Patient Education Management™

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

THOMSON™
AMERICAN HEALTH CONSULTANTS

IN THIS ISSUE

■ **Computer documentation:** Without a doubt, it is beneficial; but it's not the solution to every compliance problem . . . cover
— Include must-have features when designing on-line systems 136
■ **Patient and family councils:** Create opportunities for patient input; help health care professionals walk in patient's shoes 136
■ **Educator profile of Kerry Harwood, RN, MSN:** To keep on track, methodically work toward vision 138
■ **Battling the bulge:** To achieve weight loss, create individual plan 140
— Put focus on health rather than weight. 141
■ **News Briefs** 143
■ ***Focus on Pediatrics*** **insert:**
— To curb adolescent obesity, focus on health not diet 1
— Teach parents the dangers of secondhand smoke 2
■ 2003 Index of Stories . . insert

DECEMBER 2003
VOL. 10, NO. 12 • (pages 133-144)

Computer documentation big help, but no cure for all compliance problems

Make good use of the available technology and listen to staff

For years, patient education managers have been reworking documentation forms trying to streamline the process to make it fast and efficient to increase compliance. No one ever designed the perfect form.

Now that technology quickly is making pen-and-paper charting obsolete, will the conversion to on-line documentation be just as difficult to perfect? Although only a fraction of health care facilities currently document on-line, those that have installed computerized charting do find that they reap many benefits.

When **Jennifer Robinson**, RN, MHS, patient education coordinator at Roper St. Francis Healthcare in Charleston, SC, queried various disciplines for comments about on-line documentation, no one had anything bad to say about the health care facility's system, which was implemented in 2002.

EXECUTIVE SUMMARY

As health care facilities bring charting on-line, computerized documentation of patient education seems to naturally follow. When designed correctly, on-line documentation can be much more convenient — though many patient education managers say it does not necessarily take less time because some disciplines do better charting. However, there are many features on a computer that can boost compliance. In this issue of *Patient Education Management,* we discuss on-line documentation to see if it is the solution to many of the barriers to documentation of patient education that kept compliance in some institutions low.

The benefits mentioned:

• It helps staff focus on the important elements of teaching when they are busy so they don't leave anything out.

• Gaining access to the documentation form is quicker and much more timely on-line because there is no waiting for a chart. Several disciplines can chart on the same patient at the same time via a computer.

• You can document or review documentation from any location, including the office, so it is easier to review what has been taught by other disciplines.

• Documentation is more legible and communication is improved because there is one uniform place to see where everyone has documented.

• The progression of patient education from day to day is more easily visible because those reviewing it can scroll back to the day before.

• It is user-friendly because staff just point and click to document and then type a few words for further detail.

However, just because documentation is computerized doesn't mean that staff will embrace it. Computer technology must be used fully, and systems need to fit the user and their needs. **(To learn more about tailoring software to fit the needs of the users, see article on p. 136.)**

When the on-line documentation system for patient education was designed at New York-Presbyterian Hospital in New York City, the goal was to create the familiarity of the paper form that staff had become accustomed to while making full use of technology. It usually is not efficient to transfer the paper form to the electronic system, says **Virginia Forbes**, MSN, RN, program director of patient and family education.

"You can design it so you have some familiarity of look and the content that is required by regulatory agencies and your own needs, but still make it more efficient to use," she says. Efficiency comes with incorporating such computer technology as drop-down menus and links to protocols or resources.

To document, staff log onto the flow sheet section and bring up the patient education documentation on the screen. Much of the documentation can be completed from drop-down menus; however, the option of entering text also is available. drop-down menus are used to document the learner, the topic taught, the method of teaching, the evaluation of teaching, and barriers to learning. These sections are mandatory, and there is an automatic sign-off when they are completed.

For example, to document the method of teaching, the educator could select from a drop-down menu with several teaching methods such as a one-to-one session or using a video or CD. Once this is documented, the next mandatory screen is the evaluation of learning.

When converting a paper form to the screen format, it is important to be open minded and not force an exact duplicate, says **Karen Guthrie**, RN, MS, coordinator of patient education at Mount Carmel East in Columbus, OH.

The paper form at Mount Carmel East had a lot of sections for writing text, while the computerized documentation has a lot of point and click. For example, educational topics are listed

Patient Education Management™ (ISSN 1087-0296) is published monthly by Thomson American Health Consultants, 3525 Piedmont Road N.E., Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodicals postage paid at Atlanta, GA 30304. POSTMASTER: Send address changes to **Patient Education Management**™, P.O. Box 740059, Atlanta, GA 30374.

Subscriber Information

Customer Service: (800) 688-2421 or fax (800) 284-3291. Hours of operation: 8:30 a.m.-6:00 p.m. Monday-Thursday; 8:30 a.m.-4:30 p.m. Friday EST. E-mail: customerservice@ahcpub.com. World Wide Web: www.ahcpub.com.

Subscription rates: U.S.A., one year (12 issues), $449. Outside U.S., add $30 per year, total prepaid in U.S. funds. Two to nine additional copies, $359 per year; 10-20 additional copies, $269 per year; for more than 20, call (800) 688-2421. Missing issues will be fulfilled by customer service free of charge when contacted within one month of the missing issue date. **Back issues**, when available, are $75 each. (GST registration number R128870672.)

This continuing education offering is sponsored by Thomson American Health Consultants, which is accredited as a provider of continuing education in nursing by the American Nurses Credentialing Center's Commission on Accreditation. Provider approved by the California Board of Registered Nursing, provider number CEP 10864, for approximately 18 nursing contact hours.

Opinions expressed are not necessarily those of this publication. Mention of products or services does not constitute endorsement. Clinical, legal, tax, and other comments are offered for general guidance only; professional counsel should be sought for specific situations.

Editor: **Susan Cort Johnson**, (530) 256-2749.
Vice President/Group Publisher: **Brenda Mooney**, (404) 262-5403, (brenda.mooney@thomson.com).
Editorial Group Head: **Coles McKagen**, (404) 262-5420, (coles.mckagen@thomson.com).
Managing Editor: **Christopher Delporte**, (404) 262-5545, (christopher.delporte@thomson.com).
Production Editor: **Nancy McCreary**.

THOMSON
AMERICAN HEALTH CONSULTANTS™

Editorial Questions

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

in alphabetical categories, such as topic E-L and M-P. When a user clicks on the A-D section of topics, he or she would find topics such as angioplasty, blood transfusion, chemotherapy, and dressing change. There's also a screen for teaching methods — demonstration and outcomes, such as "performed independently" or "needs reinforcement."

While lists are convenient, it is important not to make them too complex or tedious, says Guthrie. "We learned this by experience," she says. In the past, designers went overboard on selections, providing way too many choices. She suggests including the most frequently selected categories and allowing space for text so that disciplines can provide written comment.

A close match of the paper form and computerized system can work if the form is designed with the conversion to on-line documentation in mind, says Robinson. The team designing the computerized documentation of patient education at Roper St. Francis Healthcare knew it would be well received by staff because a multidiscipline team had streamlined the paper form so that it easily could be converted to a paper version.

"The staff were very receptive to it because they were already familiar with it, and we had already had a lot of success with the paper version," reports Robinson.

Creating a good fit

However, the system does not always work perfectly from the start. Therefore, feedback from staff helps with improvements. The documentation of patient education was added to Mount Carmel East's computerized charting system two years ago upon staff request. Staff members said it would be easier to document patient education on-line because they already were on the computer for other charting.

Each discipline has screens for charting, and patient education documentation is included in these specific sections. However, the information entered is transferred to a common screen that all disciplines have access to so that they can review teaching in its entirety.

Another improvement to the system that was made after its implementation was the addition of separate documentation screens for diabetes and heart failure. The diabetes educators said they would like more detail for diabetes teaching documentation, as did disciplines that work with patients who have heart disease.

SOURCES

For more information about documenting patient education on-line, contact:

- **Virginia Forbes**, MSN, RN, Program Director of Patient and Family Education, New York-Presbyterian Hospital, 525 E. 68th St., New York, NY 10021. Telephone: (212) 746-4094. E-mail: vforbes@nyp.org.
- **Karen Guthrie**, RN, MS, Coordinator, Patient Education, Mount Carmel East, CHICSiegelCenter, 5975 E. Broad St., Columbus, OH 43213. Telephone: (614) 234-6062. E-mail: kguthrie@mchs.com.
- **Jennifer Robinson**, RN, MHS, Patient Education Coordinator, Roper St. Francis Healthcare, 316 Calhoun St. Charleston, SC 29401. Telephone: (843) 724-2130. E-mail: Jenny.Robinson@ropersaintfrancis.com.

At New York-Presbyterian Hospital, a link to teaching protocols was added when staff said that it would be easier if they could go to a source that provided information on what to teach for a particular health issue, such as managing acute pain. If a staff member is teaching on any one of 20 topics for which there are protocols, he or she can pull up that resource on the computer.

Determining if people actually are documenting patient education and where compliance is lax certainly is easier when the process is on-line, says Robinson. Instead of having to manually pull 10 charts to review documentation, those monitoring compliance can check charts from the computer moving from one patient to the next in a quick and efficient manner.

Currently, each interdisciplinary department monitors the documentation of patient education at Roper St. Francis Healthcare giving its information to Robinson, who converts it to graph form so it can review its compliance over the years. The latest results were 97% compliance on documentation, but Robinson attributes the high numbers to the fact that each department monitors its own compliance. Before on-line documentation was implemented, compliance was high because departments are consistently focused on documentation through the monitoring process, she says.

Yet other facilities have seen an improvement in documentation by moving the process from pen and paper to the computer. Compliance increased by 30% at the campuses within Forbes' health care system that have on-line documentation. While there are many reasons why compliance might improve, she says that the simplicity

of on-line documentation makes it much more likely that staff will comply.

However, on-line documentation has not improved physician compliance. "Although all clinical disciplines are expected to document, we have a low compliance with physician entries," says Forbes. In the upgrade of the system that currently is taking place a component on patient teaching is being added to the physician entry section. These entries automatically would crossover to a general patient education documentation section for the patient that all disciplines easily could access.

Although on-line documentation may not solve all problems associated with noncompliance most patient education managers agree that the conversion has been greatly beneficial.

"We always had a difficult time deciding where to keep our care plan and patient education record, whether at the bedside or in the chart. Now no matter what unit you are working on you can easily get to the patient education documentation screen," says Guthrie. ■

Must-have features for on-line systems

Teaching tools, records, and reminders

Although All Children's Hospital in St. Petersburg, FL, purchased a software package for its on-line charting system, it is not being implemented as is. Many aspects of the program have been customized to fit the unique requirements of the health care facility, says **Carole Holsonback**, MSN, ARNP, trauma program manager and chair of the patient education committee.

One addition is the discharge teaching tools. The nurses spent a lot of time developing the tools and testing them for accuracy and patient satisfaction. Their inclusion on the computer system will allow nurses to easily track the progress of discharge planning, she reports.

A historical education flow sheet also was designed for the system. Often educators start at ground zero when teaching patients because it is difficult for them to pull together what the patient has been taught and who did the teaching, says Holsonback. The flow sheet has all the topics from the education screen and tracks what education has been taught and which discipline did the teaching.

For example, if a patient were taught about a specific asthma medication, that information would appear on a historical flow sheet. The information is automatically pulled from the education documentation screen.

Another feature that was added to the software is the ability to automatically transfer information from the admission assessment screen to education and discharge planning sections when appropriate.

During the process of making the entire patient medical record electronic at All Children's Hospital, Holsonback worked with an interdisciplinary group to build the education and discharge planning piece. When documenting patient education on a paper form, every discipline had its own form and method for documentation. Now all will use the same format.

Also, reminders to document patient education will automatically pop up on the screen at appropriate times while during charting. These reminders will remain on the screen until the appropriate documentation has been completed, says Holsonback. ■

SOURCE

For more information about tailoring a computer system to meet the needs of your organization, contact:

- **Carole Holsonback**, MSN, ARNP, Trauma Program Manager, All Children's Hospital, 801 Sixth St. S., St. Petersburg, FL 33701. E-mail: holsonbc@allkids.org.

Councils are important outlets for patient input

Providing access to sensitive information helps

Input from patients and family members who have gone through the cancer treatment experience at Dana-Farber Cancer Institute in Boston is important to leadership at the health care institution. That is why an Adult Patient and Family Advisory Council was established in 1997, and a Pediatric Patient and Family Advisory Council was formed three years later.

Each has 14-16 members who commit to attending a monthly meeting that is 3½ hours long. Those interested in sitting on the councils fill out an application.

"We are looking for people that have the time to commit back to the institution and really be advisors to us on almost every aspect of our work," says **Karen A. Conley**, RN, MS, AOCN, a nurse program manager for pediatric oncology and the administrative liaison for both councils. Her role as liaison is to make sure that council members are on the right hospital committees to provide appropriate feedback.

The councils are called upon to address issues and concerns the institution has as well as the concerns of patients and family members. As a result, they frequently have access to sensitive data. For example, members sit on the joint quality improvement and risk management committee, where they hear about quality improvement activities and risk management opportunities.

Council members also are involved in the institution's care improvement teams, and they participate in any renovation or construction planning. Every major capital renovation project has to go through the patient and family advisory council for it to be approved.

Marketing campaigns frequently are run past the council members to get their impressions. The councils also review publications and letters for patients and families. Members sit on the patient education committee as well.

"We share our patient satisfaction data with them; and in our problem areas, they help us brainstorm ways to improve the scores," says Conley.

Members of the councils also produce a quarterly newsletter for patients and families called "Side by Side." Some are trained to do rounds in the waiting areas to elicit feedback from patients and family members.

Council members frequently bring up concerns they believe the institution needs to address. For example, they felt as if there was a lapse in the transition from the inpatient setting to the outpatient experience because a lot of home care agencies did not know how to take care of oncology patients. Therefore, the education department at Dana-Farber Cancer Institute partnered with the councils to sponsor a workshop for all home care providers on caring for the cancer patient at home.

The pediatric council members were concerned about bringing children with compromised immune systems from cancer treatments into the emergency department at Children's Hospital Boston where they would be exposed to other sick children. As a result, a program was developed where families with a child undergoing cancer treatment were given placards to show the security guard at the emergency department door. Families with a placard would be ushered to the triage nurse, who would take them to a private room.

"We have involved council members in so many things and have taken so many of their suggestions that they see they aren't just a token patient sitting on that committee but that we really listen to them and acknowledge them," says Conley.

At the last survey by the Oakbrook Terrace, IL-based Joint Commission on Accreditation of Healthcare Organizations, patient and family members sat at the table with the multidisciplinary teams so they were able to answer questions about the system. Also, they were present when the surveyors revealed the final score. "Never had a Joint Commission survey team had that experience before," says Conley.

Meetings run by members

To cover business in a timely manner, councils have subcommittees such as the arts and environment committee that looks at facility planning and art that goes into the institute. The council chair calls for reports from each subcommittee during monthly meetings. Council members not only run the meetings, they drive the agenda. Only groups who want feedback from the council are allowed to present. "The council decides what its priorities are going to be for the year," says Conley.

Each council has two co-chairs who work with Conley. She meets with them on a weekly basis to make sure things are moving along and plan for the next meeting.

Members of the adult council serve three-year terms, but they can remain on the committee as an emeritus member, which means they can attend meetings but they do not have a vote. The pediatric council has not evolved to this point yet but soon will implement this system to allow new council membership.

In addition to patients and families, several staff members are involved in the councils, including the chief medical officer and chief nurse.

The first council was organized at Dana-Farber Cancer Institute during a consolidation of adult cancer services between the institute and Brigham and Women's Hospital. At that time, all inpatient

SOURCE

For more information on creating patient and family member councils, contact:

- **Karen A. Conley**, RN, MS, AOCN, Nurse Program Manager, pediatric Oncology, Administrative Liaison, Patient and Family Advisory Councils, Dana-Farber Cancer Institute, 44 Binney St., Dana 352, Boston, MA 02115. Telephone: (671) 632-4685. E-mail: Karen_conley@dfci.harvard.edu.

beds were transferred to Brigham and Women's Hospital, which alarmed patients. "We started having town meetings and found that patient and families had a lot to say," says Conley.

To help form the councils, the institute worked with the Institute for Family-Centered Care in Bethesda, MD.

The process has worked quite well for Dana-Farber Cancer Institute. "We have made improvements we never would have thought of without having patients and families sitting at the table with us. They open our eyes to all new issues and possibilities just by sitting at the table and listening to all we have to deal with and bringing the patient perspective with them," says Conley. ■

To keep on track, work toward vision methodically

Use patient evaluation to assess effectiveness

As director of the cancer patient education program at Duke University Medical Center in Durham, NC, **Kerry Harwood**, RN, MSN, coordinates the overall direction, organization, and resources for the education of cancer patients and their families. This includes assessing patient education needs, selecting or developing materials, evaluating what has been put in place, and training staff. She also oversees the coordinator of the patient/family resource center.

While director of cancer patient education is Harwood's main job title, she also has the title of oncology clinical nurse specialist. In this capacity, she serves as an expert resource to the organization, staff, patients, families, and the community on cancer and education issues.

Harwood has a third role. She is one of six advanced practice nurse team leaders. In this capacity, she supervises 12 advance practice nurses. She reports to the director of the department of advanced practice nursing, who reports to the chief nursing executive.

A separate staff member, who reports to the director for hospital education, coordinates education for noncancer patients. The two areas of education are integrated through the hospital-wide patient and family education committee.

Cancer is one of the top two specialties at Duke University Medical Center. "I think my position is there because of patient need and the leadership in that area has a commitment to it," says Harwood. She has been in the position for nine years.

The requirements according to the job description include a master's of nursing degree and a minimum of five years of nursing experience with at least two of these in oncology. Harwood has been an oncology nurse for 25 years.

While Harwood's job focus is cancer patients and their families, there certainly is overlap with patient education in other areas of the medical center. For example, oncology patients were asking for more information about tests and procedures they were scheduled for, so Harwood coordinated the effort to create computer-generated handouts accessible throughout the health care system. Many of the procedures were not cancer-specific.

"I have responsibilities to cancer patients, but the information that they need is not exclusively used by cancer patients," says Harwood.

In a recent interview with *Patient Education Management,* Harwood discussed her job, her philosophy on patient education, challenges she struggles with, and the skills she has developed that help her to do her job well.

Question: What is your best success story?

Answer: "I have been working on disease-specific notebooks for all the standard oncology diseases. Some of the sections are generic to all cancer patients. For example, in the front section, is a patient's comprehensive guide to cancer care and the last section is a structured diary called 'Your Personal Health Log.' The middle two sections, 'Your Disease and Treatment' and 'Taking Care of Yourself,' are customized to the specific disease. I thought this would be a good approach but it really has exceeded my expectations in terms of how well that they work."

Patients get lots of different treatments over a long period of time, and although they come to

the medical center for treatment they return to their homes, which often are miles away. They need to be able to take care of themselves at home managing symptoms and side effects. In addition, a big part of the stress of cancer is feeling a loss of control and the notebooks give people back some of that control.

In an evaluation conducted with GYN-oncology patients, 77% had a clinical problem at home and were able to go to their notebooks and figure out what to do. For 65% of those patients, the notebook helped them determine that they needed to contact their health care provider.

The notebooks help to empower patients, and they reduce calls into the clinic without compromising safety because patients know when they need to call. Family members use the notebooks to help loved ones manage physical problems at home.

In spite of the fact that there is a lot of text, each section has a table of contents so patients don't have to read the entire section to find the information they want. Also, the text was written according to readability standards, so patients of all educational levels like it.

Building toward a vision

Question: What is your area of strength?

Answer: "What I think is most helpful is having a clear vision and in a very methodical way building the pieces of that vision. There is so much to do in hospitals and so many wonderful things that many people get pulled in a lot of different directions and don't end up with much to show for their effort because they are not working toward a vision. We have been working real hard to have a clear vision and build the blocks for it."

The vision for patient education at Duke University Medical Center is to have a comprehensive set of materials, prepared with interdisciplinary involvement that accurately reflect the medical center's practice available for all patients in a variety of ways that include electronically, verbally, and in writing.

Question: What is your weakest area?

Answer: "In the context of a very large complex organization with a lot of different reporting relationships, there are two things that are related. These are communication and computer technology."

For example, when technicians upgraded a program recently on the computers, they didn't upgrade the printers. The printers weren't connected to the computers and some educational handouts would not print.

A few years ago when putting together an education newsletter for staff, the biggest challenge was creating the mailing list, which consisted of clinicians directly involved in the treatment of cancer patients. It did not include researchers or those who sometimes work with cancer patients but mainly treat people with other diseases. The mailing list had more than 700 people.

Now she does more electronic education when working with staff although their comfort level with computers varies widely. Therefore, she tries to use other educational methods such as hanging posters where staff will see them.

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

Answer: "If we are going to take vision into the realm of fantasy, what I think would really make the difference would be very tailored patient education that looks at the needs at the time, the person's readiness to learn, and his or her preferred learning style. There are methods to quickly assess that and then tailor the education right to the patient. Some of this is being done in a research setting, but I haven't seen it translated into clinical practice yet."

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

Answer: "It wasn't related to the visit; it was related to the feedback I got in focus groups and in our patient satisfaction data about patients wanting more information about tests and procedures."

To meet this need, question-and-answer fact sheets all in the same format were created on all tests and procedures. They are on the intranet so they are available whenever the physician orders a test.

Harwood routinely conducts evaluations in a variety of ways. These include telephone interviews, surveys, and focus groups. They are particularly useful when introducing new materials or a new approach to something. Before creating the disease-specific notebooks for cancer patients, she did a number of focus groups with different types of patients and family members to determine what they thought about the approach, what ideas they had, what type of information they would want in the notebook and what level of information. Members of the focus groups were asked to review information on a certain type of cancer and its treatment written at three different levels of complexity and the group

SOURCE

For more information about the issues discussed in this article, contact:

- **Kerry Harwood**, RN, MSN, Director, Cancer Patient Education Program, Duke University Medical Center, DUMC Box 3677, Durham, NC 27710. Telephone: (919) 681-5288. Fax: (919) 681-7473. E-mail: kerry.harwood@duke.edu.

discussed the pros and cons of each one.

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

Answer: "The Internet is great. I do a Google search if I am going to create a new document to see what kind of content others have put into their material. Also, I rely on the cancer patient education network, which is a listserv for the educational representatives of all the National Cancer Institute-designated cancer centers. From there I would draft something up and then get feedback from our staff and some of our patients." ■

To achieve weight loss, create individual plan

Motivation must be personal to achieve change

Cookie-cutter approaches to weight loss don't work for everyone. While one person may find a written meal plan helpful, others may prefer to eat less by skipping the second helping or eating smaller portions.

Therefore, each person who wants to lose a few pounds should first conduct an assessment to determine what is right for him or her, says **Rita Jones**, RD, LD, CDE, MEd, a patient education specialist at the Mayo Clinic in Rochester, MN. This assessment begins with the question: "Am I ready to make a change?"

People need to be motivated to commit to a lifetime change in eating habits and exercise patterns. Health problems such as high blood pressure or diabetes often are not motivation enough. They need to lose weight because of something they value, such as obtaining good health so that they will live to see their grandchildren grow up, she explains.

When people are not sure if they are ready to commit to a lifestyle change, Jones has them list the pros, or the benefits of losing weight, and the cons, or reasons that they would not put the effort into it. "They must look at the list and decide for themselves that the benefits outweigh the barriers. They need to personally come to the decision to change," she says.

When people determine that they are ready to make changes in their lifestyle to obtain a more healthy weight, the next step is to determine a method. "I ask where they have been successful before and have them analyze why they were successful," Jones explains. They need to look at what they did and apply it to weight loss, building upon what they already know.

For most people to change behavior, they need to be successful up front. When they aren't they often become frustrated and quit. Jones helps people by having them focus on one change at a time. For example, they may determine that they are willing to add exercise to their daily routine such as walking three times a week for half an hour. Once they have reached success with their first goal, they can build on it or tackle another one.

"Many times, people establish these huge goals, and I try to get them to break it into smaller pieces," says Jones. When goals are grand, her question to the person making them is, "How realistic is that?"

Often, people who are considerably overweight look at behavioral changes as deprivation or punishment. Therefore, Jones suggests that they add something to their lifestyle rather than take something away. For example, instead of giving up sweets, they may decide to eat more fruits and vegetables. As a result, they may be too full to eat as many sweets as before. **(To learn how to take the focus off weight loss and put it on health, see article on p. 141.)**

Plan for success

Once an assessment of their readiness to change has been made, an action plan is put into place to help them achieve the goals that they have set. For example, if a person is willing to walk for exercise, he or she must determine the details such as how often, how long, and at what time of day.

It often helps to be accountable to someone, says Jones. When she determined to attend

SOURCE

For more information about creating a program to help people make lasting behavioral changes to achieve a more healthful weight, contact:

- **Rita Jones**, RD, LD, CDE, MEd, Patient Education Specialist, Section of Patient Education, Mayo Clinic, Siebens SL 200, First St. S.W., Rochester, MN 55905. E-mail: jones.rita@mayo.edu.

water aerobics classes at the YMCA during the winter months, Jones hooked up with a friend. On those evenings after work when it was cold and she did not want to leave the house, the fact that her friend would be at aerobics and she had promised to support her motivated Jones to stick with it.

If items such as cookies and potato chips in the pantry were determined to be too tempting during the assessment phase, then the plan should include a discussion with family members to ask them not to bring such snacks into the house.

Patient education managers might offer options for people trying to make lifestyle changes for a healthier weight that they may include in their action plan. Often a support system is helpful. This may be a support group for weight management or the opportunity to meet with a dietitian once a month or quarterly.

The next step after a plan of action is created is to implement it, however this is not the final step. People need to evaluate the action plan periodically to see what has worked and what hasn't, says Jones.

Frequently a reward system will keep people on track but it isn't always good to focus on loss of weight as the reason for receiving a reward. That's because people may start an exercise program and begin building muscle. Although they are becoming slimmer, muscle weighs more than fat and the scales may not reflect the change, says Jones. A more appropriate reward system may focus on commitment to certain exercise goals such as walking for 30 minutes, three times a week.

The issue of maintaining a healthy weight is complicated. Sometimes people select foods with concentrated calories; other times, they eat more because the food tastes good. Often people eat the right foods, but just too much of them. Currently, carbohydrates are getting blamed for weight gain in the press, but they are the body's primary body fuel. It isn't that they are bad for people; it's just that often too many of them are consumed in a day.

"On the flip side, it isn't that people eat too much but that they aren't burning it off because they don't get enough physical activity. Our society is very convenience-oriented," says Jones. ■

Put focus on health rather than weight

Increase physical activity and good nutrition

Dieting should never be a New Year's resolution, says **Frances M. Berg**, MS, LN, a licensed nutritionist and family wellness specialist in Hettinger, ND, and adjunct professor at the University of North Dakota School of Medicine.

Currently, there are no effective weight-loss programs, she says. Weight may come off initially but is not permanent. A better strategy is for people to learn to be healthy at the size they are, and this puts the focus on health rather than weight, explains Berg. **(To celebrate Healthy Weight Week in January, see editor's note at end of article.)**

The first step to a healthier lifestyle is to become more active. The focus with physical activity should be on fun, however, and not on how many calories are burned. Physical activity will make a big change in a person's health status and usually make some change in their weight too, says Berg.

There are health risks associated with obesity; this doesn't mean that obesity causes them, she says. However, if people are more active and get regular exercise, they can improve these health risks.

Nutrition plays a factor in good health too, but it isn't just what people eat; it is how they eat. If people would eat more balanced meals — from all five categories on the food guide pyramid — at regular mealtimes, they would be more satisfied.

"If you eat at mealtime, you tend to be hungry at mealtime and then eat until you are full and satisfied," says Berg.

People who diet to shed pounds usually lose 10 pounds and then gain back 15 pounds. Often there is a pattern of gaining and losing weight time and again. There is research that shows that this weight cycling is hazardous to a person's health, reports Berg.

The key is to maintain a healthy lifestyle with

SOURCE

For more information about behavioral changes through focusing on exercise and healthy eating, contact:

- **Frances M. Berg**, MS, LN, Family Wellness Specialist, 402 S. 14th St., Hettinger, ND 58639. Telephone: (701) 567-2646. E-mail: fmberg@healthyweight.net.

exercise a priority rather than dieting. Frequently, the New Year's resolution to diet is made because of extra pounds put on over the holiday season. Yet people will not gain weight if they eat normally and don't binge, says Berg. This means eating when hungry and stopping when full and continuing to exercise.

When people gain 10 pounds over the holidays, they should go back to their regular eating and exercise habits, and the extra weight will come off, Berg suggests.

There are several reasons diets don't work. When people restrict calories, their body uses fewer calories, she explains. Also, the body regulates itself becoming used to a certain weight so the metabolism may speed up or slow down to maintain that weight or get back to it if weight is lost or gained.

The body tends to want to be at its usual weight, which is called a set point, says Berg. No one is sure how to change the set point, but one way appears to be through physical activity. When people become more active, they seem to lower that set point.

"If people can lose weight gradually, they are more likely to keep it off," says Berg.

According to Berg, better New Year's resolutions might be to:

- Enjoy health at whatever size you are.
- Quit obsessing about food or weight and instead live actively in ways that you enjoy.
- Eat well.
- Eat balanced meals from all the food groups and eat normally.
- Relax and nourish health and well-being.

People should quit focusing on weight and food and concentrate on reducing stress in all areas of life, says Berg.

(Editor's note: Healthy Weight Week is scheduled for Jan. 18-24, 2004. It is a time to celebrate healthy lifestyles that last a lifetime and prevent eating and weight problems. This health observance is sponsored by the Healthy Weight Network created by Frances M. Berg, MS, LN, a family wellness specialist. For educational activities to celebrate Healthy Weight Week, visit www.healthyweight.net.) ■

Opportunities for Community outreach

In addition to Healthy Weight Week covered in this issue of *Patient Education Management*, there are several health observances in January that provide community outreach education opportunities.

They include:

- **National Volunteer Blood Donor Month.** American Association of Blood Banks, 8101 Glenbrook Road, Bethesda, MD 20814. Telephone: (301) 215-6526. E-mail: aabb@aabb.org. Web site: www.aabb.org. Materials available.
- **Cervical Health Awareness Month.** National Cervical Cancer Coalition, 16501 Sherman Way Ave., Suite 110, Van Nuys, CA 91406. Telephone: (818) 909-3849. Fax: (818) 780-8199. E-mail: ncccak@nccc-online.org. Web site: www.nccc-online.org. Materials available.
- **National Birth Defects Prevention Month.** March of Dimes Birth Defects Foundation, 1275 Mamaroneck Ave., White Plains, NY 10605. Telephone: (888) M-O-DIMES. E-mail: askus@marchofdimes.com. Web site: www.marchofdimes.com. Materials available, contact: Pregnancy and Newborn Health Education Center.
- **National Glaucoma Awareness Month.** Prevent Blindness America, 500 E. Remington Road, Schaumburg, IL 60173-5611. Telephone: (800) 331-2020. E-mail: info@preventblindness.org. Web site: www.preventblindness.org. Materials available.

To learn more about health observance months, visit www.healthfinder.gov/library/nho/nho.asp. Also see the January 2004 edition of *Patient Education Management* to learn how to use health observance months as a patient education tool. ■

NEWS BRIEFS

EMTALA sourcebook cuts through new regs

You and your facility waited more than a year for the final revisions to the Emergency Medical Treatment and Labor Act (EMTALA), but are they really good news? How do you provide proper staff education on the new, controversial regulations?

Emergency department (ED) managers and practitioners, hospital administrators, staff educators, and others must quickly digest this complex regulation and determine how the changes will affect patient care.

EMTALA: The Essential Guide to Compliance from Thomson American Health Consultants, explains how the changes to EMTALA will affect EDs and off-campus clinics. Key differences between the "old" EMTALA and the new changes are succinctly explained. Here are some of the vital questions you must be able to answer to avoid violations and hefty fines:

- Do the revisions mean hospitals are less likely to be sued under EMTALA?
- How does EMTALA apply during a disaster?
- What are the new requirements for maintaining on-call lists?
- How does EMTALA apply to inpatients admitted through the ED?
- What are the rules concerning off-campus clinics?

Edited by **James R. Hubler**, MD, JD, FACEP, FAAEM, FCLM, attending physician and clinical assistant professor of surgery, department of emergency Medicine, OSF Saint Francis Hospital and University of Illinois College of Medicine, Peoria, *EMTALA: The Essential Guide to Compliance* draws on the knowledge and experience of physicians, nurses, ED managers, medicolegal experts, and risk managers to cover the EMTALA topics and questions that are most important to you, your staff, and your facility.

EMTALA: The Essential Guide to Compliance provides 18 AMA Category I CME credits and 18 nursing contact hours. To order your copy today for the special price of $249, call (800) 688-2421 and receive this valuable guide to the new EMTALA. ■

COMING IN FUTURE MONTHS

- Using health observances for outreach education
- The changing role of patient education managers
- Jump-start discharge planning upon admission
- Collecting evidence for patient education positions
- Strategies for timely project completion

CE Questions

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

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

21. The benefits of on-line documentation include:
A. Quicker access to documentation form
B. Document from various locations
C. Improved efficiency with features such as drop-down menus
D. All of the above

22. Patient/family advisory councils help medical facilities improve their customer service in which of the following ways?
A. Providing advice on patient satisfaction problems
B. Providing design review on building projects
C. Evaluating employee performance
D. A and B

23. People who need to lose a few pounds first should conduct an assessment to determine if they are ready to make lifestyle changes and the best method for making lasting changes.
A. True
B. False

24. To protect children from secondhand smoke, parents need to be taught:
A. To create a smoking room in their home
B. To change clothes after smoking
C. To never smoke in the family car
D. To always turn on ceiling fans when smoking at home

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

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

To curb obesity, target child's health not diet

Develop good eating habits paired with exercise

Obesity is on the rise among children in America. However, dieting is not the answer, says **Frances M. Berg**, MS, LN, a family wellness specialist in Hettinger, ND, and an adjunct professor at the University of North Dakota School of Medicine.

The focus should be on healthy habits, such as exercise and eating good nutritious foods. Children tend to fill up on empty calories by eating foods from the tip of the food guide pyramid rather than eating food from all categories that include proteins, fruits and vegetables, and carbohydrates. When children are served foods from all five food groups, they tend to eat fewer empty calories, says Berg.

Yet, good nutrition is more than the selection of food. It also involves eating patterns. Many American families eat chaotically, skipping meals, eating much less than their bodies want, or binging and eating way more than their bodies want.

Families need to shift to normal eating, which usually is three meals a day with one or two snacks to satisfy hunger. It's also important for people to be attuned to their body's needs eating until they are full and satisfied.

Parents need to guide children in their food choices. "Children tend to eat what is there, so it is up to parents to put on the table what they believe are good foods for their kids," says Berg.

Make the food available, but let children decide which foods to eat and how much to eat, advises Berg. If a child refuses to eat a food such as cheese, don't assume that he or she doesn't like it. Keep offering the food, because often it takes up to 15 times of presenting the food to the child before he or she begins to eat and enjoy it.

"Parents should provide the different kinds of good food and provide a good example. If the parents are eating the foods, the children will eventually eat the food," says Berg. It's important that parents not make a fuss over the food, insist that children eat foods they don't want to eat, or talk about a dislike for a certain food in front of their children, she says.

In addition to providing nutritious food and regular mealtimes, parents need to provide ways for their children to get exercise. A sedentary lifestyle, probably more than any other factor, leads to obesity, says Berg.

When speaking before groups, Berg often asks adults how many rode their bikes or walked to school as a child, and almost every hand goes up. However, when asked if their children walk to school, few raise their hands. "This is the pattern of people's activity today," says Berg.

Experts recommend that parents allow their children no more than two hours of recreational screen time, says Berg. That includes watching television and playing computer games or surfing the Internet. Using the computer for homework purposes would allow for additional screen time.

Teaching parents to prevent or address obesity by helping children develop healthy habits is the best way to solve the spiraling weight problem. Research shows that diets and food restriction don't work, says Berg. In fact, in the long run, dieting can lead to increased weight gain, eating disorders, and malnutrition, she says.

[Editor's note: Francis Berg is the author of 11 books on healthy living. Her most recent book is Underage and Overweight: America's Childhood Obesity Crisis — What Every Family Needs to Know *printed by Hatherleigh Press. The cost of the publication is $24.95. The book brings together weight and eating research, making it easily accessible to those who work with children. It contains many charts, graphs, lists, short items, and an appendix providing resources for professionals.To order: Francis Berg, MS, Editor, Healthy Weight Network, 402 S. 14th St., Hettinger, ND 58639. Telephone: (701) 567-2646. Web site: www.healthyweight.net.]* ■

SOURCE

For more information about teaching parents how to help their children develop a healthful lifestyle, contact:

- **Frances M. Berg**, MS, LN, Family Wellness Specialist, 402 S. 14th St., Hettinger, ND 58639. Telephone: (701) 567-2646. E-mail: fmberg@healthyweight.net.

Teach parents dangers of secondhand smoke

By age 5, child could inhale 102 packs of cigarettes

There now is a lot of evidence that secondhand smoke puts children at risk for several health problems, says **Virginia Reichert**, NP, director of the Center For Tobacco Control for the North Shore-LIJ Health System in Great Neck, NY. Yet approximately 42% of all children in the United States are exposed to secondhand smoke on a regular basis. Most of the time, the exposure is in their home or in the family car.

Part of the reason for this exposure is that those addicted to nicotine are in denial about the hazards of secondhand smoke. Others simply do not know.

"As people are educated about secondhand smoke, the more willing they are to change their behavior," says Reichert.

Some of the information that smokers need in order to understand how their smoking might impact the health of their children is that the chemicals from the cigarettes permeate everything. Often, parents who smoke will say that they only light a cigarette in the kitchen with the exhaust fan turned on or they smoke with their head out the window.

Reichert's response is that these methods of smoking are similar to urinating in one part of the pool. The carcinogens and poisons in cigarettes enter the atmosphere in the smoke and land on the carpets, upholstery, and drapes. "You can scrape a pint of tar off the walls in the house of a smoker within one year of smoking," says Reichert.

There are more than 4,000 chemicals in secondhand smoke and 200 are poisonous, 43 are carcinogens, and nine are Class A carcinogens, which in large doses can cause cancer. Smoke from a lit cigarette left in an ashtray is especially harmful. When a smoker inhales on the cigarette the temperature is raised and as the tobacco mixes with oxygen, the hazardous particles are more completely combusted than when a cigarette is left smoldering in an ashtray, says Reichert.

Studies show that children who live with a smoker are much likely to get ear infections, and there is a fourfold increase in sudden infant death syndrome in children who are born into a family where someone in the house smokes. The chances of developing asthma increase as well. About 26,000 new cases of pediatric asthma are diagnosed every year because of exposure to secondhand smoke.

Neurological effects of smoking

There is a possibility that secondhand smoke may decrease a child's IQ. There is evidence that secondhand smoke is toxic to the brain. It could affect the area of the brain that causes a person to be satiated after a meal and therefore lead to a higher incidence of childhood obesity.

Reichert tells smokers that if they aren't ready to quit, they need to make sure that they never smoke around their children. That means smoking outside, no matter what the weather is like. Also, they must never smoke in their car whether the children are present or not. That's because the carcinogens and poisons permeate the upholstery and carpet. "A child living with a smoker inhales 102 packs of cigarettes by the age of 5," she reports.

Children are smaller, their respiratory rate is faster than adults, and their lungs are developing. Exposure to secondhand smoke in childhood affects a person's lung function as an adult. "From the age of 18 or 20, lungs start to get old. The rate of decline is much greater in smokers and it is greater in kids who are exposed to secondhand smoke on a regular basis," says Reichert.

Adults who live with smokers increase their risk for lung cancer by 30%. A recent study tracked couples in Japan where men frequently smoke but women do not. Researchers looked at the cause of death of women married to smokers to determine how many had died of lung cancer to calculate the risk. They found that the women who lived with a pack-a-day smoker had an 80% risk of developing lung cancer. If their husband smoked two packs of cigarettes a day, their risk of getting lung cancer jumped to 94%. ■

SOURCE

For more information about educating parents about the dangers of secondhand smoke, contact:

- **Virginia Reichert**, NP, Director, Center for Tobacco Control, North Shore-LIJ Health System, 225 Community Drive, South Entrance, Great Neck, NY 11021. Telephone: (516) 466-1980. E-mail: Reichert@nshs.edu.

Patient Education Management™

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

2003 Index

When looking for information on a specific topic, back issues of Patient Education Management *newsletter, published by Thomson American Health Consultants, may be useful. For additional information, contact our customer service department at P.O. Box 740060, Atlanta, GA 30374. Telephone: (800) 688-2421 or (404) 262-7436. Fax: (800) 284-3291 or (404) 262-7837. E-mail: customerservice@ahcpub.com.*

Assessment
- for proper teaching aids, MAR:31
- to individualize weight loss, DEC:140

Budgeting
- determining cost-effectiveness of translation, SEP:100
- following application rules for grant money, JUL:76
- funding programs with grant money, JUL:74
- managing funds through outreach partnerships, MAY:49
- searching for grants on-line, JUL:75
- staying on budget with community partnerships, MAY:52
- ways to avoid budget ax, JUN:61

Complementary therapy
- Bach flower essences, APR:44
- emotional states targeted by essences, APR:45
- reducing stress with feng shui, SEP:105
- resources for feng shui, SEP:105

Community outreach
- criteria for outreach partnerships, MAY:49
- during Health Care Education Week, AUG:89
- education for myasthenia gravis awareness month, APR:46
- education for National Kidney Month, JAN:10
- evaluating fit of community partnerships, MAY:53
- Great American Smokeout, OCT:115
- staying on budget with community partnerships, MAY:52
- with educational bits in catalogue, JUL:82

Cultural diversity
- determining cost-effectiveness of translation, SEP:100
- Hmong STD education videos, OCT:119
- language services tool, OCT:118
- meeting needs of patients, SEP:98
- overcoming cultural barriers to diabetes education, SEP:101
- questions for better dialogue, SEP:101

Disease management
- educational support system for kidney disease, JUN:69
- individualizing weight loss plan, DEC:140
- with healthy focus to reverse risks of obesity, DEC:141

Disease-specific programs
- biological therapy education for cancer, MAY:54
- binder on cancer for standardized teaching, MAR:insert
- education for mammography callbacks, NOV:126
- education for radiation therapy, JUN:66
- educational support system for kidney disease, JUN:69
- education techniques for chemotherapy, APR:43
- to increase awareness of ovarian cancer, AUG:94

Documentation
- creating on-line systems, DEC:133
- selecting best on-line features for, DEC:136

Educational materials
- best use of pamphlets, JAN:5
- buy-in from professionals while creating, JAN:8
- consumer review of, JAN:5
- determining cost-effectiveness of translation, SEP:100
- Hmong STD education videos, OCT:119
- writing in plain language, FEB:18

Evaluating effectiveness
- guidelines for consumer review, FEB:20
- of copy by consumer review, FEB:19
- of patient ed for Joint Commission, JAN:4
- with follow-up calls after therapy, JUN:71

Handouts, forms, protocols, checklists, surveys
- educational materials review form, JAN:insert
- notice of privacy practices (HIPAA), APR:insert
- patient education materials survey, MAR:insert
- patient safety tip sheet, AUG:insert
- tips to help children cope with disaster, FEB:insert

Health literacy
- writing in plain language, FEB:18

Improving programs
- using patient/family councils for, DEC:136

Joint Commission
- measuring patient education outcomes for, JAN:4
- preparing staff for with fun activities, JUL:77
- reorganization of standards for patient ed, OCT:110

Medication education
- teaching pediatric medication safety, SEP:insert

Management issues
accomplishing goals, DEC:138
creating time-efficient department, OCT:116
dealing with staff shortages, JUN:64
ensuring staff have tools/education processes, JUN:67
making education a priority, NOV:127
thinking outside the box to solve problems, JUL:80
using marketing approach to, SEP:102
using research skills and passion for learning, AUG:92
working with committee structure, MAY:57

Mental health
preventing depression in elderly, MAR:29
signs and symptoms of depression in elderly, MAR:28
tracing therapy success, JUN:71

Pain management
chiropractic care for pain prevention, JAN:9
nonpharmacological for children, APR:insert
nonpharm pain management tips for parents, APR:insert
pain, signal of poor posture, MAR:34

Patient empowerment
creating system of family-centered care, NOV:121
four principles of family-centered care, NOV:123
services for implementing family-centered care, NOV:125
teaching patients to be advocates for safety, AUG:85
using patient/family councils for, DEC:136

Patient safety
evaluating safety at rehab facility, NOV:130
on-line fact sheets for, AUG:88
pre-testing tools for, AUG:88
safety seat inspection clinics, NOV:insert
teaching patients to be advocates for, AUG:85
teaching pediatric medication safety, SEP:insert

Pediatrics
age-appropriate signs and symptoms of trauma, FEB:insert
binder on cancer for standardized teaching, MAR:insert
coping with disaster, FEB: insert
creating family friendly facilities, OCT:insert
creating good habits for healthy weight, DEC:insert
education on injury prevention, JAN:insert
education on trach care, MAY:insert
good dental hygiene, JAN:insert
information on breast-feeding for new moms, JUL:insert
medication safety, SEP:insert
NG tube insertion, NOV:insert
nonpharmacological pain management for children, APR:insert
nonpharm pain management tips for parents, APR:insert
preparing children for procedures, OCT:insert
preparing for ostomy surgery, AUG:insert
safety seat inspection clinics, NOV:insert
smoking cessation for pregnant women, JUN:insert
teaching central line care, JUL:insert
teaching CPR for safe discharge, JUN:insert
teaching dangers of secondhand smoke, DEC:insert
teaching with asthma pathway, MAR:insert
techniques for teaching school-age children, SEP:insert
techniques for teaching teens, AUG:insert
teen pregnancy prevention, MAY:insert

Population-specific
addressing changes in aging process, JUN:64
designing units for geriatric patients, MAY:55
follow-up calls to new moms after discharge, MAR:30
information on breast-feeding for new moms, JUL:insert
physical changes of aging, JUN:65
preventing depression in elderly, MAR:29
teaching good posture in developmental years, MAR:33
signs and symptoms of depression in elderly, MAR:28
smoking cessation for pregnant women, JUN:insert
teaching school-age children, SEP:insert
techniques for teaching teens, AUG:insert

Prevention
of kidney disease by lifestyle change, JAN:10
of musculoskeletal problems with good posture, MAR:32
of pain by chiropractic care, JAN:9
of pain with good workstation, MAR:34

Process improvement
follow-up calls to new moms after discharge, MAR:30

Professional growth
networking with colleagues, MAY:56

Regulatory compliance
practical HIPAA information for patients, APR:37

Staff education
case studies to teach problem solving, MAR:27
during Health Care Education Week, AUG:89
during new employee orientation, MAR:25
for Joint Commission survey, JUL:77
handouts on education tips, AUG:91
inservices to increase use of database, SEP:106
methods for educating staff on myths, JAN:3
on smallpox vaccine, FEB:17
portable posters for staff education, APR:41
to teach staff to teach, APR:40
use of bulletin boards for, APR:41

Standardization
binder on cancer for standardized teaching, MAR:insert

Surgery
informed decision for cancer surgery, JUL:78
preparing families for ostomy surgery, AUG:insert

Symptom control
Age-appropriate signs and symptoms of trauma, FEB:insert
signs and symptoms of depression in elderly, MAR:28

Teaching techniques
for correcting myths/inaccuracies, JAN:1
integrating teaching into care, FEB:13
methods for educating staff on myths, JAN:3
smoking cessation intervention on admission, OCT:113
to teach staff to teach, APR:40

Teaching tools
portable posters for staff education, APR:41
to streamline educational process, FEB:15
topic binders for duplication, FEB:16

Technology
computer-based inventory for brochures, FEB:21
creating on-line systems for documentation, DEC:133
Internet resources for medical information, OCT:111
on-line fact sheets for patient safety, AUG:88
searching for grants on-line, JUL:75
selecting best on-line features for documentation, DEC:136