Patient Education Management™

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

AHC Media LLC

IN THIS ISSUE

Financial Disclosure: Editor Susan Cort Johnson, Associate Publisher Coles McKagen, and Managing Editor Jill Robbins report no consultant, stockholder, speaker's bureau, research, or other financial relationships with companies having ties to this field of study. Consulting Editor Magdalyn Patyk reports a consultant relationship with Pritchett and Hull Association.

APRIL 2008
VOL. 15, NO. 4 • (pages 37-48)

Create a standard for communication despite patient's level of health literacy

Health outcomes for low literacy patients improve with good teaching

Health literacy, according to the Institute of Medicine, is "the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions" and research has shown that patients are not all created equal.

According to the National Assessment of Adult Literacy issued by the U.S. Department of Education, people with below basic health literacy skills do not recognize a medical appointment on a form or when to have a specific medical test from clearly written, basic information.

So how does a health care institution make sure all patients, no matter their level of health literacy, have the ability to make appropriate decisions? By teaching staff how to educate these patients and providing the tools they need to do a good job.

The starting point is to make sure staff are aware of the problem and the importance of addressing it.

"Staff need to be given an 'awareness' session on health literacy during

EXECUTIVE SUMMARY

In this issue of *Patient Education Management*, the second in a three-part series, we look at how health care institutions can teach patients at all levels of health literacy to achieve good health outcomes.

In the May issue we will discuss programs that are in place at health care institutions to reach people who are uninsured or underinsured for not only treatment but education as well.

orientation, or as a mandatory continuing education module," says **Sandra Cornett**, RN, PhD, director of the AHEC Clear Health Communication Program at The Ohio State University College of Medicine in Columbus.

They need to learn how to assess literacy skills and the strategies to use when communicating with these patients, adds Cornett.

People need to know what health literacy is, that the problem exists, and how it impacts their patient population, says **Helen Osborne**, MEd, OTR/L, president of Health Literacy Consulting in Natick, MA.

Staff need more than facts, the topic must become personally relevant to them, she adds. They need to know that people in health care are not only part of the problem but can also be part of the solution.

"Not only do people need the facts but they need to have that internal sense of why it is important and how they can make a difference," says Osborne.

She gets the point across at workshops by having conversations with the professional staff, sharing stories, and encouraging them to talk amongst themselves and reflect on the issues.

The key is effective communication no matter the level of health literacy. One of the best teaching strategies for people at basic or below basic health literacy is found in "Ask Me 3" (www.askme3.org), a program of the Partnership for Clear Health Communication, says **Kathy Ordelt**, RN-CPN, CRRN, patient and family education coordinator at Children's Healthcare of Atlanta.

The first question is, "What is my main problem?" The health care professional should first tell the patient what is wrong with him or her. The second question is, "What do I need to do?" Then the patient would be given specific information such as how to take medication or follow a diet plan. The third question is, "Why is it important for me to do this?" The patient would learn how taking the medication or following the diet plan would benefit him or her.

Ordelt says this method of teaching fits the five basic goals of patient education, which are:

- Make sure patients understand the needed treatment so they can give informed consent.
- Teach patients what they need to know to provide self-care at home.
- Provide the information needed to recognize problems, such as signs of infection.
- Make sure patients know who to contact when problems occur.
- Give patients time to speak and have their questions answered.

Focus on teaching strategies

Providing education that answers the Ask Me 3 questions is a good basic teaching strategy. But for patients who have a difficult time understanding verbal instruction or reading information, teachers should keep instruction short and simple, advises Ordelt; discuss the health problem in conversational language and chunk information into small sound bites, she says.

There are a multitude of teaching strategies that will improve the education of low literacy

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

Subscriber Information

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

Subscription rates: U.S.A., one year (12 issues), $489. Add $17.95 for shipping & handling. Outside U.S., add $30 per year, total prepaid in U.S. funds. Discounts are available for group subscriptions, multiple copies, site-licenses or electronic distribution. For pricing information, call Tria Kreutzer at 404-262-5482. Missing issues will be fulfilled by customer service free of charge when contacted within one month of the missing issue date. **Back issues**, when available, are $82 each. (GST registration number R128870672.)

AHC Media LLC is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

This activity has been approved for 15 nursing contact hours using a 60-minute contact hour.

Provider approved by the California Board of Registered Nursing, Provider # 14749, for 15 Contact Hours.

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. It is in effect for 24 months from the date of publication.

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

Editorial Questions

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

Editor: **Susan Cort Johnson**, (530) 256-2749.
Senior Vice President/Group Publisher: **Brenda Mooney**, (404) 262-5403, (brenda.mooney@ahcmedia.com).
Associate Publisher: **Coles McKagen**, (404) 262-5420, (coles.mckagen@ahcmedia.com).
Managing Editor: **Jill Robbins,** (404) 262-5557, (jill.robbins@ ahcmedia.com).
Production Editor: **Ami Sutaria**.

AHC Media LLC

patients. One is the use of plain language in conversation and in print — which is using words people know or explaining clearly terms they need to learn, says Osborne. Ideas can be conveyed by drawing simple pictures or using models that people can see, touch, and manipulate.

Osborne says one of her favorite teaching methods is the use of metaphors or comparing new, unfamiliar medical information to something familiar in a person's life. **(To learn more about strategies for better communication, see article, pg. 40.)**

"The fall-back plan of education has been talking at people and giving them something to read; yet learning about health and really comprehending what needs to be done is so much more than that," says Osborne.

The assessment is important, which includes asking people how they learn and offering examples of learning styles such as reading, watching television or conversation. Another important technique for good teaching is to confirm understanding by stopping after key points and asking the patient to explain what was said. Using the teach-back approach, practitioners need to listen for what is not said and correct any misunderstandings, says Osborne.

Cornett says an important element of good teaching is to individualize the information by using examples to which the patient can relate. Also, information given should be relevant to a patient's lifestyle and current situation such as his or her age, gender, occupation, marital status, and culture.

There are even techniques to improve understanding when answering a patient's question. In a paper Cornett wrote, titled *Effective use of Teaching Methods*, she provides a list of such strategies. For example, practitioners should rephrase the question to make sure they are addressing what the patient wants to know and limit the information to what was asked without adding additional detail.

Addressing the issue of low health literacy with good education techniques is vital as studies have linked low literacy skills to poor health outcomes and a greater use of health care resources, says Cornett. For example, patients with low health literacy skills are more likely to misinterpret prescriptions or to be non-adherent with HIV/AIDS therapy. They have more emergency department visits and are at greater risk of being admitted to the hospital.

The good news is that teaching staff good strategies for education will benefit all patients. Good teaching strategies apply to all patient education, regardless of whether a patient has limited literacy skills, says Cornett. ■

SOURCES

For more information about teaching patients with low literacy skills, contact:

- **Sandra Cornett**, RN, PhD, director, AHEC Clear Health Communication Program, Outreach & Engagement, The Ohio State University College of Medicine, 052 Meiling Hall, 370 W. 9th Ave., Columbus, OH 43210. Phone: 614-688-3327 (Tues/Thurs). E-mail: sandy.cornett@osumc.edu.
- **Kathy Ordelt**, RN-CPN, CRRN, patient and family education coordinator, Children's Healthcare of Atlanta, 1600 Tullie Circle, Atlanta, GA 30329. Phone: (404) 785-7839. Fax: (404) 785-7017. E-mail: Kathy.ordelt @choa.org.
- **Helen Osborne**, MEd, OTR/L, president, Health Literacy Consulting, 31 Highland St., Suite 201, Natick, MA 01760. Phone: (508) 653-1199. E-mail: Helen @healthliteracy.com. Web site: www.healthliteracy.com.

Improving care for low health literacy patients

Resources to use when creating a plan

There are many resources that help health care institutions develop strategies for teaching people how to appropriately access health care and use it to their best interest. Following is a description of two sites:

- www.healthliteracy.com — The official web site of Health Literacy Consulting based in Natick, MA. In addition to a description of services offered by this company such as writing, editing, and workshops, the site has several resources.

These resources include an archive of articles with titles such as: *Actively listening for what patients do not say*, *Confirming understanding with the teach-back technique,* and *Using graphics and humor to convey healthcare essentials.* Monthly tips are also posted such as how to use stories to

explain health concepts and teaching in ways people learn.

• medicine.osu.edu/ahec/4977.cfm — The Ohio State University Medical Center College of Medicine Area Health Education Center has details addressing health literacy in a section titled "Clear Health Communication Content."

Information includes: *Guidelines for selecting and writing easy-to-read materials*, *Getting your message across*, *Who's reading your writing: How difficult is your text?* and *Creating a shame-free and patient-centered environment for those with limited literacy skills.*

There are also details on consultative services such as training workshops, audience research, and developing and field testing new materials. ■

Improve system navigation for low literacy patients

Assessment of environment reveals barriers

To determine what barriers prevent patients with low health literacy from navigating a health care system, it's important for organizations to do an inventory. Once an inventory is complete, the information should be used to come up with strategies on ways to improve the environment, says **Sandra Cornett**, RN, PhD, director of the AHEC Clear Health Communication program at The Ohio State University College of Medicine in Columbus.

To help one Ohio hospital complete an organizational inventory, the AHEC Clear Health Communication program created a staff survey to assess the environment. It was adapted from a tool called the Literacy Audit Kit produced by Literacy Alberta in Canada (www.literacyalberta.ca).

The purpose of the staff survey is to determine how well the hospital communicates with patients. The areas assessed include promotion/publicity, telephone communication, printed materials, verbal communication, and staff awareness of literacy issues. To complete the survey staff read a statement and check one of four option: We are NOT doing this; We ARE doing this but could improve; We are doing this WELL; or Does not apply to our hospital.

Statements on the survey include:

• If there is an automated phone system, it offers the option of repeating parts of the message.

• We regularly review our printed materials, including forms, to check how easy they are to read.

• We avoid hospital jargon when we talk with patients.

• Staff, volunteers, audio or video tapes are available to help patients fill out our forms.

• Once the staff survey is completed and the data analyzed a patient/family/community survey will be conducted.

Cornett said this tool has not yet been finalized but some of the possible questions are:

• Was it hard to find the hospital (office) the first time you came here? If it was hard to find, please explain why.

• In the lobby or reception area, is it easy to find information that you want or need (brochures, posters, signs, how to register, etc.)? If it is hard to find the information, please explain why.

• If you were asked to fill out a form, did the staff member offer to help you? How helpful was the staff member in assisting you fill in the form?

• If staff used medical or technical terms, did they explain them? How helpful were the explanations staff gave you? What are some of the words or terms that were hard to understand? ■

Make time for skin cancer education in May

Observance month, community outreach a natural

Education about skin cancer is still needed, says **Linda K. Franks**, MD, FAAD, director of Gramercy Park Dermatology in New York City, though it is common to see adults on vacation making little effort to avoid the known risks for skin cancer, which is exposure to ultraviolet radiation.

"The behavioral aspect of melanoma can be changed. It is like asking people not to smoke and decreasing the incidence of lung cancer; it is the same thing with the sun and melanoma," says Franks.

To raise awareness of prevention of skin cancer and importance of the early detection of melanoma the American Academy of Dermatology has designated May Melanoma/Skin Cancer Detection and

Prevention Month.

Its purpose is to help people learn the warning signs of skin cancer and catch melanoma early as well as to teach about skin cancer prevention.

"It's important to remember that sun damage is cumulative," says **Ronald S. Davis**, MD, MS, FAAD, a dermatologist practicing in Tyler, TX, and a professor of dermatology at Tulane University Medical Center in New Orleans.

Davis says studies have shown that damage begins after only a few minutes of sun exposure and accumulates over the course of the day with five minutes here and there. It's not just extensive time in the sun while at the beach, pool or playing tennis or golf.

"Most skin cancers are directly related to lifetime sun exposure, so education needs to begin in childhood, both with parents and children," states Davis.

To help prevent skin cancer, people need to know how to protect themselves from ultraviolet rays. According to Davis, sunscreens are the primary means of protection and most dermatologists recommend a waterproof, broad-spectrum sunscreen that protects against both types of ultraviolet radiation: UVA and UVB.

The UVB rays cause sunburn and the UVA rays penetrate the skin more deeply, causing wrinkling. According to the Skin Cancer Foundation, "UVA rays also exacerbate the carcinogenic effects of UVB rays, and increasingly are being seen as a cause of skin cancer on their own."

Davis says the greatest stumbling block to the prevention of skin cancer is the persistent idea of a "healthy tan."

"There is nothing healthy about a tan. It is simply an indication of the skin's response to sun damage. This has been difficult to change in the public mind, especially among teenagers. The proliferation and use of tanning beds has made matters worse. I think early and continued education is the key," says Davis.

According to the Skin Cancer Foundation, determining which sun protection factor (SPF) to choose when selecting a sunscreen can be calculated by knowing how much protection the ratings offer. For example, if it takes 20 minutes for unprotected skin to start turning red, a sunscreen with an SPF of 15 would protect the skin 15 times longer, or about five hours.

Davis recommends an SPF of at least 20 to 30; however the degree of protection also depends on a person's skin color. The more fair-skinned a person is the greater their need for protection; people with darker skin, including African-Americans, can get skin cancer from sun exposure, too, he says.

Putting on sunscreen should be something that is done routinely such as brushing teeth, says Davis. Year-round use is especially important for people in sunny climates such as the southern states and California.

Other measures recommended

In addition to the proper use of sunscreen, people should know that clothing can protect their skin from the sun as well. However, the value of each piece of apparel depends on the weave and the fabric — some are too thin to block sunrays. There also are products that can be added to the wash that increase the protection factor and several companies make clothing with a high SPF rating, explains Davis.

Hats are also important because they help protect the ears, which are very sensitive. Davis says a hat should have a four-inch brim. Sunglasses with UVA and UVB protection listed on the label should be worn as they help decrease sun damage to the eyelids where it is often difficult to apply sunscreen, adds Davis.

Spotting the warning signs

While people need to know what steps to take to prevent skin cancer, equally important is knowledge of the warning signs. Most important is to learn the warning signs of melanoma because if caught early it can be cured with simple surgery, but when diagnosed late it has a high mortality rate, says Franks.

Melanoma in situ is on the surface of the skin and is completely curable with surgery. The critical factor of a melanoma is its thickness measured in the skin at the time of diagnosis, says Franks. A very early, thin melanoma has a prognosis higher than 95%. The worse prognosis is a four-millimeter-thick melanoma, which means there is a high chance it has spread, says Franks.

To catch skin cancer, especially melanoma early, she tells her patients to stand in front of a full-length mirror naked and do a skin check every two months.

The ABCs of melanoma

The first five letters of the alphabet provide a guide:

SOURCES

For more information about skin cancer detection and prevention and ways to get the word out, contact:

- **Ronald S. Davis**, MD, MS, FAAD, 700 Olympic Plaza Circle, Suite 404, Tyler, TX 75703. Phone: (903) 595-2737. E-mail: md@rdavismd.com.
- **Linda K. Franks**, MD, FAAD, director, Gramercy Park Dermatology, 60 Gramercy Park, New York, NY 10010. Phone: (212) 475-2312. E-mail: lkfmd@aol.com.
- **American Academy of Dermatology**, 930 E. Woodfield Road, Schaumburg, IL 60173. Phone: (847) 330-0230. Web site: www.aad.org.
- **Skin Cancer Foundation**, 149 Madison Ave., Suite 901, New York, NY 10016. Phone: (800) 754-6490. Web site: www.skincancer.org.

• The A stands for asymmetry and during a body check people would look for moles where one half is different from the other. It may be higher, a different texture or different color.

• The B is for border irregularity. "Your mole should not look like the coast of Maine. It should have a smooth, round border. A tiny bit of notching is allowable but when there starts to be jagged edges or tails jutting out that is an irregular feature of a mole and could be a warning sign that it is evolving into melanoma," explains Franks.

• C is for color. If a mole has two or three colors or a variation that includes blue, black, or red, that is a warning sign.

• D is for diameter and moles larger than six millimeters, which is about the size of a pencil eraser, should be checked by a physician.

• E stands for evolving or changing and moles should be watched to determine if they have changed in any way.

While routine personal skin checks are important, people should also have their skin examined by a dermatologist. Franks says every adult should have a baseline skin exam completed. People who have any of the risk factors for skin cancer should have a yearly skin exam by a dermatologist.

These risk factors include having fair skin, which is typified by blond or red hair and blue or green eyes. Also a family history of melanoma puts people at greater risk, as well as having three or more blistering sunburns as a child. People who have spent a lot of time in the sun as a child or teenager working as a lifeguard or golf caddy or simply laying on a beach are more likely to develop melanoma as are those who have had other types of skin cancer or precancerous skin lesions.

People who have a lot of risk factors or a lot of moles should be checked by a dermatologist every six months, says Franks. Others should see a dermatologist if they notice a change in a mole or other warning signs when doing a skin check.

Melanoma/Skin Cancer Detection and Prevention Month is a good time to distribute information on skin cancer, hold seminars, and do free skin screenings, says Franks. Conduct a seminar at a community pool, a country club or the local middle and high schools, advises Franks. Offer a list of places where people can receive a free skin cancer screening. ■

Teen birth rate rises for first time in 14 years

It's time to redouble efforts to stem adolescent pregnancy. Preliminary birth statistics released by the Centers for Disease Control and Prevention indicate the U.S. birth rate rose by 3% between 2005 and 2006 among females 15-19 after dropping 34% between 1991 and 2005.[1]

According to the report, prepared by the National Center for Health Statistics, the birth rate for ages 15-19 rose from 40.5 live births per 1,000 females to 41.9 births per 1,000 in 2006. This increase follows a 14-year downward trend in which the teen birth rate fell by 34% from its all-time peak of 61.8 births per 1,000 in 1991.

The increase raises several important questions, says **Bill Albert**, deputy director of the National Campaign to Prevent Teen and Unplanned Pregnancy in Washington, DC. "Why did the rate increase?" he asks. "Is the increase the beginning of a trend or a statistical anomaly, and, of course, what can be done to reverse the increase and continue to drive down rates of teen births?"

Throughout the 1990s, teen sexual activity in the United States decreased and contraceptive use improved, says **John Santelli**, MD, MPH, professor and chair of the Heilbrunn Department of Clinical Population and Family Health and professor of clinical pediatrics at Columbia

University in New York City. In an estimate of trends in use and nonuse of effective protection among adolescents from 1991-2003, analysts found that condom use increased significantly, from 46.2% in 1991 to 63% in 2003.[2] The percentage of teens reporting use of withdrawal or no method steadily declined, from 32.6% to 18.8%.[2]

However, an analysis of data from the 2005 Youth Risk Behavior Survey indicate a deterioration in contraceptive use, says Santelli.[3] For the very first time in almost 20 years, analysts saw a small decrease in condom use for young women, and they noted an increase in nonuse of birth control.

Complacency sets in?

Does the increase signal just an increase or the start of a trend? It does represent a reversal in the downturn of births among adolescents, observes **Anita Nelson**, MD, professor in the Obstetrics and Gynecology Department at the University of California in Los Angeles (UCLA) and medical director of the women's health care programs at Harbor-UCLA Medical Center in Torrance.

Complacency may have become the enemy of progress when it comes to lowering teen pregnancy rates, says Albert. Fourteen consecutive years of declines in the teen birth rate may have led to complacency and may have diverted attention, resources, and funding to other pressing issues, he observes. "The birth rate is up among women of *all* ages — women in their teens, 20s, 30s, and 40s — and among all racial and ethnic groups, which suggests that a broader set of forces may be at play," Albert notes.

Improvement in teen birth rates in the 1990s may have come as a result of an emphasis on condom use, heightened by concerns about HIV, observes Santelli. Today's teens may not see HIV in the same light and may not be as consistent in using protection, he notes.

Less contraceptive use?

In the United States, there were 441,832 teen births in 2006. Compare this number to 50,752 teen births in the United Kingdom for 2004 and 2,549 in the Netherlands for 2006.[3] For Santelli, who wrote an editorial for the on-line version of the British newspaper *The Guardian*, the major behavioral difference between European and U.S. teenagers is better use of contraceptives among European adolescents. Rates of sexual activity are similar among the two groups, but European teens report a higher use of oral contraceptives and use of the "Double-Dutch" method — simultaneous use of condoms and hormonal methods, states Santelli.[3]

"I think the problem is that we're a pretty anti-contraceptive society," Santelli comments. "To the Europeans, if you want to talk about responsibility as an adolescent, you talk about not getting pregnant and you talk about contraception," he says. "People are very open about that, and that is the social norm."

America as a society is much different, Santelli points out. The social norm promoted to teenagers may be more along the lines of "don't get a disease, and you shouldn't have sex anyway," he observes.

"I think in a society where sexuality is expected and understood and seen as normal, it's much easier for people to use contraception," Santelli comments. "I think we haven't gotten there yet."

Abstinence-only debated

Release of the new data has reignited debate about abstinence-only sex education programs, which receive about $176 million a year in federal funding.[4] Findings from a 2007 analysis of four abstinence-only education programs indicated that such programs do not keep teenagers from having sex. Such programs neither increase nor decrease the likelihood that if teens do have sex, they will use a condom, the analysis concludes.[5] A 2006 paper concludes there is no evidence base for providing "abstinence-only" or "abstinence-until-marriage" messages as a sole option for teenagers. The report finds abstinence-only programs demonstrate little evidence of efficacy in delaying initiation of sexual intercourse.[6]

In contrast, a new report released by the National Campaign to Prevent Teen and Unplanned Pregnancy showed that a growing number of sex education programs that support abstinence and the use of contraception for sexually active teens have demonstrated positive effects in delaying first intercourse, improving contraceptive use, and preventing pregnancy or sexually transmitted diseases among teens.[7] Two-thirds of sex education programs examined by the National Campaign report that focused on abstinence and contraception had a

positive effect on teen sexual behavior. None of the programs that discussed abstinence and contraception hastened the initiation of sex or increased the frequency of sex among adolescents.[7]

What is the next step?

What needs to happen in light of the new report? In the National Campaign to Prevent Teen and Unplanned Pregnancy and others will try to determine what might account for the rise in the teen birth rate, says Albert.

"At the same time, we will redouble our own efforts to shine a spotlight on the importance of continuing to focus on teen pregnancy," states Albert. "We will also encourage colleagues nationwide to use this sobering news to intensify their own programs and outreach to policy-makers, practitioners, the press, parents, and, of course, teens themselves."

If you are a family planning clinician who is working with an adolescent population, don't let frustration cloud your efforts in helping teens make wise decisions about their reproductive health, says Santelli.

"People who work in family planning are primarily responsible for those big declines up until 2005," Santelli observes. "We saw birth rates drop by a third among teenagers and even higher among the younger teens, so people who have been doing this work, even though they're not getting rewarded, clearly were the people responsible for that decline."

References

1. Hamilton BE, Martin JA, Ventura SJ. Births: Preliminary data for 2006. *Natl Vital Stat Rep* 2007; 56: 1-18.
2. Anderson JE, Santelli JS, Morrow B. Trends in adolescent contraceptive use, unprotected and poorly protected sex, 1991-2003. *J Adolesc Health* 2006; 38:734-739.
3. Santelli J. Knocked up. *The Guardian*. Accessed at: commentisfree.guardian.co.uk/john_santelli/2007/12/knocked_up.html.
4. Stein R. Teen birth rate rises in U.S., reversing a 14-year decline. *Washington Post*, Dec. 6, 2007:A01.
5. Trenholm C, Devaney B, Fortson K, et al. *Impacts of Four Title V, Section 510 Abstinence Education Programs*. Princeton, NJ: Mathematica Policy Research; 2007.
6. Santelli J, Ott MA, Lyon M, et al. Abstinence and abstinence-only education: A review of U.S. policies and programs. *J Adolesc Health* 2006; 38:72-81.
7. Kirby D. Emerging Answers 2007: Research Findings on Programs to Reduce Teen Pregnancy and Sexually Transmitted Diseases. Washington, DC: The National Campaign to Prevent Teen and Unplanned Pregnancy, 2007. ■

Web site links to valued post-discharge resources

On-line information replaces piles of documents

Instead of handing patients piles of papers during the discharge planning process, case managers and social workers at The Valley Hospital in Ridgewood, NJ, simply refer them to the hospital's Valley C.A.R.E.S. web site, a resource with links to more than 2,000 agencies, facilities, organizations, and informational sites.

Valley C.A.R.E.S. is the brainchild of social worker **Karen Barbato**, MSW, and **Molly Schenk**, office supervisor for the case management/social work department. They initiated the project, planned it, did the research, and worked with **Ken Parker**, manager of marketing and communications, to set up the on-line resource. The acronym stands for Community Access Resource Education System.

"This project streamlined work processes and organized information in one place. It's a tremendous resource for patients and family members because it has everything related to discharge planning and finances at their fingertips, whether they are in the hospital or a family member in another state," says **Maryann Vecchiotti,** director of case management/social work.

Impetus for project

The project was developed when Barbato and Schenk volunteered to update the packets the hospital gave to families with information about long-term care options. As they went through the information on hand, they discovered that much of it was out of date and some of it had been copied so many times, it was hard to read. The team wanted to create additional packets for other types of patients, such as maternity patients or people with disabilities, and started writing down the categories of packets and the type of information they wanted to include.

"We realized it would cost an exorbitant amount of money to make copies and people would still get information they wouldn't need but they might not get information they would find useful. Then, we still would be challenged to update the information frequently and discard the old information," Barbato says.

Barbato and Schenk began by listing the topics

they wanted to list on the web site, what details they wanted to include on each one, and how they should link together.

Major categories include bereavement services, caregiver resources, community resources, disability programs, discharge planning information, end-of-life care, long-term care services, maternal/pediatric/adolescent services, medication assistance programs, mental health and emergency services, senior services, support groups, veterans' services, and health organizations and agencies.

Schenk researched the Internet to identify links that should be included for each topic, starting with the department's internal resource list. Barbato wrote the introductory section for each topic.

"It's a compilation of everything the hospital staff have collected as a group. It's been extremely helpful because the web sites are frequently updated so we always have the latest information," Schenk says.

The hospital's webmaster set up a way that they could look at the web site offline, proofread it, and check the links. "We took a long time developing it because we wanted it to be correct, comprehensive, and attractive," Barbato says.

Five of the largest post-acute health care centers in the area donated $50,000 to fund the project.

"As soon as we showed them what we wanted to do, they were eager to be a part of it," Barbato says.

Putting information to work

The purpose of the project is to shorten the time and improve the efficiency of the discharge process by offering families research capabilities that enable them to access information that is pertinent to them without having to wade through pages of information, Barbato says.

"Our goal is to try, in a concise way, to lead a family through everything that we discuss face to face — to show them the process, their choices, and what they need to do," she says.

The webpage is especially useful for family members who live in other parts of the country and can't spend a lot of time visiting nursing homes or assisted living centers, Barbato says.

"In the past, we sent them a list that said, 'Bergen County Nursing Homes.' Now we send them a link that allows them to tour the nursing home web sites and get an idea of what the facilities are like as well as check the nursing home reports cards," she says.

The daughter of one patient who has dementia wanted to place her mother in a long-term care facility closer to her home in New York. Barbato helped the daughter go on-line, identify potential facilities, and download a checklist of what to look for in a facility. In the case of another patient, who was failing at home, Barbato was able to direct the family to caregiver resources, education and support groups, and adult day care facilities.

"When I talk to someone on the telephone and they can't be here, I send them an e-mail that includes links to the various parts of the web site they may find useful," she says.

The social workers and case managers guide the family members through the process if they aren't familiar with computers or the Internet. As soon as the hospital's wireless Internet network is complete, they will be able to take laptop computers into the patients' rooms and show patients and family members discharge options at the bedside. In the meantime, the hospital has set up a computer kiosk in one of the waiting rooms, giving family members access to the information.

"Sometimes I bring them into my office if it's convenient and they're not computer-savvy. Other times, if they just want to sit down and look at it, I walk them to the computer station and show them how to get started," she says.

Web site cuts phone calls

Having an on-line resource has cut down on calls from physician offices and the public who are seeking resource information, said Schenk, who handles telephone calls from the public.

"We were being inundated with calls from doctors' offices who wanted our home care list, our nanny list, or community support groups. Now the doctors can print out information from our web site or give their patients a card with the web site information on it. We can refer the public to the web page for the information they need," Schenk says.

Feedback has been positive from patients and family members, physicians, and especially from the hospital staff, Barbato says.

"It gives staff members centrally located and accessible up-to-date information and resources, saving them time and making the discharge process more effective," Barbato says.

(Editor's note: For more information, contact

***Karen Barbato**, MSW, social worker, The Valley Hospital, e-mail: kbarbato@valleyhealth.com.)* ■

Partial knee replacement is option for some patients

Patients find quick return to normal activity

Patients with limited arthritis in their knees typically had to live with pain and discomfort or wait until deterioration reached a point at which they could undergo a total knee replacement, but new technology gives patients a third option that allows them to return to normal activity without pain earlier in their lives.

Partial knee replacements reduce the cost of the procedure and enable a patient's quicker return to normal activities. The procedure is another orthopedic surgery that easily can be moved to the outpatient surgery program.

"Because this procedure is minimally invasive there is little blood, and it is routinely performed on younger, healthier patients, so it is ideal for the outpatient or 23-hour stay setting," says **Keith Berend**, MD, orthopedic surgeon at Joint Implant Surgeons in New Albany, OH. "Patients who are good candidates for this procedure are usually working, so they don't want to undergo a procedure that requires the eight- to 10-week recovery required by a total knee replacement, but they want to eliminate the joint pain caused by arthritis in their knee."

A partial knee replacement can be performed on patients who have knee arthritis limited to one side of the knee joint and have no torn meniscus, says **Frosty Moore**, MD, an orthopedic surgeon in Austin, TX. "I always order an MRI to rule out other damage to the knee," he says.

In addition to making sure that the patient doesn't have any other knee damage, there are other attributes of the ideal candidate for partial knee replacement, suggests Moore. "Patients must be motivated to follow through on physical therapy, they must understand pain and how to deal with it, and they must be younger and willing to get up and get moving quickly," he says.

In a partial knee replacement, an implant replaces the diseased part of the knee to correct the deformity caused by arthritis and to restore the knee to the pre-diseased state, says Berend. Partial knee replacement requires less removal of bone and cartilage and gives patient a more natural motion following surgery, he adds.

Berend uses the Biomet Partial Knee System that has been approved by the Food and Drug Administration (FDA) for this use. It differs from other partial knee implants because it contains a free-floating meniscal bearing, he says.

The FDA approval mandates specific training with the device before use on patients, he points out. This is an important issue for outpatient surgery managers who are reviewing privileges for new procedures, Berend adds. "Not only should surgeons who want to perform partial knee replacements on an outpatient basis be experienced with the procedure in the inpatient department, but if they are using the Biomet system, they must attend Biomet-specific training courses," he says. This additional training ensures not only that the surgeon understands the implant, which does differ from other implants, but that all other aspects of the procedure and the recovery process are addressed, he adds.

Training for the operating room staff involves a demonstration of the special leg holder that is used for the partial knee replacement, points out Berend. "This leg holder and the position in which the patient's leg must be placed during the procedure is different from other knee procedures," he says.

Although the implant and the surgeon's skill are important to a good outcome, Moore believes that patient education prior to the procedure is just as critical to a successful recovery. "We set expectations up front by lining up physical therapy, setting up an exercise schedule and continuous passive motion," says Moore. Patients also are told what type of pain to expect so they can distinguish between normal pain during recovery and unusual pain that requires a call to the surgeon, he adds.

Pain control begins before the procedure as the anesthesiologist administers a femoral nerve block and then places an indwelling catheter that will remain for two days to block the pain in the knee, explains Moore. "By reducing the pain during the first days, we increase the patient's mobility and that improves recovery," he says.

Because the typical patient for this procedure is between 40 and 60 years of age and is working, reimbursement is not an issue, Moore says. Patients are usually covered by private insurance offered through their employers rather than Medicare, he explains. "The cost of the implant varies according to contracts with the vendor, but insurance companies like the lower cost of the outpatient procedure compared to the cost of an

inpatient stay," he says.

Partial knee implants last up to 20 years, so there should be no reason for another surgery, says Berend. "There is always a chance that arthritis might develop on the other side of the knee but generally, it does not," he says.

Patients are grateful that the partial knee replacement option exists, says Moore. "Our pre-op planning and education teaches patients how to recover, so after the surgery they are ready to go home, which is where they want to recover," he says. ■

CNE 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 credit letter. When your evaluation is received, a credit letter 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. ■

NEWS BRIEF

Study says low use of outpatient rehab after MI

Just 35% of heart attack survivors reported receiving outpatient cardiac rehabilitation services when surveyed by the Centers for Disease Control and Prevention. Only 21 states and the District of Columbia participated in the 2005 survey. Possible reasons for low rates of use include cost and lack of referral or access to services, the authors said. ■

COMING IN FUTURE MONTHS

- Strategies for implementing learning needs assessment
- Best practice for evaluating reading materials
- Comply with Joint Commission on pain management education
- Setting in place patient pathways
- Targeting the education needs of the working poor

CNE Questions

13. To individualize teaching to the needs of low literacy patients, staff might do which of the following?
A. Provide information regardless of reading level.
B. Provide information written in plain language.
C. Use teach-back after instruction.
D. B and C

14. To help prevent skin cancer, patients need to learn which of the following?
A. Sunscreen is only for the beach.
B. Tans are a sign of skin damage not health.
C. Any hat regardless of brim-size is good protection.
D. Clothing no matter the weave or fabric is good protection.

15. According a report prepared by the National Center for Health Statistics, the birth rate for U.S. teenagers ages 15-19 rose by how many percentage points from 2005 to 2006?
A. 10%
B. 7%
C. 5%
D. 3%

16. What are the key components to ensure the successful outcome of partial knee replacements, according to **Frosty Moore**, MD?
A. Set expectations and schedule physical therapy prior to surgery
B. Obtain insurance verification and MRI studies
C. Explain normal pain and prescribe continuous passive motion prior to surgery
D. A and C

Answers: 13. D; 14. B; 15. D; 16. D.

On-line bonus book for *PEM* subscribers

Readers of *Patient Education Management* who recently have subscribed or renewed their previous subscriptions have a free gift waiting — *The 2008 Healthcare Salary Survey & Career Guide*.

The report examines salary trends and other compensation in the hospital, outpatient, and home health industries.

For access to your free 2008 on-line bonus report, visit **www.ahcmedia.com**. ■