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Patient Education Management™

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

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Vested team members build interdisciplinary teaching through referrals, consults

JCAHO will expect proof of team approach

(Editor's note: This month, we continue our series on perplexing problems in patient education with an article on ways to ensure that teaching is interdisciplinary and documented. The Joint Commission looks for evidence of interdisciplinary teaching, and we show you how health care facilities are proving that their education process is a collaborative effort. In February, we tackled another difficult issue: physician involvement in patient education. We'll look at providing consistent education across the continuum of care.)

Short hospital stays can be good for patient education. How? They can make teaching more interdisciplinary because busy nurses are more likely to call in other disciplines when the teaching is outside their area of expertise, says **BJ Hansen**, BSN, patient education coordinator at Grant/Riverside Methodist Hospitals in Columbus, OH.

Also, departments and disciplines have come together out of necessity to develop more efficient patient teaching plans, observes **Virginia Forbes**, MSN, RNC, CNA, patient education coordinator at New York Presbyterian Hospital and New York Weill Cornell Center in New York City. These teaching plans specifically stress teaching "survival skills" in the inpatient setting and the use of referrals to outside sources for follow-up throughout the continuum of care.

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COMING IN FUTURE ISSUES

- Tailoring discharge instructions to patients' needs
- Providing patient education across the continuum of care
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Outside referrals are a good way to accomplish interdisciplinary teaching. The atmosphere is usually more conducive to learning, says **Joyce Dittmer**, RN, MSN, director of educational services at Saint Joseph's Hospital of Atlanta. It's often difficult for all the appropriate disciplines to schedule time with a patient due to shortened hospital stays.

In addition, patients are frequently too sick to learn while in the hospital. Community-based programs at Saint Joseph's now provide interdisciplinary teaching on an outpatient basis. What the physical therapist and dietitian used to try to teach at bedside as part of the cardiac rehab team, for example, is now taught at the heart school.

Much is being set in place to foster interdisciplinary teaching at Saint Joseph's. Employees understand that education is the responsibility of all disciplines; it's part of administrative policy, and it's included in their orientation and evaluation process. Charts are audited to ensure that interdisciplinary teaching is being done.

An interdisciplinary patient education committee guides all the patient teaching in the hospital. Teaching materials are reviewed by the committee and approved by physicians. Interdisciplinary teaching is part of all care pathways, and there is an interdisciplinary patient education record that all disciplines document on, explains Dittmer.

The model for developing teaching plans at the University of Washington Medical Center in Seattle is interdisciplinary. Whether developed by the hospitalwide patient education committee or a clinic, the team is to be mixed, says **Cezanne Garcia**, MPH, CHES, manager of patient education services. People support what they help to create, she explains. "Key clinicians that will be impacted by whatever practice expectations we're going to have really need to be part of the dialogue," says Garcia.

Interdisciplinary teaching can be triggered in many ways. At Grant/Riverside Methodist Hospitals, prompters on the patient health assessment completed during the admission process trigger a referral to the appropriate discipline. For example, if a diabetic is having trouble understanding the appropriate diet, a dietitian would be contacted.

The clerk on the unit enters the information into the computer, so the disciplines are automatically notified. Clinical pathways and preprinted physician orders automatically result in a consult with the indicated discipline as well, adds Hansen.

"Teaching has been a multidisciplinary effort for a long time, becoming more collaborative and

interdisciplinary in recent years. It often flows automatically as part of a plan of care," says Forbes. The plan of care usually is completed during patient care conferences and includes education issues.

Referrals also are prompted in other formal and informal ways. For example, if a nurse were to encounter a patient on several medications with potential interactions, the pharmacist can be called for assistance. However, teaching provided by physical therapy evolves from a formal consultation requested by the physician or nurse practitioner.

If a patient is put on a new diet, the dietitian is automatically notified via the computer system. However, regular, informal communication among health care providers is essential to ensure the development of an effective teaching plan, says Forbes.

No matter what system of interdisciplinary teaching is in place, there must be proof of it when the Joint Commission comes to survey, or you don't always get credit. There are several ways to provide the evidence. "The most prominent evidence is in the medical record on the interdisciplinary teaching record," says Forbes.

Other evidence of collaboration at her health care facility includes the work of the interdisciplinary patient and family education committee, a hospitalwide policy on the process of patient education, and an interdisciplinary mechanism for review and approval of resources. Interdisciplinary teams also develop and evaluate patient education programs.

Documentation shows that teaching took place and what the outcome of that teaching was, while the other evidence reveals the collaborative processes that are in the background, says Forbes.

During a recent Joint Commission survey, the collaborative process was important to the surveyors. "They were particularly interested in how resources were reviewed and approved and whether the process was interdisciplinary," she explains. **(For more information on documentation, see article, p. 28.)**

It's important to provide clear evidence that education is interdisciplinary, says Garcia. She creates a two-page document on all quality improvement initiatives pertaining to patient education. These written records describe which disciplines were actively involved in developing the process improvement. She also keeps records of all interdisciplinary documentation forms that have been customized by teams.

However, the best evidence of collaboration is found on the unit floor when surveyors interview staff, says Garcia. Examples include a nurse telling whom the contact person is at the pharmacy for food and drug interaction information or a care team member explaining how education fits into patient rounds. To help prepare staff for these interviews, Garcia has created work sheets on how to prepare for Joint Commission surveys as an individual clinician and as a clinical team.

To help prepare staff for these interviews, Garcia has created work sheets on how to prepare for the Joint Commission survey as an individual clinician and as a clinical team. The Joint Commission staff preparation checklist for individuals is a multiple-choice guide that is tailored to the University of Washington Medical center processes and procedures for patient teaching. Staff check off the examples that demonstrate how they apply each of the principles to their practice.

The department preparation checklist is a guide used by managers to prepare their clinical

service area for the site visit. The intent of the guide is to help management and staff by focusing their responses for the Joint Commission interview to reflect the medical center's patient education systems structure, tools, and policies. "It helps highlight what the specific clinical service area team does well and how and where they can improve their team's practice. The checklist also informs the team of some options and resources available to help their team with preparing for JCAHO," explains Garcia. ■

One is the number for documentation forms

Joint Commission wants to streamline process

Documentation is one of the first pieces of evidence surveyors from the Joint Commission look for to determine if patient education is not only taking place, but also is interdisciplinary. As a result, many health care facilities are implementing interdisciplinary patient education records.

"The one recommendation the Joint Commission made the last time they were here was that we needed one place for all disciplines to document, and we have taken that recommendation and developed an interdisciplinary form," says **Joyce Dittmer**, RN, MSN, director of education services at Saint Joseph's Hospital of Atlanta.

Nursing is very good at documenting on the form, but with a Joint Commission survey scheduled for April, other disciplines need to improve, says Dittmer. One problem is that they refuse to let go of the other places where they document teaching in the patient record. Therefore, they see the request as double documentation.

Dittmer is persistent in her pursuit of interdisciplinary documentation on one patient education form. She constantly tells all disciplines that the form is a communication tool and is best for the patient. Documenting on one form saves time in the long run because it helps disciplines avoid duplicating tasks.

Several months ago, a multidisciplinary committee at Grant/Riverside Methodist Hospitals in Columbus, OH, determined that patient education should be documented on an interdisciplinary form. It wasn't a new concept; several versions of these forms had been implemented in the past, and only certain disciplines used them. However, this time was different. "This time we had multidisciplinary input on the form up front," explains **BJ Hansen**, BSN, patient education coordinator at the hospital system. **(For information on creating an interdisciplinary documentation form, see this month's guest column, p. 32.)**

Seven basic areas of knowledge were incorporated into the form: diet, activity, medication, procedures and treatments, disease process, procedures and tests, and community resources. Disciplines with expertise in each of these areas were asked to choose three basic outcomes that would be preprinted on the form.

For example, in the diet category, dietitians chose such outcomes as "can describe foods to avoid." "I find the biggest barrier to documentation is time and ease," says Hansen. With the form just implemented in December 1999, she has yet to determine if the ease of documentation will improve performance.

While it's important to make sure documentation of patient education is easy, it also must be pertinent and thorough, says **Virginia Forbes**, MSN, RNC, CNA, patient education coordinator of New York Presbyterian Hospital, New York Weill Cornell Center in New York City.

Therefore, documentation of patient education is part of every employee orientation and is part of the annual mandatory review process in nursing and other disciplines. "Sharing the results of medical record reviews at departmental meetings

SOURCES

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also helps raise staff awareness about documentation," says Forbes.

To get disciplines to document on one patient education form, apply Prochaska's Stages of Change theory, advises **Cezanne Garcia**, MPH, CHES, manager of patient and family education services at the University of Washington Medical Center in Seattle. According to this theory, people may or may not be ready to change based on what stage of change they are in at the moment. The stages include pre-contemplation, contemplation, preparation, action, and maintenance. **(For more information on using this theory to create behavior change, see *Patient Education Management*, February 2000, p. 22.)**

Applying the theory, Garcia partners with the clinics and units ready to use the form and on-line system that are in the action stage. Because they do a good job, she is able to use them as an example for others in order to improve documentation throughout the medical center. With these examples, she tries to move disciplines that are in the pre-contemplation or contemplation stage into the action stage. Garcia is able to determine which stage disciplines are in as she works with them.

This works because she is able to show these noncompliant units that by documenting outcomes, they can monitor whether their education is having the intended effect for which it was implemented. For example, fewer patients call back with questions or patients aren't readmitted. Health care outcomes are becoming very important and are beginning to equal liability and communication as incentives to document education, says Garcia.

"I get a lead person from the clinician team that is successfully using documentation as a way to look at outcomes or achieve successes with their patient care to talk to the other teams. The greatest power is to use clinicians who have had success," says Garcia. ■

Skills Training Program

Education techniques for behavior change

Program teaches how to tailor lessons to students

Behavior change is the goal of an educational technique called Brief Negotiation taught to staff at Kaiser Permanente medical facilities throughout Northern California. It is a way of educating patients that takes into account whether the patient is able or willing to comply with a treatment regimen. Rather than simply giving patients knowledge, staff make sure patients are willing to put the information into action.

Most patient education managers agree that it is not enough to provide health care professionals with resources to teach. Staff must be taught teaching skills in order to use the resources effectively. In the third piece in our series on preparing staff to teach, we look at Kaiser Permanente Northern California in Oakland, which has a training program that focuses on behavior change called Brief Negotiation. We discuss this technique in this article and other training sessions the HMO has on teaching, including a few tailored for physicians, in additional pieces on pp. 30 and 31.

"We try to include the patient in the decision-making process in terms of whatever lifestyle changes they are willing to work on. Instead of lecturing them on how things should go, teaching sessions are really focused on creating an environment of rapport and support," says **Robyn Hoban**, MA, adult primary care training project manager for Regional Health Education at Kaiser Permanente Northern California in Oakland.

A health care worker doesn't approach a patient with a set educational agenda, but negotiates with the patient on the information to be discussed. A provider's interaction with a patient would match the patient's readiness to learn.

Educators who learn the Brief Negotiation technique begin a teaching session by introducing themselves. Also, they let the patient know how much time they have available to teach and ask permission to talk about a topic, such as the patient's smoking habit. The patient's response shapes how the education session continues. The educator assesses where the patient is in terms of changing that particular health behavior before proceeding with the discussion.

"The technique is really using strategic open-ended questions where you get the patient to tell you information as opposed to just answering yes and no questions," explains Hoban. The educator uses an empathetic, nonjudgmental style of interviewing so the patient doesn't put up walls of resistance. During the discussion, the educator also summarizes what the patient said so the patient knows he or she is being heard correctly.

Learning skills for group education

Strategies include honing listening skills

All teaching does not take place one on one. Therefore, Kaiser Permanente Northern California in Oakland has created classes that provide education skills for teaching groups of people. Staff who educate in a group setting are taught basic facilitation skills, such as how to listen to the audience. They also learn the key components of an effective presentation, which includes having an opening, middle, and closing so the audience can easily follow.

"We want group teaching to be interactive, so we give some techniques and strategies to capture the audience's attention and involve them," says **Robyn Hoban**, MA, adult primary care training project manager for Regional Health Education at Kaiser Permanente.

During the training, participants can have their classroom presentation videotaped so they can see where they might improve. They also receive one-on-one coaching on their style and presentation.

The workshop lasts two days. On the first day, participants are taught facilitation skills; on the second day, they do a presentation where they are videotaped and coached.

A second workshop is designed to help participants learn how to provide education during a group appointment. The group appointment is new at Kaiser, and is basically an education class type structure with a clinical intervention. For example, several diabetes patients would be given a group appointment and meet with a team of health care providers who present to the group, including a physician, clinical health educator, and pharmacist.

During these sessions, patients could have their medicine adjusted or learn how to manage their diet better. The medical professionals can use the patients as a group to solve problems. For example, if one patient is having difficulty exercising, the other members could explain what they do. "Group appointment training teaches professionals how to work as a team and also teaches them facilitation skills," says Hoban. ■

A scale is used to determine a patient's readiness to change a behavior. For example, in the case of a smoker, the educator might ask the patient to choose a number between 0 and 10, with 0 being not ready to quit and 10 being ready to throw the pack of cigarettes in the garbage immediately. If the patient is somewhere in the middle of the scale, the health care professional might help the patient explore reasons why he or she doesn't want to quit smoking yet.

The health care professional needs to be ready to give an advice statement at the end of the conversation. For example, if the patient doesn't want to quit smoking, the professional would explain briefly that it is bad for the patient's health and make sure the patient has resources to turn to when he or she is ready to quit.

Because there are things the patient needs to know, the nurse or whoever is teaching makes the pertinent information part of the dialogue, whether in the advice statement or conversation. The goal is to tailor the conversation so the patient is receptive to the information, explains Hoban.

The Regional Health Education department at Kaiser provides two-day workshops on the Brief Negotiation technique. The training is open to all members of Kaiser's adult primary care teams, which include clinical health educators, nurse case managers, physical therapists, pharmacists, and physicians. **(For more information on training tailored for physicians, see article on p. 31.)**

The first training session is eight hours long and is very interactive. Workshop attendees learn the technique by lecture, discussion, and practice. They are taught how to present information to the patient based on the patient's readiness to change. For example, staff learn what kinds of questions to ask if the patient is not ready to make any behavior changes.

The two trainers bring scenarios for practice sessions, but they also spend time practicing and troubleshooting real case scenarios brought by participants. The second part of the workshop is scheduled for the following week so participants can practice in real-life situations during their work and bring any problems they had back for discussion.

While the workshop is not mandatory, all care team members are encouraged to go. They are notified of the course offering by e-mail and employee newsletters. **(To learn about other programs that teach staff how to teach, see article above.)**

SOURCES

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Workshop participants receive a packet of information to reinforce the teaching, which includes a Brief Negotiation road map that walks the health care professional through a teaching session. "The tricky part about the model is that there is really no one way to do it. It is really using the skills the best you can in the environment you are in," says Hoban. ■

Skills Training Program

Communication skills boost educational outcomes

Physicians get primer on teaching patients

Several workshops offered to physicians at Kaiser Permanente Northern California are designed to improve educational opportunities at health care facilities. This is accomplished by equipping physicians with the skills they need to be effective teachers. Physicians are taught the following techniques:

- communication skills;
- establishing rapport and soliciting the patient's point of view;
- solving problems;
- skills for working with difficult patients or challenging situations;
- behavior change counseling.

"Much of teaching is based upon a foundation of an ability to communicate effectively with the patient," explains **Cecilia Runkle**, PhD, MPH, training and development consultant in Physician Education and Development at Kaiser Permanente Northern California in Oakland. These workshops are provided so the time physicians spend educating patients about their condition is fruitful.

There are three basic programs offered by the communication skills division of the physician education and development department. They include:

- **Five-Day Residential Program.**

This program is for clinicians who desire to improve their communication skills with patients. During the teaching sessions, physicians work in small groups with a trained communication specialist who is either a physician or a psychologist. The communication specialists critique audiotapes of patient encounters that the physicians bring with them to the sessions. They also coach physicians during scenarios in which professional actors play the role of a difficult patient in several problematic situations, such as a patient who is noncompliant with his or her recommended diet, angry, or emotionally distant.

- **Patient-Provider Interaction.**

This four session, facility-based program teaches basic communication skills. During the sessions, which are each two hours long, physicians learn how to establish rapport with patients by soliciting their point of view; how to solve problems; how to work through challenging situations; and how to effectively close a visit. "At the close of the visit, the physician would summarize the action steps that have been agreed upon during the appointment by the physician and patient," explains Runkle.

- **Thriving in a Busy Practice, Thriving Two, and Thriving Three.**

These three one-day programs focus on skills to foster improved communication and health behavior change in patients. Thriving in a Busy Practice and Thriving Two teach communication skills, but the second program also offers an opportunity for physicians to practice with a trained actor. For example, they may work on a situation where the patient is angry or is not following his or her medication regimen. "It's small-group work with about six to eight clinicians and a trained facilitator. In the group, we coach using scenarios that are particularly challenging to the clinician," says Runkle.

Thriving Three teaches counseling for health behavior change. This program is called Brief Negotiation and is based upon principles of motivational interviewing. The teaching is a combination of brief presentations about the theory of behavior change and the model they are using, along with small group work. Hour-long coaching sessions are conducted twice during the day-long seminar. Each group has a facilitator and professional actor who portrays the patient. Using common clinical scenarios, each group of physicians is coached on the application of the Brief Negotiation model. The scenarios include the following:

• a diabetic patient who is not checking his or her sugar levels;

• a patient who experiences chronic pain and wants more medication but is unwilling to go to a pain management course;

• a patient who is experiencing a lot of stress at work and wants the physician to provide medication (the physician wants to work on other options for helping the patient manage stress);

• a patient with chronic back pain who wants a note from the physician so he or she doesn't have to go back to work. In the physician's professional judgment, the patient needs to go back to work and learn to manage pain more effectively.

"The Brief Negotiation model is effective because it allows our clinicians to establish a partnership with the patient. Clinicians assess the patient's readiness and competence in being able to change and adapt the intervention to the patient's stage of readiness," says Runkle. ■

SOURCES

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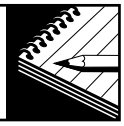

Review of old process uncovers better methods

Improving documentation step by step

By **Stephanie Minix**, RN
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The Patient and Family Education department at the Medical Center of Central Georgia in Macon has been involved in a process improvement project using an internal process called the 7-Step Operation Improvement Model. The purpose of this project is to improve interdisciplinary documentation of patient and family education in the medical record. The steps of this Operation Improvement project include:

1. Identify the problem.

Closed medical record data from November 1997 to August 1998 were used to evaluate continuumwide compliance with documentation of activities that meet Joint Commission standards for Patient and Family Education. The findings revealed there was inadequate evidence in the patient record of the educational process being collaborative and interdisciplinary as appropriate to the plan of care. The threshold of compliance for this Joint Commission standard (PF.4.2) is 100%, and compliance at The Medical Center was in the 80th percentile.

Prior to our Joint Commission survey in 1996, a documentation process and tool were being used for patient education. The tool was kept in a standardized location in the medical record so all disciplines could clearly identify and access it. Based on data collected, this had ceased to be effective.

An interdisciplinary Operation Improvement (OI) team was formed with representatives from inpatient, outpatient, and ambulatory areas. Several of the OI members are also members of the organization's Patient Education Advisory Committee. The advisory committee is involved in addressing patient and family education issues and needs throughout the organization. The committees' functions include:

• development of policies, procedures, and guidelines related to patient education;

• standardization of patient education materials;

• monitoring Joint Commission standards and compliance;

Do you have any insights into persisting problems in patient education or new ideas that have improved patient education? If so, we invite you to share them with readers of *Patient Education Management* as a guest columnist. This month, patient education coordinators at The Medical Center of Central Georgia in Macon explain how they created a better form for patient education. If you would like to be a guest columnist, please contact Susan Cort Johnson, Editor, at (916) 362-0133, or via e-mail at suscortjohn@ earthlink.net.

• dissemination of patient education information to clinical areas;

• identification of training needs for staff related to patient education;

• identification of continuumwide patient education needs.

Disciplines represented on the OI team included pharmacy, nursing, case management, outcomes management, respiratory therapy, health educators, medicine, information systems, and dietary.

2. Describe current process.

The current process for documentation of patient education was identified through flowcharts describing this process for the following clinical areas: Schoolhouse Health, Radiology, Just For Today, Respiratory, Case Management, Nursing, Nutrition, Pharmacy, Med Centers, Children's Health Center, Physicians, Family Health Center, Rehabilitation Services, Financial Services, Surgical Associates, Emergency Center, and Diabetes Treatment Center. The flowcharts revealed that each of the clinical areas mentioned had a different process for documentation of patient education.

3. Identify root causes.

Reasons identified for lack of interdisciplinary documentation included: time constraints, chart and teaching form unavailable, lack of leadership commitment and follow-through, employee apathy, inadequate education and training, and multiple documentation requirements. Root causes were identified through team participation in an affinity exercise diagram, where a large number of ideas and issues were grouped into major cause categories. Then a fishbone diagram was developed to show relational causes to a lack of interdisciplinary documentation.

Survey validated OI team's conclusions

A staff survey was conducted to determine whether root causes identified by the interdisciplinary team were the actual reasons for the lack in documentation. The survey included the major root causes identified for lack of interdisciplinary documentation and measured the frequency with which these causes occurred over four days. In order to be representative of fluctuations in staffing and census, the survey was conducted on both weekday and weekends. This survey validated the conclusions of the OI team.

4. Develop solution and action plan.

The team evaluated major root causes based on the Pareto chart developing and identifying those within their control. A Pareto chart is used to focus on key problems by showing their relative frequency or size in a descending bar graph. Key problems were:

— other work was a priority;

— duplication of documentation;

— the medical chart was unavailable;

— the form was not available.

Based on the data obtained through the assessment and evaluation process, three solution / action plans were developed to improve interdisciplinary documentation.

• **Action Plan No. 1:** The Multidisciplinary Plan of Care and Teaching Record were integrated to increase interdisciplinary / collaborative documentation of patient and family education by decreasing the "documentation" workload. This step also facilitated fuller integration of patient education into the plan of care.

• **Action Plan No. 2:** Internal monitoring mechanisms that would increase the sample size of records reviewed to identify compliance issues were created. This involved identifying existing departmental internal monitoring mechanisms that would supplement the current closed medical record review process. The decision was made to expand the number of closed medical record reviews rather than incorporating another process.

• **Action Plan No. 3:** Staff meetings were changed to include patient and family education as a standard agenda item. The purpose is to review unit-specific data relative to documentation compliance, areas for improvement, and other patient education issues. The department-based educator or some other designated staff member presents patient education on each clinical department staff meeting agenda.

5. Implement solution or process change.

Following Action Plan No. 1, the Multidisciplinary Plan of Care and the Teaching Record were combined to decrease the documentation workload and implemented in September 1998. **(See example of this document, inserted in this issue.)** Approximately 910 of 1,200 employees documenting patient teaching in the medical record attended the mandatory blitz. The employees unable to attend were taught on their individual units by the department-based educator and the patient education coordinators.

The patient education coordinators developed a new process of reporting data pulled from the closed medical record. A comparative report of the data was sent to directors, assistant directors, and department-based educators of all inpatient and ambulatory sites throughout the institution.

As areas for improvement were identified, the patient education coordinators would meet with these individuals to develop action plans for improvement.

According to Action Plan No. 2, the number of closed medical records reviewed was increased from 4% to 5% of all discharges for each unit. This increased identification of compliance issues.

In accordance with Action Plan No. 3, the patient education coordinators attended staff meetings to emphasize proper use of the form and to address other patient education issues. Patient education was added to all clinical department staff meetings. The specific item on the agenda is determined by current unit issues related to patient education and is presented by the department-based educators or other designated staff member.

6. Evaluate result of change.

The closed medical record data from September 1998 to March 1999 showed a significant improvement in compliance with the Joint Commission standard to make the educational process collaborative and interdisciplinary (PF.4.2). Hospitalwide compliance reached 99% in March 1999. The average for this standard over the past year is 95.6% and ranged from 99% to 88%.

7. Apply experience.

The patient education coordinators periodically conduct unit spot checks of staff documentation to identify areas for improvement and answer questions regarding the form. When they met with leaders of various units, suggestions were made to improve compliance with the Joint Commission standards on their units. During one of the meetings, the suggestion was made to evaluate the effectiveness of having preprinted information on the form. This would assist staff in documenting pertinent issues related to the plan of care and likewise meet those Joint Commission standards in which we were consistently below the compliance threshold.

The suggestion was implemented, and preprinted information has increased compliance. The three standards selected to be preprinted on the documentation tool were medical equipment (PF 1.4), food and drug interaction (PF 1.5), and medications (PF 1.3). Increased compliance was noted for documentation of education on medical equipment and medications. We continually evaluate how we can achieve compliance with the Joint Commission PF standards. As compliance issues are identified, the patient education coordinators work with specific units to correct deficiencies. To further enhance documentation compliance throughout the organization, they share unit success stories with other units needing assistance. ■

SOURCES

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Educational package tells it like it is

Designed for first-time home caregivers

Real-life scenarios, used to show the emotional, physical, and financial impact of taking care of chronically ill loved ones, have proven to be an effective form of instruction for families considering home care. The slices of life are viewed on video and are part of a home care family education package produced by Washington, DC-based State of the Art. The package is designed for caregivers in the early stages of at-home care to provide a realistic view of the role they are about to assume.

"The package focuses on the laymen, recognizing that people come to home care from a wide range of preparedness, both in terms of their formal education and in terms of their training and understanding of medical terms and their coping ability," says **Grady Watts**, MA, vice president of State of the Art, a multimedia communications company.

The project was funded by a grant from the Rockville, MD-based National Institute of Mental Health, Office for AIDS Research. As part of the grant requirements, two of the scenarios in the videotape series focus on families caring for loved ones with AIDS. However, the information on care is general in nature and covers a cross-section of home care, including care that is highly technical in nature and end-of-life care in the home.

Because home care is distinctively different for each age group, there is a video that focuses on the care of children, one on adults, and a third on older adults. In each stage of life, there are issues of community involvement — whether school, work, or participation in retirement activities — that are important to an individual's well-being, says Watts. "We wanted to present home care as integrative as opposed to isolating, based on the notion that psychosocial factors are very important in the recovery and treatment of disease," he explains.

The written materials also contain age-specific information. Symbols depicting a child, an adult, and an older adult quickly direct caregivers to appropriate information within the text. For example, in the section on where to go for help, the adult symbol alerts readers to tips on where to find transportation for adults with disabilities. The older adult symbol is next to information about selecting an adult day care center. The child symbol draws parents to a paragraph that discusses trading baby-sitting hours with other families who have a child with medical needs.

Research finds material helpful

State of the Art designed a study before marketing the home care education package to make sure the information and delivery system were beneficial to home caregivers. They found that 96% of those participating found the video helped them provide better care for their family; 95% reported that the video helped them increase their knowledge about home care; and 91% mentioned that the video improved their outlook of their situation as caregiver.

The study used a sample of 130 caregivers of critically and chronically ill clients of home health agencies. The caregivers were given pre- and post-tests to determine how the materials had made a difference in their home care-related knowledge, attitudes, behaviors, and circumstances. A control group received the educational materials after data collection.

The design of the materials played a big part in their success, says Watts. Each video profiles three families who were selected to show a diverse group of home caregivers. Families without much money are depicted to show that you don't have to be rich to afford home care, and a male caregiver is profiled even though women typically are the caregivers. "We also wanted to address ethnic diversity and regional diversity, so we filmed this all over the country," says Watts.

The Home Care Organizer is a three-ring binder so caregivers can rearrange the sections and add information they come across. There are five categories, which include:

- **Getting Started.**

This section explains what home care is, where to go for help, how to choose the right home care agency, and ways to pay for home care. It also explains how to adapt a home to the patient's needs and how to make sure the caregiver does not burn out.

- **Patient Information.**

This section has handy sheets for listing pertinent numbers, such as that of the home care agency and supporting caregivers. It also has a sheet for scripting calls during a medical emergency. For example, there is a section in which to write the symptoms that require medical attention, what to tell the emergency dispatcher, and what medications the patient is on. There are also schedules for

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daily and weekly needs as well as for medications. All the sheets for tracking can be photocopied.

• **Caregiver Communication.**

This section contains a log so all parties involved in the patient's care can communicate efficiently.

• **Resources.**

The home caregiver will find contact information for several organizations in this section. Categories include disease-specific organizations, home care and hospice organizations, and age-specific organizations. There are also lists of hotlines and publications.

• **Glossary.**

The glossary provides definitions for medical terms (such as foley catheter) and medical professionals (such as oncologist).

These materials can easily be adapted to many health care settings. Families can watch the video before the patient is discharged at the patient/family resource center, or the video could be installed on the hospital's closed-circuit television system. Copies could be made available for checkout, or a copy could be given to the patient to keep along with the home care organizer. The materials can be available at a hospital, clinic, or home care agency.

In May, a version of the home care organizer will be on-line so all family members can participate in the home care process, even if they live far away. They will be able to do so through an e-mail/bulletin board arrangement. "It will bring families together, providing a hub between the local caregiver, the primary caregiver, and extended family. Anyone who wants to get involved in the process and support it can do so on-line," says Watts.

(Editor's note: A public television broadcast using video from the nine scenarios depicted in State of the Art's Home Health care series will air in May 2000. Dana Reeve, wife and primary caregiver of actor Christopher Reeve, who was paralyzed in a riding accident, will host Caregivers: The Heart of Home Care. *See local listings for times.)* ■

SOURCES

For more information on the Home Care Family Education Program, contact:

- **Grady Watts**, MA, Vice President, State of the Art, 4455 Connecticut Ave., N.W., Suite B-200, Washington, DC 20008. Telephone: (202) 537-0818. Fax: (202) 537-0828. The videos cost $12.95 each, and the organizer is $14.95. Add $5 for shipping and handling. To order, call (800) 790-9267. Web site: www.forhomecare.com.

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

Type II diabetes on rise in children

More education needed on lifestyle change

More education programs are needed to halt the rise in Type II diabetes in children, which increases the risk of mortality at an early age. If children developed healthy eating habits and exercised more, they could prevent the development of the disease in childhood, according to experts.

At the diabetes center at Children's Hospital of Philadelphia, clinicians are seeing one to two patients diagnosed with Type II diabetes a month, which is about triple the number they saw even a year ago, says **Nicole Celona-Jacobs**, MS, RD, CDE, a clinical nutritionist at the center.

The sharp increase throughout the nation is attributed to obesity. Out of approximately 100 cases of Type II diabetes being treated at the center, 90% of the children are overweight and 75% are obese.

Risk factors include obesity, family history, and age, says **Anita Powell**, RN, BSN, CDE, a diabetes educator at Saint Joseph's Hospital of Atlanta. Therefore, obesity seems to be the trigger for children who have a family history of Type II diabetes. In the diabetes center at Saint Joseph's, adolescents in the 200- to 300-pound range are coming in for treatment of diabetes.

The American diet is a major cause of obesity. Families are eating more meals at fast food restaurants and purchasing convenience foods at grocery stores such as frozen dinners and prepackaged lunches. A second factor is a sedentary lifestyle. A survey conducted by the U.S. Surgeon General in 1992 found that half of all American youth ages 12-21 were not vigorously active on a regular basis. Rather than participating in recreational activities, children are more likely to play video games, work at the computer, or watch television.

Behavior change is difficult, says Celona-Jacobs. The U.S. Surgeon General recommends 30 minutes of moderate to intense activity daily. When parents learn this, most are shocked, she says. Therefore, educators at Children's Hospital of Philadelphia often begin by trying to get patients to cut back on the amount of time spent in sedentary activity. For example, kids could spend one hour watching television after school, and the rest of the time before dinner doing an activity where they move around.

Change is difficult. The diabetes center at Children's Hospital tried offering free memberships to the local YMCA, but not many families took advantage of the offer. Their advice on what types of food to purchase and serve often goes unheeded as well. Part of the problem is that supermarkets are not easily accessible in some Philadelphia neighborhoods.

"The bottom line is changing beliefs and attitudes. We find that the more family support the children have, the more successful they are," says Celona-Jacobs. By simply losing 20 pounds, a child could improve his or her blood sugar levels.

Once a child develops Type II diabetes, learning to control blood glucose levels is very important. "High blood sugar levels over time can lead to complications," says Powell. Complications might include eye problems, blindness, and increased risk for heart attacks.

To help prevent obesity in children, Celona-Jacobs recommends that pediatricians take a good weight assessment and family history. "When children are at risk, try to educate families about the danger of obesity. It is a matter of changing their attitude," she explains. ■

SOURCES

For more information on prevention of Type II diabetes in children, contact:

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Team building enhances diabetes compliance

Teens and parents learn ways to reduce conflict

Conflict between parents and children usually increases during the adolescent years, and diabetes often exacerbates it. The regimen followed to manage the disease is very demanding and can hamper teens' social activities when followed correctly.

Parents, worried about their children's health, often will criticize and nag in the hope of keeping them compliant. As parents become more desperate, the conflict often escalates into screaming matches.

To help remedy this situation, a team at the Joslin Diabetes Center in Boston designed an educational component to build teamwork between parent and adolescent and avoid conflict in diabetes management. "Our goal was to try to teach parents a more productive way to provide the support that teenagers need to follow this demanding regimen, but get them out of the role of policeman and critic," says **Barbara J. Anderson**, PhD, senior psychologist at Joslin and associate professor in psychiatry at Harvard Medical School.

Much of the education focused on behavior change, teaching parents and adolescents new ways of discussing the monitoring of the disease. For example, rather than using critical language like "bad blood sugars" or "bad numbers," they were taught to refer to blood glucose levels as being "in range" or "out of range."

The office-based educational intervention was tested in a one-year study. During the study, 85 patients with Type I diabetes were randomly assigned to one of three study groups: teamwork, attention control, and standard care.

Patients assigned to the teamwork group had a 20- to 30-minute education session with their parents participating either before or after their routine office visit. They had a total of four sessions at three- to four-month intervals. Research assistants who had received diabetes training taught the educational sessions. The research assistants used written teaching modules designed for the study and followed a scripted protocol to insure consistency. (These written modules should be available from the Joslin Diabetes Center by December 2000.)

At the first session, the parent and teen negotiated a responsibility-sharing plan that outlined who would be responsible for such tasks as drawing up insulin, determining the dose, giving the injection, and monitoring blood glucose. They also discussed how parental criticism often promotes negative behavior such as causing kids to stop checking their blood glucose levels.

At each meeting, the educator, parents, and teen would evaluate the family's diabetes management for the last three months, examine how they were working as a team, and look for ways to improve.

Families assigned to the attention control group would attend educational sessions at office visits but received traditional diabetes education. There was no discussion of conflict resolution issues, and the families did not negotiate a plan for teamwork. The third group received routine care but no educational interventions.

To determine the effect of the educational intervention, parents completed the Diabetes Family Conflict Scale at the start of the study and at its conclusion. The scale measures the degree of family conflict in 17 diabetes management tasks such as blood glucose monitoring. Parents also complete a checklist that assesses their perception of the frequency of supportive and unsupportive responses they have in regard to their child's diabetes management.

The study found that parental involvement in diabetes tasks declined in the families who were not involved in the educational intervention that fostered teamwork. Although fostering parental involvement in their teens' diabetes management increased the potential for conflict, the families in the teamwork group did not experience increased conflict. Some reported a decrease in conflict.

"Most of the patients who go to a good tertiary care center know what to do to manage their diabetes. It's just doing it; that is where the breakdown occurs. Education needs to be on the family management, and that was what was unique about our educational approach," explains Anderson. ■

SOURCES

For more information on this office-based intervention to maintain parent and adolescent teamwork in diabetes management, contact:

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