the Prentice Ambulatory Care (PAC) Clinic of Northwestern Memorial Hospital in Chicago set in place a peer counseling program. Their efforts boosted the rate of women initiating breastfeeding to 84%, from 40%.

"Their goal was to place a peer counselor in the clinic to provide education and support during pregnancy and up to a year postpartum to improve the rates of breastfeeding initiation, exclusivity, and duration," explains **Pam Chay**, RN, IBCLC, patient care coordinator for Multiple Births and Education at Northwestern Memorial Hospital.

PAC provides outpatient women's services, including obstetrics and gynecological care, to about 500 patients a year within the Chicago community. Many of these patients are underinsured or uninsured. "The breastfeeding rates in the clinic were quite a bit lower than our private insured patients. The data showed there was about 40% initiation of breastfeeding for the patients at PAC, compared to 85% for our private insured patients, so that is why the program was implemented," says Chay. *(For information on the impact the peer counseling program is making, see article below right.)*

Money was given to fund the project in 2008 by The Evergreen Invitational Grand Prix Women's Health Grant Initiative. The program was ready to launch in 2009, and it continues to receive funding through this grant. The grant is called "Partnership to Improve Breastfeeding Rates Using Peer Counselor Education and Support."

Providing personal attention

The peer counselor, who is paid through grant monies, meets one-on-one with patients to discuss the benefits of breastfeeding, answers questions, and dispels myths. She meets with patients a second time during a clinic visit, whether or not they are intending to breastfeed their baby, just to see if they have anymore questions, says Chay.

Also she instructs a prenatal breastfeeding class for clinic patients once a month. It is two hours long and consists of lecture, discussion, demonstration, and a short video-clip on breastfeeding. The class is free and includes a catered lunch for the families attending. Couples also receive a book by Amy Spengler titled "Breastfeeding: A Parents Guide." They are also given a DVD called "Breastfeeding Intensive" by Mother of 7 at no cost to them. *(For ordering information, see resources, 67.)*

The peer counselor puts patients who have a high desire to breastfeed on her caseload and usually has about 30, says Chay. These are the women she talks to after delivery while they are in the hospital. If they are having difficulty breastfeeding, she makes sure they get help from the nurses and, if needed, from a board-certified lactation consultant.

Once the mother and baby are discharged, the peer counselor calls to provide support and guidance. The patient has the counselor's number as well. The peer counselor calls at least every three weeks and meets with the mother at her six-week postpartum visit at the clinic. If she still is breastfeeding exclusively at the time of the clinic visit, an incentive package is given that includes a T-shirt for baby, a camisole for mom, and a baby sling. "Even the patients who are not on her caseload have her phone number, so if they have any questions or issues they can call her," says Chay.

To be a peer counselor for PAC, a woman must have successfully breastfed her baby exclusively for at least four months and have been a patient of the federally funded Women, Infants, and Children (WIC) health and nutrition program. Also she undergoes 20 hours of training through HealthConnect One. This Chicago-based nonprofit agency offers training and technical assistance to service providers promoting the health of mothers, infants, and families.

EXECUTIVE SUMMARY

Is your healthcare facility trying to boost rates of breastfeeding within a particular patient population? Prentice Ambulatory Care Clinic created a peer counseling program that more than doubled the rate of women initiating breastfeeding in the hospital.

- The program includes a breastfeeding class for couples.
- It also includes follow-up phone calls after discharge.

SOURCE/RESOURCE

For more information about creating a peer counselor program to support breastfeeding mothers, contact:

- **Pam Chay**, RN, IBCLC, Patient Care Coordinator, Multiple Births and Education, Northwestern Memorial Hospital, 250 E. Superior, No. 03-2201, Chicago, IL 60611. Telephone: (312) 472-8946. E-mail: pchay@nmh.org.
- *Breastfeeding: A Parent's Guide* by Amy Spangler is available at her web site Babygooroo. Web address: www.babygooroo.com. Click on "store" and scroll down to the book title. The book costs $12.50 plus shipping and handling for one copy, with discounts for bulk orders.
- *Breastfeeding Intensive* produced by Mother of 7 available at www.motherof7.com for $57 plus shipping and handling. ■

Data supports peer counseling

Breastfeeding is on the rise

The data on the Breastfeeding Peer Counselor program and free breastfeeding classes for mothers receiving care in the Prentice Ambulatory Care Clinic in Chicago show it is successful.

From January 2009 to December 2010, the breastfeeding peer counselor has done the following:

- Counseled 861 women.
  — 84% initiated breastfeeding; compared to 40% previously.
  — 40% breastfed exclusively in the hospital.
- Conducted a total of 230 hospital visits with mothers in the postpartum unit.
- Provided 20 breast pumps for mothers that are separated from their babies.
- Taught a total of 23 breastfeeding classes; 340 people have attended a class.
- Enrolled 71 women were enrolled in a more intensively supported caseload.
  — 94% initiated breastfeeding;
  — 51% breastfed exclusively at the hospital; compared to 14% previously.
  — 70% continued to breastfeed at six weeks; compared to 17% previously.
  — 52% continued to breastfeed at three months;
  — 36% continued to breastfeed at six months;
  — 9% continued to breastfeed at 12 months. ■

Low health literacy linked to death risk

Poorer health status also found

Low health literacy in older Americans is linked to poorer health status and a higher risk of death, according to a new evidence report by the Agency for Healthcare Research and Quality (AHRQ). More than 75 million English-speaking adults in the United States have limited health literacy.

The report, an update of a 2004 literature review featuring findings from more than 100 new studies, also found an association between low health literacy in all adults, regardless of age, and more frequent use of hospital emergency departments (EDs) and inpatient care, compared with other adults.

The report's authors also found a link between low health literacy and a lower likelihood of getting flu shots and of understanding medical labels and instructions and a greater likelihood of taking medicines incorrectly compared with adults with higher health literacy. They also found evidence linking poor health literacy among adult women and underuse of mammograms.

Furthermore, evidence from a small but growing body of studies suggests that differences in health literacy levels are related to racial and ethnic disparities. For example, flu shot rates among seniors, enrollment of children in health insurance programs, and taking medications as instructed by a healthcare professional are lower among minorities.

"Ensuring that people understand health care information is critical to a high-quality, safe healthcare system," said AHRQ Director **Carolyn M. Clancy**, MD. "Improving health literacy will be a major step in the nation's efforts to enhance health care quality and safety."

In addition, the authors concluded that intensive self and/or disease management programs appear to reduce disease severity, emergency department visits, and hospital admissions among patients with limited health literacy. The authors were led by Nancy D. Berkman, PhD, and Stacey Sheridan, MD, MPH, of the AHRQ-supported RTI International — University of North Carolina Evidence-based Practice Center.

Health literacy is national focus

In May 2010, the Department of Health and Human Ser Joy,vices launched the National Action Plan to Improve Health Literacy to engage organizations, professionals, policymakers, communities, individuals and families in a linked, multi-sector effort to improve health literacy.

The plan calls for improving the jargon-filled language, dense writing, and complex explanations that often fill patient handouts, medical forms, health web sites, and recommendations to the public. Among the other objectives of the plan are promoting changes in the health care system that improve health care information, as well as improving patient-provider communication, low health literacy individual's ability to make healthcare decisions based on evidence, and access to health care. Information on the plan is available at the web site http://www.health.gov/communication/hlactionplan. The report, *Health Literacy Interventions and Outcomes: An Update of the Literacy and Health Outcomes Systematic Review of the Literature*, is available on the AHRQ web site at www.ahrq.gov/clinic/tp/lituptp.htm.

For more information on AHRQ funding, studies, tools and other resources related to health literacy and cultural competency, go to http://www.ahrq.gov/browse/hlitix.htm. ■

ED-based intervention aids outcomes, LOS

Focus on geriatric fracture care patients

Hip fractures are among the most debilitating and expensive diagnoses to treat, but your hospital can significantly improve outcomes and lower costs if it moves hip-fracture patients into surgery quickly, explains **Anthony Balsamo**, MD, an orthopedic surgeon and head of the Geriatric Fracture Care Program (GFCP) at Geisinger Wyoming Valley Medical Center in Wilkes-Barre, PA.

ED personnel can play a crucial role in identifying fragility fractures and linking these patients with appropriate care and education as swiftly as possible, adds Balsamo. "Statistics show that if you operate on someone right away, the results, in terms of morbidity and mortality, are significantly improved when the patient is over the age of 65," he says. "If you can get that hip stabilized, and you get the patient ambulating, there are fewer complications."

Balsamo established the GFCP in August 2010 because he recognized the opportunities to improve care while also reducing length of stay and other costs associated with treating fragility fractures, which are common in older patients. With the baby-boom generation reaching retirement age, Balsamo notes that fragility fractures are expected to be a huge drain on healthcare budgets going forward, particularly in regions such as northeastern Pennsylvania, where baby boomers comprise more than 19% of the population.

However, optimal care involves more than just getting patients to surgery quickly. It also requires patient and family education and appropriate follow-up interventions to lessen the chances of a repeat fracture. These are all components of the GFCP, but Balsamo points out that much of this process begins in the ED.

Get family involved

Central to the GFCP is a geriatric nurse coordinator who works within the orthopedic department but is alerted to the ED via pager whenever an older patient presents with a fragility fracture — a fracture that is primarily the result of low bone density as opposed to trauma.

"We focus mainly on hip fractures, but I will see any geriatric fracture patient who comes into the ED," explains **Michele Gingo**, RN, the nurse coordinator of the GFCP. "I explain to them what their surgery is going to entail, what their recovery is going to entail, and I evaluate their home situation."

The main purpose of the interaction is to ensure that the patient and family understand what will be required for optimal recovery and that they identify and remove any safety hazards that could complicate recovery and potentially lead to repeat fractures. "I educate the family that they are to go home and remove any throw rugs and make sure there are no extension cords in the way because when the patient comes home, he or she will most likely have an assistive device, and a throw rug or a cord could facilitate a fall," says Gingo.

In addition, Gingo explains that while pain medication will be available, patients should not expect to be pain-free right away. "We need them to be able to participate in therapy," she says. "We don't want them to be sleepy and unable to get out of bed the next day, so I explain that bed rest has many complications including, but not limited to, blood clots in their legs or lungs and pneumonia."

Gingo provides the family with a packet of information they can use as a resource for such questions as how to get in and out of a car after surgery or how to get dressed, she says. It also includes information about osteoporosis, because most of these patients will require follow-up treatment to strengthen their bones and prevent future fractures. "While patients are in the hospital, a rheumatologist will see them for our high-risk osteoporosis clinic, and there will be a follow-up office visit with the rheumatologist in a few weeks," says Gingo. "I explain to them what is going to happen. They will see physical therapy, they will see occupational therapy, and they will see a clinical nutritionist."

While hip fractures are a priority, Gingo sees other geriatric fracture patients as well. In those cases, she might help with splinting or casting, and she will discuss with the ED provider whether the patient should be referred on to the high-risk osteoporosis clinic. In the case of an ankle fracture where there is too much swelling for surgery, for example, the injury might be splinted and the patient sent home until the swelling goes down, explains Gingo.

It took some time to get the ED physicians accustomed to the new program, acknowledges Gingo. In the early stages of the program, she would reach out to the ED physicians when they

had geriatric fracture patients and explain her role. "It is key to talk to the providers and let them know that you are eager to be [called in on a case]," she says. "I take the beeper home with me, and while I won't return a call in the middle of the night, they know I will be there first thing in the morning."

Now ED providers are part of the GFCP approach, and they appreciate having a nurse who can come down to the ED and spend more time with their patients than they are able to do. "ED doctors buy into the program because there is all this information for them, someone is organizing it, and care is not delayed," says Balsamo. "Nothing is keeping that patient from surgical intervention."

SOURCES

For more information on ED-based intervention, contact:

- **Anothony Balsamo**, MD, Director, Geriatric Fracture Care Program, Geisinger Wyoming Valley Medical Center, Wilkes-Barre, PA. Phone: 570-808-1093 E-mail: ajbalsamo@geisinger.edu.
- **Michele Gingo**, RN, Nurse Coordinator, Geriatric Fracture Care Program, Geisinger Wyoming Valley Medical Center, Wilkes-Barre. Phone: (570) 808-7300. ■

Maternity patients educated on demand

Teaching times to become patient's choice

Education on the maternity care unit at Community Hospital East in Indianapolis, IN, will take place on the patient's schedule, rather than the nurses. That's because they soon will have access to on-demand educational programming via the television in their room that will provide access to education on topics such as caring for the new baby, breastfeeding, and safety issues.

These interactive, educational programs will empower patients and help them become more actively engaged in their care, according to **Paige Dooley**, MSN, MBA, RN, NE-BC, vice president of nursing at Community Hospital East.

"This is an opportunity to reach patients in a different way. The maternity population tends to be younger, and they tend to engage well with technology and the TV," explains Dooley.

When the subject matter is taught by the nurses, patients sometimes feel like it is being pushed on them, Dooley says. It is not something they can access when they are ready or when their husband or significant other is with them, she says.

Once the on-demand system is up and running, the nurses will assign the appropriate education for the patient and be the champion for the use of the tool, says Dooley. Patients will answer questions at the end of the program, and the information will be transferred to an electronic record. In this way, the nurse also will know what the patient has watched. Stops can be placed in the programming that requires patients to answer correctly before further use of the television set. "The opportunity is always available for the nursing staff to have patients verbalize understanding and to do a return demonstration of something when that makes sense," says Dooley. Nothing replaces the nurse at the bedside reinforcing and assessing learning, she adds.

A $30,000 grant from the Nina Mason Pulliam Charitable Trust to launch educational programs at the hospital was awarded to the Community Health Network Foundation. The grant and an in-kind donation from the GetWellNetwork, the Bethesda, MD-based company that produces the television-based patient education programs, accounted for about half the cost. The foundation contributed the rest of the money, says Dooley. *(For contact information for the GetWellNetwork, see resource box at the end of this article.)* Programs can be selected from those produced by the company, but videos used by the hospital also can be added.

Dooley estimates it will take a few months to have the system running smoothly, but it will be a valuable asset to patient education. "When you apply principles of adult learning readiness, the patient will get the most out of it and will attend to it when it makes the most sense, on their schedule, not on the nurses," says Dooley.

SOURCE/RESOURCE

For more information about the use of on-demand TV programming on a maternity care unit, contact:

- **Paige Dooley**, MSN, MBA, RN, NE-BC, Vice President of

EXECUTIVE SUMMARY

On-demand TV educational programs are being implemented on the maternity care unit at Community Hospital East in Indianapolis, IN, to solve scheduling problems for teaching patients.

- New moms will pick the best time to view lessons.
- Family members will be more easily involved.

Nursing, Community Hospital East, 1500 North Ritter Ave., Indianapolis, IN, 46219. E-mail: pdooley@eCommunity.com.

• GetWellNetwork, 7920 Norfolk Ave., 10th Floor, Bethesda, MD 20814-2500. Telephone: (877) 633-8496 or (240) 482-3200. Web: www.getwellnetwork.com. E-mail: info@getwellnetwork.com. ■

6 ways to prevent hospital readmissions

How to get the information you need

To prevent hospital admissions, hospital staff should gather as much information as possible about the patient's discharge needs, psycho-social needs, and support systems in the community, says **Cory Sevin**, RN, MSN, NP, director with the Institute for Healthcare Improvement. They should talk to family members and primary care providers who know the patient and can provide first-hand information, Sevin says.

Here are five more tips from the experts on how you can keep your patients from being readmitted to the hospital:

• Staff should look for barriers, such as cost or lack of transportation, that could prevent patients from receiving post-acute treatment, and problem-solve before the patient leaves the hospital.

Staff should work with patients to make sure that they can pay for any outpatient services or medications that are not covered by insurance, and help them get assistance if they can't pay. If something isn't covered by their insurance, contact the doctor to see if the treatment plan can be changed, suggests **Donna Zazworsky**, RN, MS, CCM, FAAN, vice president of Community Health and Continuum Care for Carondelet Health Network in Tucson, AZ.

• Staff should make sure that chronically ill patients have the equipment they need to monitor their conditions after discharge and know how to use it, Zazworsky suggests.

For example, make sure patients with diabetes obtain a glucometer that is covered by his or her health plan, she adds. If possible, provide the glucometer before the patient leaves the hospital.

Push disease management

• Help patients with chronic illnesses enroll in a disease management program, Zazworsky recommends.

• Make sure patients and caregivers understand the patient's condition, medication regimen, red flag signs and symptoms, and who to call if they occur, Sevin suggests.

Use the teach-back method to make sure patients and caregivers understand, rather than just

Continued on p. 72

COMING IN FUTURE MONTHS

- ■ New strategies for improving healthy literacy
- ■ Best ways to document understanding
- ■ Methods for keeping educational materials current
- ■ Avoid time constraints with online classes

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 this month, 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.

Upon completion of this educational activity, participants should be able to:

- identify the management, clinical, educational and financial issues relevant to patient education
- explain the impact of the management, clinical, educational and financial issues relevant to patient education on health care educators and patients
- describe practical solutions to problems health care educators commonly encounter in their daily activities
- develop patient education programs based on existing programs.

CNE QUESTIONS

21. Staff at many health care institutions creating programs to address childhood obesity, state they have found through literature searches which of the following educational methods to be most effective?
A. Interactive/hands-on
B. The inclusion of family members
C. Lecture
D. A and B

22. According to Carolyn Landis, PhD, a clinical psychologist at Rainbow Babies & Children's Hospital in Cleveland, OH, a program named Healthy Kids, Healthy Weight uses participatory education to increase the self-efficacy of the children involved.
A. True
B. False

23. On-demand TV educational programs are expected to improve education on the maternity unit at Community Hospital East in Indianapolis, IN, because patients will be able to do which of the following, according to the vice president of nursing?
A. Become engaged in their care
B. Learn when they are ready
C. Include family members in lessons
D. All of the above

24. A breastfeeding peer counseling program implemented at Prentice Ambulatory Care Clinic in Chicago has improved the initiation of breastfeeding in the hospital from 40% to 84%?
A. True
B. False

Answers: 21. D; 22. A; 23. D; 24. A.

Continued from p. 71

lecturing them.

• Staff should implement a good hand-off to the providers in the next level of care, whether it's a rehab facility, skilled nursing facility, home care nurse, or physician.

Staff should make sure they have all the information about the patient's reason for hospitalization, medications, test results, plan of care, and discharge plan along with the ability to use the teach-back method to educate patients. Instead of waiting weeks after discharge to send the information, staff should create a system to transmit it in a timely way, Sevin recommends. ■

Name _____ FREQUENCY FORM Date _____

Grain ❑❑❑❑❑❑❑❑❑❑

Dairy ❑❑❑❑❑

Fruit ❑❑❑❑❑

Protein ❑❑❑

Vegetable ❑❑❑❑❑❑

Fat ❑❑❑❑❑

Dessert ❑❑

Water ❑❑❑❑❑❑❑❑❑❑ (each box is 8oz of water)

Physical Activity (each box is 10 minutes)
❑❑❑❑❑❑❑❑❑❑❑❑❑❑

Screen Time (each box is 15 minutes)
❑❑❑❑❑❑❑❑❑❑❑❑❑❑❑❑❑❑

SOURCE: Arkansas Children's Hosptial, Little Rock.

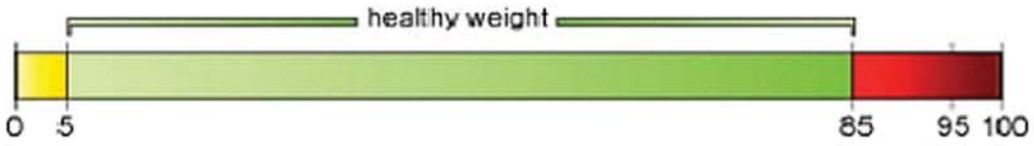
Healthy Eating
Body Mass Index (BMI)

BMI stands for **B**ody **M**ass **I**ndex. BMI uses your child's weight and height to see if your child is too heavy, too thin or a good weight for his/her age. It is given to you as a number. You can also see how your child compares with children who are the same age with the BMI-for-Age percentile.

We know that kids who are overweight or obese are more likely to have medical problems. Sometimes, families may not even know the child has a problem.

BMI Percentile Number

- If the BMI is in the yellow area, your child may be underweight.
- If the BMI is in the green area, your child is at a healthy weight
- If the BMI is in the red area, your child may be overweight or obese.



Issues That Affect Weight

BMI does not tell the whole story. Many things other than height and weight can affect your child's BMI, like:
family history
amount of muscle and fat. If a child is very athletic and has a lot of muscle, the BMI may be high even though he/she is not overweight.

Maintaining a Healthy Weight

Help your child (age 2 and older) get to a healthy weight. Just follow these goals – think 5-2-1-0! It is a countdown to success.

5 Eat at least 5 fruit or vegetables servings every day

2 Limit screen time (TV, video games and computer) to less than 2 hours per day

1 Get at least 1 hour of activity every day. Go for a walk, play outside, dance or jump rope

0 Get Zero calories from drinks except for skim, fat-free or 1% milk

Additional Resources

http://www.cdc.gov/healthyweight/assessing/bmi/

Adapted from the BMI Screening Guidelines for School Massachusetts Department of Public Health.

SOURCE: Cincinnati (OH) Children's Hospital.

Name: _____ Date: _____

Food Recall

How many times in the last week did you sit down together as a family and eat a meal at the table? ___

Food eaten (remember all foods and beverages)	How was it prepared? (fried, boiled, baked, etc.)	Amount eaten

Name: _____ Date: _____

Food Recall

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Food eaten (remember all foods and beverages)	How was it prepared? (fried, boiled, baked, etc.)	Amount eaten

Name: _____ Date: _____

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How many times in the last week did you sit down together as a family and eat a meal at the table? ___

Food eaten (remember all foods and beverages)	How was it prepared? (fried, boiled, baked, etc.)	Amount eaten

SOURCE: Arkansas Children's Hospital, Little Rock.

patient education MANAGEMENT

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

PEM060111TM

PLEASE NOTE: If your correct name and address do not appear below, please complete the section at right.

Please make label address corrections here or PRINT address information to receive a certificate.

Account # _____

Name: _____

Company: _____

Address: _____

City: _____

State: _____

Zip _____

Fax: _____

Phone: _____

E-mail: _____

CNE Evaluation: Please take a moment to answer the following questions to let us know your thoughts on the CNE program. Fill in the appropriate space and return this page in the envelope provided. **You must return this evaluation to receive your certificate.**

CORRECT ● INCORRECT ⊘ ✓ ✗ ⚠

1. If you are claiming nursing contact hours, please indicate your highest credential: ○ RN ○ NP ○ Other _____

	Strongly Disagree	Disagree	Slightly Disagree	Slightly Agree	Agree	Strongly Agree
After participating in this program, I am able to:						
2. Identify the management, clinical, educational and financial issues relevant to patient education.	○	○	○	○	○	○
3. Explain the impact of the management, clinical, educational and financial issues relevant to patient education on health care educators and patients.	○	○	○	○	○	○
4. Describe practical solutions to problems health educators commonly encounter in their daily activities.	○	○	○	○	○	○
5. Develop patient education programs based on existing programs.	○	○	○	○	○	○
6. The test questions were clear and appropriate.	○	○	○	○	○	○
7. I detected no commercial bias in this activity.	○	○	○	○	○	○
8. This activity reaffirmed my clinical practice.	○	○	○	○	○	○
9. This activity has changed my clinical practice.	○	○	○	○	○	○

If so, how? _____

10. How many minutes do you estimate it took you to complete this entire semester (6 issues) activity? Please include time for reading, reviewing, answering the questions, and comparing your answers to the correct ones listed. _____ minutes.

11. Do you have any general comments about the effectiveness of this CNE program?

_____

I have completed the requirements for this activity.

Name (printed) _____ **Signature** _____

Nursing license number ***(required for nurses licensed by the state of California)*** _____