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INSIDE

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Hit the benchmark bull's-eye to develop stronger patient education programs

Comparison of data helps identify which areas to improve

More and more patient education managers are jumping on the benchmarking bandwagon, but is it a good idea? **Cezanne Garcia**, MPH, CHES, manager of patient and family education services at the University of Washington Medical Center in Seattle, gives benchmarking a thumbs-up. It provides qualitative and quantitative data to allow you to compare and contrast your patient education system with others, she says.

"I come to it from the perspective of what can I learn from the data we have collected and continue to make this system or process better. I also come to it hoping that at some point, we can make a contribution to literature or the research body to help all of us working in the patient education field do better and be better," says Garcia.

To improve patient education at the University of Washington Medical Center, Garcia benchmarks patient education efforts against data from other university medical centers. This is possible because her facility pays a fee to be part of the Boston-based Picker Institute Patient Satisfaction Data program.

The institute sends surveys to patients at subscribing health care facilities and compiles the data the facilities send back. An institution can compare its overall program to others, as well as comparing each category of data.

For example, patients are asked if the nurses give them information in a way they can understand. A hospital with an average score in this area can call hospitals with a high score and ask them what they do differently that contributed to that high score.

Using the data, it's also possible to benchmark within your own facility, says Garcia. Her facility receives nine breakouts for the outpatient clinics providing information on which clinics are strong in an area of patient education and which clinics do poorly. "What's beneficial here is that we can assume the clinics are operating under the same set of

resources, such as staffing and general overhead, as well as in a very similar health care environment internally and externally," says Garcia.

While the Picker Institute provides quantitative data, Garcia also is involved in a qualitative benchmarking project. The University of Washington Medical Center is partnering with two other local health care facilities to provide the community with comprehensive oncology services. To set up the best program, staff are contacting facilities that have strong cancer patient education services across the nation to interview program directors in order to determine best practices.

They also are using the Bethesda, MD-based National Cancer Institute's (NCI) *Guidelines for Establishing Comprehensive Cancer Patient Education Services*. **(For information on discovering best practices, see article on p. 99. For information on the NCI guidelines, see article on p. 101.)**

A time for benchmarking

Benchmarking is of value when you are putting together a new program or patient education delivery system because it not only helps you see what is being done, but also what the best way of doing it is, says **Sandra Cornett**, RN, PhD, program manager for consumer health education at The Ohio State University Medical Center in Columbus. When Ohio State was setting up an in-house Intranet system, Cornett benchmarked with the Rochester, MN-based Mayo Clinic after learning that Mayo was more advanced than most facilities at delivering patient education materials via the Intranet. Cornett learned about Mayo's status in this area by networking with colleagues.

When the patient education committee at St. Joseph's Hospital in Marshfield, WI, began to explore ways to improve the delivery of patient education, they assembled a survey and sent it to 12 institutions of similar size that were accredited by the Oakbrook Terrace, IL-based Joint Commission on Accreditation of Healthcare Organizations. Currently, they are waiting for all the surveys to be returned. "Before we put a proposal together to give to our administration, we want to find some best practices," says **Sue Church**, RN, CDE, program manager of the diabetes center of Marshfield at St. Joseph's.

Once all the surveys have been returned, Church plans to look for similarities. For example, if 90% of the hospitals surveyed have one full-time employee in charge of coordinating and distributing patient education materials, the committee will suggest that their institution's program create a similar position. "Through our research, what we are able to see are the commonalties between institutions, the strong areas, and almost piece-meal together the ideal patient education center learning from the lessons of other institutions," says Church. **(See a copy of the survey, inserted in this issue.)**

Church provided a telephone and fax number, in addition to a stamped envelope, for survey responders.

To find health care facilities similar in size to St. Joseph's, the committee used a directory from the Chicago-based American Hospital Association. They then called the patient education department at each facility to identify the person in charge and ask him or her to fill out the survey.

Benchmarking is not only valuable for determining best practices for new projects, but for overhauling existing ones as well. When you discover a gap or deficiency in your patient education, benchmarking can help you determine how to solve the problems, explains Cornett.

Other institutions provide comparative data

For example, your nurses may not be documenting patient education. In benchmarking, you would look to other institutions or literature to determine what is currently being done in this area. You would use this information as comparative data. That legwork should be done during the assessment phase because the data would provide information on changes that could be made to correct the deficiency, says Cornett. "Benchmarking is getting information from other sources so you have some comparative data," she explains.

However, what works at another institution won't necessarily work at yours, she warns. Budget restraints, policies and procedures, or differences in the patient population could prohibit implementation of such practices.

Data comparison is an important element of benchmarking, but patient education managers should not stop there, advises **Charles M. Kilo**, MD, director of Idealized Design at the Institute for Healthcare Improvement in Boston. "A more robust meaning of benchmarking is not only understanding the data of whatever best is found, but actually understanding the processes," says Kilo. "What are the specific process differences between organization X and your organization?"

SOURCES

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- **Sandra Cornett**, RN, PhD, Program Manager, Consumer Health Education, The Ohio State University Medical Center, Department of Consumer & Corporate Health Education & Wellness, 1375 Perry St., 5th floor, Columbus, OH 43210. Telephone: (614) 293-3191. Fax: (614) 293-3690. E-mail: cornett.3@osu.edu.
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The truth is, best practices are most likely to be found in bits and pieces, and no single program can claim the title, says Kilo. Therefore, it is a good idea to take those bits and pieces — and the specific processes that lead to a great performance — and string them together to create a new system.

That is why interviewing is an important step in the benchmarking procedure, adds Garcia. However, the patient education manager should first identify the objective of the project and define what he or she is trying to measure.

Once the objective is on paper, the next step should be searching the World Wide Web, the literature, or other resources for details on best practices and writing health care systems for descriptive information. "Use the person's time during the interview for more analytical or reflective information," says Garcia. Find out what kind of outcome data they have to document or substantiate that they are on the right track, she explains.

For best results during the telephone interview, develop a defined set of questions. Meet with the interdisciplinary group working on the project, and develop a wish list of everything you would like to ask. Then break that down to four to eight open-ended questions, advises Garcia.

After the benchmarking data have been gathered, a final step is to summarize the information. Rather than write a narrative report, use a table format, says Garcia. Look at the qualities and characteristics discussed in the various interviews and build a grid, she suggests.

However, keep in mind during the research process that "best practices" might not exist, says Kilo. "One can argue that the whole health care system needs to be redesigned, and no level of performance we are currently achieving is where it should be. Therefore, benchmarking keeps you bound to our current framework of how we ought to be practicing medicine. What we really need to do is change that framework altogether," he explains. ■

Reader Questions

Discover the 'best' practices for comparison

Try multiple sources based on sound principles

Question: "What do you use as best practice standards for patient education? Where do you go to get information on best practices? How do you ensure that your staff are adhering to the best practice standards you have established?"

Answer: There is not a single source for patient and family education best practice standards, says **Kathy Ordelt**, RN, CRRN, CPN, patient and family education coordinator at Egleston-Scottish Rite Children's Healthcare System in Atlanta.

Ordelt uses multiple sources, including:

- *Patient Education Management* newsletter;
- journal articles;
- books;
- Joint Commission information and publications;
- networking at conferences;
- telephone conversations;
- e-mail;
- experiences at her own facility.

"We try things based on sound principles, and they work or don't work. We try again until we find what works best for our staff and our patient population," explains Ordelt. In her quest for best practice, Ordelt uses a performance improvement (PI) model called FADE.

The acronym stands for: Focus, Analyze, Develop, Execute/Evaluate.

"One of the things that is very helpful to me regarding best practice is a citywide group of patient education directors and managers that I co-chair," says **Judith Nierenberg**, RN, MA, patient education manager at St. Luke's-Roosevelt Hospital Center in New York City. "The sharing that goes on there is invaluable."

The group currently is trying to find the best way to motivate staff to use a single interdisciplinary form for documenting patient teaching — and there's universal resistance to it.

The group is examining and evaluating the effect of using customized forms for specific diagnosis-related groups rather than forms with areas for narrative information. The group wants to determine which type of form gets the best compliance.

When creating a teaching sheet, **BJ Hansen**, BSN, patient education coordinator at Grant/Riverside Methodist Hospitals in Columbus, OH, does a literature search and also looks at materials from other patient education sources such as associations and publishing companies.

Compare Internet info with literature

She uses the Internet, but always tries to back up information gathered from a Web site with other literature. "I work with the clinicians in the specialty area to make sure it matches our practice as well as practice standards in the field," she says.

Fran London, MS, RN, health information specialist at Phoenix Children's Hospital, has found the most practical definition for best practices on a Web site: www.best4health.org. According to this Web site, a protocol, guideline, standard, clinical pathway, or outcome can be considered a best practice if it:

- has been implemented and produces superior results;
- leads to efficient and exceptional performance in cost, quality, and speed, or is innovative;
- satisfies key stakeholders (patients, clinicians);
- is recognized either internally or externally as being the best practice (an award or presentation in publication, by an expert, by a consortium, etc.).

"I have not been able to find any examples of best practices that I know meet the four-part definition," says London. She contends that health care facilities need to create their own best practices, based on the research available.

These best practices should be individualized to a facility's regional health environment, strategies and mission, organizational or community culture, or practice systems. Then institutions should share these best practices with other health care providers so that all benefit. **(To learn more about how to apply patient education research findings to practice, see editor's note at the end of this article.)**

If a protocol, guideline, standard, or clinical pathway produces superior results and satisfies the key stakeholders, professional staff will embrace it because they are among the satisfied key stakeholders, says London.

> "I firmly believe that the best resource we have for great patient education is a well-informed and knowledgeable staff."

Ordelt has put into place a system to ensure that staff practice what is considered best practice for the Atlanta children's health care facility. This includes thorough inservices and education, management support to promote compliance, and evaluation through the PI structure. "I firmly believe that the best resource we have for great patient education is a well-informed and knowledgeable staff," she says.

Virginia Forbes, MSN, RNC, CNA, patient education coordinator at New York Presbyterian Hospital in New York City, agrees. "It is essential that staff are aware of the requirements and how to incorporate them into their practice," she says. This information is provided to each orientation group and reviewed in annual mandatory education programs.

A *Patient and Family Education Handbook* is kept in each clinical area and department so staff can quickly review such information as guidelines for teaching patients, cultural and religious considerations and barriers to learning, and teaching through the life span. The handbook was produced in-house.

It's not enough to provide the tools, however. Patient education managers must evaluate as well in order to determine if the process works. "We performed a survey of patients who were near discharge with the intent of learning the patients'

SOURCES

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- **BJ Hansen**, BSN, Patient Education Coordinator, Grant/Riverside Methodist Hospitals, 111 South Grant Ave., Columbus, OH 43215. Telephone: (614) 566-5613. Fax: (614) 566-8067. E-mail: bhansen@ohiohealth.com.
- **Fran London**, MS, RN, Health Information Specialist, Phoenix Children's Hospital, The Emily Center, 909 East Brill St., Phoenix, AZ 85006. Telephone: (602) 239-2820. E-mail: FranLondon@compuserve.com.
- **Judith Nierenberg**, RN, MA, Patient Education Manager, St. Luke's-Roosevelt Hospital Center, 1000 Tenth Ave. 2B-30, New York, NY 10019. Telephone: (212) 523-8595. E-mail: jnierenberg@slrhc.org.
- **Kathy Ordelt**, RN, CRRN, CPN, Patient and Family Education Coordinator, Egleston-Scottish Rite Children's Healthcare System, 1001 Johnson Ferry Road, NE, Atlanta, GA 30342. Telephone: (404) 250-2757. Fax: (404) 250-2255. E-mail: kordelt@srcmc.org.

perception of what was taught, who taught it, and how satisfied they were with the teaching, including the methodology," says Forbes.

The survey showed that 93% of the patients surveyed were satisfied with the teaching and its method during the course of their hospitalization. Follow-up phone calls to a sample of those patients revealed overall continued satisfaction with information received.

It is important to evaluate education and how it is delivered to determine if the institution's standards have been met, says Ordelt. For example, evaluations have been done on asthma education. Skill checks are used to evaluate patient and family learning as well as monitoring factors that would indicate problems with the education, such as readmission for inpatient teaching and re-encounters for outpatient teaching.

The most concrete way to check staff compliance with patient and family education is through documentation, says Ordelt. "I check patient and family education via a bimonthly PI monitor," she says.

(Editor's note: Details on how to apply patient education research findings into practice are offered in: London F. No Time to Teach? A Nurse's Guide to Patient and Family Education. *Philadelphia: Lippincott Williams and Wilkins; 1999.)* ■

Does your patient education measure up?

NCI guidelines provide standards for services

Many of the "best practice" standards come from organizations that create guidelines for programs in a particular specialty. The National Cancer Institute (NCI) in Bethesda, MD, for example, is one of these organizations. In 1998, NCI published a revised edition of *Guidelines for Establishing Comprehensive Cancer Patient Education Services.*

Best practice standards were established by a task force of cancer patient educators from the NCI Cancer Patient Education Network (CPEN), which is a group of leaders in NCI-designated cancer centers around the country.

The task force reviewed patient and family education standards created by the Oncology Nursing Society in Pittsburgh, the Joint Commission on Accreditation of Healthcare Organizations in Oakbrook Terrace, IL, and the Association of Community Cancer Centers in Rockville, MD, in composing the guidelines.

What resulted is a set of guidelines easily adaptable to any setting and not limited to cancer patient education services, says **Annette Mercurio**, MPH, CHES, task force chair and director of health education services at City of Hope National Medical Center in Duarte, CA, an NCI-designated cancer center.

Just substitute 'institution' for 'cancer center'

"The major categories covered within the guidelines, such as the philosophy and mission, the organization and structure, and functions, are building blocks for an effective institutionwide patient education program," explains Mercurio. Although the words "cancer center" are frequently used, patient education managers can very easily substitute "institution" or "medical center" because the guidelines are quite broad, she says.

For example, every institutionwide education program needs a well-developed mission statement that is tied directly to the strategic objectives of its organization's mission. To show administrators what contribution patient education makes to the organization, you have to be able to show how it is helping to advance strategic objectives.

SOURCES

For more information about the use of the *Guidelines for Establishing Comprehensive Cancer Patient Education Services*, contact:

- **Annette Mercurio**, MPH, CHES, Director of Health Education Services, City of Hope National Medical Center, 1500 East Duarte Road, Duarte, CA 91010-0269. Telephone: (626) 301-8926. Fax: (626) 301-8868. E-mail: amercurio@smtplink.Coh.ORG.

For a copy of the guidelines, write or fax:

- **National Cancer Institute (NCI)**, Office of Cancer Information, Communication and Education, Patient Education Branch, 31 Center Drive, MSC 2580, Building 31, Room 10A10, Bethesda, MD 20892-2580. Fax: (301) 496-7063. Or, call the NCI cancer information service at (800) 4-CANCER.

"Basically, the elements within the guidelines are all elements that are key to gaining administrative support and also building high-quality institutionalized programs," says Mercurio.

During the guideline revision process, the task force surveyed CPEN members and found that they either used the guidelines extensively or let them gather dust on a shelf. Therefore, the team developed a couple of tools to help patient education managers implement the guidelines.

First, they gathered case examples of how members used the guidelines. For example, one manager used the guidelines to develop her strategic plan for education. She pinpointed areas she would need to address to move her program closer to where she wanted it to be in five years.

They also gathered practical documents patient educators developed to implement any of the nine areas of the guidelines, such as tools used to evaluate patient education programs under the quality / performance improvement section of the guidelines. The information was placed in binders and shown at conferences, but eventually the task force hopes to have an online notebook at the NCI Web site.

An institutional self-assessment tool included in the guidelines makes it possible for patient education managers to evaluate current programs and determine areas that need improvement. For example, they may find they are strong in policy and procedure but weak in the area of performance improvement. "I have never met any patient education manager who feels that he or she is exactly where they want to be," says Mercurio. ■

Awards elevate materials to 'best practice' level

Raise stature of patient education

Do you have a patient education video, pamphlet, or program produced in-house that has award-winning potential? If so, you may want to enter it in a contest.

"An award brings visibility to my program at the medical center. It validates that what we are doing is at a high level of quality," says **Carol Maller**, RN, MS, CHES, patient education coordinator at the Veterans Affairs (VA) Medical Center in Albuquerque, NM.

When the Oakbrook Terrace, IL-based Joint Commission on Accreditation of Healthcare Organizations (JCAHO) comes to survey, Maller routinely uses any awards, recognition, and publications to showcase the patient education program. "It allows us to reference an external review of excellence or best practice, and JCAHO seems to like that very much," says Maller. Top management likes it as well. To showcase the awards, she creates storyboards, displays trophies, and mounts certificates. "I do anything I can to promote our accomplishments," she says.

Winning an award has many benefits, agrees **Jackie A. Smith**, PhD, patient education coordinator at the University of Utah Hospitals and Clinics in Salt Lake City. An award brings recognition to the institution and staff that produced the material. It makes patient education more valuable in employees' eyes and they are more likely to use it. Also, it provides incentive for staff to continue to produce top-quality materials. "Overall, the quality of patient education practice is improved," says Smith.

If you want to sell the patient education materials to other institutions, award recognition helps promote sales, says **Christine Style**,

Patient Education Management is actively looking for ways you can add value to your work. In the August issue, we discussed selling patient education materials to other institutions. This month, we look at obtaining award recognition with your efforts. Next month, we look at publishing opportunities regarding your program.

Pick contest entries with a critical eye

And the winner is . . .

Before entering patient education videos, pamphlets, or programs in a contest, make sure your entry is suitable, says **Christine Style**, coordinator, audiovisual / television services at Egleston-Scottish Rite Children's Healthcare System in Atlanta. Look at the contest sponsor and what the award is for, she advises.

For example, for a video entry, look to see if the contest is focused on the technical aspect of the film or the content and how effective the video is at getting the message across to the viewer. Then make sure your entry fits.

Also, consider the competition. Is it a national, regional, or local contest? If your video cost $5,000 to produce and it's up against videos with a $200,000 production budget, the chances of winning an award are slim.

It is easier to target your contest entry if the contest has categories. For example, if all videos compete as a category, educational videos would be compared to marketing videos, staff training videos, and other educational videos, says Style.

She advises patient education managers to call the contest sponsor and find out who the winners were the previous year. Then find out if it is possible to get a copy of the winning video or booklet.

During the telephone conversation with the contest sponsor, find out who will be judging the entries. Ask people who have the same job at your facility to pre-judge the material. For example, if public relations people are the judges, ask a few people from your public relations department to look at the video or pamphlet, advises Style.

Read the entry instructions twice, then set them aside to read again later, suggests **Carol Maller**, RN, MS, CHES, patient education coordinator at the Veterans Affairs Medical Center in Albuquerque, NM. "You really have to give careful thought to contest sponsors' intent. What are they looking for?" she says.

Often, there is only a two-sentence explanation. To gain more clarification, Maller might call the sponsor to discuss the criteria before making a decision on whether or not to enter a contest.

Once you determine that your entry is right for the contest, take the time to fill out the entry form with care, says Style. Make sure you give clear answers to such questions as "Who is your audience?" and "What is the purpose of the material?" "I sit on judging panels for videos. I know its important to be clear on the answers to the questions," says Style. ■

coordinator of audiovisual / television services at Egleston-Scottish Rite Children's Healthcare System in Atlanta. The *Basics of Asthma* video, which won a Certificate of Excellence at the Health Science Communications Association 1995 media festival, is sold through Children's Hospital of Wisconsin's Maxishare catalog.

The External Fixator: What to Expect won Best of Show at the American Society for Healthcare Education and Training's 1996 film festival. The physical therapist at Egleston-Scottish Rite frequently shows the film at speaking engagements and takes orders for the film at that time. "Having won an award is a good way to help sell videos," says Style. **(To learn how to find contests and for information on several ongoing competitions, see article on p. 104.)**

If the judges provide feedback on the video, pamphlet, or program that is entered in the contest, the information can be invaluable because it helps you improve on the next project, says Style. Also, awards are personally beneficial, she says. They indicate that you are good at what you do. Often, just being able to say you collaborated on an award-winning video helps during job performance evaluations.

While the recognition from awards is beneficial to patient education, unless you have an unlimited budget, you'll want to enter contests with care because most have entry fees associated with them.

"It is very hard to get my institution to fund contest entries on the hope that they will win an award. My budget is solely for direct care, patient education materials, things that go in the hands of the patients," says Maller. At times, Maller has personally paid the entry fee. Therefore, she chooses entries with care.

(Continued on page 105)

Be aware of calls for entries

Annual contests provide opportunity for awards

There are several ways to discover contests that offer awards for patient education efforts such as videos, pamphlets, audio materials, newspaper and magazine articles, and Web sites. Awards often are linked to national conferences, and a notice will be mailed with the conference brochure, says **Carol Maller**, RN, MS, CHES, patient education coordinator for the Veterans Affairs Medical Center in Albuquerque, NM.

"That is where I find most of the contests I enter," she says.

Memberships in organizations will ensure that mailers on contests are sent, says **Christine Style**, coordinator of audiovisual/television services at Egleston-Scottish Rite Healthcare System in Atlanta. Tell hospital staff in other areas of expertise to be on the lookout for contest opportunities that they can pass along as well, she advises.

For example, each year the public relations department staff at the medical center pass along the entry form for the Phoenix Awards, given by the Georgia chapter of the Public Relations Society of America.

Following is a short list of annual competitions to get you started:

• **American Academy of Nursing.**

This organization's Media Award is presented to individuals or organizations in a variety of categories including newspaper and magazine articles, books, radio programs, and feature films. Entry fee is $75.

The Media Award is presented for:

— media that has increased public awareness of the impact of specific public policies on the health status of individuals, communities, or the general population;

— media that has been responsible for motivating specific actions to improve health care for diverse groups of people;

— media that has depicted specific examples of health-enhancing interactions, culturally sensitive health care, health-promoting activities, or healing actions.

For information on the awards or the next deadline, contact: American Academy of Nursing, 600 Maryland Ave., SW, Suite 100 West, Washington, DC 20024. Telephone: (202) 651-7240.

• **Health Information Resource Center.**

This organization sponsors the National Health Information Awards for the best in consumer health information. Entries can include audiotapes, books, pamphlets, magazine articles, newsletters, posters, and videotapes. The entry fee is $42. The center recently launched a new contest for the best health-related Web sites for consumers and professionals. The World Wide Web Health Awards will be given twice a year, in the spring and fall. The entry fee is $39 per Web address.

For more information on the awards or the next deadline, contact: Health Information Resource Center, 621 East Park Ave., Libertyville, IL 60048. Telephone: (800) 828-8225 or (847) 816-8660. Fax: (847) 816-8662. E-mail: hlthinfo@aol.com. Web site: www.healthawards.com.

• **Health Science Communications Association (HeSCA).**

The HeSCA Festival Awards are open to print, film, Web site, and video entries on a health, medical, or bioscience subject of educational value to health professionals, biocommunicators, students, or the general public. Entry fees vary depending on the category but range from $25 to $130.

For more information on the awards or the next deadline, contact: HeSCA Media Festivals, One Wedgewood Drive, Suite 28, Jewett City, CT 06351-2428. Telephone: (860) 376-8150.

• **Telly Awards.**

A national competition to recognize outstanding non-network and cable commercials as well as film and video productions. Finalists receive a bronze statuette. Winners receive a silver statuette. The entry fee is $35, and each finalist and winner is billed $110 to help defray the cost of the awards and competition. For more information on the awards or the next deadline, contact: Telly Awards, 4100 Executive Park Drive, #16, Cincinnati, OH 45241. Telephone: (513) 421-1938. ■

SOURCES

For more information on winning awards for your patient education efforts, contact:

- **Carol Maller**, RN, MS, CHES, Patient Education Coordinator, VA Medical Center, 2100 Ridge Crest Drive, SE, Albuquerque, NM 87108-5128. Telephone: (505) 265-1711, ext. 4656. Fax: (505) 256-2870. E-mail: albuq@msn.com.

Awards won:

★ American Journal of Nursing Company, 1996 Media Festival Award, First Prize for *Eating for a Healthy Heart* video.

★ American Society for Healthcare Education and Training (ASHET), 1996 ASHET Film Festival, winner in the Wellness/Health Promotion Category for *Eating for a Healthy Heart* video.

★ Pritchet & Hull, Innovations in Patient Education contest, Third place tie for originality, effectiveness, and efficiency of Distribution Center for Patient Health Education Materials.

★ Telly Awards, 17th annual awards, Telly for *Eating for a Healthy Heart* video.

- **Jackie A. Smith**, PhD, Patient Education Coordination, University of Utah Hospital and Clinics, 50 North Medical Drive, Salt Lake City, UT 84132. Telephone: (801) 581-4804. Fax: (801) 585-5280. E-mail: jackie.smith@hsc.utah.edu.

Awards won:

★ American Academy of Nursing, 1993 Media Award-Certificate of Merit for a book titled *Babysitting Basics: A How-to Workbook for the Beginning Babysitter.*

★ Telly Awards, 14th annual awards, finalist for *First Impressions-What to Expect During your Hospital Stay* video.

- **Christine Style**, Coordinator, Audiovisual/Television Services, Egleston-Scottish Rite Children's Healthcare System, 1001 Johnson Ferry Road, NE, Atlanta, GA 30342-1600. Telephone: (404) 250-2522. Fax: (404) 250-2890. E-mail: cstyle@srcmc.org.

Awards won:

★ Health Science Communications Association (HeSCA) 1995 Media Festival, Certificate of Excellence for *The Basics of Asthma* video.

★ Public Relations Society of America, Georgia chapter, 1996 Phoenix Awards, Outstanding Project Award for *Picture This! An Inside Look at Diagnostic Imaging* video.

★ American Society for Healthcare Education and Training (ASHET), 1996 Film Festival, Best of Show Award for *The External Fixator: What to Expect* video.

★ Public Relations Society of America, Georgia chapter, 1998 Phoenix Awards, Certificate of Excellence for *Scottish Rite is the Right Place for Kids* video.

What makes patient education materials potential award winners? Materials that are a collaborative effort, especially if they have been part of a pilot study, usually are strong entries, says Maller. "They tend to be the projects that were longer in design and have the different quality improvement pieces built in. They are not projects that happen overnight, but have been carefully planned," she explains. These well-planned projects will have evaluation data further validating that the product is of high caliber.

While the piece must be of high quality to make it worthy of an award, other factors that help measure its potential include whether or not the patients like it, if it has met the needs of its target audience, and if positive outcomes resulted from its use, says Smith. **(For information on positioning contest entries to win, see article on p. 103.)**

Timeliness is a key criterion to consider, according to Maller. The video *Eating for a Healthy Heart*, produced by the VA Medical Center in Albuquerque, won three awards because it was produced when the nation's medical community first began widely advocating a healthier lifestyle. People were learning to read food labels and see the link between heart disease and lifestyle choices.

One of the best ways to determine if patient education materials are award-worthy is to listen to your customers, advises Maller. Eavesdrop on staff conversations in the hallway or elevators and listen to the patients. "Your customers will tell you when you are right on the mark. If people keep telling you the piece is great, or you keep running out of it, you have to know you did something well," says Maller. ■

Combination teaching provides the best of both

Mixed method gets better results

The learning centers at the University of Wisconsin Hospital and Clinics in Madison have a dual purpose. They offer informal learning by giving visitors answers to their health questions. Also, they provide formal teaching on specific topics that have been defined by the hospital or clinic in conjunction with the learning center at that location.

"When the inpatient units or outpatient clinics send patients to us for teaching, they know what they are getting in terms of the teaching sessions," says **Zeena Engelke**, RN, MS, senior clinical nurse specialist for patient and family education at the medical center. This is not only because the curriculum is defined, but several research studies have helped to prove their value. **(For more information on these studies, see article, p. 107.)**

In both inpatient and outpatient learning center settings, patients receive a multisensory approach to teaching with the registered nurses that provide the lessons. These nurses make use of videos, discussion, and hands-on demonstration and skills practice. "Practically speaking, on the inpatient units or even during clinic visits, it may not be possible to provide all those options to patients and families," says Engelke. All education at the learning centers is documented in the patient's medical record.

Smoking room becomes a learning center

The learning center at the hospital opened in the fall of 1995, in response to a challenge by the vice president of nursing who asked that staff come up with a creative way to use the space that was once the hospital's smoking room. The learning centers in the clinics are being included with construction of these facilities. The West Clinic learning center opened in June 1999, and the East Clinic learning center will open in November 1999.

The teaching focuses on areas where the clinics or inpatient units have a strong education need that is tough to meet. The first area of need identified for the hospital learning center was preoperative teaching for major orthopedic surgeries such as hip and knee replacements. That preoperative teaching expanded to cardiac surgery. When people come to the hospital for their surgery work-up visit, their first stop is the learning center, where they learn what to expect during the work-up visit and what to expect during their hospital stay.

In the acute care setting, patients who are admitted to the hospital and need surgery also are sent to the learning center for preoperative teaching. In addition, diabetes skills, such as insulin injection or use of a glucose meter, are taught at the learning center. The education focus is on skills that are needed for a safe discharge; therefore patients are not taught how to manage their diabetes. Central catheter care and advance directives are taught to all patients referred for such instruction on the inpatient setting as well.

In the West Clinic location, patients are scheduled for pediatric ear, nose, and throat pre-surgery teaching. Sessions also are scheduled on dermatology medications and general diabetes education. In both inpatient and outpatient settings, appointments are scheduled by referral from a health care professional such as a physician or nurse.

While the specific teaching needs of each location dictate which topics are addressed, the physical design of each facility restricts group sizes. Most of the teaching at the inpatient learning center takes place one on one, but two or three patients can be educated at one session. "It hasn't been possible to do large groups because of the restrictions of the size of our room, but with the new clinic, I expect to have larger groups," says Engelke.

One room dedicated to walk-in patients

The inpatient learning center is one room, but at the clinic there are three rooms. One room is dedicated to helping walk-in patients who have health questions and is staffed by a program assistant who assists guests with questions and also performs secretarial duties. The room has pamphlets and research capabilities via the Internet.

None of the learning centers has an extensive library. The remaining rooms are for teaching and have a table and chairs, videos, and computers with interactive CD-ROM and Internet capabilities. The room for pediatric teaching also has a rocking chair.

COMING IN FUTURE MONTHS

- Adding alternative treatment education to community outreach
- Integrating wellness/disease prevention concepts into patient education efforts
- Evaluating the effectiveness of patient education to justify programs
- Become a part of the literature: Get published
- Outreach strategies curb domestic violence

Patients learn to succeed through empowerment

Instill belief that patient can master skills

The patient learning center at the University of Wisconsin Hospital and Clinics in Madison focuses on patient empowerment and self-efficiency to ensure educational outcomes are successful. The teaching programs empower patients and family members by involving them in care and care decisions. The programs also help to instill in them a belief that they will be able to master a particular skill and gain the appropriate knowledge.

Those two components have been a successful formula for the learning center located among the inpatient units of the hospital. Staff know the formula works because they have been conducting an ongoing series of research studies since the center opened in 1995.

"People talk about learning centers being such a grand idea, but nobody has really done much to see if they are making a difference," says **Zeena Engelke**, RN, MS, senior clinical nurse specialist for patient and family education at the medical center.

To make sure the learning center is making a difference, staff conducted research studies on several of the teaching programs, including orthopedic pre-op teaching, inpatient pre-op teaching, cardiac surgery pre-op teaching, diabetes skills teaching, post-transplantation teaching, and most recently, general diabetes teaching.

"We are looking at the same components throughout to see whether or not we are making a difference in terms of the patient's view of empowerment and self-efficacy as well as the patient outcome itself," says Engelke.

To gather the information, patients are asked to complete a survey tool before teaching and again prior to discharge. Chart reviews also are conducted. Several weeks after hospitalization, study participants are interviewed over the telephone. Generally, the same or similar questions are asked via a written tool or phone interview before initial teaching, after teaching, at discharge, and several weeks after hospitalization.

Patients receiving the traditional teaching within the clinic and on the inpatient units are the control group, while the patients participating in the new teaching program in the learning center are the experimental group.

"We did the orthopedic study in 1995-96 and were able to demonstrate that there were higher levels of empowerment and self-efficacy for the patients that were seen in the learning center," says Engelke.

Results from the other studies are not yet available. ■

At the hospital, because patients and drop-in guests share the room, time must be allotted for the needs of each group. Therefore, patients are scheduled for teaching between the hours of 8:00 a.m. and 1:00 p.m., and the public can visit the learning center from 1:00 p.m. to 4:00 p.m. Monday through Friday. The clinic setting is open from 8:00 a.m. to 4:30 p.m. Monday through Friday.

A registered nurse is scheduled for all the teaching. At the inpatient learning center, another nurse is available during times when the prescribed teaching needs of the patients are greater than the center's capabilities.

The RN travels to the patient's bedside to teach. A total of one full-time nurse and three part-time nurses make up the clinic teaching staff. A full-time program assistant is at the hospital, and a half-time program assistant is located at the West Clinic. Volunteers are not part of the staff mix.

Staff aren't restricted to either learning center. Engelke plans to rotate the RNs depending on their teaching skills. For example, those who teach diabetes well will do the teaching on that topic at both sites whenever possible.

"Having a learning center raises general awareness of patient and family education throughout the hospital and clinics in terms of availability of materials. We see about half patients and families and about half staff," says Engelke. ■

SOURCES

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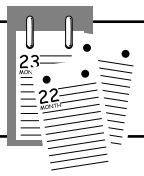
CALENDAR



• **Managing the Millennium: Moving Organizations Through Education and Innovation** — Sept. 16-19, 1999, Las Vegas. The annual conference of the Philadelphia-based Health Care Education Association (HCEA) will focus on technology, organizational and human resource development, and consumer education. Sessions will cover such topics as Internet-based education opportunities and the role of the educator in JCAHO accreditation. Cost is $395 for HCEA members and $475 for nonmembers. For more information, contact: Marcie Pallante, conference coordinator, Health Care Education Association, 1211 Locust St., Philadelphia, PA 19107. Telephone: (888) 298-3861 or (215) 985-0216. ■

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Editorial Questions

For questions or comments, call **Susan Cort Johnson** at (916) 362-0133.

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

Wellness and prevention paired to stem teen suicide

Efforts aimed at adults as well as teens

Since Acadia Hospital in Bangor, ME, launched an awareness campaign on teen suicide, the number of calls to a statewide crisis hotline has jumped 50%. While the *Speak Out for Kids* campaign can't take all the credit, the link cannot simply be a coincidence, says **Alan Comeau**, MA, manager of community relations for Acadia, a mental health and substance abuse treatment facility.

The main reason for the campaign's success is that it does not just focus on youth suicide prevention, but youth wellness, too. "In reality, a lot of kids who come to the conclusion that suicide is an option for them reach that decision because things have happened to them, or haven't happened to them, and youth wellness can address that," says Comeau.

The campaign addresses the issues that lead to teen suicide in a couple of ways. First, workshops for adults help to improve parenting skills, communication skills, and knowledge about mental illness. Workshops have covered such topics as how to talk to a teenage son or daughter, childhood development, children and depression, and children and divorce.

About three to five workshops are scheduled each year and broadcast via an interactive TV network to geographically isolated towns. Since the program began in 1996, Acadia has hosted 10 seminars on a variety of childhood / adolescent issues. Many of these workshops attract 80 or more participants.

A second project targets teens. Acadia funded the design and distribution of book covers and posters that address the range of emotions teens feel and ways to cope. "We wanted the posters and book covers to speak to the whole kid, whether they are feeling good or bad. There are also affirmations on them like, 'It is OK to ask for help' or 'Speak out, you could help a friend.' They are sayings they can hold onto and identify with," says Comeau.

The materials are designed like a collage with photos and artwork, and all have the toll-free crisis hotline number on them. Approximately 27,000 book covers and 2,200 posters have been distributed to over 50 middle schools and high schools in five counties over the past three years. Materials also are distributed to churches, libraries, and youth organizations such as the YMCA. This year, the state government of Maine purchased 20,000 posters and distributed them to every high school in the state. **(To learn how to obtain these suicide prevention and youth wellness materials, see editor's note at end of article.)**

A third component of the campaign, a gun lock giveaway, falls into the suicide prevention and wellness campaign. Each fall, Acadia staffs a phone bank with volunteers and offers callers a free gun lock. In 1998, 2,100 gun locks were given away in one day, says Comeau. "We are going a long way to diminish potential suicide and also accidental gun injury," he says.

Brochures, newspaper ads target adults

To prevent suicide, Acadia published a brochure on the facts about youth suicide that is written for adults. People can obtain the brochure by contacting Acadia, or they can access the information on the World Wide Web at www.emh.org. Television spots address the teen suicide problem and provide the toll-free crisis hotline number.

Acadia also does a series of newspaper ads, mainly aimed at adults, that discuss the myths of teen suicide. For example, one ad addresses the myth that when a depressed or suicidal teen suddenly becomes happy again, he or she is past the crisis. Actually, that is when teens are at highest risk for suicide, says Comeau. Eight newspaper ads rotate throughout the year and are placed in rural newspapers as well as papers in larger communities.

Four radio ads aimed at teens feature teens discussing substance abuse, depression, stress management, and mental illness. These ads include the toll-free crisis hotline number.

The Speak Out for Kids campaign was created in response to information gathered by a

SOURCES

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statewide task force on adolescent suicide and self-destructive behavior. However, before Acadia created a program to address the problem, a local task force was assembled, consisting of teachers, youth counselors, mental health care workers, law enforcement, and clergy. "We wanted to involve people who deal with youth in different scenarios because we knew they would all bring different issues to the table," says Comeau.

To determine if the campaign was working, Comeau tracked material use and participation in outreach efforts. For example, he tracked how many brochures have been distributed, how many times the media has reported on the campaign or suicide-related issues, how many book covers and posters are distributed, and how many times books on youth that have been donated to the public library by Acadia are checked out.

Each year, Comeau assembles youth focus groups as well and has them analyze the materials aimed at youth. It was through the focus groups that he discovered the radio ads were not working. The use of language was not right and kids weren't really listening. When the music stops, they tend to tune out the ads, according to the focus groups Comeau talked with.

"There is no way of knowing if your campaign is reaching its target audience unless you ask people and track information. I think it is a much better campaign because every year I get to tweak it," says Comeau.

[Editor's note: Anyone can purchase pieces or all of the Speak Out for Kids campaign materials. Cost is $12,500 to $16,500 for packages. Individual items range from $1,050 for 1,000 brochures to $5,000 for use of the television ad for one year. 100 posters cost $2,250 and 1,000 book covers cost $2,350. For more information or to order, contact Liz Santos, DW Communications Group, Blue Hill, ME at (207) 374-5400. Office hours are Monday through Friday 8:00 a.m. to 5:00 p.m. EST.] ■

Small Infant Program focuses on education

Parents learn new baby care and high-risk skills

The Small Infant Program at Mt. Washington Pediatric Hospital in Baltimore provides a segue from the intensive care unit to a normal environment so families with premature or low birth weight babies can prepare for discharge. It is a time for parental bonding with and nurturing of the infant as well as a time for education.

"Part of the goal of this program is to introduce the families into a lower-intensity environment before they go home and really concentrate on parent education during that time," says **Kay Mathias**, RNC, NNP, nurse practitioner for the Small Infant Program.

When babies are referred to the program from hospitals throughout the Baltimore area, parents receive an education list upon admission. Included on that list is basic newborn care, which they were unable to learn when their baby was in intensive care. Nurses teach parents how to give a newborn a bath, how to take the baby's temperature, how to dress the baby properly, and child safety such as the proper use of a car seat. Parents also learn how to administer any medications the baby will go home on, and the signs and symptoms of illness that would warrant a physician's care.

"Child life usually tries to meet with the family to go over normal developmental ranges for the next couple of months," says Mathias. Child life will also do tests to see how the infant handles certain kinds of stress a full-term baby might easily tolerate, such as a lot of movement. This information is then passed along to the parents.

Parents of the high-risk infants are also asked to take a class on infant CPR that is available to all parents who have babies at the hospital on a volunteer basis. ■

SOURCES

For more information on the Small Infant Program, contact:

- **Kay Mathias**, RNC, NNP, Nurse Practitioner, Small Infant Program, Mt. Washington Pediatric Hospital, 1708 West Rogers Ave., Baltimore, MD 21209. Telephone: (410) 578-8600, ext. 336. Fax: (410) 367-4196.