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INSIDE

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Keep patient education from being the red-headed stepchild

Do your efforts measure effective education, or are your data meaningless?

Most patient education managers are aware of the problem: Patient education is undervalued by administrators. As a result, staff in patient education departments find themselves holding their breath during budget-crunching, hoping that patient education won't be the target of staff and budget cuts.

Administrators often want proof that patient education makes a difference. For example, did the teaching improve the bottom line by reducing length of hospital stay, readmissions, or visits to the emergency department? Did teaching create behavior changes, such as the CHF patients' consumption of sodium, that improved their ability to manage the disease? Did teaching improve self-efficacy and provide the confidence needed to perform a task such as monitoring blood glucose levels? These data are hard to come by, but possible to find.

Measuring the effectiveness of patient education programs, teaching protocols, and materials is difficult, says **Fran London**, MS, RN, a health education specialist at Phoenix Children's Hospital. It's easiest to measure outcomes of programs when they're applied to patients who all have the same diagnosis. The outcomes of patients in the program can be compared with those from a similar patient group not enrolled in the program.

For example, at the University of Wisconsin Hospital and Clinics in Madison, learning center staff evaluated orthopedic patients receiving presurgery education at the center vs. those who were taught in the clinics. To gather the information, staff ask patients 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. The study showed that there were higher levels of empowerment and self-efficacy for the patients

that were taught in the learning center, says **Zeena Engelke**, RN, MS, senior clinical nurse specialist at the facility. **(For more information on the learning center, see *Patient Education Management*, September 1999, pp. 105-107.)**

Most teaching is done individually in the office, clinic, or hospital within the context of an interaction, not in groups or programs, says London. While it is easy to measure short-term effectiveness of one-on-one teaching by asking questions or having the patient demonstrate a skill, it's difficult to know if the change has a lasting impact. In this situation, it is impossible to create a control group because it would be unethical to choose not to teach a patient. Therefore, it is hard to determine — let alone demonstrate to others — the long-term impact of informal teaching, says London.

Telephone follow-up surveys also help gather data. Staff at St. Joseph's Hospital of Atlanta, for example, call patients to determine whether a teaching protocol for diabetics following open-heart surgery is effective. In helping these patients learn how to manage their diabetes after discharge, staff educators make a follow-up call one to two months after discharge to assess the patient's retention of teaching and behavior change.

During the patient's hospitalization, a nurse makes sure the patient has a blood glucose meter and knows how to use it. Patients also are taught how often to monitor blood glucose levels, when to call their physician, the signs and symptoms of hypoglycemia and its treatment, and that diabetes is a major cause of coronary artery disease. Post-heart surgery patients with diabetes were chosen because it is important for diabetics to monitor their blood sugar closely and to follow measures to control their blood sugar after surgery. This will help prevent post-op complications, such as infection, that could lead to readmission.

"This project will help us evaluate the effectiveness of our teaching and assist us in making any changes in this program," says **Jodi Langford**, RN, BSN, patient education coordinator at the health care facility.

The follow-up questions include:

- Do you remember being seen by an educator?
- Do you know that diabetes is a major cause of coronary heart disease?
- How often do you monitor your blood glucose level?
- Do you have a high or low blood glucose reading?
- What do you do when the reading is high or low?

Follow-up during the April, May, and June 1999 quarter showed that 30 out of 31 patients remember being seen by the nurse educator, despite post-op fatigue or the effects of medication, which can hamper teaching. The results show great retention and application of knowledge, says Langford.

A short patient and family education survey delivered twice a year at Children's Healthcare of Atlanta provides a peek into the effectiveness of education and the patient's satisfaction with it, says **Kathy Ordelt**, RN, CRRN, CPN, patient and family education coordinator at the facility.

Patients and family members are asked to rate patient education on a scale of one to five, ranging from very poor to very good. A couple of yes-or-no questions were included on the survey. Some of the areas people were asked to rate on the May 1999 survey include:

- Information about your child's care explained in a way you could understand.
- Degree to which your child was included in the teaching (if over three years old and able to understand).
- Ease of asking questions or expressing concerns about your child's care.
- Staff attention to your child's special needs.
- Your understanding of the teaching materials provided.

On most questions, the patient education department wants to achieve an overall 4.5 — or, for the yes-and-no questions, a 90% positive response — but the ratings are set individually each time. "I have never found a way to come up with hard-core statistics to go to our CEO and top leaders and say, 'look what patient education does.' I collect soft data," says Ordelt.

The satisfaction surveys do show how satisfied patients and families feel in managing their health care when they are discharged, and that is important to consumers today, she says.

Define what effective education is

Many patient education managers have trouble proving the effectiveness of patient education because they are not clear on what would constitute effective teaching, says **Kate Lorig**, RN, DrPH, director of the Stanford Patient Education Research Center at Stanford University School of Medicine in Palo Alto, CA.

The first step in the evaluation process is to articulate what you want your teaching to accomplish. Define what effective education is or what you

SOURCES

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- ***Outcome Measures for Patient Education and Other Health Care Interventions***, by Kate Lorig and Assoc. This book includes several examples of tools for measuring outcomes. The book costs $24.95 plus $3.50 shipping and handling. California residents must include sales tax. Contact: Sage Publications, 2455 Teller Road, Newbury Park, CA 91320. Telephone: (805) 499-0721. Fax: (805) 499-0871.

want to know, she says. For example, ask yourself the following questions: Do you want the outcome to change health behavior, health status, health care utilization, or satisfaction with the system?

To determine a good health outcome, think about why you have created the teaching protocol, program, or educational materials. Ask who cares. "If you can't answer the 'who cares' question in about 15 seconds, it is not the right outcome," says Lorig.

Evaluations must be tailored to your audience. If it is administrators who care, then the outcome you are trying to achieve might be fewer visits to the emergency department for asthma patients. To show whether a program is cost-effective, measure utilization the year before the program is launched and one year after the program is up and running to determine if there is a difference, says Lorig. The utilization may not be emergency department visits, but rather frequent physician visits or hospital admissions. "In our chronic disease self-management program, we showed that people who attended the program had eight-tenths of a day less hospitalization over six months than people who did not attend the program. That is a big cost savings," she explains.

Once you determine what you are trying to achieve and who cares, you must determine how to measure the outcome. To determine the best way to measure patient education, go to the literature and look to see what other people used. Measurement tools are always referenced in an article, says Lorig. "I would advise patient educators never to write their own instruments, because writing an instrument is a very difficult task," she says. **(For information on a resource that contains several evaluation instruments, see source box at left.)**

Perhaps the best aspect of evaluation is that it doesn't have to be complicated. Lorig quickly summarizes the elements of evaluation:

- what you want to know;
- why you want to know it;
- straightforward and simple measures. ■

If a project takes time, consider a byline

Efforts in patient education rewarded by publishing

Can't find that important information on patient education? Maybe it hasn't been written yet — and you might be the best author for it. That's the opinion held by **Margaret M. Duffy**, EdD, RN, CNN, clinical educator and adjunct associate professor at the College of Nursing, Medical University of South Carolina in Charleston.

"If I can't find something when I do a literature search, then I figure there are other people looking for the same information," says Duffy. Searches that come up empty-handed point to opportunities for articles in that particular area.

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; in September, we focused on obtaining award recognition for patient education efforts. This month, we wrap up the series with a look at how you can be published.

Duffy came to patient education when her position as case manager was eliminated. When she had trouble finding the specifics she needed when trying to meet the patient education needs at her institution, she wrote about what she did when handed the job. The article, "Designing a Hospital-wide Patient Education Program," was published in the July 1999 issue of *Advances in Renal Replacement Therapy*. Now, she frequently writes or collaborates on articles on patient education projects at the Medical University of South Carolina. **(For information on submitting articles to journals mentioned in this piece as well as to other publications, see article, p. 113.)**

When lots of time and energy go into a project, you want to get the most out of it, and publishing is one way of doing that, says **Magdalyn Patyk**, MS, RN, coordinator of nursing development at Northwestern Memorial Hospital in Chicago. When Patyk spent a year with a doctoral student examining the effectiveness of computerized touch-screen education for brain injury patients, she co-wrote an article for *Rehabilitation Nursing*, a journal published by the Glenview, IL-based Association of Rehabilitation Nursing.

Be familiar with the literature before writing

There are many benefits to publishing, both for you as a professional and for your organization, says **Jackie A. Smith**, PhD, patient education coordinator at the University of Utah Hospitals and Clinics in Salt Lake City. You create better projects from the start when you expect to publish articles about them later. Publishing keeps you in touch with current literature and helps you become involved in your profession. It also can bring favorable publicity to your program and organization, she explains.

Yet just as a good article brings favorable publicity, a poor one could cause problems internally, warns Smith. That's why it is important to be familiar with the current literature on a topic before writing an article. "Don't shoot yourself in the foot by making statements like, 'This project has not been done before,' or 'no one has reported this type of study before,' when in fact you have not done your homework," she advises. "Not looking at what others have done will severely affect your credibility."

The best projects to write about are those that are important for others to learn about and are significant improvements to the field, says Smith. Also, they should be well-thought-out and statistically sound.

No matter how sound the topic, an editor won't agree to look at an article if the subject is not of interest to the publication's readers. Read the journal so you understand who the audience is, and then read the writer's guidelines if they are available, advises Patyk.

Be familiar with the topics the journal addresses, the style and length of articles, and the types of charts and graphics the publication uses, says **Fran London**, MS, RN, a health education specialist at Phoenix Children's Hospital. London is the author of several journal articles and a book titled *No Time to Teach? A Nurse's Guide To Patient and Family Education*, published by Hagerstown, MD-based Lippincott Williams & Wilkins. "You have a greater chance of acceptance if the editor can immediately see how your piece fits into the journal," says London.

The best way to approach an editor is with a query letter that explains what the article is about and why it is appropriate for that particular journal, says Patyk. She usually faxes or e-mails the query to the editor.

On the other hand, Duffy writes the entire article and submits it to the editor. "I basically look to see if the journal handles that kind of article, and then send it to the editor with a letter asking if it is something he or she can use," she explains. **(To learn more about the writing process, see article on p. 113.)**

To find an appropriate journal, go to the library and look for journals that publish articles similar to yours, advises Smith. If you are stumped, ask other professionals in the patient education field.

At Northwestern Memorial Hospital, it is the expectation that everyone in nursing development will publish, says Patyk. With this mindset, most staff are keenly aware of journal content and slant and will suggest publications where colleagues might publish on a particular project.

For example, Patyk's supervisor informed her of a journal that was looking for articles on project management. That gave Patyk the opportunity to publish a piece about a strategic planning project for patient education on which she had worked.

While publishing takes time and effort, it is very rewarding, says Smith. "Patient educators will greatly increase their professional level through publishing and the field will grow dramatically," she says. ■

Here's your reference for references

If you seek the right publication, you will find it

After completing a patient education strategic planning project, **Magdalyn Patyk**, MS, RN, coordinator of nursing development at Northwestern Memorial Hospital in Chicago, wrote an article about the project management piece of the process for a medical journal. Now she is looking for a publication that would accept an article on how to get direction for patient education activities within the hospital, which would discuss the entire project rather than a piece of it.

Often it is possible to write several articles on one topic simply by slanting the information differently, says Patyk. You just have to find the right publication for each angle.

Following is a list of publications to help you find a suitable placement for your article ideas:

• ***Advances in Renal Replacement Therapy***, Allen R. Nissenson, MD, Editor-in-Chief, Professor of Medicine, Director, Dialysis Program, UCLA School of Medicine, 7-137 Factor Building, 10833 Le Conte Ave., Los Angeles, CA 90024-1689.

• ***Journal of Nursing Care Quality***, Patricia Schroeder, MSN, RN, Editor, 524 BelAire Drive, Thiensville, WI 53092. Telephone: (414) 242-9262. Fax: (414) 242-0121. E-mail: pschroed@execpc.com.

• ***Nursing 2000***, Cheryl L. Mee, RN, C, MSN, Clinical Director, 1111 Bethlehem Pike, Springhouse, PA 19477. Telephone: (215) 646-8700. E-mail: cheryl.mee@springnet.com.

• ***Nurse Educator***, Suzanne P. Smith, EdD, RN, FAAN, Editor-in-Chief, 4301 32nd St. W., Suite C12, Bradenton, FL 34205. Telephone: (941) 753-5662. E-mail: DrSuzSmith@aol.com.

• ***Orthopaedic Nursing***, Ann Butler Maher, MS, RN, ONC, Editor, 11 Louis Drive, Budd Lake, NJ 07828. Telephone: (201) 691-0568. Fax: (201) 691-3436. E-mail: naon@mail.ajj.com.

• ***Outcomes Management for Nursing Practice***, Marilyn H. Oermann, PhD, RN, FAAN, Editor, 168 North Cranbrook Cross Road, Bloomfield Hills, MI 48301-2508. Telephone: (248) 594-6933. Fax: (248) 594-6934. E-mail: moermann@msn.com.

• ***Patient Education Management***, Susan Cort Johnson, Editor, 9551 Butterfield Way #42, Sacramento, CA 95827. Telephone: (916) 362-0133. E-mail: suscortjohn@earthlink.net.

• ***Pediatric Nursing***, Veronica D. Feeg, PhD, RN, FAAN, Editor, 18 Lipscomb Court, Sterling, VA 22170. Telephone: (703) 993-3141. Fax: (703) 993-3162. E-mail: rfeeg@osfl.gmu.edu.

• ***Rehabilitation Nursing***, Nancy Poore, Editor, 4700 W. Lake Ave., Glenview, IL 60025-1485. Telephone: (847) 375-4825. E-mail: deenbaar@ uwm.edu.

(Editor's Note: Nurse Author & Editor, *published by Susan Hall Johnson, will help you keep abreast of the needs of several nursing journals. Her Web site lists contact information for many publications. For more information, send e-mail to suzannehj@aol.com. Web site: http://members.aol.com/suzannehj/naed.htm.)* ■

Write the article once, and once again

Lots of polish is required to see your words in print

There is no "right" way to write a journal article. The process will vary depending on the author. "I know what I want to go into an article, so I don't really create an outline. Instead, I start typing on the computer and bolding my section areas, then I write to those sections," says **Margaret M. Duffy**, EdD, RN, CNN, a clinical educator and adjunct associate professor at the College of Nursing, Medical University of South Carolina in Charleston. However, before sitting down at the computer to write the article, she thinks a lot about it and what information to include in it.

Before **Magdalyn Patyk**, MS, RN, coordinator of nursing development at Northwestern Memorial Hospital in Chicago, starts writing, she makes sure the message she wants to convey is clear in her mind. Once she is clear on the main point, she begins writing.

Others, like **Jackie A. Smith**, PhD, patient education coordinator at the University of Utah Hospitals and Clinics in Salt Lake City, write whatever comes to mind when creating the first draft. "Once something is down on paper, you

SOURCES

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can adjust, fix, and rewrite," she explains. If you have trouble writing, dictate the article into a tape recorder or record a lecture you give, she suggests. Once you've transcribed the tape, you have a rough draft of the article.

When collaborating on an article, always select a primary writer to oversee the process and work with the editor, says Patyk. Usually, each person will write portions of the piece, but it should read as if one author wrote the article.

One thing these three writers agree on is that the first draft of the article is never what gets submitted to the journal. Duffy writes three or four drafts before the article is polished enough to submit to an editor. When reviewing the article, she looks for information she has left out and always has others read it to see if they understand the points she's trying to make. It's a good idea to have someone with lots of knowledge about grammar read it over as well, she says.

No matter how well you have polished the article before submitting it to a publication, be prepared to do additional work on the piece once it has been edited. Usually, several reviewers and the editor or assistant editor will make suggestions about ways to make points more clear or other aspects that might be considered in the piece, says Duffy. "Rarely does an article go to an editor and come back exactly the way you sent it," she says.

Don't take the editor's comments personally, advises Smith. While rewriting can be frustrating, it does help to refine the article. However, to keep from having to do major rewrites, make sure the piece is tailored to the journal. "I have found that the more I am in tune with what is required with a particular journal, the more likely they will accept the article as written," she says.

There is one instance when editors should not have the last word: when their suggestions change the intent of the article. "Make sure your message isn't misinterpreted. When editors offer suggestions or actually make editorial changes, you don't want them to skew what you have written, so read the rewrites carefully," advises Patyk. ■

The devil's usually in the details

What's on paper isn't always reality

The plan on paper for the patient and caregiver learning center at City of Hope National Medical Center in Duarte, CA, was based on meticulous research by the members of a multidisciplinary committee, but the reality wound up differing from the plan.

The committee gathered information about learning centers across the country and evaluated several models to determine what would work best at their institution. Also, they gathered information about the needs of family caregivers to see what resources and services they should include to meet those needs. Interviews with patient education managers who had already created resource centers were conducted to learn more about budgeting, staffing, and space requirements.

Staff at the medical center were surveyed to determine what they saw as the areas of greatest

In response to interest in patient resource centers among patient education managers, *Patient Education Management* began a series of profiles on centers in the July issue. This month, our featured resource center is at City of Hope National Medical Center in Duarte, CA. This center is unique in several ways:

- Its focus includes the caregiver.
- It began as a virtual learning center.
- It has a complementary service, the Supportive Care Resource Desk.

Center is no hand-me-down

Coming up short on funds and staffing

To launch a patient and caregiver learning center at City of Hope National Medical Center in Duarte, CA, administration provided two rooms and the salary for a part-time staff member. Without money for resources, **Annette Mercurio**, MPH, CHES, director of health education services at the national cancer center, looked for grant money.

About $35,000 to support start-up of the learning center was provided by a foundation grant and a memorial fund at the medical facility. She used part of the grant money to purchase computers, a TV and VCR unit, and books. Mercurio will use the remaining funds to continue to develop and update the resource material.

Volunteers are used to keep the learning center open when paid staff are not present. These volunteers have worked with City of Hope for a while and are familiar with the medical center's services. Additionally, they received instruction on the community resource Web site that was created for the center. They also were told the scope of their role so they would know what kinds of questions needed to be answered by a nurse. Much of the training took place at the supportive care resource desk located in the ambulatory care building.

Currently, the learning center is open on weekdays from 10 a.m. to 2 p.m. It is staffed by a volunteer two days a week and a resource specialist the rest of the time.

"In the future, I think we will get some additional funding from the medical center, but I think we will have to continue to get outside support as well. It will be a combination of funding," says Mercurio. ■

need for a learning center as well as to ask their opinion about the types of resources a center should have. Family caregivers attending a symposium at City of Hope were given a similar survey.

Once the information was gathered, the committee put together a proposal to give to the administration. What they envisioned and what they settled for were two different things, says **Annette Mercurio**, MPH, CHES, director of health education services at City of Hope, a national cancer center.

They had hoped to be in an area with heavy patient traffic as well as having enough space to dedicate a room to patient and family caregiver skills training. However, they opened the Patient and Caregiver Learning Center in June 1999 in two rooms in an isolated area of the hospital.

The largest room has bookshelves with books and pamphlets that focus on cancer treatment and three computer terminals with Internet access and Web site bookmarks. The second room has a big-screen TV and a VCR with a collection of videos. The skills training component has been put on hold. **(For information on staffing and funding for the center, see article above.)**

"You can't always begin where you want to be. Therefore, we wanted to at least get the center off the ground and begin testing some of our ideas about the services and get together some of the materials we want to have," says Mercurio.

In about two years, the medical center plans to locate several patient service departments in one area, such as health education, pastoral care, clinical social work, and patient advocacy. At that time, the learning center will move to a more prominent location, where it will be located in a general waiting area.

Long before space was allocated for the learning center, Mercurio and the committee members began to work on resources that would make it a success. Their staff and caregiver survey identified a need for information on community resources. Therefore, they decided to create a community resource Web site with information on such resources as hospices, home care services, transportation, and support groups. The administration provided funding to hire a college student to do the research. **(The address for the Web site is www.infosci.coh.org/community.)**

"We looked at the Web site as the very foundation of the learning center because the idea for the center was to integrate information about resources available to patients and their family members. In a sense, it was our virtual learning center before we had space allocated for it," says Mercurio.

In addition to the learning center, City of Hope opened a supportive care resource desk in the ambulatory care building in May 1999. The mission for the desk and learning center is to give patient and family members one-stop, easy access

Desk offers everything but a bellhop

Complementing services offered at learning center

A $45,000 grant from a pharmaceutical company made it possible for City of Hope National Medical Center in Duarte, CA, to create a supportive care resource desk in the lobby of the ambulatory care building. The area is set up similar to a hotel concierge desk, with a full-time coordinator distributing pamphlets, looking up information on the computer, or responding to questions about hospital support services.

"The type of health information provided at the desk tends to be focused on managing symptoms or cancer-related pain," says **Annette Mercurio**, MPH, CHES, director of health education services at the national cancer center.

Its location makes it handy for outpatients on their way to a physician appointment or chemotherapy treatment. Patients can stop by the desk for materials to read to pass the time. They can also check out CD players and tape players so they can listen to music during treatment.

The resource desk is actually a small resource center. It is an alcove with two chairs in front of the coordinator's desk. There is also a computer patients can access and a TV-VCR that displays relaxation videos that show beautiful scenery accompanied by instrumental music. The desk is open weekdays from 9 a.m. to 4 p.m.

The coordinator gets quick questions. Many patients stop to ask about a service or a need. "If the coordinator identifies a patient or caregiver who wants more in-depth information and has time to look over books or wants to see a video, she will send the patient to the learning center," says Mercurio. ■

to information. The desk provides information about support services, while the learning center focuses on helping people cope with cancer. **(For details on the resource desk, see article above.)**

The resource desk often refers patients and family members to the learning center, which helps to increase its use. Mercurio has used other methods to increase foot traffic to the center as well. She chairs a number of committees and has taken the members on tours of the center to help familiarize them with its services and therefore generate referrals. For example, the discharge planner who sits on the patient and family education committee has found many opportunities to refer patients.

The learning center research specialist met with the manager of the outpatient village where the bone marrow and stem cell transplant patients stay, and he now refers family members to the center. Patient education staff created a brochure on the center, to be placed in patient education packets and hospital admission packets. Posters advertising the learning center are displayed in the main lobby, the elevators, and the cafeteria.

All these publicity efforts have increased traffic to the center, but they have not been able to overcome the effects of a bad location. "I don't think we will get a really high volume of use until we move and are closer to patient activity," says Mercurio. ■

SOURCE

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Patients become their own miracle workers

Acupressure eases pain, muscle tension, anxiety

To aid a young boy in critical condition from an asthma attack, **Jill La Rue**, RN, CMT, NB, a holistic health practitioner with Earth Touch in Stillwater, MN, was asked to perform daily acupressure. She did acupressure and massage for 10 days, and the boy walked out of the hospital in two weeks. This patient happened to be under the care of a pulmonologist who frequently uses La Rue's services for his pediatric asthma patients.

However, La Rue doesn't simply use her skills to ease wheezing and shortness of breath. She teaches the children where the acupressure points are on their own bodies and how to apply pressure

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Acupressure one piece of holistic health puzzle

People can fit the pieces together in different ways

While good acupressure practitioners can teach people proper acupressure techniques for self-care, such practitioners are valuable in other ways as well. They can help people work on finding the underlying cause of their ailment, which is an important element of holistic health, says **Shaun Brown**, LCMT, owner of Be Well, a Sacramento, CA-based private massage and acupressure practice.

For example, a person with temporomandibular joint syndrome (TMJ) could apply pressure to the appropriate acupressure points, but the problem will only return if the root cause is not identified and behavioral changes made. "People with TMJ tend to be very quiet and they don't say what they need to say. So it is important to learn what is going on in your life that could contribute to the problem," says Brown.

According to Chinese medicine, the underlying cause of issues in the lung is fear, and fear often plays into an asthma attack, says **Jill La Rue**, RN, CMT, NB, a holistic health practitioner with Earth Touch in Stillwater, MN. She always discusses this theory with asthma patients when introducing acupressure.

Taking account of mind and spirit

Acupressure is not just about fixing the pain. A person also must find out where his or her mind and spirit are as well. "That is the whole essence behind holistic health, and that is where complementary therapies come in. It is the only piece of health care that does speak about not just fixing your body but your mind and spirit as well and dealing with whatever the issue is," says La Rue. **(For more information on how the mind and spirit affect health care, see *Patient Education Management*, May 1999, pp. 49-53, and June 1999, pp. 61-65.)**

Well-trained practitioners with knowledge of holistic health also may discuss dietary considerations for different common ailments. For example, according to Chinese medicine, there are foods that dilute the blood, making a patient colder, and foods that thicken the blood, making the patient warmer, explains **Michael Reed Gach**, PhD, director of the Acupressure Institute in Berkeley, CA.

However, before introducing other aspects of Chinese medicine to a patient, make sure the patient is receptive, advises La Rue. As a practitioner, she feels that it is important that new clients understand that acupressure is a form of Chinese health care and that it moves energy. It's a foreign concept to many people, and she wants to know their perception of whether or not it will work. "If a person is not receptive, it doesn't matter what they do because it won't work," she explains.

When a client is new, La Rue takes a complete medical history and tries to determine what the client is hoping to achieve by using acupressure. She then discusses what to expect during a session and provides a short background description of acupressure.

Books facilitate self-instruction

Massage therapists often will incorporate acupressure into their practice. To find a skilled practitioner, contact the American Oriental Body Work Therapy Association, advises Gach. **(See source box on p. 119 for contact information for the Association.)** However, a person does not need to go to an acupressurist for a diagnosis before using acupressure techniques for self-help, he states. There are many good books that provide instruction, and although it is helpful to be shown the technique, many people who find relief are self-taught.

Mary Hobbs, MPH, a project manager in Regional Health Education for Northern California Kaiser Permanente in Oakland, uses acupressure to relieve her own aches and pains. Hobbs' sister, who is a physical therapist, relieved a painful spasm in Hobbs' leg with acupressure, which made Hobbs an instant convert. She began reading about acupressure and eventually offered community outreach classes on the subject at Kaiser.

"I sat in on the class to make sure that the instructors were good, and I learned so much that I have been able to apply it whenever I have an ache, pain or spasm. I can usually figure out where the acupressure point is. I love the fact it is something I can do for myself," says Hobbs. ■

to these points for relief. "If you give a child a job or information that somehow makes him feel like he can make the situation better, that is very empowering," says La Rue. She also teaches the patient's family members how to use acupressure to help ease and prevent asthma attacks.

Acupressure benefits patients who take the time to practice it regularly. The benefits become very noticeable if the patient incorporates acupressure into his or her lifestyle, states La Rue. That is why it is important to give patients the skills to use it on a daily basis, she says.

Michael Reed Gach, PhD, director of the Acupressure Institute in Berkeley, CA, agrees that acupressure is best used as a holistic treatment rather than simply for symptomatic relief. For example, if a person has temporomandibular joint syndrome, acupressure will relieve their jaw clenching and pain but also can be used to prevent those episodes and retrain and rebalance the body. Once the muscle has been retrained, acupressure can be used for maintenance.

"It's important for practitioners interested in practicing holistic health to learn how to give their patients the tools to help themselves. Then the patient is a team member instead of just a passive recipient," says Gach. **(For information on how to teach health care workers to instruct their patients on acupressure, see editor's note at the end of this article.)**

An integral part of Chinese medicine, acupressure is related in principle to acupuncture, in which needles are applied along these same points (known as acupoints) instead of pressure. The Chinese believe that both these techniques establish a balance of energy they refer to as qi (pronounced "key"). Qi flows freely through the body along meridians. When qi is blocked, the energy is imbalanced and illness or an ailment of some sort occurs. Pressure applied to acupoints along the meridians restores the flow of energy so it is balanced and the body is then able to heal. **(For more information on acupuncture, see *Patient Education Management*, July 1999, pp. 79-81.)**

"You would use acupressure when the electromagnetic current is blocked due to accident, injury, stress, trauma, or anything unnatural that happens to the body," says **Shaun Brown**, LCMT, owner of Be Well, a Sacramento, CA-based private massage and acupressure practice.

Acupressure works for a variety of ailments, says La Rue. It can be used to ease anxiety problems such as panic attacks and pain such as low back pain or headaches. It also can be used to boost the immune system when a person is feeling tired.

Muscular tension often implicated

Putting pressure on acupoints relieves a multitude of common complaints, many of which are related to muscular tension in the body, says Gach. For example, a person with asthma who is wheezing and having trouble breathing often has certain muscles that tense and restrict the respiratory system. The same is true for other health problems such as menstrual cramps and carpal tunnel syndrome.

"With carpal tunnel syndrome, there are specific tendons and muscles in the wrist area that develop chronic, muscular tension and restriction, and the acupressure points can be used to retrain those muscles and relieve the pain and pressure," explains Gach. In addition to relief of muscular tension, acupressure can be used to relieve pain, increase circulation, and prevent common ailments, he says.

While acupressure works best if patients learn how to use it regularly, in order to become self-sufficient it is good to start with a person trained in acupressure and master the skills during therapy, says La Rue. For example, La Rue sees young asthma patients once a week for four to six weeks while having the family practice acupressure daily. After that time period, the situation is evaluated.

"I tell parents to have a routine and set aside 20 minutes to do acupressure daily and they will see a difference within two to four weeks," she says. **(For information on finding a good practitioner, see source contact information at end of article.)**

COMING IN FUTURE MONTHS

- What's the Joint Commission's view on education evaluation projects?
- Ideas for taking advantage of Health Care Education Week
- Outreach strategies to curb domestic violence
- Effectively addressing suffering for the dying patient
- The impact of nursing-sensitive indicators on outcome measures

SOURCES

For more information on learning the techniques of acupressure or teaching it to patients, contact:

- **Shaun Brown**, LCMT, Be Well, 8903 Genoa Ave., Orangevale, CA 95662. Telephone: (916) 966-4822.
- **Michael Reed Gach**, PhD, Director, Acupressure Institute, 1533 Shattack Ave., Berkeley, CA 94709. Telephone: (800) 442-2232. E-mail: info@acupressure.com or gach@acupressure.com. Web site: www.acupressure.com.
- **Jill La Rue**, RN, CMT, NB, Holistic Health Practitioner, Earth Touch, 13961 60th St., N., Stillwater, MN 55082. Telephone: 651) 439-6285. Fax: (651) 439-6290. E-mail: larue@spacestar.net.
- **American Oriental Body Work Therapy Association**, Glendale Executive Campus, Suite 510, 1000 Whitehorse Road, Voorhees, NJ 08043. Telephone: (609) 782-1616.
- ***Acupressure's Potent Points, A Guide to Self-Care for Common Ailments***, by Michael Reed Gach, PhD. This book is available from the Berkeley-based Acupressure Institute for $16.95 and can be ordered via the Internet. Telephone: (800) 442-2232. Web site: www.acupressure.com.

A catalogue with other health care products such as charts, books, and videos can also be obtained from the Acupressure Institute. Call the 800 number or send an e-mail message with your mailing address to: info@acupressure.com.

It's wise for people to learn self-acupressure from their practitioner or from a trained professional at a workshop so they can learn how to apply the pressure correctly, agrees Brown. She teaches clients during sessions and also regularly conducts classes. "It is the difference between taking a class on hair-cutting and having someone cut hair so you can watch. You need to learn how to breathe correctly if you are going to relieve tension on yourself," she explains.

(Editor's Note: Michael Reed Gach, PhD, Director of the Berkeley, CA-based Acupressure Institute, conducts training workshops for health care professionals on acupressure and how to teach patients self-acupressure skills. The course is $195 per person if fees are paid in advance and $225 if not. There must be 18 or more professionals enrolled in a workshop before Gach will travel to the institution to teach.

Courses on acupressure are available at the Institute as well. These include advanced acupressure training programs in pain management, women's health, and emotional balancing including dealing with trauma, abuse, and emotional imbalances.) ■

NEWS BRIEF

Music provides positive environmental impact

Anyone who has ever walked the halls of a health care facility knows that it is not a quiet place. However, patients can find respite with music. That's why Reno, NV-based Healing HealthCare Systems markets products and services that impact the environment. The company designs the auditory environment of the health care setting, explains **Susan Mazer**, MA, company

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Editorial Questions

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president. "Music therapists treat patients, and what we do is treat the space in which patients are placed," she says.

Three products create a relaxing environment for the patients. They include:

• The C.A.R.E. (Continuous Ambient Relaxation Environment) Channel.

This 24-hour channel available on the closed-circuit TV system at hospitals combines music with relaxing scenes. Both the videos and the music are original, produced specifically for very sick patients. "Commercial nature videos move too fast, which doesn't work well if patients are medicated and their eyesight is blurry. Our visual images move very slowly. We look at the television monitor as being a window outdoors to confined patients," says Mazer. The videos are also day- and night-sensitive, with a star field at night so the scenes aren't out of context.

The music is designed to be cross-cultural and cross-generational. Nature sounds, when included in the music to enhance a scene, are used very sparsely.

• C.A.R.E. with Music.

This custom-designed music can be distributed throughout the health care system, providing a veil of protection between the patient and the environmental noise to promote relaxation.

• The Sondrex System.

This is a portable personal music delivery system for patients undergoing clinical procedures. This compact disc-based system has a small computer that acts as an interface, allowing the physician or nurse to talk directly to the patient through headphones. When the health care worker communicates with the patient, the music recedes behind the voice. When the communication is complete, the microphone is deactivated and the music increases in volume.

"The patient is insulated in a very seamless environment," says Mazer.

For more information on the products produced by Healing HealthCare Systems, contact: Healing HealthCare Systems, 100 W. Grove St., Suite 175, Reno, NV 89509. Telephone: (800) 348-0799 or (775) 827-0300. Fax: (775) 827-0304. E-mail: healhealth@aol.com. World Wide Web: www.healinghealth.com.

The C.A.R.E. Channel costs $150 to $175 a month for hospitalwide broadcast; the cost is based on the size of the hospital. C.A.R.E. with Music runs between $75 and $90 a month. The Sondrex System is $1700 per unit. ■

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

Database identifies high-risk pregnancies

Interventions help improve outcomes

"Healthier Babies," the name of a collaborative Medicaid project in Philadelphia, says it all. That's the purpose and goal of this comprehensive clinical database system that helps identify and track the health behaviors of the pregnant Medicaid women in a five-county region of southeastern Pennsylvania.

The four managed care companies in the region that are participating in this project have access to the data for their members. This access means health plans can try to affect birth outcomes with educational interventions such as smoking cessation programs or nutritional counseling.

"We use the data from Healthier Babies to find out in real time what is going on with each of our pregnant members rather than finding out after the delivery," says **Deneen Vojta**, MD, chief medical officer for Health Partners, the Philadelphia-based not-for-profit HMO that developed Healthier Babies. A risk assessment tool created by Health Partners helps the company use the database daily to identify women in certain risk categories that the HMO wants to target with educational interventions.

The women who are identified as high-risk are referred to a lay home visitors program for education, which uses trained, culturally sensitive educators to teach women in their homes. For example, if a woman is identified as having a history of pre-term deliveries, she would fall into the high-risk category. She has double the chance of having a pre-term delivery.

The trained lay visitor visits the woman in her home and educates her about pre-term labor. The education includes the signs and symptoms of pre-term labor and what to do if signs should occur.

Other red flags for intervention might be drug and/or alcohol use, smoking, and medical conditions such as diabetes or HIV/AIDS.

When a Medicaid patient comes to a physician's office for prenatal care, the provider fills out an evaluation form and submits it to Healthier Babies so the information can be entered into the database. A follow-up form is filled out at each subsequent visit. Use of the forms was implemented in May 1998.

If the woman changes plans and goes to another provider, the process begins again because the collection system is confidential. Only insurance companies have access to the data, and they are only allowed to see information about their members.

Currently, the database allows HMOs to identify women at risk for low-birth-weight babies and then make sure they get the services they need. In the future, as more data are collected, the database should provide enough information to allow providers to determine which intervention programs make a difference.

"What this means for patient education is that we can be a little more sophisticated in the way we deliver educational interventions to patients who might need them," says **Richard J. Baron**, MD, president and CEO of Healthier Babies, Inc.

Putting the data to good use

Health Partners currently is in the middle of a project analyzing outcomes related to its use of Healthier Babies data. "I think what is most interesting about this analysis is that we are looking at why people have refused education," says Vojta. The analysis has so far identified the following four main reasons that patients refuse to allow a lay educator to come to the their home to teach:

- I have other children and I know this information.
- I don't want to let strangers into my house.
- I am afraid child protective services will take my other children.

SOURCE

For more information about Healthier Babies, contact:

- **Richard J. Baron**, MD, President and CEO, Healthier Babies Inc., c/o PHMC, 260 S. Broad St., 18th Floor, Philadelphia, PA 19102. Telephone: (215) 985-2517. Fax: (215) 242-5086. E-mail: rjbaron@ghouseint.com.

• I don't need education; what I need is a ride.

"Using this analysis, we are trying to come up with more culturally acceptable interventions," says Vojta. Some of the solutions being considered are using community centers for the lay educator's visits, trying to offer education in another way such as the physician's office, and providing transportation. ■

Techno touching breaks isolation restrictions

Interactive teaching enhances learning

When the Zoo Mobile visits Children's Hospital in New Orleans, the kids in isolation are no longer out of the loop. They get to see the animals and listen to the stories the zookeeper tells about each species. The connection is made with the aid of Starbright World, a private and secure interactive computer network designed for hospitalized children.

This videoconferencing capability not only makes it possible for children in isolation to participate in activities with kids on other units; kids at other hospitals across the nation can take part too, as long as they are connected to Starbright World. The computer network has a variety of communication choices in addition to videoconferencing. These include audio and text chat spaces, bulletin boards, and e-mail.

This means of communication makes it possible for children to learn from their peers. For example, children who have already gone through a particular procedure, such as a magnetic resonance imaging procedure, are able to ease the fears and anxiety of their peers by sharing what the experience was like for them.

"We are finding that it is really empowering for the kids. The children in the hospitals are sad, lonely, and withdrawn. They sometimes experience a lot of anxiety, so the program is really geared to addressing all of those different aspects and it allows them to connect with other kids who face similar challenges so they recognize they are not alone," says **Jordana Rene Huchital**, director of healthcare initiatives for the Starbright Foundation in Los Angeles.

Children's Hospital finds that the videoconferencing capabilities of Starbright World provide an easy way to include children in isolation, and the hospital uses it frequently. The system often allows these children to participate in activities held in the playroom.

"The videoconferencing helps out a lot, especially with the kids in isolation. They don't feel like they are out of touch," says **Kim Leaumont**, Starbright coordinator for Children's Hospital.

The child life specialist at Children's Hospital is frequently able to use Starbright for educational purposes because the system has a series of interactive programs that teach children and their families about medical procedures and conditions.

One morning, the Starbright program *Medical Imaging: Welcome to the Radiology Center* was used as part of a playroom activity called X-Ray Fun Day. The children looked at X-rays, discussed bones, and used the Starbright program to learn about having an X-ray. They finished the activity by making casts. The specialist also teaches children individually with the interactive programs.

The other interactive educational topics cover IVs, blood tests, bone marrow aspiration and biopsy, spinal taps, and cystic fibrosis. These programs will be available on CD-ROM in the fall of 1999.

Corporate sponsors who provided in-kind donations, such as Shawnee Mission, KS-based Sprint and Santa Clara, CA-based Intel Corporation, have helped Starbright keep down costs to health care organizations. The cost for Starbright World is $24,000 for the first year of use and $15,000 for subsequent years. The fee includes five high-end computers for the system, maintenance and support of the network, and staff training.

When hospitals don't have money in their budget for the Starbright system, its foundation works with the hospital to identify a local donor who might want to cover the cost. At Children's Hospital in New Orleans, for example, the system is funded by the local chapter of the National Council of Jewish Women. ■

SOURCE

For more information on Starbright World, contact:

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