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# Patient Education Management

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

THOMSON
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## IN THIS ISSUE



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# Positives far outweigh the negatives in funding programs with grant money

*Those who can't meet the requirements or obligations need not apply*

There are many benefits to obtaining grant money. The most obvious is that grants provide additional resources for projects. "There is always room for more money to supplement the departmental budget whether it has to do with creating a program or expanding or enhancing an existing program," says **Virginia Forbes**, MSN, RNC, program director of patient and family education at New York-Presbyterian Hospital in New York City.

In addition, grant dollars provide an opportunity to be very focused on a particular intervention. For example, grants could provide the startup money for a learning center, educational materials for outreach, or multimedia materials, says **Cathy Abeita**, MA, an education program specialist at Southwestern Indian Polytechnic Institute in Albuquerque, NM.

Grants also can provide an opportunity to apply research findings, she says. For example, current diabetes research showing the benefits of exercise could trigger a research-based exercise program for people with diabetes.

Forbes has found grant money very beneficial. A few years ago, she received $150,000 from a foundation for a grant she co-authored for a bone

### *EXECUTIVE SUMMARY*

This month, in the last of our three-part article series on stretching budgets, we look at grant money as a funding source. Many patient education managers find that grants are a good way to implement or supplement educational programs when budgets are tight. However, it is wise to be aware of the strings attached or restrictions before answering a request for proposal.

marrow transplant education and support program. The foundation was looking for programs that would facilitate patients' convalescence.

With the grant money, New York-Presbyterian Hospital was able to provide more frequent support groups for transplant patients and laptop computers for each patient's room, as well as an educational video and CD-ROM. "The patients are delighted to have access to the Internet and e-mail right in their rooms," says Forbes.

The main drawback to the use of grant money for project design and implementation is that patient education managers must figure a way to sustain or institutionalize a program once the grant money is gone.

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**Editorial Questions**

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"Make sure the important parts of the program can be sustained. It may not look exactly the same, but if patients and their families have become reliant on something, the grant dollar allows you to be sure that the same kinds of concepts and theories that are driving your program aren't going to be lost," suggests Abeita.

Many funding sources require that grant recipients figure a way to sustain the program once grant funds are gone, says Forbes. When she used grant money to initiate an interpreters' training program she knew that the $45,000 startup money wouldn't last long, but she was able to obtain $35,000 in follow-up funding.

The grant was used to hire a program coordinator to train volunteers and to develop training materials. "The hospital picked up the program, and we now pay external interpreters, as well as trained volunteer interpreters, because we need to be able to reach them right away," says Forbes. However, the program was put in place by a grant.

There are a few drawbacks to grants. Some have restrictions on the use of the funds, says Forbes. For example, funds may be used to create patient education materials, but may not be used not for human resources.

The grant money often has been allocated for a specific purpose and goal, and if that changes over the course of the project, the changes must be presented to the funding source, says Forbes. Very often the source will agree to the new direction the project is taking, based on the information submitted, she says.

The benefits far outweigh the drawbacks of using grant money to implement ideas for patient education that the budget doesn't cover. However, patient education managers who are grant-savvy say it is important to take the right steps.

Know whether your organization has a grant or development office and what the policy is on submitting grant proposals. Many funding sources only want to receive one proposal from an organization; so all grant solicitations should be submitted for approval before they are written, says **Barbara Giloth**, DrPH, director of program development for Advocate Charitable Foundation in Park Ridge, IL. This helps prevent the submission of grant proposals from several different departments within the organization.

## *Goals in alignment*

Before applying for grant dollars, also make sure that the program or project for which funds

## To uncover grant money, get lost in cyberspace

*Creativity is needed for an effective search*

When looking for grants, you often must be unconventional, advises **Cathy Abeita**, MA, an education program specialist at Southwestern Indian Polytechnic Institute in Albuquerque, NM.

While computer search engines such as Google make the hunt for grant money convenient, to uncover all source possibilities, patient education managers must get creative, she says. When looking for money to develop a diabetes program, Abeita first focused on diabetes, then began to think about everything associated with the program. For example, materials development was part of the program, so she researched education grants.

Start out specific and then expand your search wider and wider, she says. If physical fitness is associated with the program, think about companies that produce exercise equipment or produce athletic clothes or shoes that might offer grant money. There also are athletes who have foundations. "That is how broad you have to get. You have to take every single piece of your program apart," says explains.

Also think about the population the program targets. Dollars often are set aside for minority populations. Think broad as well as specific, says Abeita. For example, the National Institutes of Health based in Bethesda, MD, has many divisions, and the Atlanta-based Centers for Disease Control and Prevention has several centers, institutes, and offices.

There is a multitude of funding sources that include state and federal agencies, foundations, associations, and corporations, says Abeita. A company such as General Mills that produces food products may offer funding for nutrition programs. In addition, large corporations with regional offices often will offer local funding opportunities ranging from about $5,000-$20,000.

"There are sources you just don't think about at first until you allow yourself to get lost in cyberspace and wander your way through thinking about whether or not a company funds this or that," says Abeita.

Start locally and use the services in your own organization. If you have a development office, you should go there and find out if they have suggestions, says **Virginia Forbes**, MSN, RNC, program director of patient and family education at New York-Presbyterian Hospital in New York City.

"Hospital auxiliaries and volunteer departments are often sources of funding and are great for smaller grants," adds Forbes.

Once you uncover a foundation, corporation, or agency that provides the type of funding you need, find out if they have an electronic mailing list so that you can automatically receive request for proposals, says Abeita. You also can bookmark web sites and simply check them once a month or every couple of weeks, she says. ■

are sought is aligned with the mission and goals of your health care institution and that the focus of the grant dollars is a match, says Abeita.

It is a good idea to talk to a program officer at the funding source to make sure that your idea matches the request for proposal before putting in the time to write the grant. Sometimes organizations will ask for a letter of intent or an outline of the idea to ensure that the proposals submitted will be aligned with their goal. Only those who have their outline approved can submit the proposal, she says.

Sometimes a request for proposal will be an exact match for a project or program in the planning stages. At other times a request for proposal will trigger an idea. When looking for funding sources, it helps to know which organizations are the best sources for your project. **(For more information about finding grant money, see above article.)**

For the most part, independent foundations are interested in funding new programs or pilot programs, says Giloth. Also, they often are interested in hard-to-reach or disadvantaged populations. However, family foundations are not as likely to have strict guidelines, she says. They are created as a way for families to make contributions, and the grants usually are associated with family interests. For example, if the family has experienced the death of a baby, they may be receptive to neonatal support or a bereavement program.

All funding sources want to know that their

**SOURCES**

For more information on obtaining grant money to fund patient education programs, contact:

- **Cathy Abeita**, MA, Education Program Specialist, Southwestern Indian Polytechnic Institute, P.O. Box 10146, Albuquerque, NM 87184. E-mail: cabeita @sipi.bia.edu.
- **Virginia Forbes**, MSN, RNC, Program Director of Patient and Family Education, New York-Presbyterian Hospital, 525 E. 68th St., New York, NY 10021. Telephone: (212) 746-4094. E-mail: vforbes@nyp.org.
- **Barbara Giloth**, DrPH, Director, Program Development, Advocate Charitable Foundation, 205 W. Touhy, Suite 125, Park Ridge, IL 60068. Telephone: (847) 384-3410. E-mail: Barbara.Giloth@advocatehealth.com.

dollars are being used wisely and will require some sort of reporting. Some require their grant recipients to participate in an evaluation, she adds.

All requirements are identified in the request for proposal. For example, there may be geographical restrictions, or a health care organization may be asked to partner with another institution. **(To learn how to meet the requirements in the application process, see article, below.)**

If your grant is rejected, try to get comments from reviewers and people who made the decision. Make a note of the mistakes you made because grant writing is a learning process, says Abeita.

Grant writing may be competitive, but if you never write a grant proposal, you never will get any funding. "You just have to give it a try. The more you do it, the better you get; and sometimes the first time out, you will be successful," she says. ■

# Read application rules; then read them again

*Lack of compliance can result in disqualification*

When applying for grant money, pay close attention to the application requirements and follow them precisely, advises **Cathy Abeita**, MA, an education program specialist at Southwestern Indian Polytechnic Institute in Albuquerque, NM.

Grants often have specific requirements; therefore, it is important to follow the instructions because if you don't they may not even look at your proposal, says **Virginia Forbes**, MSN, RNC, program director of patient and family education at New York-Presbyterian Hospital in New York City.

Instructions may include font size, page-numbering requirements, line spacing, size of margins, and number of copies to be submitted. "There are a lot of components in the writing, and it is important to strictly follow them. If they say they want 500 words on the background and one statement on your purpose and objective, that is what you need to give them, because that is what they are interested in seeing," says Forbes.

A budget will be required and the proposal usually specifies how it should be presented. There usually are budget lines for personnel and items other than personnel and the amount of money requested for each item will need to be included. The funding source often wants to know how much your health care organization is going to provide, she says.

Sometimes they want a bibliography, letters of support, and the resumes of those who will be running the project.

The proposal also may ask for a one-page abstract, a needs-and-background section that is no more than five pages, and a five-page program design description, adds Abeita. The instructions will provide information on what to include and what not include. Sometimes the proposal states that reviewers will not look at the appendix. Therefore, if there is something in the appendix that they need to be aware of, make sure the information is in the body of the grant.

Heed the objectives of the grant proposal and make sure that it is clear that your project meets them. Support your case site references and show statistics. For example, if you are talking about what has happened to the Native-American population with regards to diabetes, put charts in that are relevant to the population, advises Abeita. "If you are building upon some already successful programs, you want to make sure that information is in the text," she says.

Even if a timeline is not specifically requested, it should be considered for inclusion because it shows that the project is well thought out and planned, says Forbes. Usually, information on how you are going to evaluate the outcome of your project is required, Abeita says.

If any part of the project is research-based, find out what your health care organization's policy is for approving research. There usually is an institutional review board. If this process isn't followed, you may receive the grant and then find out you can't do the project because the institutional review board didn't approve the research, says Forbes.

While grants up to $2 million may be awarded by the funding source, it is wise to research the average dollar amount awarded and then request an amount just a little above the average, advises Abeita.

During the application process, always keep the due date in mind and make sure you allow enough time for edits because it is important to have someone other than the author read the copy to make sure it is clear. There also needs to be enough time to obtain the necessary signatures for the grant application. "More than likely, the grant writer doesn't have the authority to commit the institution to the grant requirements," says Abeita. ■

# Joint Commission survey prep made fun for staff

*Games, prizes help reinforce teaching of standards*

It is not unusual to form committees to help staff prepare for a survey by the Oakbrook Terrace, IL-based Joint Commission on Accreditation of Healthcare Organizations (JCAHO). Lake Region Healthcare Corp. in Fergus Falls, MN, put in place workgroups for each chapter on the JCAHO standards a year and a half before its survey to ensure that the medical center was in compliance. In addition, the chapter chairs decided to form a JCAHO Fun Committee to brainstorm fun and unique methods to educate staff.

"We wanted to create a fun learning environment for our employees. We have found from past experiences that implementing fun into adult learning creates more compliant employees who receive, process, and understand the information in an accepting manner," says **Brandi Sillerud**, RN, education coordinator at Lake Region Healthcare and a member of the Fun Committee.

The committee came up with two ideas that would make learning fun but also reach as many staff as possible. The first was a colorful display board near the employee cafeteria with cutouts and phrases that staff could look at as they were walking by even if they were in a hurry. The display focused on one chapter of JCAHO standards at a time, highlighting the changes that had been made in that chapter.

The phrases for patient and family education included:

- every patient should be taught about his or her diagnosis;
- every patient should be taught about pain management;
- every patient should be taught about any new medication started.

Staff could pick up a crossword puzzle on JCAHO standards from a table next to the cafeteria. There also was a box on the table for the completed puzzles.

The web site puzzlemaker.com was used to create the puzzles that consisted of 10-16 questions about the chapter covered on the display board. Some of the questions were about hospital policies. "We wanted them to look into the policy books if they had questions so they would know where to find the answer," says Sillerud. She knows that at least some of the employees were pulling the policies and looking up answers because she received a call from a nurse one day asking for the answer to four/across on the puzzle. "We have looked in every policy book and we cannot find the answer," she told Sillerud.

Before changing the topic on the display board, members of the Fun Committee drew 10-15 puzzles from the box and awarded small prizes for participation. They included certificates for meals, desserts, or drinks in the cafeteria, which the committee had purchased. The committee's average return on the puzzles was 33% to 50%.

### Face-to-face encounters

The second activity implemented by the Fun Committee to educate staff was a mock survey. Committee members took turns visiting different departments to ask staff survey questions. When visiting a unit, they took a cart that had a basket filled with questions from the various JCAHO chapters from which employees would draw. They also had baskets of candy to reward those employees who participated. All participants also were signed up for a drawing for such prizes as gift certificates, shirts, and blankets.

The questions focused on new information in the chapters or most frequently asked questions by surveyors. To determine which questions surveyors might ask, the committee gathered several reference books published by the Joint Commission.

During the mock survey, employees were given cheat sheets to place behind their name badges that contained several commonly asked JCAHO questions, such as the name of the patient safety officer at the health care facility.

**SOURCE**

For more information about the JCAHO Fun Committee and its educational methods on Joint Commission standards, contact:

- **Brandi Sillerud**, RN, Education Coordinator, Lake Region Healthcare Corporation, 712 Cascade St. South, Fergus Falls, MN 56537. Telephone: (218) 736-8364. E-mail: BrandiS@lrhc.org.

The questions in the basket were no surprise to staff because each floor had been given a copy of the questions and answers before the mock survey took place. One-page flyers on all the information pertaining to the display boards and crossword puzzles also were posted in advance. "We just took the standards and wrote them in the form of a question. When we did the crossword puzzle we reworded it," says Sillerud.

Questions from the patient and family education chapter included the following:

• How are patients educated about pain and managing pain as part of their treatment and where is pain management education documented? [All patients are taught about pain on admission via a pain management handout, with pain scale, pain management posters in all rooms and verbal explanation by the caregivers. We document on the interdisciplinary education record.]

• Who participates in the planning and providing of education to patients and families? [All patient care providers — it is an interdisciplinary process.]

• How do you determine the learning needs of patients and families? [By asking questions.]

• What variables do you consider when assessing a patient's needs, abilities, and readiness for education? [Variables such as cultural, religion, emotional, motivation, physical and cognitive limitations, language, and cost are considered.]

• When do you provide education to patients or family members? [At the first communication.]

• Where do we document patient education? [On our interdisciplinary patient education record.]

• What grade level are patient education materials written? [Sixth-grade.]

While there is a big push to make sure staff know the standards before a survey, they are covered on a regular basis whether a Joint Commission survey is scheduled or not. When a new standard is implemented, such as managing pain, an educational blitz on the topic takes place. To teach staff about pain management, Sillerud distributed handouts, put up posters, and attended unit meetings to discuss the new standards.

"When a new standard is implemented, we send out a newsletter. We did one specifically on pain and how to teach patients about pain management and making sure they understand how to use a pain measurement scale," says Sillerud.

Reinforcing the teaching about JCAHO standards with fun activities such as the display boards and crossword puzzles was very helpful. "We invested very minimal amounts of money but staff appreciate getting things in return for their time or seeing others win small prizes. I believe that by incorporating fun into learning staff are more willing to participate because it goes faster and they actually learn," says Sillerud.

*[Editor's note: If you have implemented a new or innovative program and/or created unique ways of teaching staff and patients in the area of patient education, let us know. We always are looking for ideas to share with the readers of* Patient Education Management*. Contact Susan Cort Johnson, Editor,* Patient Education Management*, (530) 256-2749 or suscortjohn@onemain.com.]* ■

# Surgery not always best cancer treatment option

*Weigh advantages and disadvantages before decision*

Unlike chemotherapy, radiation, or biological therapy, most patients are familiar with surgery for it is a common form of treatment. Yet there are many issues about surgery to remove a malignant tumor that patients might not be aware of, says **Robin Gemmill**, RN, MSN, CNS, professional practice leader of surgical oncology at City of Hope National Medical Center in Duarte, CA.

There is a misconception that people have surgery, the tumor is removed, and everything is fine, she says. However, with a cancer diagnosis, the treatment is not always so simple.

Depending on the location of the tumor, surgery may not be an option. For example, if it were located too close to the heart, the surgery would be too risky.

The growth rate of the cells also determines if surgery is an option, says Gemmill. "Generally speaking, surgery is more successful if it is done on a slow-growing cancer vs. a very rapid-growing cancer, because you can't get your hands on it

## 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; and in May, we covered biological therapy. In June we looked at radiation therapy. In the last part of our series, we discuss surgery, which frequently is accompanied by radiation and/or chemotherapy. Many people have the misconception that surgery will remove the cancer and the treatment will be completed.

so to speak," she explains. If the cancer cells might migrate and spread, surgery might not be an option.

Obviously, the physicians will look at the efficacy of whatever surgery they propose. It has a lot to do with the type of cancer that the patient has and what research studies have shown," says Gemmill. They will want to see if surgery on that type of tumor has been shown to be a "cure," or if it is a good treatment because it extends life, she says.

Of course, in order for the patient to make an informed decision, he or she will need to understand the purpose of the surgery. Is the goal to cure the cancer, or has it metastasized and therefore the surgery is a palliative treatment?

Patients need to understand the advantages as well as the disadvantages of surgery, says Gemmill. For example, the surgery might require the amputation of a limb or cause disfigurement. Some of the head and neck patients have to go through reconstructive types of surgery following their cancer operation. Yet surgery may also be recommended to ease pain and thus improve a patient's quality of life.

Also important for patients to know is whether or not the surgery has long-term effects. For example, could it result in sexual dysfunction and incontinence? Anything that would impact the quality of life should be relayed to the patient to help him or her make an informed decision.

### Education according to cancer type

Once a decision on surgery has been made education will depend on the type of cancer that is being treated. Some may go home with special equipment such as drains and need special care at home. "Generally, we like to get caregivers involved early so they have time to learn what they need to do because usually the patient doesn't stay long in the hospital," says Gemmill.

When patients go home with equipment, hands-on learning is best with demonstration of the procedure followed by a successful return demonstration by the patient or caregiver. It helps to provide a video that they can take home with them or detailed handouts that give step-by-step instructions.

Nutrition education also is important early on to ensure that people are eating correctly because that helps with the healing process.

In addition, patients need to know how to manage pain following surgery and what to expect in the way of pain. Some surgeries such as lung cancer are painful because surgeons are cutting on a large area of tissue; and whenever you start getting into several tissue areas, you tend to have more pain, says Gemmill.

All surgery patients need to know about how to help prevent complications such as pneumonia. This involves learning how to cough and deep breathe.

Pre-op education works best because it gives people a chance to ask questions and helps with the surgery because if people are less anxious, they probably will do better after the operation, says Gemmill.

Patients need to know about expected recovery time both in and out of the hospital setting. This will help them make arrangements for needed help at home and deal with issues related to work and children. New, less-invasive technology has reduced the length of stay in most cases, she says. "Patients may even go home in 48 hours, depending on how well they do," Gemmill adds.

Cancer treatment often is a combination of several therapies. The patient may have chemotherapy or radiation to shrink the tumor before the surgery and that will impact recovery time. For example, the wound may heal more slowly. Sometimes chemotherapy or radiation follows

## SOURCE

For more information about educating patients on surgery for cancer treatment, contact:

- **Robin Gemmill,** RN, MSN, Professional Practice Leadership for Surgical Services, City of Hope National Medical Center, 1500 E. Duarte Road, Duarte, CA 91010. Telephone: (626) 359-8111, ext. 65550. E-mail: RGemmill@coh.org.

surgery. Usually if a physician prescribes both treatments after surgery, chemotherapy will be first so that there is time for the wound to heal before radiation is administered to the area. ■

# Outside-the-box thinking yields creative solutions

*Manager shares insights on working in education*

As the manager of the Center for Education and Development at University of Missouri Health Care in Columbia, **Ceresa Ward**, MS, RN, oversees the operational, financial, and personnel activities at the center, which has 20 employees. She is responsible for strategic planning, staff development, and patient and family education as well as leadership, service quality, and compliance training.

She took this position in March 2001 when the medical center underwent a redesign due to financial difficulties. At that time patient education, community education, and staff development merged into one department.

"It has been an effective model, and we work well as a team but it was difficult merging departments at first," says Ward, who previously was the coordinator of patient and community education and manager of health improvement services. She has worked in some form of patient and staff education since March of 1986. In her current position, she reports to the chief human resources officer.

Ward has a background in nursing and worked as a supervisor in the general medicine/cardiac area for five years and as an advanced practice nurse in cardiothoracic surgery and in thoracic intensive care. She received a bachelor of science in nursing in 1981 from Truman State University in Kirksville, MO, and a master of science degree in nursing education and clinical specialty in 1986 from the University of Missouri.

University of Missouri Health Care has more than 4,000 employees and 319 attending physicians. It is comprised of many entities, including University Hospital, Children's Hospital, Ellis Fischel Cancer Center, Mount Vernon Rehabilitation Center, Columbia Regional Hospital, and associated clinics. University Hospital is the only Level I trauma center and helicopter service in central Missouri.

"We are also affiliated with other hospitals, rural clinics, and providers through mid-Missouri," says Ward.

### *Sharing lessons learned*

In a recent interview with *Patient Education Management*, Ward provided information about the lessons she has learned working in the field of patient education. Following is the information that she shared:

**Question:** What is your best success story?

**Answer:** "It's hard to pinpoint one area for success. To make improvements along the way that impact patient care, the community or the training that staff receive are always rewarding," says Ward. Most recently she facilitated the integration of all patient and staff education into one department during redesign, but there are many other successes.

She helped to open a very successful community resource center at a local mall that operated for 13 years until the hospital began experiencing severe financial difficulties.

Ward helped immunize about 10,000 people annually with flu shots. Flu immunization sites were implemented around the community to reach a large segment of the population. Sites included the health information center at the mall, businesses, and community access points such as grocery stores.

Staff would set up a drive-through site in the stadium parking lot on the college campus where people could be screened and immunized without ever having to leave their car. About 2,500 people would be immunized in one morning.

The flu immunization program began as a free service to the community but eventually was altered so that only the elderly and high-risk population received free shots. Others paid a minimal fee.

In addition, she worked with an advance practice nurse to establish the Day of Surgery Admission Center several years ago when such establishments were rare. Part of its purpose was to provide better pre-op education.

The development of the preprinted interdisciplinary patient teaching records was another success for Ward. It is unique in that the generic form, that outlines basic education needs such as the assessment of barriers to learning, is paired with diagnosis specific teaching records.

For example, if a patient had open-heart surgery, the form would be used to document

education. It lists specific teaching materials as well as expected outcomes. The nurse would still assess the patients learning needs to provide individualized education but overall the form helps to provide better instruction and consistency, says Ward.

Currently all 22 patient teaching records are being put on the electronic medical record. "It is a lot of work, but I think it will make documentation more effective and more accessible," says Ward.

Ward also spearheaded the creation of an on-line centralized inventory of patient education materials that can be ordered on-line and delivered within 24-48 hours.

**Question:** What is your area of strength?

**Answer:** The fact that Ward is detail-oriented yet creative is perhaps her greatest strength, she says. "I have always been organized and detail-oriented, but sometimes that can leave you a little flat. You work too much within the rules and don't see the bigger picture. I have learned to think outside the box and be creative," she explains.

A good example is the material development process. Rather than sending drafts back and forth and having them sit on people's desk a new group development process has been initiated. The experts come to the table with the writer to produce the product. "The product is produced a lot faster with the content experts there to give feedback," says Ward.

**Question:** What lesson did you learn the hard way?

**Answer:** Ward has learned that that it can be difficult to make major organizational changes in a nonrevenue-generating department. For example, she feels that patient care would improve if an on-demand closed-circuit television system were installed at the hospital. A number of times she has submitted proposals, but funding has not yet been allocated.

Also, she has learned that while the education department can supply the best education tools unless there is administrative support for the documentation of patient education, it isn't a priority with staff. "We can get staff input on the tool development and they can be 100% behind it, but if their administrators don't make it an expectation except when it is being audited, it tends to drop," says Ward.

Accessing physicians for training is a major challenge as well. Because Ward does not oversee their training, it is difficult to get the message to them when there is a new standard or a patient concern. "There is not a good communication link," she says.

**Question:** What is your weakest link?

**Answer:** The lack of financial resources and thus the inability to replace key positions needed to make leadership training possible is the weakest link, she says. Although the institution is set to launch a big leadership initiative and the plan is in place, there needs to be a part-time person dedicated to putting the program together and there is no money to hire that person. "Without the personnel with the expertise and time to concentrate on that, it is very hard to get those kinds of programs developed and initiated," says Ward.

**Question:** What is your vision for patient education for the future?

**Answer:** University of Missouri Health Care is implementing an electronic medical record; therefore, on-line versions of the patient teaching records are being created, and a lot of in-house-developed materials will be available on the Internet, she explains.

"My dream for patient education would be that all resources for patient teaching are readily available and follow a consistent standard for all staff to access. I would like to see interdisciplinary planning occur as well as interdisciplinary delivery and documentation," says Ward.

Patients and families need to be active participants in their education and have their needs and fears addressed, says Ward. There also needs to be resources readily available either through outpatient or community access for ongoing follow up of diagnosed conditions as well as wellness and prevention activities.

"I guess this is more a dream than a realistic vision," says Ward.

**Question:** What have you done differently since your last JCAHO visit?

**Answer:** There have been new patient safety standards and the Health Insurance Portability and Accountability Act requirements have been implemented concerning patient confidentiality. Therefore, there has been staff and patient training on these two topics, says Ward.

The education department also is much more cognizant of cultural and limited-English proficiency issues. It is becoming more and more common even in rural Missouri to find people of different cultures, says Ward. Therefore, the health care system has acquired a telephone language service and is trying to improve on-site interpreter services. Many of the patient education materials have been translated into Spanish.

**SOURCE**

To obtain additional information about programs or concepts mentioned in this profile on **Ceresa Ward**, MS, RN, Manager, Center for Education & Development, University of Missouri Health Care, contact her at: One Hospital Drive, DC030.00, Columbia, MO 65212. Telephone: (573) 882-7126. E-mail: wardc@health.missouri.edu.

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

**Answer:** Ward works with a patient education committee and nursing patient education unit-based representatives as well as content experts such as physicians, advanced practice nurses, and other clinical experts such as dietitians, respiratory therapists, nurses, and pharmacists. Also, she subscribes to the PatEdNet listserv to get information and looks to pre-developed sources for materials such as commercial vendors and professional organizations. Staff at University of Missouri Health Care uses Micromedex CareNotes as a primary resource for patient drug information and as a supplemental resource for patient education materials.

"I don't like to reinvent the wheel unless our need is incredibly specific to our organization," says Ward. ■

# Educational bites make catalog a teaching tool

*Information included between class descriptions*

Biannually, the Hospital for Special Surgery in New York City mails a catalog on its classes, workshops, lectures, and support groups to more than 7,000 members of the community. It used to be a simple informational piece that described each program along with the date, time, and its costs if a fee was to be charged. However, recently, it became an educational tool as well.

"We decided to incorporate some actual education into the catalog so that while people are reading it they will see a few health facts as well as quotes from people who have taken the classes and found them helpful. In this way, it is more than a calendar of events but also something from which people can learn," says **Chandler Wilson**, MPA, assistant director of public and patient education at the Hospital for Special Surgery, which specializes in orthopedic and rheumatology conditions.

In addition to changing the content of the catalog, the title was changed as well. It is now "From Education to Empowerment." While reading the class evaluation forms submitted by participants, Wilson realized that involvement in the various programs did more than educate people it helped them to live better lives.

The statement, "Did you know that . . . " precedes the educational facts included throughout the catalog. In the Spring 2003 catalog, the following facts were included:

• Did you know that osteoporosis is a metabolic bone disease characterized by low bone density resulting in fragile bones that are more likely to break? The disease affects 25 million people in the United States and is responsible for 1.5 million fractures annually. Exercise may play an important role in maintaining stronger, healthier bones.

• Did you know that lupus is two to three times more likely to occur in African-Americans, Asian-American, and Native-Americans? Although lupus can affect men and women of all ages, the condition occurs 10-15 times more frequently in adult females than adult males.

• Did you know that a prolonged lack of activity or immobility can often result in joint pain and stiffness and the loss of muscle tone? Research indicates that an exercise program can decrease pain in people with arthritis, and regular activity helps keep joints healthy.

• Did you know that Healthy Weight Week is celebrated Jan. 20-26? Anytime is the right time to learn about valuable weight management tools and tips that may help you for a lifetime.

• Did you know that Medicare currently covers more than 38 million people? Learn more about your eligibility for available benefits and services and how to access information.

Quotes from class participants included in the catalog provide testimony as to the benefits of the class. A few of the quotes that Wilson has included are:

• Imagery for Health/Healing participant:
"I have learned how to destruct the negative thinking."

• Yoga Level 1-Beginners class participant:
"Yoga has helped my breathing and balance. I always thought you had to be like a rubber band

**SOURCE**

For more informational on including educational pieces in course catalogues, contact:

- **Chandler Wilson**, MPA, Assistant Director, Public and Patient Education, Hospital for Special Surgery, 535 E. 70th St., New York, NY 10021. Telephone: (212) 606-1057. E-mail: wilsonc@hss.edu.

to do yoga (which I am not), but I was wrong. With the right teacher, you can find your own level and reach your own potential."

The new catalog design is drawing a lot of attention, says Wilson. Corporation executives have been asking Hospital for Special Surgery to collaborate on health initiatives since the new version of the catalog was distributed. ■

NEWS BRIEFS

## New guide addresses staff education efforts

Are you one of the many readers of *Patient Education Management* that wears "more than one hat?" If your responsibilities include staff education, consider the newly released *Joint Commission Guide to Staff Education.* The book, a collaborative effort between JCAHO and the Health Care Education Association (HCEA), provides advice from experts in the field and examples from organizations breaking new ground in health care staff education.

Topics covered in the book include:

- competency assessment;
- orientation for new staff mentoring, preceptorship, and coaching;
- technological advances in learning mediums;
- ensuring administrative support;
- budgeting;
- using consultants vs. inhouse resources;
- linking staff development to business strategy;
- documentation.

The price of the guide is $55; $46.75 for HCEA members. To order, visit www.jcrinc.com, or call (630) 792-5800. ▼

## Promotion of events on patient education

If your organization is sponsoring a future event pertinent to patient education managers, send us the information at least two months prior to the scheduled date and we will help you get the word out. Details should include event title, theme and purpose, dates and times, and cost. Information can be sent via e-mail to Susan Cort Johnson, Editor, *Patient Education Management*: suscortjohn@onemain.com. Or mail information to: P.O. Box 64, Westwood, CA 96137. ■

### CE instructions

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

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

**COMING IN FUTURE MONTHS**

- Developing relationships with home care services for continuum of education
- Managing a diverse group of employees
- Providing education for a culturally diverse population
- Ensuring safety through patient education and partnership
- Providing education to parents on complex topics

## CE Questions

*For more information on the Continuing Education program, please contact customerservice at (800) 688-2421 or e-mail: customerservice@ahcpub.com.*

1. The benefit of obtaining grant money for patient education programs include:
A. Supplementing departmental budget
B. Focusing on specific intervention
C. Applying research findings
D. All of the above

2. A fun way to reinforce education on JCAHO standards before a survey is to cover the information in a crossword puzzle that employees can win prizes for completing.
A. True
B. False

3. In order for a patient to make an informed decision about cancer surgery, he or she will need to know:
A. Meal choices for inpatients
B. The purpose for the surgery
C. If massage is part of pain management
D. How close visitor parking is to the hospital

4. Which of the following teaching methods are used at Children's Healthcare of Atlanta to help parents learn central line care?
A. Research on own at resource center
B. Demonstration on a mannequin by a nurse
C. Watching a video
D. B & C

**Answers:** 1. D; 2. A; 3. B; 4. D.





## 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

# Teaching central line care: A combo method

*Parents learn by observation and demonstration*

Educating parents on the care required when their child is discharged with a central line is probably an eight in complexity on a rating scale of one to 10, says **Winnie Kittiko**, RN, BSN, MS, a clinical educator at the AFLAC Cancer Center at Children's Healthcare of Atlanta.

The most important lesson they learn is changing the dressing. It is a clean procedure and parents know that because the central line goes into their child's bloodstream, the risk of infection is greater. Parents also must learn how to flush the lines to keep them from clotting, she says.

Children are discharged with central lines for a number of reasons. Often it is for the long-term administration of medications, such as chemotherapy. They also might need a central line for long-term antibiotics or for nutritional support.

A central line is a small tube that comes out of the skin usually in the upper chest on the right or left side. It is a single line for about five inches, depending on the size of the child, and then it splits into two catheters, says Kittiko.

To learn the steps for changing the dressing, parents first watch a video that demonstrates the procedure. They then watch a demonstration by the nurse on a mannequin named Chester. Once parents have the opportunity to observe the procedure they are asked to demonstrate back either on Chester or their child. "We like parents to practice the procedure before they go home," Kittiko adds.

To help boost parents confidence about changing the dressing on their own, they are told that they can ask for assistance from the home health nurse that works for the company that delivers the supplies for the central line care to their house. Also, they can call the clinic or hospital.

A teaching sheet provides information on when to change the dressing, which is once a week unless the dressing gets wet or dirty. It also lists the steps for the dressing change as well as the supplies they will need. "We provide hints to make it easier, like having a place to spread out all the equipment they need and how to gather it all together," says Kittiko. Often parents keep their supplies on a tray table or bedside table.

Hints on how to prepare children for a dressing change, such as distracting them by showing a video are covered on the teaching sheet as well. "In the beginning when children are learning how this has to be done, they are more anxious; but usually the parents can get into a routine with their child and although he or she may not be happy at least they will cooperate and lie still," she says.

Information on proper hand washing is included on the sheet because it is an important step in a clean procedure. Signs of an infection or problems that would warrant a call to the physician also are included.

## Demonstration works best

Like the dressing changes, the method for flushing the lines is taught by demonstration. The mannequin is used to demonstrate the procedure, however the parents are able to observe the process during their child's hospital stay as well because the process is done more often in the hospital. That's because it is often used to administer such things as medications to the child.

"During their child's hospital stay when we are flushing the line we explain what we are doing and then give them the opportunity to do it in the course of the daily care," says Kittiko.

The amount of time spent teaching depends on the parents. Often they have to prepare mentally to learn the task. "Sometimes parents aren't ready to be taught when we are ready to teach them so we have to go at their pace, but there comes a point in time when they need to learn," she says.

It works best to break the information up so that

### SOURCE

For more information about educating parents on the care of central lines, contact:

- **Winnie Kittiko**, RN, BSN, MS, Clinical Educator, AFLAC Cancer Center, Children's Healthcare of Atlanta, 1001 Johnson Ferry Road N.E., Atlanta, GA 30342-1600. Telephone: (404) 250-2368.

parents have an opportunity to absorb it, she says. The nurse often will demonstrate the procedure on the mannequin, but there won't be time for parents to practice, therefore they will watch the video again and demonstrate back another day. Some parents watch the video several times over the course of their child's hospital stay. Nurses try to work at whatever pace is comfortable for the family.

"We usually tell the parents that whatever they are doing whether flushing the line or changing the dressing to try and set up a routine time, such as at night after their child's bath or in the morning when the family first gets up," says Kittiko. ■

# To breast-feed or not to breast-feed

*Mothers need information early*

Breast-feeding is a learned skill. Just as teens must be taught to drive a car, women unfamiliar with nursing must be taught to feed their baby, says **Gail Peterson**, RN, BSN, MSN, ARNP, IBCLC, a lactation consultant at Sacred Heart Medical Center in Spokane, WA.

"If you grew up watching women breast-feed, it is part of your cultural norm; whereas if it is not something you have seen and done, you need to learn how to do it," she says.

Formula-feeding babies became a fashionable practice among the rich during the industrial age and then slowly became popular with the masses because it represented status. In the 1950s, marketing by formula companies helped make bottle-feeding a common practice. "There has been generations of women who haven't breast-fed and it isn't an accepted cultural norm," says Peterson. However, an increasing number of new mothers now are choosing to breast-feed.

The decision on whether to breast-feed or bottle-feed usually is made within the first 28 weeks of pregnancy, says Peterson. There are many influencing factors, including the attitude toward breast-feeding of a woman's husband and relatives as well as her physician's position on breast-feeding. Many women see their physician as the expert on the subject. If a woman's maternal mother breast-fed, they are more likely to breast-feed, says Peterson.

It's important that women learn about the benefits of breast-feeding early in their pregnancy so that they can make an informed decision, says Peterson. Colostrum, the milk made in the early days of a baby's life, seems to protect him or her from bacteria that can cause illness, she says.

**SOURCE**

For information about educating women on breast-feeding babies, contact:

- **Gail Peterson**, RN, BSN, MSN, ARNP, IBCLC, Lactation Consultant, Sacred Heart Medical Center, Sacred Heart Medical Center, 101 W. Eighth Ave., Spokane, WA 99220-4045. Telephone: (800) 474-2400.

Working mothers need to know that they can return to work and still breast-feed their babies. They can purchase or rent a pump so breast milk is available for the baby when they are not there.

At Sacred Heart Medical Center, a lactation consultant visits women who have decided to breast-feed their baby before discharge because many factors influence how well they will do. These include the size and shape of a baby's mouth and his or her tongue positioning as well as the size and shape of the mother's breast and nipples. "It is part of our policy to see each mom, particularly first-time moms," says Peterson. In that way, the consultant can help the mother and baby adjust to breast-feeding.

Lactation consultants at Sacred Heart encourage women to breast-feed for at least a year. The American Academy of Pediatrics based in Elk Grove Village, IL, recommends that babies be given breast milk exclusively for the first six months and that mother's continue breast-feeding to 1 year of age. The World Health Organization in Geneva recommends breast-feeding a child to age 2.

While there are many American women who now breast-feed their child past a year, society frowns upon it, says Peterson. People feel it is strange for the baby to come up and ask for the breast, although it is considered perfectly normal in Europe. There is a natural weaning point between 15 and 18 months, although some babies are interested in breast-feeding longer, she adds.

"We tell moms that when it comes to the point where they resent breast-feeding more than they enjoy, it they should stop," says Peterson.

*[Editor's note: La Leche League International offers a variety of publications on breast-feeding. To obtain a catalog, contact the organization at 1400 N. Meacham Road, P.O. Box 4079, Schaumburg IL 60168-4079. Telephone: (800) 522-3243 or (847) 519-7730. Web site: www.lalecheleague.org.]* ■

# *Patient Education Management*

## 2003 Confidential Salary Survey

This confidential salary survey is being conducted to gather information for a special report later in the year. Watch in coming months for your issue detailing the results of this survey and the overall state of employment in your field.

**Instructions:** Fill in the appropriate answer directly on this form. Please answer each question as accurately as possible. If you are unsure of how to answer any question, use your best judgment. Your responses will be strictly confidential. Do not put your name or any other identifying information on this survey form.

**1. What is your current title?**

- ☐ A. vice president
- ☐ B. patient education coordinator
- ☐ C. director, health wellness
- ☐ D. director, staff education
- ☐ E. manager
- ☐ F. unit coordinator
- ☐ G. community outreach manager
- ☐ H. staff nurse
- ☐ I. consultant
- ☐ J. other_____

**2. Please indicate your highest degree.**

- ☐ A. LPN
- ☐ B. ADN (2-year)
- ☐ C. diploma (3-year)
- ☐ D. BSN
- ☐ E. MSN
- ☐ F. MS
- ☐ G. other master's
- ☐ H. PhD
- ☐ I. other doctorate
- ☐ J. other_____

**3. What is your certification?**

- ☐ A. CDE
- ☐ B. FPNC
- ☐ C. CHES
- ☐ D. RNC
- ☐ E. AOCN
- ☐ F. CPNP
- ☐ G. RD
- ☐ H. LD
- ☐ I. HNC
- ☐ J. other_____

**4. How long have you worked in your present field?**

- ☐ A. less than 1 year
- ☐ B. 1-3 years
- ☐ C. 4-6 years
- ☐ D. 7-9 years
- ☐ E. 10-12 years
- ☐ F. 13-15 years
- ☐ G. 16-18 years
- ☐ H. 19-21 years
- ☐ I. 22-24 years
- ☐ J. 25 or more years

**5. How long have you worked in health care?**

- ☐ A. less than 1 year
- ☐ B. 1-3 years
- ☐ C. 4-6 years
- ☐ D. 7-9 years
- ☐ E. 10-12 years
- ☐ F. 13-15 years
- ☐ G. 16-18 years
- ☐ H. 19-21 years
- ☐ I. 22-24 years
- ☐ J. 25 or more years

**6. What is your age?**

- ☐ A. 20-25
- ☐ B. 26-30
- ☐ C. 31-35
- ☐ D. 36-40
- ☐ E. 41-45
- ☐ F. 46-50
- ☐ G. 51-55
- ☐ H. 56-60
- ☐ I. 61-65
- ☐ J. 66 or above

**7. What is your sex?**

- ☐ A. male
- ☐ B. female

**8. What is your annual gross income from your primary health care position?**

- ☐ A. Less than $30,000
- ☐ B. $30,000 to $39,999
- ☐ C. $40,000 to $49,999
- ☐ D. $50,000 to $59,999
- ☐ E. $60,000 to $69,999
- ☐ F. $70,000 to $79,999
- ☐ G. $80,000 to $89,999
- ☐ H. $90,000 to $99,999
- ☐ I. $100,000 to $129,999
- ☐ J. $130,000 or more

**9. On average, how many hours a week do you work?**

- ☐ A. less than 20
- ☐ B. 20-30
- ☐ C. 31-40
- ☐ D. 41-45
- ☐ E. 46-50
- ☐ F. 51-55
- ☐ G. 56-60
- ☐ H. 61-65
- ☐ I. more than 65

**10. In the last year, how has your salary changed?**

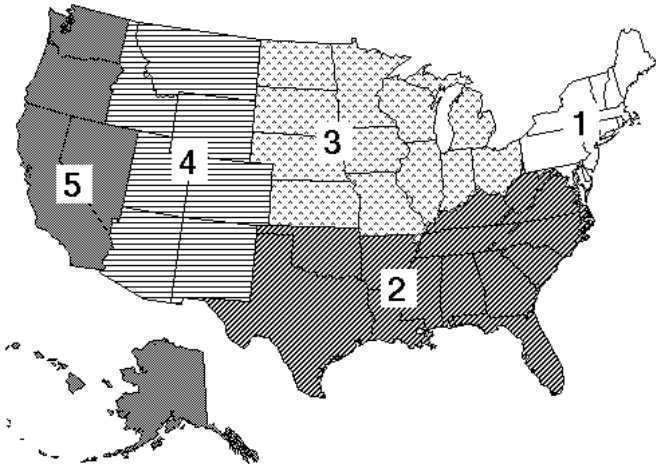
- ☐ A. salary decreased
- ☐ B. no change
- ☐ C. 1% to 3% increase
- ☐ D. 4% to 6% increase
- ☐ E. 7% to 10% increase
- ☐ F. 11% to 15% increase
- ☐ G. 16% to 20% increase
- ☐ H. 21% increase or more

**11. Which of the following best describes the location of your work?**

- ☐ A. urban
- ☐ B. suburban (outside large urban area)
- ☐ C. medium-sized community
- ☐ D. rural

**12. Using the map (right), please indicate where your employer is located.**

- ☐ A. region 1
- ☐ B. region 2
- ☐ C. region 3
- ☐ D. region 4
- ☐ E. region 5
- ☐ F. Canada
- ☐ G. other_____




**13. Which best describes the ownership or control of your employer?**

- ☐ A. college or university
- ☐ B. federal government
- ☐ C. state, county, or city government
- ☐ D. nonprofit
- ☐ E. for profit

**14. Which of the following best categorizes the work environment of your employer?**

- ☐ A. academic
- ☐ B. agency
- ☐ C. city or county health department
- ☐ D. clinic
- ☐ E. college health service
- ☐ F. consulting
- ☐ G. hospital
- ☐ H. private practice

**15. If your work in a hospital, what is its size?**

- ☐ A. <100 beds
- ☐ B. 100 to 200 beds
- ☐ C. 201 to 300 beds
- ☐ D. 301 to 400 beds
- ☐ E. 401 to 500 beds
- ☐ F. 501 to 600 beds
- ☐ G. 601 to 800 beds
- ☐ H. 801 to 1,000 beds
- ☐ I. >1,000 beds
- ☐ J. I don't work in a hospital

**Deadline for responses: August 15, 2003**

Thank you very much for your time. The results of the survey will be reported in an upcoming issue of the newsletter, along with an analysis of the economic state of your field. Please return this form in the enclosed, postage-paid envelope as soon as possible. If the envelope is not available, mail the form to: Salary Survey, Thomson American Health Consultants, P.O. Box 740058, Atlanta, GA 30374.