Patient Education Management™

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

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IN THIS ISSUE

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Take proactive steps to keep funds from being slashed by the budget ax

Show that patient education funds are well spent; create cost savings

To justify the money allocated for patient education and hang onto it, spend the money in your budget, advises **Kathy Ordelt**, RN, patient and family education coordinator at Children's Healthcare of Atlanta. If you don't, when administrators work on the budget the next fiscal year, the amount that wasn't spent probably will be slashed.

It is important, however, to show that the use of the money was deemed worthwhile by staff, patients and family, and the health care system as a whole, says Ordelt. Statistics that prove the worth of a program can be gleaned from customer service or satisfaction surveys.

The systemwide survey at Children's Healthcare of Atlanta includes five patient education questions such as whether patients received materials written at a level they could understand and whether physicians and nurses explained procedures and treatments clearly.

"Our administration pays a lot of attention to our customer satisfaction survey results," says Ordelt. This includes staff surveys that determine if patient education is meeting employees' needs.

EXECUTIVE SUMMARY

In the May issue of *Patient Education Management*, we began a series of articles on budgetary concerns because many readers told us that funding for patient education in a tight market often is not a top priority for administrators. Last month, we covered partnerships for community outreach as a way to stretch dollars. In this issue, we discuss ways to keep patient education budgets from being slashed. Don't wait for the budget ax, many patient education managers advise. Instead, be a team player and become proactive in uncovering cost-saving strategies.

To evaluate staff, Ordelt uses a software program from which she creates questions related to the resources produced and the inservices provided during a six-month period. She then distributes the questionnaire by e-mail to staff she has worked with during that time period. To complete the survey, they use a rating system between 1 and 5, with 5 being the best. There also is space for written comments after each question.

In one of her most recent surveys, Ordelt asked staff to:

- rate the overall service you receive from patient education;
- rate the courtesy given to you by patient education;
- rate the staff education and inservices provided by the patient education department;
- rate how well you are kept informed of the status of your project with patient and family education.

"At Children's, every department is responsible for doing internal customer service surveys twice a year," says Ordelt. Surveys also are distributed following each inservice to get immediate feedback.

Continually assess patient needs to make sure that the education strategies are tailored accordingly. Also evaluate what already has been implemented on a continuous basis to ensure that it is still on target, advises **Louise Villejo**, MPH, CHES, director of patient education at M.D. Anderson Cancer Center in Houston.

Recently, patients at M.D. Anderson were asked to evaluate the chemotherapy education package, which consisted of a booklet, information sheets and other materials given to patients in a folder. The patients said that they wanted the information provided in a booklet with sections divided by tabs so specific details were easier to find. Although the booklets were more expensive, administrators gave the project the go-ahead because of the assessment that had been done beforehand.

Information on how to prepare for a diagnostic test now is included on an appointment reminder letter sent to patients because an evaluation of the education process revealed that many were showing up for tests unprepared.

Also, patients now can check out a video on chemotherapy because an assessment showed that they wanted to be able to watch it at home.

Consistent evaluation of programs, classes, resources, distribution methods, or teaching methods that result in improvements helps to prove that patient needs are being met especially when patients are involved in the process. "That is important as far as keeping your program vital and funded," says Villejo.

Be proactive

Another strategy for avoiding the budget ax is to be proactive in looking for ways to save money. Instead of being a stumbling block, become part of the team helping to look at budgetary concerns, advises Ordelt.

"It's constantly reassessing and evaluating how to do things in a better or cheaper way," she explains. For example, 700 teaching sheets in both

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English and Spanish are available on the intranet at Children's Healthcare of Atlanta. In this way, staff can quickly obtain handouts from the computer system, which can be updated easily.

However, it was determined that this method of distribution was not cost-effective for frequently used handouts. When teaching sheets are needed in bulk, the time spent at the copy machine as well as the toner that is used in the process of making copies is cost-prohibitive. As a result, high-volume teaching sheets, such as those on ear infections, are sent to a printer. Clinical staff order packets of 100 sheets right from their desktop and they are delivered the next day and billed to that department.

Although the cost savings does not directly affect the patient education budget, it does impact the overall budget. This method of printing high-volume sheets also has improved customer satisfaction because employees no longer have to stand at the copier for long periods of time, says Ordelt.

Demonstrate to administrators that you are looking at ways to reduce waste, agrees **Dorothy Ruzicki**, PhD, RN, director of the department of educational services at Sacred Heart Medical Center in Spokane, WA. Analyze processes to determine if they can be done with fewer staff or fewer steps. "I saved a position for the medical center by just cross-training some of my staff to do the same work," she says. **(For more information on creative ways to staff during a budget crisis, see article on p. 64.)**

To prevent budget cuts, try to tie patient education into the main organizational objectives and look for ways to support other departments and initiatives, says **Magdalyn Patyk**, MS, RN, BC, a patient education consultant at Northwestern Memorial Hospital in Chicago.

This might include developing and obtaining appropriate patient education resources for systemwide patient safety and pain initiatives or helping all departments adjust the reading level of their pamphlets. When looking at replacing closed-circuit television systems, consider multiple needs. Rather than limiting the programming to patient education, evaluate the possibility of including patient surveys for quality improvement, menu selection for nutrition services, and staff education on demand for the staff development department, explains Patyk.

It's vital to show that patient education supports the health care institution's strategic plan, says Villejo. When the president of M.D. Anderson announced the new strategic plan and initiatives, Villejo's supervisor instructed the patient education department to create a bulleted list of everything done to support the new initiatives.

"We listed the goal of the strategic plan and then our activities that supported the goal. A number of times when developing proposals to request funds for different projects I explain how it will support the strategic plan," says Villejo.

Keep leadership informed

Get administrators' attention, and make sure they are consistently aware of accomplishments in patient education, says Villejo.

She issues a very short monthly report to keep leadership abreast of what patient education is doing. For example, the number of participants in classes at the learning center is listed. Also, major projects for the month are trumpeted. For example, during Fatigue Awareness Week, 900 people attended presentations and a health fair.

After evaluating a patient education program and presenting results to clinical leadership, Villejo met with members of that leadership committee on an individual basis as work was done to improve the program to get input on improvement strategies as well as to create champions for patient education. In this way, these leaders support patient education at key meetings, she says.

To gain support for programs or resources in the planning stages, make sure your ideas are

SOURCES

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known, advises Villejo. To do this, she includes these ideas in her budget even though she knows funding is a long shot.

"If you put your ideas on paper, they are there when the time is right," she says. For example, Villejo pitched a learning center for years, but when she finally obtained funding, there was no space available for the center.

However, because the need for a patient and family learning center was well publicized throughout the health care system, space eventually was obtained. Patient relations approached the patient education department offering to share space it had, and a small center was established.

Shortly after that, cancer prevention services obtained a large space and invited the patient education department to move the learning center. "We moved from a closet area to share their big space, and a couple years later they gave it to us," says Villejo. ■

Creativity is the key to your staffing woes

Subcontract, find ways to justify positions

When budgets are tight, the amount of staff available to complete patient education projects often dwindles. In addition, patient education managers frequently have extra duties added to their job description as well. As a result, it is important to look creatively at staffing problems, says **Kathy Ordelt**, RN, patient and family education coordinator at Children's Healthcare of Atlanta.

"I have people that I work with on an as-needed basis, and I contract with different companies on jobs that we had done in-house with a fulltime staff person," Ordelt explains.

When there isn't enough staff to get the work done, look for people both within your health care organization as well as outside organizations to work with on an as-needed basis. It is often cheaper to subcontract projects than to hire employees. Ordelt keeps a list of companies as well as staff within her health care system that she can use when they are needed to get a job done.

When employees are essential, it's important to justify the need for their position, says **Mary Szczepanik**, MS, BSN, RN, manager of cancer education, support, and outreach at OhioHealth Cancer Services in Columbus. The most difficult task is to add new positions, she says.

"I've been most successful in adding new positions by starting with a part-time position, which is funded by grant dollars. Then, as the program grows, I've been able to justify the need and convert the position to my budget as a permanent position," says Szczepanik.

Currently, about 40% of the part-time positions in cancer education are funded by grant dollars. Such staffing requires knowledge about what grants are available and how to write them, says Szczepanik. It also requires dedicated employees and lots of work on team building, she says. **(*Patient Education Management* will cover strategies for obtaining grant dollars in the July issue.)**

Szczepanik recently added a fulltime employee based on declining satisfaction scores in symptom management and emotional and spiritual support. Data was collected for six months and then combined with the systemwide patient satisfaction scores to prove the need for the position.

In this way, Szczepanik was able to justify transferring a vacant position in another area of cancer services to cancer education, support, and outreach. The funds for the position now are part of her budget. ■

SOURCES

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- **Kathy Ordelt**, RN, Patient and Family Education Coordinator, Children's Healthcare of Atlanta, 1001 Johnson Ferry Road N.E., Atlanta, GA 30342. Telephone: (404) 929-8641. E-mail: kathy.ordelt@choa.org.
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Education prepares for the aging process

Addressing change improves quality of life

For successful aging, people need to know what to expect so they can prepare, says **Sandra Fong**, MS, administrator at Gramercy

Prepare for the physical changes of getting older

Help the aging cope early; know the facts

At Gramercy Court, a skilled nursing facility in Sacramento, CA, staff understand the aging process.

"We are used to being around seniors, so we don't have expectations from the past. When they come to Gramercy, we accept them the way they are," says **Janet Hamil**, director of marketing.

Some of the signs of aging that staff are taught include the following:

- **Vision**

After the age of 60, a person's ability to see drops dramatically. Changes in the lens make it more difficult to see close objects clearly, see well in poor lighting conditions, and distinguish some colors.

- **Hearing**

Individuals older than the age of 65 are more likely to need a hearing aid than younger people. They often have difficulty hearing certain pitches or screening out background noise.

- **Taste and smell**

As people age a reduction in nerve sensitivity impairs their ability to taste and smell. Therefore, food is often no longer as flavorful.

- **Motor Performance**

Motor coordination and speed decline with age. Also, bone mass declines from 5% to 10% each decade after age 40.

- **Cardiovascular**

After the age of 60, the heart pumps about 1% less blood per year. Consequently, elderly people's hearts do not respond to stress or heavy exercise as well as a young person's heart. ■

SOURCES

For more information about successful aging, contact:

- **Sandra Fong**, MS, Administrator, and/or **Janet Hamil**, Director of Marketing, and/or **Leesa Wilson**, RN, Director of Nursing, Gramercy Court, 2200 Gramercy Drive, Sacramento, CA 95825. Telephone: (916) 482-2200. E-mail: admin@gramercycourt.com.

Court, a skilled nursing facility in Sacramento, CA.

Understanding the physical and psychological changes that often accompany aging helps the elderly as well as their family members take the maturing process in stride. People adjust throughout their lifetime to the stages of life; and if they look at the aging process in a positive manner rather than in a negative way, they will adjust better, Fong says.

For example, if arthritis prevents a person from playing the piano, he or she still can appreciate music by listening, she explains.

It's important that families become familiar with the aging process because people are living longer. When **Leesa Wilson**, RN, director of nursing at Gramercy Court, first began working with the elderly, most residents in a skilled nursing facility were in their 70s. Now the average age is 93. Having residents celebrate their 100th birthday is no longer unique, so people need to learn how to prepare and cope with aging, she says.

Families often are frightened when they first bring a loved one to a skilled nursing facility, says **Janet Hamil**, director of marketing for Gramercy Court. "The reaction is probably from not being aware of the aging process and understanding that what is happening to Mom or Dad is typical. It doesn't mean the end. It just means that things are changing, and their lives will be a little different," she explains.

Families can prepare for aging just as they make preparations for other stages in their life such as the birth of a new baby, the empty nest when children grow up and leave home, or retirement.

For example, as people age, it becomes more difficult for them to see nearby objects clearly. They also have difficulty seeing well in dim lighting conditions. Therefore, changes in the lighting fixtures at their house might be in order. Large-print books and good reading glasses would prove beneficial as well.

Motor coordination declines with age, and with advancing years, people move more slowly and are less agile. Therefore, it is important that the elderly remove throw rugs and other household hazards that could cause them to fall. **(To learn other physical changes that might be expected with aging see article, left.)**

The life changes that occur with aging can be stressful, so it is important to have a support system, says Wilson. "It's important to be involved

with others that are dealing with the same issues," she says. This might be accomplished by attending programs designed for seniors such as exercise or dance classes or by joining a support group.

Preparation helps skirt problems

When people understand the aging process and adjust their lives accordingly, many problems are avoided. For example, safety proofing the home will help prevent falls and keep the elderly out of skilled nursing facilities longer. A gradual loss in ambulatory skills is much easier to adjust to then a sudden loss from a trauma, says Fong.

Safety is a key issue and community outreach classes on the prevention of falls would be helpful, says Wilson.

Remaining independent is another key issue, she says. People usually age better if they are able to keep their independence for as long as possible. "A lot of times when our loved ones age and their eye sight is poor and they can't walk as well as they used to, we want to do everything for them. But that is not what we should do," she explains. Instead, make the necessary changes in their environment so that they can remain self-reliant for as long as possible.

People who take care of themselves also age better, says Wilson. Drinking enough water, eating nutritious foods and exercising will keep bones healthier and improve general health as well. In addition, the elderly should not smoke. If they drink alcohol, it only should be consumed in moderation.

Socialization is important as well. The elderly should stay involved in activities they enjoy and socialize regularly.

Signs of confusion, dizziness, and other physical symptoms that often lead to placement in a nursing facility can be due to the misuse of medication, says Wilson. Therefore, the elderly need to know that it isn't wise to take a lot of over-the-counter drugs including herbs and vitamins without consulting their physician to see if there is an adverse reaction with any of their prescribed medicines.

Elderly couples generally have the most difficult time when one spouse must care for another. The caregiver often neglects him or herself because all energy is focused on the loved one. It is important for the caregiver to learn where to get support because the stress is deadly. "Often the caregivers pass before their loved one does because of the stress and the fact that they have not taken care of themselves," says Wilson. ■

Education for radiation therapy not so simple

Details depend on cancer, location, tumor size

The concept of radiation therapy is not difficult to explain. The Bethesda, MD-based National Cancer Institute (NCI) describes it as "the treatment of disease using penetrating beams of high-energy waves or streams of particles called radiation." Specific amounts of radiation aimed at cancer cells either kill the cells or keep them from growing or dividing.

Education about radiation therapy for patients who will undergo the procedure is not so simple because the method of treatment varies depending upon the type of cancer, its location, and its size.

"Not all patients get the same type of radiation therapy," says **Beth Archer**, RN, BSN, oncology nurse specialist in radiation therapy at Riverside Radiation Oncology in Columbus, OH. Education on radiation therapy for someone with brain cancer is different than the teaching that someone undergoing radiation for breast cancer would receive. Yet there are basic steps to the education that can be followed.

A good strategy on education for radiation therapy is important because more than half of all people with cancer are treated with some form of radiation, according to NCI.

Like surgery, radiation therapy is a local treatment affecting the cancer cells in a specific area of the body. Radiation often is used in conjunction with surgery to shrink a tumor before the operation so it is easier for the surgeon to remove it or following surgery to prevent the growth of any cancerous cells that remain.

EXECUTIVE SUMMARY

In the April issue of *Patient Education Management*, we began an article series on the education that is required for various cancer treatments. The first piece in our series was on chemotherapy. In May, we covered biological therapy; and in this issue, we look at radiation therapy. Like chemotherapy, it is a term that is familiar to many people. Although it is common, patients need to be prepared for the procedure that will be used in their case.

SOURCE

For more information about radiation therapy education at OhioHealth Cancer Services, contact:

- **Beth Archer**, RN, BSN, Oncology Nurse Specialist, Radiation Therapy, Riverside Radiation Oncology in Columbus, OH. Telephone: (614) 566-5717. E-mail: barcher@sbcglobal.net.

Radiation is sometimes combined with treatments that reach all parts of the body as well, such as chemotherapy, to improve results. For many patients, radiation therapy is the only cancer treatment their oncologist recommends.

At Riverside Radiation Oncology, education begins before the consultation to discuss treatment options with the physician. At that time, patients are given a day planner that has sections to track doctor's appointments, the results of lab work, and weight gain or loss.

There also is a section to write down all medications prescribed, the name of the physician who ordered it, the reason for taking it, along with the dosages and how often they should be taken. The date the patient started taking the medication is recorded, and if they stop taking it, that date also is noted. The notes help the patient communicate with each physician on the health care team.

The planner has a general overview of the diagnosis of cancer and information on cancer treatments, such as chemotherapy and radiation, as well as their possible side effects. Also, there is a glossary of medical terms and a section with the telephone numbers for all cancer services and libraries at the health care facility, as well as good web sites for cancer information.

Tailoring education to patient

Education is personalized by providing patients with handouts for the planner that are specific to the cancer that he or she has and its treatment. For example, if patients were having radiation therapy for the abdomen, they would receive a handout on radiation for that specific area. They also receive a handout on the possible side effects of radiation, such as skin irritation, fatigue, and loss of appetite.

"Patients can review the information when they get home. It is a good reference for them later," says Archer.

The handouts complement one-on-one education about the radiation therapy a patient will receive. The procedure not only is explained in detail, but patients usually are shown the equipment that will be used, such as the machine that aims specific amounts of radiation at tumors. They learn what the first treatment will be like and how the following treatments will differ, if there is any difference.

Radiation therapy can be either external, with a machine directing the energy rays, or internal where the radiation source, sealed in an implant, is placed inside the body.

"It is important to give the specifics before patients have radiation therapy so they understand what will happen. Our doctors are good at explaining that, too," says Archer. Patients also are given their treatment schedule.

In addition to the explanation of the radiation therapy process, patients need to know the different disciplines involved in their therapy. The team may include a radiation physicist who oversees the equipment, a dosimetrist who helps calculate the amount of radiation to be delivered, and a radiation therapist who positions the patient for treatment and runs the equipment. The team also could include the patient's physician, oncologist, radiation oncologist, and the nurse that coordinates the care and provides education.

"We try to help the patient know what each team members involvement will be in their care," says Archer.

On return visits, patients receive additional help with any side effects they may be experiencing. For example, if they were losing weight due to loss of appetite, they would be given sheets with high-calorie recipes for such items as milkshakes and smoothies. ■

Create workable groups for systemwide education

Motivate staff to develop processes that work

As patient education liaison and performance consultant at Baptist Health South Florida in Miami, **Yvonne Brookes**, RN, works with staff at four hospitals and four community wellness centers. It is her job to make sure staff have the tools they need for patient education and that processes for teaching are in place.

These tasks are accomplished in several ways. She directs a systemwide patient education board

EXECUTIVE SUMMARY

Many readers appreciate the contact information for sources that is printed at the end of each article in *Patient Education Management*, because it is a good addition to a *PEM*'s networking database. To further promote the exchange of ideas, we added a new feature last month — a profile of a patient education coordinator that will frequently be included in the newsletter. The suggestion came from an editorial board member who thought it might offer networking opportunities similar to those experienced at a conference. This month, we profile **Yvonne Brookes**, RN, patient education liaison and performance consultant at Baptist Health South Florida in Miami.

with representatives from all the hospitals and wellness centers, which meets quarterly. She also is the facilitator for all the hospital patient education committees.

"My role is to increase communication about patient education strategies, standards and activities across the system," says Brookes. If a particular form works well at one institution, she pitches it to the others.

She also is the source of information on national trends and local events regarding patient education. To keep abreast of trends she reads publications, monitors a listserv, and networks with colleagues. Belonging to patient education-oriented associations is a good way to make connections, she says.

A hospital or unit will solicit her help if they are having problems with documentation or standards are not being followed. In such cases, she assesses the situation and provides inservices to correct the problem. She also makes sure that all institutions within the system are meeting the Oakbrook Terrace, IL-based Joint Commission on Accreditation of Healthcare Organizations (JCAHO) standards for patient education.

"I have been able to establish groups at each hospital and get them to work [both] as a team and independently, so I go in truly as their consultant," says Brookes.

She was given the position of patient education liaison in September 1996 when the hospital at which she worked merged with several other health care facilities in the area. In 2000, she was asked to do all the new nursing orientation at the largest hospital in the system. In addition, she conducts cultural diversity training.

Brookes' first position in patient education was at Homestead (FL) Hospital, which is part of the Baptist Health system. She was put in charge of diabetes patient education and all community outreach programs. This assignment was given to her because she constantly promoted the importance of educating patients.

The position Brookes fills is in the department of education and she reports to the director of education. She also works closely with the vice president of nursing at each of the health care facilities.

Her background in nursing is on a medical surgical unit and she often works this unit on the weekends when there is a staff shortage. She does this to keep her knowledge and understanding of barriers to patient education fresh.

Working a system

While performing her role of patient education liaison and consultant within a large health care system, Brookes has learned many lessons. In a recent interview with *Patient Education Management*, she shared some of her insights. The following is some of the information she presented:

- **What is your best success story?**

At Homestead Hospital, Brookes helped establish a patient education document tool that is workable. Staff completes the documentation. To accomplish this, a simple form was implemented that focuses on the outcome rather than on the content of the teaching. Codes are used to indicate whether the patient was able to demonstrate a skill or answer certain questions to show that the teaching was successful.

The process of patient education at Homestead truly is interdisciplinary as well, Brookes says. When nurses do the initial assessment, they watch for triggers that would prompt them to contact another discipline. For example, if the patient has recently fallen or is having difficulty walking or sitting, physical therapy is alerted via the hospitalwide computer system to screen the patient and determine what education needs to take place. If a patient is on five or more medications, pharmacy is contacted.

- **What is your area of strength?**

Brookes says her area of strength is the ability to get people to work with her very easily and stay onboard. She thinks it comes from the fact that she is committed to patient and family education and sees that it is the essence of nursing. With that

SOURCE

For more information about creating workable groups for systemwide education, contact:

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conviction, she has been able to motivate other people to work well within groups and committees to really develop processes that work for patients. Organizationally, she is well respected, well known, and people want to work with her.

• What lesson did you learn the hard way?

"I learned that what you are able to institute at a smaller hospital with a smaller group of people relatively quickly will take five times as long at a larger hospital," says Brookes.

Although you want to give up and just let staff do what they want, it's important to stick to the task knowing that it will happen in time, she says. At a small hospital one group of people make the decision and at a larger hospital five groups of people do, so it's important to have the patience to go through the process.

• What is your weakest link?

It's difficult for Brookes to support the community wellness centers in the fashion that she would like to because the system has experienced such rapid growth. "I really want them to have the same standards and support as the patient who is coming out of the hospital. The weakest link is to be able to connect those two," says Brookes.

• What is your vision for patient education in the future?

Working with the patient education board for Baptist Health South Florida, Brookes would like to develop a model of excellence for patient and family education that they could publish. That would mean that all the health care facilities within their system used the same education tools, methods of documentation, and followed the same standards. All patients would be connected with community programs before they were discharged from the hospital as well.

• What have you done differently since your last JCAHO visit?

One larger hospital in the system needed to improve documentation and the interdisciplinary process of patient education. Therefore, the documentation tool that is successful at Homestead was implemented at this hospital. Now that better tools are in place, documentation is being monitored to see if it improves.

• When trying to create and implement a new form, patient education material, or program, where do you go to get information/ideas from which to work?

When establishing something new, Brookes goes to other hospitals to ask for copies of the forms and protocols needed for the task and to gather information. Then she sits down with a group to examine the material to determine if something similar could be instituted with a few adjustments.

"It saves a lot of time; and if it has worked somewhere else, there is no reason that parts of it shouldn't work with us," says Brookes. ■

Preserving function is goal with kidney disease

Include information about changes in lifestyle

Kidney disease is a chronic illness that can greatly impact a person's lifestyle as well as that of family members. Chronic kidney disease often leads to dialysis or a kidney transplant. Therefore, 10 years ago, a class series was implemented at the University of Washington Medical Center in Seattle called Kidney Information Support System (KISS) for people diagnosed with kidney disease.

"Before we started, I was thinking that people having babies have classes to learn, simply because their life changes. With kidney disease, you have to know a lot to really manage and to be living a good life. That's why we started the class," says **Annie W. Tu**, MS, ARNP, CNN, a renal clinical nurse specialist.

A variety of people contribute to the class and include health care professionals as well as patients and family members who are impacted by kidney disease. The professionals include a physician, nurses, a social worker, dietitian, and finance counselor. One patient who helps teach was on dialysis for 19 years and had a kidney transplant nine years ago. In spite of her chronic disease, she is able to water ski and runs her own business. She is a good role model for the other patients, says Tu.

Everyone involved in this semiannual class series, which meets twice a week for three weeks when in session, volunteers his or her time.

Classes run from 7 p.m. to 9 p.m.

The first class covers the function of the kidneys and what happens when this organ fails. The kidneys produce and eliminate urine through a complex system of nephrons, which filter blood removing soluble wastes. The kidneys eliminate the wastes as urine and return the purified fluid to the blood. Diseased kidneys begin to lose their ability to filter blood.

Class time during the second session is devoted to the preservation of kidney function. Because diabetes is the No. 1 cause of chronic kidney disease and hypertension is No. 2, patients are taught to control their blood pressure and regulate their glucose to prevent the need for dialysis for a longer period of time, says Tu.

They also learn the components of a healthy lifestyle such as diet and exercise. A dietitian talks about good nutrition with lots of emphasis on selecting low-sodium foods to control blood pressure.

To preserve kidney function those with this chronic disease must be very careful about what medications they take because certain drugs will damage kidneys. Patients with kidney disease need to advise all physicians and lab technicians of their condition.

Lessons on treatment choices

During three of the classes, each of the treatment choices are covered, including hemodialysis, peritoneal dialysis, and kidney transplant.

With hemodialysis a patient's blood is filtered through a machine to remove impurities or wastes. Class discussion on this treatment modality includes a description of the process, the amount of time it takes, the frequency of treatments, and having dialysis at a center vs. being trained to do it at home.

A patient or the family member that helps with dialysis speaks to the class for 20 minutes about what it is like to do dialysis at home, says Tu. The class also goes to the kidney center to talk to patients on dialysis. "In this way, they know what to expect. Otherwise, they have no idea what it is and they are very scared," she explains.

During the session on peritoneal dialysis, a procedure where blood is filtered with the aid of the membrane that covers the wall of the abdomen, or the peritoneum, patients are taught about self-care at home and again a nurse pairs with a patient to provide the instruction. Patients help teach the classes because they have firsthand experience, says Tu.

SOURCE

For more information about KISS — Kidney Information Support System, contact:

- **Annie W. Tu**, MS, ARNP, CNN, Renal Clinical Nurse Specialist, University of Washington Medical Center, 1959 N.E. Pacific, Seattle, WA 98195. Telephone: (206) 598-4442. E-mail: annietu@u.washington.edu.

A financial counselor spends about 40 minutes discussing how patients might pay for these treatments and what they should do to make sure funding is available. There are other financial issues as well. For example, the patient might not be able to continue work.

The third class covers the kidney transplant and the nurse who is the transplant coordinator talks about the workup, transplant, and long-term care. This includes a discussion of possible complications and suitable donors. A nurse also summarizes the information on treatment choices to help people be able to make decisions, says Tu.

At the final class, a physician discusses living a long and healthy life with kidney disease. This presentation is followed by a panel discussion on coping with kidney disease, which is moderated by a social worker. Several patients with kidney transplants or who are on dialysis, along with their family members, sit on the panel. It is difficult to get people to go home after this session because most want to stay and talk to the panel members, she says.

Physicians usually refer patients to the class, but many people return to the class again on their own initiative as their disease progresses and the time for a treatment choice grows closer.

All patients who attend are given a notebook that supports the curriculum even though there is no enrollment fee. Money for most of the materials is obtained through grants. The local chapter of the American Nephrology Nurses' Association provided the start-up funds for the class and continues to provide $500 a year for postage and copying fees.

Tu expects KISS to be needed for a long time to come because in America there is an epidemic of obesity, diabetes, high blood pressure, and the elderly population is growing.

"Our class series is open to the community, so we have patients drive 60 miles one way to attend; and when they come, they usually attend all six. Very few drop out," says Tu. ■

Follow-up calls track the success of therapy

To determine whether electroconvulsive therapy (ECT) is helping patients months after it is administered, staff in the ECT department at Sacred Heart Medical Center in Spokane, WA, began conducting follow-up calls at two-week, six-week, and six-month intervals following therapy.

The long-term success of the treatments were calculated with the aid of a questionnaire, which patients completed prior to ECT and during each follow-up call, says **Barbara Stagg**, RN, charge nurse in the ECT department.

The questionnaire, called a Bech Depression Scale, has 21 categories that cover emotional and physical symptoms and each has four choices for patients to choose from. For example, to help determine a patient's emotional state he or she would be asked to select the statement that best mirrors his or her outlook from the following selections:

- I am not particularly discouraged about the future.
- I feel discouraged about the future.
- I feel I have nothing to look forward to.
- I feel the future is hopeless and things cannot improve.

Statements to uncover physical symptoms that indicate depression, such as fatigue, include:

- I don't get more tired than usual.
- I get more tired more easily than I used to.
- I get tired from doing almost anything.
- I am too tired to do anything.

Although the follow-up calls were initiated in 1999 to determine if ECT was working on patients with major depression who often have a borderline personality disorder, it proved so beneficial that the practice was continued.

A lot of mentally ill people don't have a good support network and end up back in the same lifestyle and old behavior patterns that may initiate depression. "We have caught a couple people who have isolated themselves and are almost suicidal again," says Stagg.

To help prevent depression, these patients often are asked to do a maintenance treatment where they return to the ECT department once a month or once every several months depending on their support system. Some may have a counselor and a caseworker. Those who have strong family support do better as well.

The RNs on staff at the ECT department make the follow-up calls. Administration had asked that a secretary make the calls but a layperson is not equipped to respond to emergencies such as a suicidal patient, said Stagg. "The patients know us and give us a better, more truthful report of

SOURCE

For more information about follow-up calls to track therapy success, contact:

- **Barbara Stagg**, RN, Charge Nurse, Sacred Heart Medical Center, Spokane, WA. Telephone: (509) 474-3037. E-mail: staggb@shmc.org.

CE instructions

CE subscribers participate in this continuing education program by reading the articles, 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 and refer to the list of correct answers to test their knowledge. To clarify confusion surrounding any questions answered incorrectly, please consult the source material. The semester ends with this issue. You must complete the evaluation form included in this issue and return it in the provided reply envelope that is addressed **"Education Department"** to receive a certificate of completion. When your evaluation is received, a certificate will be mailed to you. ■

COMING IN FUTURE MONTHS

- ■ Uncovering grant money to stretch the budget
- ■ Managing a diverse group of employees
- ■ Meeting educational needs created by headline news
- ■ Providing education for a culturally diverse population
- ■ Creating teaching protocols for difficult pediatric cases

CE Questions

For more information on the continuing education program, contact customer service at (800) 688-2421. E-mail: customerservice@ahcpub.com.

21. Statistics that prove the worth of patient education can be gleaned from customer service or satisfaction surveys.
A. True
B. False

22. Understanding the aging process helps the elderly "age gracefully" by doing which of the following?
A. Safety proofing the home
B. Developing a support system
C. Staying involved socially
D. All of the above

23. Educating cancer patients about radiation therapy is fairly simple because the method of treatment isn't dependent upon the type of cancer, its location, and its size.
A. True
B. False

24. Cardiopulmonary resuscitation is a good skill for every parent to learn for which of the following reasons?
A. Looks good on a job resume
B. Is needed to participate in a carpool
C. Less likely to panic if child stops breathing
D. Easier to be selected as a teacher's aide

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

what they are doing," she says. The calls take from 10-25 minutes.

A chart tracks the names of each patient and the date the first test was given, then the dates for the two-week, six-week, and six-month follow-up calls are listed. During the initial treatment patients are asked for the phone numbers of relatives and friends so that staff can reach them if they should move, which often occurs.

"Although we started the follow-up calls as a study, they have become much more than that," says Stagg. ■

CE objectives

After reading *Patient Education Management*, health professionals will be able to:

- identify management, clinical, educational, and financial issues relevant to patient education;
- explain how those issues impact health care educators and patients;
- describe practical ways to solve problems that care providers commonly encounter in their daily activities;
- develop or adapt patient education programs based on existing programs from other facilities. ■

Focus on Pediatrics
PATIENT EDUCATION MANAGEMENT'S MONTHLY SUPPLEMENT

Quick classes in CPR ensure safer discharge

Classes help caregivers and kids with special needs

Cardiopulmonary resuscitation (CPR) is a good skill for every parent to learn, says **Jennifer Bay**, RN, BSN, the CPR coordinator for Children's Healthcare of Atlanta. If adults who spend a lot of time with children know CPR, they are less likely to panic when an accident occurs and will know what to do until the emergency medical service team (EMS) arrives.

For some parents, however, learning CPR is imperative for the welfare of their child. That's why CPR is offered on Monday, Wednesday, and Friday to parents with children admitted to either hospital within the Children's Healthcare system. Most attend because the physician has ordered CPR for the main caregiver before the child is discharged. Others hear about the class when it is announced or a nurse tells them, and they simply walk in.

Those parents sent by physicians usually have children with heart defects, multiple health problems, or babies with apnea who will be on an apnea monitor at home. Should the child stop breathing, these parents need to know the steps for CPR.

It is not a class offered to the community. Children's has community CPR classes throughout the year, says Bay. At the community classes, parents are certified following the instruction, and the certification process takes time.

The inpatient class only lasts an hour and is designed to teach parents in a short period of time what they need to do in an emergency. "The parents walk out of the class knowing the skills to keep their child alive until EMS arrives. An hour is long enough for parents to get the instruction they need, and they aren't away from their child's bedside for too long," she says.

The CPR instructors are contract employees, and they show up for the classes at the scheduled time whether a physician has ordered CPR instruction for a caregiver. If caregivers show up for the class, they teach; and if not, they go home, says Bay. "In this way, the classes are on a set basis and the physicians and staff know when they are held. If a caregiver needs to learn CPR on a day it is not offered, staff do the teaching," she says.

The inpatient CPR classes are open to any family member whether they are the main caregiver or not. Grandparents or a teen-age sibling who might baby-sit often will attend. Classes are limited to eight people so each participant has hands-on instruction.

Getting the information across

The class is taught by verbal instruction and demonstration on manikins with parents demonstrating the observed skill back to the instructor. "Seeing and doing is the best way to learn," says Bay.

Instructors teach everyone child CPR, which is for children ages 1 to 8. If someone in the class has a baby and needs to learn infant CPR, which is for children younger than 1, he or she receives individual instruction after the class.

The basic difference in CPR for various age groups is in the chest compressions, whether fingers are used or the heel of the hand, the placement of the fingers or hand, and the depth of the compressions.

With infants, the third and fourth fingers are positioned in the center of the baby's chest half an inch below the nipples and pressed down ½ to 1 inch. One breath is followed by five of these gentle chest compressions.

With children the heel of one hand is used for chest compressions, with the person administering CPR pressing the sternum down 1 to 1.5 inches. As with infants, one full breath is followed by five chest compressions.

Parents are encouraged to attend the community outreach CPR class for more in-depth instruction after their child is discharged from the hospital. Often they will return to the inpatient class more

SOURCE

For more information on inpatient CPR, contact:

- **Jennifer Bay**, RN, BSN, CPR Coordinator, Children's Healthcare of Atlanta, 1001 Johnson Ferry Road N.E., Atlanta, GA 30342. Telephone: (404) 929-8658.

than once to learn the skill better if their child is in the hospital for any length of time. Parents receive pocket cards and teaching sheets that list the steps for CPR and they are instructed to carry the card with them and post the sheets throughout their house. ■

Phone counseling aids stop-smoking efforts

Program designed for expectant mothers

When a pregnant woman smokes the nicotine and carbon monoxide she inhales from the cigarette reaches the baby through the placenta and prevents the fetus from getting the nutrients and oxygen needed to grow, according to the New York City-based American Lung Association.

The association estimates that 20%-30% of low-birth weight babies, up to 14% of pre-term deliveries, and 10% of all infant deaths can be linked to maternal smoking during pregnancy.

Although many women may stop smoking during their pregnancy, they frequently begin again once the baby is born, and secondhand smoke is harmful to their child. Children whose mothers smoke more than 10 cigarettes a day are twice as likely to develop asthma.

While the statistics about the effects of smoking on an unborn child are a good incentive to quit smoking, it's a very difficult habit to break. That's why Plymouth Meeting, PA-based SmokeStoppers, a company that markets telephone counseling smoking cessation programs, designed one specifically for pregnant smokers.

It's patterned after the company's standard program, where smokers who are enrolled receive a series of scheduled counseling calls coupled with a 21-day printed or web-based tutorial that teaches strategies on dealing with nicotine withdrawals.

"It's a step-by-step, one-day-at-a-time process to get people to quit smoking and keep them smoke-free," says **George Nice**, president of SmokeStoppers.

Those enrolled in the prenatal counseling program receive 11 calls over a 15-month period. Up to six counseling calls are placed during the first and second trimester. The relapse prevention counseling lasts to six months postpartum.

When people first enroll in the telephone counseling program, a counselor learns their health history, their smoking history, their addiction level, their self-efficacy, and their program preferences to determine what is most likely to help them quit on a long-term basis.

They receive either the printed QuitKit or a password for the web-based program. Both follow the same one-day-at-a-time format. However, smokers can read through the entire 21-day printed version of the program in one sitting even though they are advised not to. With the Internet program, enrollees cannot work ahead because they receive the action plan day by day. They can review previous plans.

Another benefit of the Internet version is that the content can be more closely tailored to the individual because they fill out a questionnaire when they first log onto the site. "If a woman tells us she is pregnant, she will get information that relates to pregnancy and smoking throughout the 21 days, and we will use that as a primary motivator for her to quit smoking," says Nice.

All the telephone counseling calls are outbound calls from the counselor to the participant's home or office, and are scheduled in advance. Participants also have access to an inbound toll-free number they can call anytime. They leave their name and their counselor returns their call within 24-hours.

SmokeStoppers does not market its program directly to consumers, but contracts with organizations that will offer it free of charge to the smoker, such as companies and health plans. "We have found that by and large, smokers — maternity or otherwise — will not pay for a smoking cessation program," says Nice.

The cost for the prenatal telephone counseling program is $225 per person. To help determine the success rate of the program, SmokeStoppers is working on a pilot project with a large health plan to obtain valid outcomes on its maternity population.

"We suspect the success rate for this program will be higher than a normal program because pregnant smokers have a strong motivation to quit and will have greater success," says Nice. For corporate clients, the 12-month quit rate in general is 35%-40%. ■

SOURCE

For more information about the SmokeStoppers prenatal telephone counseling program, contact:

- **George Nice**, President, SmokeStoppers. 4070 Butler Pike, Suite 800, Plymouth Meeting, PA 19462. Telephone: (800) 697-7221. E-mail: president@smokestoppers.com.