Patient Education Management

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

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IN THIS ISSUE

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Choosing a worthy messenger key to getting diabetes message across

A healthy lifestyle would help turn the type 2 diabetes epidemic around

The public is not aware of the steps it can take to prevent the onset of type 2 diabetes, says **Lois Exelbert**, RN, MS, CD, BC-ADM, administrative director of the Diabetes Care Center at Baptist Hospital of Miami.

General health guidelines for preventing other chronic problems, such as heart disease, apply to diabetes as well. These include maintaining an ideal body weight, remaining physically active, choosing healthy foods, eating regularly, getting enough sleep, and managing stress, Exelbert says.

While the message may be the same for everyone, people are more likely to listen if they identify with the messenger. That is why in New Mexico, community health representatives work within Native American communities. These community members are essentially an extension for health services and act as agents.

"If you take these community members and send them back into their communities where they are recognized, respected, and part of the cul-

EXECUTIVE SUMMARY

According to the American Association of Diabetes Educators, cases of type 2 diabetes have tripled in the last 30 years, and many can be linked to the upsurge in obesity. In addition, Native Americans, African-Americans, and Hispanics are more likely to develop type 2 diabetes than the general public.

In this month's cover article we discuss how the message should be delivered to the population that should hear it. In the August issue, we will look at teaching self-management skills to prevent complications from diabetes.

ture, the message has more meaning and they are listened to," explains **Carol Maller**, MS, RN, CHES, diabetes/AIDS coordinator for the Southwestern Indian Polytechnic Institute in Albuquerque, NM. In this case, then, the messenger is just as important as the message.

The American Heart Association based in Dallas offers programs designed to be taught by members of certain ethnic groups. For example, Search Your Heart is a faith-based program that targets African-American communities. It is a modular program with each module providing information on certain health issues such as hypertension, nutrition, physical activity, or diabetes.

"With the Search Your Heart program we have to identify someone in the health ministry or maybe a nurse in the congregation to take the program and recruit the volunteers needed to implement it," says **Erin McDonald Bicknell**, senior director for State Health Alliances in New Mexico, Montana, and Wyoming, for the American Heart Association and American Stroke Association Pacific/Mountain affiliate.

Recently Maller and McDonald Bicknell worked together to give lay educators in New Mexico health information that they could customize for their community. For example, the preparation of food is important to the prevention and management of diabetes or heart disease and includes lowering fat and sugar as well as portion control.

"We talk about these kind of concepts and then we give them opportunities to reflect on how they would bring that information back to their community in a way that has meaning," Maller says. "It might be putting together a family night and bringing people together for an evening meal where they would prepare some native traditional foods in a healthier way. It might just mean using a healthier oil for cooking or it may be portion control, looking at serving size and quantity."

Provide teaching tools

It's important for the people learning the message to be actively involved and to be taught by analogies so, in turn, they can provide hands-on learning opportunities when they teach others what they have learned, says Maller.

For example, during one training session the educators passed around different food products and beverages and showed everyone how to figure out the grams of fat and sugar per serving. They also showed how to figure the equivalence according to a measuring cup and had the volunteers put the sugar or shortening for fat in containers.

Each person would show the food product and how much sugar or fat was in a serving size. Some would measure the amount for the entire content of the bag because they knew people would most likely eat the whole thing.

"Some may be three serving sizes per container, but unless you look at that carefully you may open the bag and eat it while watching TV," says Maller.

One eye-opener, Maller reflects, was that the amount of sugar in an energy drink was

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comparable to a can of soda.

The basic message is that people can make healthy choices in their selection of food and their activity level. "We don't want a complicated message. We want a simple message of prevention," says Maller.

McDonald Bicknell says the organization she works for wants to get the message out that people need to know their numbers, including blood pressure, cholesterol, body mass index, and blood glucose.

"It's not just getting the tests done but understanding what those numbers mean. When we do community screening we typically partner with groups that are familiar and well trained to deal with the interpretation of those numbers," she says.

Exelbert says the Diabetes Care Center at Baptist Hospital gives free screenings on a regular basis; people simply need to call and make an appointment. Following the screening, the person is counseled on the results, and if there is a need to see a physician, he or she is called within two days. Anyone with a fasting blood glucose level of more than 100 is advised to talk to their doctor about pre-diabetes, a condition that leads to diabetes. They also can begin to experience the damaging effects of diabetes.

"I think most people think if they had something wrong with them like diabetes they would feel it, and the truth is they don't detect early diabetes. They blame symptoms such as fatigue on 100 other things," Exelbert says.

One of the most accessible ways for people to reduce their risk for diabetes is through exercise, says McDonald Bicknell. All that is required is 30 minutes of sustained exercise daily at an elevated heart rate for adults and 60 minutes for children.

That is why her organization has a physical activity initiative focused on walking and starting walking clubs at work sites.

"It is frightening. We are looking at the first generation that will not outlive their parents. I have seen statistics that one out of three people will have diabetes in the upcoming generation," says McDonald Bicknell.

To make the biggest impact for prevention focus on people who are borderline at risk and children, she advises.

Are the education strategies working?

Maller says she does not have any statistics; however, out in the field she has witnessed lifestyle change. At a potluck at a Native American school, she found trays of fresh vegetables, and items such as fry bread were cut in small pieces.

"It is all about balance. It is not about depriving yourself, and of course the serving size, not having huge serving sizes. I have seen some of those kinds of changes," says Maller. ■

GUEST COLUMN

Conquering the diabetes education dilemma

Consistent lessons for safe discharge

By Sue Lesser, MSN, RN, BC, LCCE
Nurse educator, Cooley Dickinson Hospital
Northampton, MA

Diabetes education for the patient in the hospital has become an impossible task for nurses who find it difficult to teach along with all their other duties. The consequence is frequently a poor outcome for the patient.

Yet patients can decrease diabetes-related complications if they are taught how to keep themselves in tight glycemic control. Patient education can reduce the morbidity and mortality of diabetes.

To improve inpatient diabetes education, a committee at Cooley Dickinson Hospital in Northampton, MA, developed a diabetes education pathway to provide guidance to all disciplines on survival skills that need to be taught to patients diagnosed with diabetes. The implementation of this pathway helps ensure health care providers will properly teach hospitalized patients so they can be safely discharged.

The curriculum includes topics based on "need to know" vs. "nice to know" information. The result is that everyone teaches by a consistent diabetes education plan. Nurses, dietitians, and case managers all participate in the education pathway. Each discipline has an educational obligation to the patient.

All disciplines teach American Diabetes Association (ADA)-endorsed patient self-management skills. Self-management skills require that people with diabetes know how to take medications appropriately, control blood sugar levels, and manage diet with regular exercise. We know that teaching self-management skills is vital because the tighter glycemic control a diabetic maintains, the fewer complications and the higher quality of life they will experience.

Nurses' responsibility in the education pathway is to teach patients about their medications (either oral or insulin injections) and the signs of and solutions for hypoglycemia. They also reinforce education on carbohydrate counting and blood glucose testing taught by other disciplines.

The dietitian initiates the diet/exercise and carbohydrate counting instruction. The case manager is responsible for contacting a meter distribution company to see the patient when education is needed on the use of blood glucose-testing meters.

The meter company will come to the hospital and see the patients before discharge to provide them with a blood glucose testing meter and education on how to test their blood sugar. If the company representative is unable to see the patient in the hospital before discharge, a visit to the patient's home will be arranged within 24 hours after discharge.

We stock the two most commonly reimbursed meters in the hospital so that, if they have to, nurses can teach the patients how to use a meter before discharge. Initially we were reluctant to have an outside vendor teach our patients; however, we found they were much more knowledgeable than we were on reimbursement for blood testing meters and they had more time flexibility to teach the patient.

Insurance companies and programs such as Medicare and Medicaid reimburse for blood glucose meters, but the type of meter they cover is not consistent. Therefore, we encourage patients to get their meters in the hospital before they go home. It is unfortunate when a patient pays out-of-pocket for a meter and then later finds they cannot get recompensed. Ultimately, we want to ensure that our patients have a meter and are confident in how to use it. Patients without means of payment are absorbed by the system and receive free meters.

A continuing education process

Hospitalization also provides an opportunity to re-educate established diabetics on new techniques and technology. We use the hospitalization to update patients who might be using antiquated meters or who have developed bad habits. Often we can use this incident to enhance their knowledge and improve their lifestyle.

To promote the continuum of care, the case manager makes an appointment for ongoing diabetes education before the patient is discharged. A diabetes nurse educator (CDE) and a diabetes nutritional specialist (RD) will see a patient newly diagnosed with diabetes or a patient in crisis one-on-one in their office within a few days of discharge. Group classes are also offered, based on an ADA evidence-based curriculum, in four weekly, two-hour sessions. Insurance is receptive to paying for outpatient diabetes education, but no one is turned away for lack of payment.

We are continuing to measure the success of our diabetes education pathway by continuously measuring the outcomes of this new program.

SOURCES

For more information on the diabetes education pathway for inpatients at Cooley Dickinson Hospital, contact:

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We believe we are now teaching self-management skills to 95% of our new diabetes patients and 90% of those inpatients with established diabetes. Furthermore, 75% of our hospital patients are being seen after discharge for further diabetes education with our community diabetes educator.

We can't ensure lifestyle changes will occur, but we can ensure that our patients are educated enough to make informed decisions about their disease. Staff nurse satisfaction has improved because patients are now receiving consistent, planned diabetes education, and consequently their patients are going home better prepared to deal with a chronic illness.

Also, many nurses are uncomfortable with their ability and knowledge base to provide diabetes education. Nurses' perceptions of the patient with diabetes in a study done in 1990 were that previously diagnosed patients were more knowledgeable than they were; so the nurses tended to teach patients newly diagnosed with diabetes more often.

Therefore, in addition to the pathway we provide formal education, workshops, and in-services within the hospital to increase the nurses' ability and confidence to teach patients and families.

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Moriarty D.R., Stephens L.C. Factors that influence diabetes patient teaching performed by hospital staff nurses. *Diabetes Educ* 1990; 16(1): 31-35. ■

A few favorite web sites for patient education

PEMs share their best Internet finds

The Internet is a wealth of information for people in all professions. So it is not surprising that patient education managers have favorite web sites they turn to time and time again.

In this article *Patient Education Management* provides insight into a few sites recommended by people in the field of patient education.

Cezanne Garcia, MPH, CHES, manager of patient and family education services at the University of Washington Medical Center in Seattle, says Medlineplus (www.nlm.nih.gov/medlineplus/) is a web site she uses on a regular basis because she says it is committed to continuous improvement and features more than 700 topics on conditions; diseases and wellness; prescriptions; over-the-counter medicines; and herbs and supplements.

The information includes pictures and diagrams as well as spellings and definitions of medical words. It has current health news and press announcements and leads to doctors, dentists, hospitals, local health services, libraries, and organizations. There also are links to international sites.

Another site Garcia frequently visits is Health Information Translations (http://healthinfotranslations.com/), a collaborative initiative between three health care organizations in Columbus, Ohio, to improve health education for limited English proficiency patients.

The site is intended as a resource for health care professionals who teach health education to patients with limited English skills. Teaching sheets on a variety of health topics are available with an accompanying English version. Languages provided include Chinese, French, Hindi, Japanese, Korean, Russian, Somali, Spanish, and Ukrainian.

Mary Paeth, MBA, RD, patient/community education coordinator at the Southwest Washington Medical Center Education Department in Vancouver, WA, has a long list of favorite web sites.

Paeth likes a web site designed by United Health Foundation (www.unitedhealthfoundation.org). The goal of the site is to provide evidence-based health information to help consumers make informed health decisions. There are a variety of educational tips, such as how to evaluate medical resources on the web and how to be a smarter patient.

Ask Me 3 (www.askme3.org/) is a health literacy web site with tools for providers, patients, and staff within health care organizations. "It has very practical ideas to help staff do a better job. There are great materials that are easy to use and good tips on how to use them," says Paeth.

Multiple formats available

For working with multicultural patients, Paeth uses the Health Information Translations web site, like Garcia. She also recommends Healthy Roads Media (www.healthyroadsmedia.org/),

which provides educational materials in a variety of formats as well as languages including Arabic, Bosnian, Russian, Somali, Spanish, Khmer, and Vietnamese. Subjects covered include abuse, asthma, cancer, and diabetes.

According to Healthy Roads Media, various formats are provided so people will have access to information in diverse situations. They write: "For example, someone who has difficulty with written materials may want to watch the on-line video or listen to the audio but also have a hand-out to take home so they can share with family members. An outreach worker who does not have access to the Internet on home visits may want to bring along handouts but also have downloaded multimedia files on her laptop that she can share during the visit."

Interactive health tutorials on Medline Plus (www.nlm.nih.gov/medlineplus/tutorial.html) use animated graphics and easy-to-read language to explain diseases and conditions and tests and diagnostic procedures. People can also listen to the tutorial. The health education resources are from the Patient Education Institute.

"What better way to meet the needs of the visual and audio learner than by having it as a movie or a handout," says Paeth.

For literacy help and answers whenever she needs them, Paeth turns to the Plain Language Service (www.pls.cpha.ca/), a part of the Canadian Public Health Association's National Literacy and Health Program.

Paeth recommends the Oregon Council of Healthcare Educators web site (www.oche.us/index.htm), which provides members access to each other through e-mail and the bulletin board. "We can network and share materials and you don't need to be in the same town to benefit," she explains.

The web site maintained by the Institute for Healthcare Improvement (www.ihi.org/ihi) has cutting-edge information for hospital improvements, says Paeth.

To obtain health facts and information at a glance Paeth logs on to a site produced by the Kaiser Family Foundation (www.statehealthfacts.kff.org/cgi-bin/healthfacts.cgi) and the Centers for Disease Control and Prevention web site (www.cdc.gov).

She also recommends the web site at her own health care facility, Southwest Washington Medical Center (www.swmedicalcenter.com/) which has a multitude of educational materials available to anyone.

SOURCES

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Laura Gebers, BSN, RN, BC, PCS programs health education coordinator at Deborah Heart and Lung Center in Browns Mills, NJ, is the adviser to a group, iAround.org, that oversees a web site for people newly diagnosed with lung cancer. The goal of those who developed the web site was to provide a high quality resource guide so that the lay person could quickly and easily master the information to help him or her achieve the best possible outcome with treatment.

The director of the site is Tina Lee, a three-year survivor of lung cancer. Copy on the site states: "As lung cancer survivors and families we remember too well how devastating it can be when you are told you have cancer. To make things worse, you have to make a slew of critical decisions, especially the initial treatment plan. However, if you are not expert in lung cancer it is very difficult, if not impossible, to acquire essential yet sufficient information and make your right choices."

The site has information on lung cancer treatment, clinical trials as well as support information that covers such topics as the financial impact, insurance coverage, and hospice and home care.

The group's motto is, "We find the best lung cancer resources so you don't have to."

(Editor's Note: Do you have a favorite web site? If you have found a site that helps you in your job as a patient education coordinator or manager please let us know. E-mail suggestions to Susan Cort Johnson at suscortjohn@frontiernet.net and include PEM favorite web site as the subject.) ■

Diabetes care program addresses specific needs

Program addresses cultural differences

Project Dulce, a diabetes care management program housed at Whittier Institute for Diabetes in La Jolla, CA, has successfully addressed not only the difficult challenge of helping patients manage their diabetes, but also another issue of growing concern to quality managers: improving outcomes among minority populations.

Using a combination of trained diabetes educators, endocrinologists, and peer educators (minority individuals who have successfully managed their own diabetes), the program has achieved impressive results.

Project Dulce, partially underwritten by Scripps Health (which owns the Whittier Institute), has cared for more than 4,000 individuals at 17 sites since its inception in 1997. In its initial 18-month pilot program alone, Project Dulce was able to reduce the average hemoglobin A1c in 300 patients from nearly 12 to eight.

"We developed an approach we thought would work," recalls **Chris Walker**, MPH, director of strategic planning and development at the Whittier Institute. "We brought together endocrinologists, plus people who had worked in the community setting and knew how to approach diabetes patients. The program combines clinical expertise and community-based knowledge about how to reach [minority] populations."

Originally designed to serve Spanish-speaking patients, Project Dulce has expanded to include Vietnamese and Filipino patients. As a hospital-sponsored program, officials of the American Hospital Association and others believe it may offer a valuable model for other hospitals.

Pilot sets model

"The New Jersey Hospital Association has called and asked us to present to their groups; they're thinking of doing something similar there," shares **Athena Philis-Tsimikas**, MD, executive director and chief medical officer of the Whittier Institute.

The staffing in the original pilot program created the model for the full-blown program, says Walker. "We had one team — a diabetes nurse educator, a dietician, and a peer health educator," she explains.

"They provided clinical management, and the nurse educator and dietitian developed the whole curriculum to train people with diabetes to deliver diabetes education," she says.

The peer educator curriculum involves a 10-week course. The peer educators also are complemented in-hospital by the nurse educators, who use handouts from the course in Spanish, English, Vietnamese, and Filipino, Walker adds.

"The nurses and dietitians we work with are all certified diabetes educators; each has had about 10 years' experience in managing diabetes," Philis-Tsimikas adds.

When a patient is identified as having diabetes by a physician in one of the participating health centers (the community clinic system and primary care physicians are part of the program), they are referred to the project. "We explain the program to them in their native language, set them up for an appointment with the nurse, and enroll them in group education classes," says Walker.

The nurse conducts an assessment, which takes about an hour. "The nurse works with the patient to develop a care plan and does the clinical management in collaboration with the physician; she takes charge of labs and medication judgment, under the physician's guidance," says Walker.

Specialization is key

Some of the nurses are not bilingual, but each has an assistant who is, Walker continues. "After all clinical exams are done, the patients come in as needed," she shares. "We collect all the data and put it in an electronic registry, which allows us to track clinical outcomes and also to track patient activities — which of them, for example, has not had a recent retinal exam."

The specialized knowledge of the educators and dietitians, as well as the experiences of the peer educators, are key to the success of the program, she says.

"Look at the ease with which [the nurse educators] use insulin," offers Philis-Tsimikas. "You have a lot of patients with type 2 diabetes, of lower income, ethnically diverse, and they have let their disease go for quite a while; many have had the disease for 10 years and have had minimal care. You have primary care physicians who are very motivated but who deal with a lot of different diseases and conditions, and their level of expertise in insulin is not that great. So when you put in a person who can teach someone to start insulin 'in their sleep,' — or any of the meds required, for that matter — the patient looks at

that person as an expert in diabetes."

Their experience also enables them to recommend the best possible combination of medications, she adds.

"And they are able to educate the patient about why it is important to take your meds, test your blood sugar, alter your diet, and so forth," she notes. "They *work* with them; that's important to the patients."

The peer educators complete the "package" of care. "They connect with them culturally," says Philis-Tsimikas.

Walker agrees. "They are from all different cultures; different belief systems impact their ability and willingness to manage their diabetes," she says.

"There might be the whole concept that the disease is their fate — that they might have done something wrong and there is nothing they can do about it. Yet studies show the key to improved self-efficacy is feeling you can control the disease. We address these issues in a culturally sensitive way and complete their education so they have more accurate information," she says.

It is that complete package that is so key, adds Philis-Tsimikas. "It is very hard to treat type 2 diabetes and get people where they need to be with their goals *just* with the peer educator," she says. "You really need the combination, because they each attack things from a different perspective."

Hospital-based programs

Just as the Scripps health organization is underwriting Project Dulce, says Philis-Tsimikas, other hospitals and health systems can pursue a similar model.

"Hospitals need to know there's a program they can send their hospitalized patients out to," she explains. "They might be admitted with something else, but if their blood sugars are running around 200 to 300 you might have to keep them in the hospital an extra two to three days — unless you know you have someone you can send them out to with whom you feel comfortable. In our communities, *we* are the program. Other hospitals can have the same sort of program set up in their own location."

That's just what Scripps Health has done, she continues. "Yes, we are subsidized, but we are able to bill for services, and we have made a really good effort to try and get as much reimbursement as possible so as to be self-sufficient; and we are pretty darn close. Scripps does help us with a little bit of the rent."

SOURCES

For more information, contact:

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Better outcomes

It's important to remember, says Philis-Tsimikas, that setting up such programs not only helps the community, but it also helps the hospital in the long run.

"For one thing, we conduct monthly professional education programs; we teach in-hospital nurses how to better care for diabetes patients," she says.

The ability to reduce LOS for patients with diabetes becomes even more significant, she says, when you realize just how many patients who are hospitalized also have diabetes.

"Our hospitals here have recently gained the ability to look at the percentage of patients who have diabetes," she shares. "It ranges from 12% of all admissions in one hospital all the way up to 35%." One cath lab, she continues, reported 40% to 45% of its patients had diabetes.

"So we're not talking about a small number of people, but a large percentage of those patients in a hospital who are affected," she emphasizes. "They have longer hospital stays — by a day and one-half on the average. If you have outpatient education plus better inpatient care, you will get better outcomes." ■

Abstinence-only education problematic, group says

Group urges comprehensive sexual health education

The Society for Adolescent Medicine (SAM) issued a position statement rejecting current administration policy promoting abstinence-only education for young people, urging U.S. educators to present abstinence as one important option in an overall sexual health prevention strategy.

"We believe that current federal abstinence-only-until-marriage policy is ethically problem-

atic, as it excludes accurate information about contraception, misinforms by overemphasizing or misstating the risks of contraception, and fails to require the use of scientifically accurate information while promoting approaches of questionable value," the authors write in "Abstinence-only education policies and programs: A position paper of the Society for Adolescent Medicine," released in January in *The Journal of Adolescent Health* (2006; 38:83-87).

Lead author **John Santelli**, MD, MPH, of the Heilbrunn department of population and family health, Mailman School of Public Health, Columbia University in New York, writes that abstinence from sexual intercourse represents a healthy choice for teen-agers, and acknowledges that teen-agers remaining abstinent, at least through high school, is strongly supported by parents and even by adolescents themselves.

"However, few Americans remain abstinent until marriage, many do not or cannot marry, and most initiate sexual intercourse and other sexual behaviors as adolescents," he writes. "Abstinence as a behavioral goal is not the same as abstinence-only education programs. Abstinence from sexual intercourse, while theoretically fully protective, often fails to protect against pregnancy and disease in actual practice because abstinence is not maintained."

SAM urges the abandonment of abstinence only as a basis for health policy and programs, calling the presentation of abstinence-only or abstinence-until-marriage messages as a sole option for teen-agers "flawed from scientific and medical ethics viewpoints," providing misinformation and withholding information needed to make informed choices.

In addition, the SAM paper suggests, federally funded abstinence-until-marriage programs discriminate against gay, lesbian, bisexual, transgender, and questioning youth, as federal law limits the definition of marriage to heterosexual couples.

Abstinence-only vs. SAM recommendations

Under Section 510 of the Social Security Act, originally enacted in 1996, abstinence education is defined by an eight-point description as an educational or motivational program that:

- has as its exclusive purpose, teaching the social, psychological, and health gains to be realized by abstaining from sexual activity;
- teaches abstinence from sexual activity outside marriage as the expected standard for all school-age children;
- teaches that abstinence from sexual activity is the only certain way to avoid out-of-wedlock pregnancy, sexually transmitted diseases, and other associated health problems;
- teaches that a mutually faithful, monogamous relationship in the context of marriage is the expected standard of human sexual activity;
- teaches that sexual activity outside of the context of marriage is likely to have harmful psychological and physical effects;
- teaches that bearing children out of wedlock is likely to have harmful consequences for the child, the child's parents, and society;
- teaches young people how to reject sexual advances and how alcohol and drug use increases vulnerability to sexual advances; and
- teaches the importance of attaining self-sufficiency before engaging in sexual activity.

The society's position, summarized in the paper, is that:

- Abstinence is a healthy choice for adolescents. The choice for abstinence should not be coerced. SAM supports a comprehensive approach to sexual risk reduction including abstinence as well as correct and consistent use of condoms and contraception among teens who choose to be sexually active;
- Efforts to promote abstinence should be provided within health education programs that provide adolescents with complete and accurate information about sexual health, including information about concepts of healthy sexuality; sexual orientation and tolerance; personal responsibility; risks of HIV and other STIs and unwanted pregnancy; access to reproductive health care; and benefits and risks of condoms and other contraceptive methods;
- Individualized counseling about abstinence and sexual risk reduction are important components of clinical care for teen-agers;
- Health educators and clinicians caring for adolescents should promote social and cultural sensitivity to sexually active youth and gay, lesbian, bisexual, transgendered, and questioning youth. Health education curricula should also reflect such sensitivity;
- Governments and schools should eliminate censorship of information related to human sexual health;
- Government policy regarding sexual and reproductive health education should be science-based. Governments should increase support for evaluation of programs to promote abstinence and reduce

sexual risk, including school-based interventions, media efforts, and clinic-based interventions. Such evaluations should utilize rigorous research methods and should assess the behavioral impact as well as STIs and pregnancy outcomes. The results of such evaluations should be made available to the public in an expeditious manner;

• Current U.S. federal law and guidelines regarding abstinence-only funding are ethically flawed and interfere with fundamental human rights. Current federal funding requirements as outlined in Subsections A-H of Section 510 of the Social Security Act should be repealed. Current funding for abstinence-only programs should be replaced with funding for programs that offer comprehensive, medically accurate sexuality education.

Position paper lauded, criticized

Advocates of comprehensive sexual health education praised the SAM paper, calling abstinence only "bad science."

"We have 8 million young people under the age of 19 who are sexually active, yet 79% of junior high and 45% of high school teachers fail to teach about condoms. No wonder we have the highest rates of teen pregnancy and sexually transmitted disease in the developed world," says **James Wagoner**, president of the national organization Advocates for Youth.

"The [SAM] report is not anti-abstinence. It clearly supports abstinence as a strategy to protect young people's sexual health. But the report makes clear that, to be effective, abstinence education needs to be delivered in a comprehensive context along with information on condoms and birth control."

Supporters of abstinence-only education, however, disagree.

"With skyrocketing STD rates and conclusive research, which shows that contraception does not offer protections against all STDs, we need to be wise in the counsel we give young people," says **Jessemyn Pekari**, communications director for the Abstinence Clearinghouse, headquartered in Sioux Falls, SD. Abstinence Clearinghouse's position is that abstinence is not "a healthy choice," it is 'the only healthy choice" for the sexual health of adolescents, she says.

SOURCE

- **Society for Adolescent Medicine**, 1916 NW Copper Oaks Circle, Blue Springs, MO 64015. Phone: (816) 224-8010. Web site: www.adolescenthealth.org.

Reference

Santelli J, et al. Abstinence-only education policies and programs: A position paper of the Society for Adolescent Medicine. Available on-line at www.adolescenthealth.org/PositionPaper_Abstinence_only_edu_policies_and_programs.pdf. ■

Osteoporosis prevention: What patients can do

Osteoporosis prevention requires adequate calcium and vitamin D intake, regular physical activity, and avoidance of smoking and excessive alcohol ingestion. Risk of fracture determines whether medication is also warranted.

A previous vertebral or hip fracture is the most important predictor of fracture risk. Bone density is the best predictor of fracture risk for those without prior adult fractures. Age, weight, certain medications, and family history also help establish a person's risk for osteoporotic fractures.

All women should have a bone density test by the age of 65 or younger (at the time of menopause) if risk factors are present. Guidelines for men are currently in development. Medications include both antiresorptive and anabolic types.

Antiresorptive medications — estrogens, selective estrogen receptor modulators (raloxifene), bisphosphonates (alendronate, risedronate, and ibandronate), and calcitonins — work by reducing rates of bone remodeling. Teriparatide (parathyroid hormone) is the only anabolic agent currently approved for osteoporosis in the United States. It stimulates new bone formation, repairing architectural defects and improving bone density.

All persons who have had osteoporotic vertebral or hip fractures and those with a bone mineral density diagnostic of osteoporosis should receive treatment. In those with a bone mineral density more than the osteoporosis range, treatment may be indicated depending on the number and severity of other risk factors.[1]

Clinician offices are the best locations for patients to access reading material, videos, and web sites on bone health, effective prevention measures, treatments for osteoporosis, and the importance of adequate calcium throughout the

life cycle. The annual examination should be the time when evaluation and identification of patient risk factors for osteoporosis are done and the patient is counseled on the need for adequate calcium, either through diet or supplement, vitamin D, and weight-bearing exercise.

Women depend on their physicians for advice and counseling regarding both prescription and nonprescription interventions and therapies for bone health. The clinician's office should have a comprehensive sampling of educational materials that are of use to patients both for educating them about general preventive health practices as well as for giving them background information that will equip them to ask the physician health questions that directly pertain to them.[2]

When working with patients, clinicians should solicit patient concerns about trying to increase their calcium intake and barriers that the patient has experienced in the past or may anticipate in the future.[3]

References

1. Cosman F. The prevention and treatment of osteoporosis: A review. *MedGenMed* 2005; 7:73.
2. Bachmann G. Calcium compliance: The clinician's role. *J Reprod Med 2005;* 50(11 Suppl):896-900.
3. Blalock SJ. Toward a better understanding of calcium intake: Behavioral change perspectives. *J Reprod Med* 2005; 50(11 Suppl):901-906. ■

NEWS BRIEF

Diabetes epidemic hurt by information gap

A recent survey highlights yet another obstacle to managing diabetes. This impediment is the disparity between what patients and physicians think is the state of disease management.

According to the survey by the Diabetes Roundtable, 69% of type 2 diabetes patients say they feel very knowledgeable or knowledgeable about managing their condition. Meanwhile, 81% of the primary care physicians surveyed say they are frustrated with the number of their type 2 diabetes patients who do not follow their treatment regimen exactly as prescribed.

The survey also found gaps between the two groups in understanding the disease. One-half of the diabetes patients said they have little or no understanding of their A1C level or had not had it checked in the last six months or are unsure if it had been checked. An A1C test eval-

CE instructions/objectives

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

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

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** patient education programs based on existing programs from other facilities. ■

COMING IN FUTURE MONTHS

- ■ Addressing changing patient education needs
- ■ Education committees; not for review only
- ■ Using consumers for material evaluation
- ■ Role of education in creating a safer health care experience
- ■ Improving newborns' survival rate with education

CE Questions

1. According to experts on diabetes education it is the message that counts and it does not matter who delivers the information to the public.

A. True

B. False

2. Which of the following teaching aids can be found via the Internet?

A. handouts in foreign languages;

B. on-line videos;

C. interactive health tutorials;

D. all of the above.

3. In its position paper on abstinence-only education, the Society for Adolescent Medicine states:

A. teaching abstinence only is the best method for education;

B. efforts to promote abstinence should not be provided in health education programs;

C. abstinence is a healthy choice for adolescents and should be included within health education programs;

D. health educators should not promote sensitivity to gay adolescents.

4. Osteoporosis prevention includes:

A. adequate calcium and vitamin D intake;

B. abstaining from smoking;

C. physical activity;

D. all of the the above.

Answers: 1. B; 2. D; 3. C; 4. D.

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uates glucose control.

However, the survey found that education does have a positive impact on how knowledgeable patients feel about self-management.

"All too often patients feel they have 'failed' and feel guilty; physicians feel frustrated; no one wins," said Diabetes Roundtable member Donna Rice, M.B.A., R.N., B.S.N., C.D.E, wellness program manager, Botsford General Hospital (MI), and president-elect of the American Association of Diabetes Educators (AADE).

"Increasingly we recognize that a team-centered approach involving the patient, primary care physician, diabetes educator, behavioral scientist and endocrinologist provides the support and resources best needed to help patients manage the disease."

The Diabetes Roundtable is a multidisciplinary group of diabetes experts convened by the AADE and the American Association of Clinical Endocrinologists with support from Merck. ■

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Dear *Patient Education Management* Subscriber:

This issue of your newsletter marks the start of a new continuing education (CE) semester and provides us with an opportunity to review the procedures.

Patient Education Management, **sponsored by Thomson American Health Consultants,** provides you with evidence-based information and best practices that help you make informed decisions concerning treatment options and administrative practices. Our intent is the same as yours — the best possible patient care.

The objectives of *Patient Education Management* are 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 patient education programs based on existing programs from other facilities.

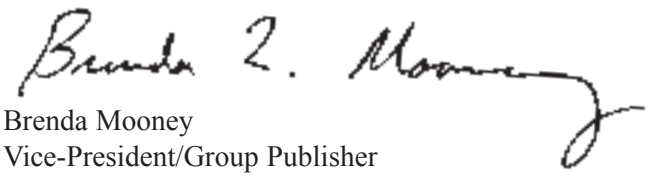
Each issue of your newsletter contains questions relating to the information provided in that issue. After reading the issue, answer the questions at the end of the issue to the best of your ability. You can then compare your answers against the correct answers provided in an answer key in the newsletter. If any of your answers were incorrect, please refer back to the source material to clarify any misunderstanding.

At the end of each semester you will receive an evaluation form to complete and return in an envelope we will provide. Please make sure you sign the attestation verifying that you have completed the activity as designed. Once we have received your completed evaluation form, we will mail you a letter of credit. This activity is valid 24 months from the date of publication. The target audience for this activity is intended for nurse managers, education directors, case managers, discharge planners, hospital clinicians, management, and other health care professionals involved in designing and/or using patient education/staff education programs.

If you have any questions about the process, please call us at (800) 688-2421, or outside the U.S. at (404) 262-5476. You can also fax us at (800) 284-3291, or outside the U.S. at (404) 262-5525. You can also email us at: ahc.customerservice@thomson.com.

On behalf of Thomson American Health Consultants, we thank you for your trust and look forward to a continuing education partnership.

Sincerely,



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