AMERICAN HEALTH CONSULTANTS®

Patient Education Management™

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INSIDE

DECEMBER 1999

VOL. 6, NO. 12 (pages 133-144)

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Make sure the right patient education measures are in your electronic records

Patient educators need to be part of team that designs system

Most would agree that patient education jumped to the forefront in the 1990s, shortly after the Oakbrook Terrace, IL-based Joint Commission on Accreditation of Healthcare Organizations (JCAHO) included the topic in its standards. Although not all health care facilities hired patient education managers, they at least formed a committee to create policies and procedures and oversee the process.

Now, poised on the cusp of a new millennium, there are new challenges and opportunities that patient education managers must become aware of, says **Leah Kinnaird**, EdD, RN, a consultant for Creative Healthcare Management in Minneapolis.

One of the most pressing issues at the turn of the century is the implementation of computerized patient records. Because we are in the age of information, computerized records are destined to be a part of every health care institution in a few years. Patient education managers need to be at the table when these systems are being designed and implemented at their institutions so patient education won't be overlooked, says Kinnaird.

They also need to pay attention to what is happening nationally in this area so the language used to measure patient education in their computerized record system can be benchmarked against other settings. This will provide a better way to evaluate patient education and prove its worth. "Patient education managers will position themselves in a more powerful position within their organization if they know what is happening," explains Kinnaird.

Another important issue in the national forefront is a drive by several researchers, working in concert with the American Nurses Association (ANA) in Washington, DC, to develop vocabulary and classification

systems specific to the delivery of nursing services and its importance to quality patient care. These systems are being used to capture outcome data that validate the importance of nursing.

Why is this important to patient education managers? Patient education is included in many of these vocabulary and classification systems and can be used to validate patient education outcomes, as well.

"We are now able to collect much more information about the quality of care and relate it to the structure and processes that are being used to deliver care. Although this is still in its infancy, the hope is that as more data are collected, better decisions can be made about how care is delivered," says Kinnaird. Much of the language that is agreed upon will become part of the computerized patient record, she explains.

Several of these vocabulary or classification systems have been recognized by the ANA, including the Nursing Intervention Classification and Nursing Outcomes Classification. To help set national standards, this organization established a committee and invited all who had created such systems to submit their tools to be evaluated by the committee.

These tools focus on patient problems, the intervention used, and the outcome, although some have only one of these components, while others have two or three, explains **Connie Delaney**, PhD, RN, FAAN, associate professor and researcher at the University of Iowa in Iowa City. **(To learn more about how the classification systems relate to patient education management, see story, p. 135.)**

In addition, the ANA evaluates computerized patient records that have been placed on the market through its Nursing Information and Data Set Evaluation Center, which Delaney chairs. "We developed a set of criteria that are similar to JCAHO and evaluate data sets that vendors develop against those standards to see if they measure up," she says. If the data sets pass the criteria, they are recognized by the ANA with a stamp of approval which should help health care facilities evaluate the software before purchase, notes Delaney.

Examples of the criteria Delaney used are standards for nursing data sets that support nursing practice.

Included were the following:

1. Nomenclature.

N1 — Terminology in data dictionaries and tables as appropriate to the nursing domain.

N2 — Structured terminology in data dictionaries or tables is available to document all phases of the nursing process.

2. Clinical associations.

CCA2 — Choices displayed as a result of branching pathways among assessments, diagnoses, expected outcomes or goals, interventions, and actual outcomes reflect current knowledge, and are therefore complete, appropriate, and accurate.

3. Clinical data repository.

CDR1 — Patient-specific data are stored permanently in electronic form in an accepted standard database format (such as ANSI). If data are not stored in a standard database format, evidence is provided that data can be exported to standard databases.

Comparing apples to oranges

While all these tools to collect data were being set in place, it became apparent that even with these information systems, there could be a problem comparing outcomes from hospital to hospital or from unit to unit within the same organization. That's because there was no way to clearly describe the context in which care was delivered.

For example, turnover can affect the quality of care, yet there was no way to know if staff on a unit were regular staff or temporary workers just in for the day. "If staff are in and out for just a day or a shift, that affects the continuity of patient care," says Delaney.

Therefore, Delaney co-developed the Nursing Management Minimum Data Set, which has 17 variables describing the environment, the personnel, and the financial aspects of the setting. Now health care organizations can know if they are comparing similar situations when evaluating outcomes. For example, if staff are temporary workers, that can be noted.

The nursing vocabularies and classifications that have been created follow the Nursing Minimum Data Set template developed in the 1980s, which collects data on diagnosis, intervention, and outcome, says Delaney. Many of these new vocabularies and classifications are patterned after this data set because it is recognized by the ANA.

"Now we have a fuller picture. The Nursing Minimum Data Set advocates capturing the patient care process, and the Management Minimum Data Set is the context. When you marry both of those, you can finally do all these outcome

NOC: Most comprehensive outcomes measurements

System is versatile, easy to use

While there are many vocabulary and classification systems that measure patient care issues, interventions, and outcomes, there's not a more comprehensive outcome measurement tool than the Nursing Outcomes Classification (NOC) developed at the University of Iowa in Iowa City.

The tool has over 100 outcomes with indicators, elements a nurse would measure to determine whether that outcome was met, and the scales on which to base the measurement, explains **Connie Delaney**, PhD, RN, FAAN, associate professor at the University of Iowa. Many of these outcomes can be linked to patient education. For example, in the area of knowledge, the outcomes include:

- knowledge of treatment regimens;
- knowledge of prescribed activity;
- knowledge of health resources;
- knowledge related to the disease process.

Knowledge of the disease process would be measured by determining how familiar a patient is with the disease name, whether or not he or she is able to describe the disease process, the cause or contributing factors, risk factors, effects of the disease, signs and symptoms, usual disease course, measures to minimize the disease progression, complications, signs and symptoms of complications, and precautions to prevent further complications. Each indicator is measured on a scale of one to five, with one equaling "no knowledge" and five equaling "extensive knowledge."

NOC can be used to design educational programs as well as evaluate the quality and effectiveness of the education. Any facility can use this outcome measurement system. If they don't have a computer to analyze data, it can be done on paper, says Delaney.

"NOC gives sustenance, so to speak, to the actual teaching, not just saying the patient met the goal or they didn't or that they understood or didn't," says **Mary Clarke**, MA, RN, informatic nurse specialist at Genesis Medical Center in Davenport, IA. The results can show that the more teaching patients receive over time, the better their score, or that retention is low and the material needs to be reinforced in some way. It's a much better method than just documenting what was taught, she says.

For example, at Genesis Medical Center, NOC was used to measure knowledge in cardiac surgical patients in three phases: pre-op, a few days post-op, and during continuing rehabilitation sessions. It also was used to determine how nursing outcome scores were affected at each point of teaching, including the preadmission nurses, nurses on the unit, dietitians, and rehabilitation nurses. "We saw improvement over time. The more information they obtained, the better the scores were," says Clarke.

While NOC is the classification tool described in this article, the nursing vocabulary or classification method used by an institution should depend on its goal and setting. However, any tool selected should be recognized by the American Nurses Association in Washington, DC, advises Delaney. ■

studies beyond a single patient or a single unit," she explains.

Another aspect of evaluation that patient education managers should pay attention to in the new millennium is the surveys for quality that include patient education statements. While administrators usually select the surveys used at an institution, PEMs need to give input on how the questions should be asked so they don't conflict with policies and procedures on how patient education is delivered. "The patient education manager tailors the questions so they are appropriate for their specific institution without varying from benchmark standards," says Kinnaird. ■

SOURCES

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A phone call a week cut costs $800 per patient

CHF program tracks three indicators

The outcomes for the Heart Failure Program at University Health Systems of Eastern Carolina in Greenville, NC, are astounding. The cost to the health care facility for 12 patients tracked during the first six months dropped from $3,300 per patient to $2,500 post-program. The Heart Failure Program, launched in October 1998, currently has 75 enrollees. More data will become available each month as more and more patients are involved long enough to track.

To determine the effectiveness of the program, three outcomes are analyzed, according to **Susan Ingram**, BSN, program coordinator. These include the number of admissions pre- and post-program, the average length of stay (LOS), and cost per patient. The 12 patients tracked were admitted to the hospital a total of 19 times before they were enrolled, and only five times post-program. Their average LOS dropped as well, from 3.4 days to 2.6 days.

"The basis of this system is to provide patients with a program that is aimed at self-management. The cornerstones of the program are intensive patient education and continuous outpatient case management," says Ingram.

There are a number of inpatient and outpatient strategies that affect the outcomes, she explains. When patients are referred to the program, Ingram evaluates them to establish a baseline. She asks a series of lifestyle questions to determine some of the dynamics that will play a role in patients' ability to comply, such as whether they are living alone, are hard of hearing, or speak little English. About 85% of program enrollees are inpatient referrals.

The evaluation also helps her determine the extremity of the heart failure, such as whether patients must sleep with three pillows or if they are short of breath at rest or with minimal exercise. The information helps her to determine whom she needs to incorporate into the teaching. For example, if someone plans and prepares the patient's meals, that person will need to be included in the education so that he or she understands the patient's diet.

At the consultation, the initial teaching is provided, unless a caregiver needs to be included. In that case, the teaching is scheduled for a later date. During the session, patients learn how a normal heart functions and how differently an abnormal heart functions. They also learn about their medications, the importance of adhering to a low-sodium diet, exercise and weight management, and symptom management. Patients receive a booklet containing the information for future referral and a pocket diary that has the warning signs of heart failure, a calendar to track weight gain, and helpful compliance reminders.

While the initial teaching session introduces patients to the four areas they must concentrate on in order to control their heart failure symptoms, behavior change takes place over time as patients work with Ingram via the telephone. During the phone call, Ingram doesn't just go over the information; she works with patients until they understand how to apply the lessons. For example, she helped one patient create a low-sodium menu for one week. Patients are encouraged to call her as well — and they do. One patient called to ask for help in interpreting the label on a canned food product.

"The success of the program is after the patient has gone home. I am doing phone compliance and behavioral modification over the phone. I am going through a questionnaire that speaks specifically about weight monitoring and exercise, symptom management, low-sodium diet, and medication compliance. I talk to these patients weekly," says Ingram. **(For details on the telephone interview, see story, p. 137.)**

During the initial evaluation, patients are entered in either phase one or phase two of the program. Those who understand heart failure and what type of exercise and diet they need to adhere to and are doing a good job controlling symptoms are placed in phase one. These patients receive a phone call once a month. The phase two patients are called weekly. Patients who have had multiple hospital admissions are automatically enrolled in phase two. The initial telephone call usually takes place two to three days after discharge.

To keep track of calls, Ingram keeps a spreadsheet that helps her quickly identify who needs a phone call. About 99% of the referrals are initially enrolled into phase two of the program. After eight to 16 calls, most are moved into phase one and receive monthly follow-up calls. There is no time limit on the program.

In addition to the Heart Failure Program, University Health Systems of Eastern Carolina has

Script prompts the right questions

Conversation presents teaching opportunities

One of the main reasons the Heart Failure Program at the University Health Systems of Eastern Carolina in Greenville, NC, has been successful is that patients receive weekly telephone calls. During the conversation, **Susan Ingram**, BSN, program coordinator, not only reinforces education, but helps the patient learn how to take this newfound knowledge and apply it to his or her life. As a result, behavior is changed.

Following is a list of questions Ingram uses during phone follow-up and information on how she conducts the conversation. To help develop a relationship with the patients, Ingram doesn't always ask the questions as written:

1. Have you been taking your medications as the doctor ordered? If no, explain.

Often she asks if the patient has run out of medications or had any side effects.

2. Are you keeping a daily record of your weight? If no, why not? If yes, specify weight for the last two days.

Mostly, Ingram simply asks patients what their weight is for that day. If they didn't weigh, she uses the opportunity to reinforce education, explaining that they need to weigh daily at the same time every day and what that information reveals about their heart muscle. If they need scales, she provides them.

3. Do you know what to do with a three- to five-pound weight gain? Explain.

4. Do you understand your low-sodium diet? If no, tell me why. If yes, specify.

"Sometimes I just ask what patients had for breakfast," says Ingram. Patients usually don't have questions until they have been discharged from the hospital and start pulling food from the cupboard to cook a meal, she says.

5. Are you keeping a record of your sodium intake? If no, do you feel you could? If yes, specify.

6. Are you keeping a daily record of your fluid intake? If no, do you feel you could? Explain.

Ingram often asks if patients are watching their fluid intake and if they are aware of how much they are drinking each day.

7. Are you able to perform your daily routine activities without becoming weak, tired, or short of breath?

At times, Ingram asks if the patient is doing any regular exercise and if he or she has had any trouble with shortness of breath or dismount exertion.

8. Have you changed your activity since you were last seen/interviewed?

9. Have you had any trouble with the following since you were last seen/interviewed: shortness of breath; dyspnea on exertion; paroxysmal nocturnal dyspnea; orthopnea?

10. Have you noticed any swelling in your ankles or abdomen? If yes, explain.

11. Have you been to the emergency department or hospital since you were last seen/interviewed? If yes, why?

During the interview, Ingram reinforces education. "Patients have a hard time making the connection that shortness of breath has something to do with their heart," she says. Also, during the telephone conversation, Ingram tries to identify any special needs patients might have that would call for the services of a social worker.

For example, a patient might not have the socioeconomic support that would enable him or her to stick to a low-sodium diet. ■

implemented a care path for patients with heart failure that is followed when patients are admitted to the hospital. A complementary home health care path was created to proceed with the continuum of care.

The key to the program has been in helping patients find ways to comply so they can better manage their heart failure, says Ingram. "I think the follow-up phone calls are definitely the catalyst for changing their behaviors," she says. ■

SOURCES

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Mall location provides easy access to education

Get 'em while they shop

Looking for space for a health resource center? Perhaps you should look beyond the walls of your health care facility. When there is no room within a hospital or clinic, look out into your community to see what prime locations might be available. The University of Missouri Hospitals & Clinics in Columbia found a successful site — at the local mall.

In an unusual community outreach effort, the health care system opened the Health Information Center at the entrance to the Columbia Mall in 1988. It was a small 750-square-foot facility; however, in 1997 it was relocated to a 1,043-square-foot space. Located next to one of the major anchors at the mall, the health center is in a much more heavily trafficked area than the previous location.

The design of the center and the services offered take advantage of the opportunity to reach consumers on a daily basis. The Health Information Center offers a broad array of services to provide easy access to accurate health information and to encourage people to take an active role in maintaining their health, says **Ceresa Ward**, MS, RN, manager of Health Improvement Services.

The health center has the services consumers generally expect at such a facility. Free brochures on a variety of health topics are available, and there are two computer stations with Internet connections that visitors can use. Also, over 400 books and tapes are available and approximately 100 new titles are added each year. Currently, about 60 books are checked out each month. Consumers also can borrow videos that address such topics as stress and anxiety, insomnia, back pain, high blood pressure, anorexia, and bulimia.

Good method for reaching healthy people

In addition, there are many ongoing services offered that health care facilities usually can only provide on a limited basis at special events such as health fairs. For example, many screening tests are available. "People who come to shop see the facility and decide to have their blood pressure checked. This is an excellent way to screen healthy people who do not visit a health facility often," says Ward.

One nurse staffs the reception area for blood pressures on a daily basis. On the days other screenings are offered, an additional nurse is scheduled. Most screenings are by appointment and either held monthly or quarterly. Some screenings are implemented by hospital staff, such as pulmonary function tests and EKG cards.

Screenings include:

- **Glucose screenings.**

People ages 13 and over can have a glucose test on the third Tuesday of each month on a walk-in basis.

- **Hearing and vision testing.**

Nurses offer adult hearing and vision screenings by appointment on Tuesdays to determine if an individual needs further testing for hearing loss, glasses, or a modification of a current glasses prescription.

- **Cholesterol tests.**

On the first Tuesday of each month, three types of cholesterol testing are available to screen for risk of heart disease: total cholesterol, total cholesterol with HDL, and complete lipid profile.

- **Blood pressure screenings**.

Blood pressure checks are available to people of all ages on a walk-in basis. The readings, along

In response to strong 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, we wrap up our series with a profile on the Health Information Center at the University of Missouri Hospitals & Clinics in Columbia.

In a panel discussion on health resource centers conducted during the September 1999 conference *Managing the Millennium: Moving Organizations Through Education and Innovation*, sponsored by the Philadelphia-based Health Care Education Association and held in Las Vegas, **Ceresa Ward**, MS, RN, manager of Health Improvement Services at the health system, spoke about the unique location of the center. Having a center in a public mall provides opportunities for:

- Easy access to health screenings.
- Outreach programs such as mall walking.
- Reaching consumers who wouldn't seek you out. ■

with a pulse check, are recorded in a computer log that can be printed out and sent to the client's physician. The nurse can provide education on ways to lower blood pressure as well as instruction on home monitoring equipment and information on medications.

• **Fitness evaluation.**

The fitness evaluation includes testing for strength and flexibility as well as body fat testing. Clients receive written results and instructions for a workable exercise plan. The cost is $10.

Another service that is convenient for consumers and helps promote health is immunizations. Tetanus/diphtheria shots are available at the health center for $8, and hepatitis B vaccinations are available for $50. Both of these immunizations are available on a walk-in basis. Flu shots are usually scheduled two days a week during October and November for $10 and are free to people over age 65. Immunizations needed for travel outside the country are available by appointment. "Often seniors let their tetanus immunization lapse, so we stress getting a booster during the summer when people work outside," says Ward.

Because the mall setting is easily accessed and has convenient parking, the site is a good place to hold community outreach classes. Although class size is limited to about 15 people due to space restrictions, this has proven to be a good size for a health class.

Topics are frequently aimed at seniors, because they are the most receptive to health promotion strategies, says Ward. Pre-packaged classes that are easy to implement are often used, such as Memory Retention, produced by the Council on Aging, and Fibromyalgia classes from the Atlanta-based Arthritis Foundation.

A popular program that was implemented 10 years ago is Mall Walking. The Mallwalkers Club meets at the Health Information Center as early as 6:30 a.m. to walk the .75 mile course within the six wings of the mall. Regular hours for the center are 10 a.m. to 6 p.m. Monday through Saturday. The center provides juice each morning to walkers and has fitness software installed on the consumer computer terminals so participants can log their personal walking progress. Senior volunteers arrive at the center early to provide staffing for the mall walk.

"We can recommend mall walking to many people who are unable or unwilling to exercise in other settings such as health clubs, bad weather, or alone at home. It is an easy service to provide, promotes health, and sometimes brings referrals into our system," says Ward.

Although the Health Information Center is in the community, a connection is made with physicians in a clinic setting through the use of a health prescription. **(See example of health prescription, above.)** The prescription gives physicians a way to refer clients for health teaching in a community setting. "It seems there is little time to do in-depth teaching during clinic visits, even when a need is identified, such as smoking cessation or how to start an exercise routine," explains Ward. ■

℞ Health Prescription University of Missouri Health Sciences Center

for _____ (Name)

Health Information Center at Columbia Mall

Please call (573) 882-6565 for your appointment.

Date: _____ **Time:** _____

__ Monitor blood pressure
How often? _____

__ Smoking cessation counseling

__ **Start exercise**
❑ Mallwalking
❑ Other exercise options

__ **Education**
❑ High blood pressure
❑ Home blood pressure monitoring
❑ Cholesterol
❑ Breast self-exam

__ **Enroll in classes**
❑ Fibromyalgia
❑ Diabetes
❑ Asthma
❑ Arthritis

__ **Self-care skills**
❑ Menopause
❑ Headaches
❑ Fatigue
❑ Depression
❑ Low back pain
❑ Neck, shoulder and upper back pain
❑ Premenstrual syndrome (PMS)
❑ Coping with stress

Provider signature _____

The Health Information Center also can help you find **community resources** or **support groups**. Please call (573) 882-6565.

Health Information Center **hours:** 10 a.m.-6 p.m., Monday-Saturday
Located in the J.C. Penney wing of Columbia Mall
Phone: (573) 882-6565 **Fax:** (573) 884-4616
Web: www.muhealth.org/~information/

Source: University of Missouri Hospitals & Clinics, Columbia.

SOURCES

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Develop programs to meet 'alternative' demands

Public wants info on complementary medicine

A holistic approach to health is very popular right throughout the general population. Scan the covers of the magazines at your local newsstand and you will find many of the article topics focus on the mind, body, and spirit approach to healthy living. Market research shows that people are spending out-of-pocket money on all kinds of alternative therapies, says **Bruce Doolin**, LMT, CPFT, owner of Wellness Works Holistic Health Center in Columbus, OH. Yet, most community outreach classes focus on traditional medicine.

That's why Doolin and his business partner began creating classes that had a holistic health point of view to support the public's quest. Classes included massage therapy for couples, self-acupressure, meditation, stretching, and yoga. Currently, Doolin conducts workshops on alternative therapies for corporations and health care organizations that focus on maintenance and prevention.

Stress relief for the deskbound

For example, at corporations, instructors teach people how to use their bodies ergonomically, do stretches at their desk, breathe properly to relieve stress, and visualize the outcome they want for a particular job. Combining stretching, ergonomics, and self-acupressure can prevent carpal tunnel syndrome, says Doolin.

The need is there, agrees **Sonia Strevy**, BSN, MS, coordinator of the Optimal Health Center at Marion (IN) General Hospital. Education services staff at Marion were doing so much programming and research in alternative and complementary health areas for both community and staff education, they developed the center that opened in August 1999, she says. The classes at the center are based on whole-person approaches so they incorporate mind, body, and spirit.

However, Strevy has been interested in holistic health for years and developed community outreach classes. Of all the classes she has developed, the one that has gotten the most response is a five-part series called Mind-Body Techniques for

Instructors must practice what they preach

Instructors for community outreach classes in complementary therapies must have experience as well as knowledge, says **Bruce Doolin**, LMT, CPFT, owner of Wellness Works Holistic Health Center in Columbus, OH. To select instructors for his business, Doolin and his partner network with practitioners in the field. They sit in on practitioners' classes and interview them as well as their clients. Doolin and his partner also review practitioners' credentials.

Doolin advises patient education managers unfamiliar with complementary therapies to contact the appropriate association. Those practitioners who are legitimate will most likely be a member, he says. Reputable schools also are good sources for instructors.

When making a decision on whether or not to use a practitioner as an instructor, look at where the practitioner received his or her training and how many hours the practitioner has completed in the field as well as the number of years he or she has been practicing. Also, ask for references. "If you are going to have someone teach your group, you will want them to have done the work before so you can call their references," he explains.

While experience is important, hiring instructors who practice what they preach is equally important, says **Sonia Strevy**, BSN, MS, coordinator of the Optimal Health Center at Marion (IN) General Hospital. "You want someone who makes a good role model and uses a variety of techniques themselves — someone that eats healthy, has some sort of exercise and movement program, and practices some relaxation techniques — because if they can't talk the talk and walk the walk, they lose credibility," she says.

A combination of formal and informal training works well. A good instructor might be a nurse or other professional who is not only trained in holistic health but has an interest in the whole-person perspective as well, says Strevy. "Instructors not only need to know their topic, but practice their topic. For this kind of education, they really need to practice it," emphasizes Strevy. ■

Good self-practice complementary therapies

The following complementary therapies improve overall health and can be taught to the public in community outreach classes:

• **Acupressure.**

Using fingertips, pressure is applied to acupoints along meridians, which are invisible, interconnected internal channels located throughout the body. According to Chinese medicine, energy or "qi" flows along these meridians and causes health problems when blocked. Acupressure eliminates the blockage along these meridians and restores the flow of energy.

• **Breath work.**

Most people breathe shallowly from the chest rather than deeply from the abdomen, yet shallow breathing can contribute to stress-related disorders. People need to relearn how to breathe correctly. Certain breathing techniques can be used to relieve stress and pain as well.

• **Cognitive therapy (positive self-talk).**

This technique helps people get rid of negative thoughts and is a good treatment for depression, anxiety, and other emotional problems. Cognitive therapy helps people change their general outlook by changing distorted perceptions.

• **Imagery and visualization.**

The mind is a powerful tool, and thoughts can be used to control pain, promote healing, and reach goals. Using imagery and visualization to relax, a person might be taught to visualize a quiet place such as a meadow. Imagery comes into play as he or she begins to hear the bees buzzing around the flowers, feel the warmth of the sun, and smell the clover.

• **Meditation or mindfulness.**

Meditation is a form of contemplation. When people use mindful meditation, they focus on their breathing and dismiss distracting thoughts.

• **Shiatsu.**

A form of acupressure, shiatsu is the Japanese word for finger pressure. However, rather than applying pressure to a particular point along a meridian, movement along the whole meridian is important.

• **Yoga.**

Yoga started as a spiritual discipline thousands of years ago. Today, yoga is used to relax and create inner calm. This is accomplished through deep breathing, gentle stretches, and clearing the mind of distractions. ■

Healthful Living. The class includes information on responses to stress, relaxation techniques, exercise and movement, healthy nutrition, cognitive restructuring, and positive self-talk and affirmation. Single-topic classes that have been the most popular are relaxation techniques and the safe use of herbs, says Strevy.

There are several complementary therapies that can be taught in outreach classes. Yoga, Tai Chi, acupressure, meditation, creative visualization or mindfulness, self-hypnosis, and shiatsu work well, says Doolin. All these techniques reduce stress. Also, when people are taught about self-empowerment, self healing, and their ability to control their own lives, they are healthier, he says.

Other good topics for outreach classes include body scanning, where people are taught to look for areas of tension and pain, deep breathing, progressive muscle relaxation, and guided imagery, says Strevy. **(For more details on what these complementary therapies entail, see article above.)**

There are several factors that contribute to a successful class. Two of the most important ones are class length and interaction between instructor and participant.

People like interactive classes

Lecture and demonstration is not enough in a complementary therapy class; interaction is key, says Strevy. "People don't just want to hear about it, they want to experience it," she says. For example, if the class is on yoga, participants will do several exercises, or if it focuses on progressive muscle relaxation, the class will try the technique.

Time is another factor that should be considered when designing an outreach class on complementary therapies. Instructors not only need to have enough time to cover the information

SOURCES

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adequately; time must allow for interaction, as well.

Also, the amount of material must be considered. For a class on herbs, Strevy covers the top 10 herbs sold in the United States and their safe use and side effects. "The topic generates a lot of discussion, and it is difficult to cover the information in less than an hour and a half or two hours," she says. Single topics usually can be covered at one class meeting, but if several techniques are covered, the class should be divided into a series, she advises.

Ongoing classes boost compliance

The ideal is to provide ongoing classes in most cases so participants can learn properly and begin to see the benefits. With corporate accounts, Doolin encourages management to provide ongoing classes in complementary therapies. The next best option is to offer a topic as a series.

"Proper breathing, stress management work, and acupressure can be taught in a day, but if you do them on an ongoing basis you will have more compliance, and the benefits will be more long-term," explains Doolin. "Stretching, yoga, and meditation really need to be ongoing, because there is a certain amount of time it takes for people to get into the process where it becomes second nature for them." ■

'Buddy system' gets word out on breast examinations

Reminder system increases use of self-exams

It is difficult to reach women with the message about early detection of breast cancer. One reason is that women are so busy, they are too distracted by other issues to pay attention. A second reason is that many think if they don't have a history of breast cancer in their family, they are not at risk.

To grab women's attention and help dispel a lot of the misinformation, Univera Healthcare, an HMO in Buffalo, NY, paired with the local NBC television affiliate to create a buddy system of sorts among local women. The BuddyCheck 2 program asks women to select a friend to call once a month in order to remind her to do a regular breast self-exam and schedule a regular mammogram. The idea behind the program is that early detection will save lives.

Is the program working? Local statistics showed that mammograms were up 4% in July 1999. "What we are hoping to do over time is to create a better source of data here so we can determine some information about breast cancer staging and when people are being identified with the disease. We want to know if they are presenting with stage one breast cancer, or stage two, three, and four," says **Pamela Pawenski**, MBA, director of the Center for Better Health at Univera.

The message that is repeated again and again on the television station in news spots and on promotions is that all women are at risk for breast cancer and the best way to beat it is to detect it early. The programming is uplifting, with features on breast cancer survivor stories.

Viewers are reminded to call their buddy on the second Tuesday of each month. The program receives a lot of air time on BuddyCheck Tuesday,

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as well as the day before and the day after. Thirty-second promotional spots also are run throughout the month, encouraging viewers to call Univera for an information packet.

When women call the Center for Better Health, they receive a kit that includes educational materials, calendar stickers to remind them to call their buddies, a mammogram reminder sticker, and a shower card that teaches them how to do breast self-exams. To create the kits, Pawenski assembled a committee of local physicians with expertise in breast cancer.

Providing mammography guidelines was the most difficult part of the kit design process, because some physicians and the Atlanta-based American Cancer Society suggest that women start having regular mammograms at age 40, while others suggest age 50. Therefore, the information in the kit instructs women to consult with their physician, but points out that the entire medical community supports annual mammograms from age 50 to age 75.

Kits not handed out randomly

Since the program began in April 1998, over 40,000 women have received the kits. "We don't hand them out randomly or leave stacks all over the place, because we know that if someone is not really interested or committed, they will take this $3 worth of materials and throw it in the trash," says Pawenski.

In addition to distribution through the mail, the kits also are distributed at community outreach events. The HMO receives many calls from civic groups, women's groups, and employer groups that want educational programs. If the group is larger than 25, the female news anchor from the TV station speaks.

She explains to the group that she is at a higher risk for cancer because her sister was recently diagnosed. She also discusses the benefits of early detection. A clinician also speaks to the group, explaining the risks and what kinds of treatments are available when the cancer is detected early.

Univera Healthcare was approached by the television station and asked to help sponsor BuddyCheck 2. It is not an original program, but appears in various forms in about 60 different cities across the country, says Pawenski. It is typically run as a partnership between a TV station and a hospital. **(To find out more on this program, see editor's note at the end of this article.)**

SOURCES

For more information on the BuddyCheck program, contact:

- **Pamela Pawenski**, Director, Center for Better Health, Univera Healthcare, 28 Church St., Room 100, Buffalo, NY 14202. Telephone: (716) 857-6317. Fax: (716) 847-1257. E-mail: pawenski_p@univerahealthcare.org.

BuddyCheck grew from a news anchor's efforts to prompt friends and family members to have mammograms and do monthly breast self-exams following the death of a very close friend from breast cancer. Currently, Baptist/St. Vincent's Health System in Jacksonville, FL, holds the trademark to the name.

It is a program that gets a lot of support, says Pawenski. "We have brought on board a legion of dedicated breast cancer survivors who wanted

Patient Education Management™ (ISSN 216) is published monthly by American Health Consultants®, 3525 Piedmont Road, N.E., Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodical 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.

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This continuing education offering is sponsored by 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.

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to play a part in educating other women about the importance of early detection," she says.

[Editor's note: To implement a BuddyCheck program, a patient education manager must obtain permission to use the name. For information on the permission process, contact: Phyllis McInnes, Corporate Planning and Communications Department, Baptist/St.Vincent's Health System, 800 Prudential Drive, Jacksonville, FL 32207. Telephone: (904) 202-4923. Fax: (904) 202-4920. Each institution implementing the program must create its own patient education materials.] ■

NEWS BRIEF

Site makes publishing easier

Have you considered writing an article about a patient education program or tool your facility has implemented, but stopped short because you don't know where to publish such a piece? A Web site has solved your problem in an orderly fashion. "Instructions to Authors in the Health Sciences," a site sponsored by the Raymond H. Mulford Library / Medical College of Ohio in Toledo, provides information on hundreds of publications listed in alphabetical order.

The instructions to authors under each listing include guidelines for submission of manuscripts. For example, the preferred medium for one publication is a computer disk accompanied by three copies of the manuscript typed double-space. Instructions also include types of manuscripts accepted, article length, style guidelines, proofreading time lines, and the number of complimentary copies received by the author.

Information on the review process of manuscripts is also covered. For example, one publication measures manuscripts according to set criteria, such as soundness of methodology and organization and writing style. The Web site is located at www.mco.edu / lib / instr / libinsta.html.

(Editor's note: For more information on how to select article topics and write a polished manuscript, see Patient Education Management, *October 1999, pp. 111-114.)* ■

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

Benchmarked anti-smoking program targets youngest

Repetitive messages are based on best practices

When the Center for Better Health — part of Buffalo, NY-based HMO Univera Healthcare — decided to implement a smoking prevention program aimed at kids, staff didn't head to the drawing board to design a new plan. Instead, they did their research to find best practice.

"There are elements of the program, 2 Smart 2 Start, that are original, but overall it is bits and pieces from benchmarking we did around the country to find out what kinds of things were working," says **Pamela Pawenski**, MBA, director for the center.

The program design is based on advice from the experts. Therefore, its aim is to make it cool not to smoke and to deliver the non-smoking message on an ongoing basis rather than providing a one-time event. Also, the program focuses on third-, fourth-, and fifth-grade students because tobacco control experts told staff that by the time kids reach the sixth grade, the message falls on deaf ears.

To reach kids on a regular basis, students in grades 3 through 12 receive a rewards card if they sign a pledge promising not to smoke. The card provides discounts at shops, movie theaters, amusement centers, and theme parks kids like to frequent. They learn about the rewards card in a television ad produced to promote the program.

The captain of Buffalo's professional hockey team endorsed the program and often goes to schools during pledge sign-ups. The program receives a big boost from the endorsement of a celebrity that kids respect. He hands out hockey cards with his picture and a non-smoking message. To date, 20,000 kids have signed the pledge since March 1999 while school was in session.

Because the rewards card is popular, kids are constantly reminded of their promise. While 2 Smart 2 Start was being created, several focus groups were used to determine what would keep kids from starting to smoke. The focus groups determined that kids wanted rewards for good behavior. What they didn't want was a lecture. "For kids, the future is today after school or what will happen to them tomorrow afternoon. If you show them a black lung caused by smoking, they may remember it briefly, but it doesn't have staying power," says Pawenski.

The rewards card is the only part of the program that is the same for all ages. The educational interventions are designed for the three age groups targeted by the program. Pawenski hired a professional theater company to develop scripts and perform skits that focus on healthy choices and self-esteem. The theater group was given guidelines and asked to consult with third-grade teachers while creating the programming to ensure that it fit the curriculum.

A peer counseling program is used to educate fourth-grade students. Middle school children, selected as counselors, are given tobacco control information that they take into the fourth grade classroom to educate the younger students. There is no set curriculum, so counselors can be creative in their approach. One of the tools taught is how to analyze tobacco ads.

Tar Wars, a program designed and sponsored by the Kansas City, MO-based American Academy of Family Physicians, is used to educate fifth-graders on the dangers of smoking. Many of

SOURCES

For more information on the 2 Smart 2 Start program, contact:

- **Pamela Pawenski**, MBA, Director, Center for Better Health, Univera Healthcare, 28 Church St., Room 100, Buffalo, NY 14202. Telephone: (716) 857-6317. Fax: (716) 847-1257. E-mail: pawenski_p@univerahealthcare.org.
- **Tar Wars Curriculum.** To obtain the free curriculum from the the Kansas City, MO-based American Academy of Family Physicians as well as information on your state's Tar Wars program coordinator, call (800) TAR WARS. The coordinator will provide information on how to implement the program and access schools in your area.

the messages taught in this program are similar to those kids learned in third and fourth grade. Volunteers such as clinicians or pharmacists are used to teach this program.

Relying on a theater group, middle school students, and professionals to teach the curriculum is essential, because the Center for Better Health has a staff of three people. However, Center staff do contact all businesses for the rewards card. Kids often call and ask staff to recruit certain vendors for the card.

Staff also produce a quarterly newsletter that is mailed to card holders. This newsletter updates kids on participating vendors and what reward they offer. For example, vendors may offer $5 off the entrance fee to a theme park or free popcorn at the movies. The local stores for many national companies were unable to participate in the reward discounts due to restrictions from the corporate office. However, most do agree to give the kids discount coupons. "The newsletter is another way to be in the kid's face on a regular basis," says Pawenski. ■

Hospital creates replicable poison dangers program

Anyone can do program with kit

The demand for speakers on poison prevention was ever present, yet the Central Ohio Poison Center at Children's Hospital Columbus could not fill the requests. With a staff of one and a service area of 3.5 million people, it could not meet this community need.

Rather than create a list of volunteer speakers to solve the problem, the center made it possible for each group to make the presentation on poison prevention on their own. Anyone can conduct a Be Poison Smart Program with the aid of a program-to-go-tote.

The tote is designed to help speakers deliver two basic messages in a 15- to 30-minute presentation, says **Carol Fisher**, education outreach coordinator at the poison center. The first message is how to be poison smart, and the second is to call the poison center when someone is exposed to poison unless they are unconscious, in which case 911 would be called.

To help speakers convey these messages, the tote contains a manual that gives all the basic information, age-appropriate scripts, six sets of "pretty poisons" for props, a laminated photo of medicines and candy, a poster that can sit on the table, brochures that reinforce the message, and telephone stickers for the poison control center. Speakers distribute the stickers and brochures to the audience.

The presentation helps adults see their home through the eyes of a child and learn how to keep poisons away from children, because 58% of the poison exposure calls to the center pertain to children age 5 and under. Young children are taught that some of the things they see that look good to eat are actually pretty poisons.

Ten totes are kept in circulation. Organizations call the poison center or write to reserve a tote. Although they must let the center know how long they plan to keep the tote, there is no time limit. Some organizations may need the supplies for a single day, while others are conducting a month-long campaign. There is no charge for the materials, either, except the cost to ship the tote back to the center. Organizations can purchase a tote for $55 if they want to keep the material.

A second community resource offered by the Central Ohio Poison Center is a display packet for health fairs. The packet has an assortment of handouts and a few posters with easels.

To encourage health care professionals to educate patients about poison prevention, the center created a caregiver packet that contains a bottle of Ipecac, telephone stickers with the poison center's number, a checklist for poison-proofing a home, and information on lead poisoning. However, before ordering the packets (which cost 95 cents each), professionals must attend a training session that teaches them how to deliver the poison prevention message. A flip-page notebook is provided as a teaching aid.

"The health care professionals must commit not to just hand the caregiver packet out, but provide the five to ten minutes it takes to go through the basic message," says Fisher. ■

SOURCES

For more information on the Be Poison Smart program, contact:

- **Carol Fisher**, Education Outreach Coordinator, Central Ohio Poison Center, Children's Hospital Columbus, 700 Children's Drive, Columbus, OH 43205. Telephone: (614) 722-2643. Fax: (614) 221-2672. E-mail: fisherc@chi.osu.edu.

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