Patient Education In Primary Care

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LOW PROBLEM SCORES FOR PATIENT EDUCATION CONSUMER SERVICE STANDARDS SPARK DISCUSSION OF EFFECTIVE STRATEGIES

The results of the 1999 Customer Service Standard survey of a random sample of veterans who made at least one primary care visit from 3/1/99 to 4/30/99 show that the national problem score average for VA hospital-based facilities is .32 as compared to a private sector average of .23. This means that the average veteran respondent reported a problem with about a third of the questions specifically related to patient education (Figure 1). To explore effective strategies to lower these scores, staff from four of the five VA hospital-sponsored outpatient clinics (Boston OPC, Durham OPC, Memphis OPC, Seattle OPC) with the lowest scores for 1999 (.11-.22) were interviewed to identify possible best practices and other factors they thought were responsible for success.

Ida Wylie, Manager, Primary Care and Telephone Care at the Durham NC Outpatient Clinic sees the team approach to care and the multifaceted involvement of nurses in patient education as the keys to success. For example, nurses coordinate clinic flow so that nearly every patient has an exit interview. If the interview is missed and there is a patient education need such as an

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WELCOME TO OUR RESOURCE FOR PATIENT EDUCATION AND PRIMARY CARE! [1]

WHAT IS IT?

The purpose of this tool is to provide a mechanism to help meet the challenges of incorporating effective patient teaching into primary health care.

WHO IS IT FOR?

VA Primary Care Teams, Patient Health Education Coordinators or Patient Health Education Committee chairs, VISN and VAMC decisionmakers

c o n t e n t s

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1. This publication may be duplicated. It is also available on the VA website at http://www.va.gov/visns/visn02/emp/education/education.html.

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upcoming diagnostic test, then the nurse calls the patient at home. A telephone care program now staffed by RNs from 8:00am-4:30pm daily provides advice using agreed upon protocols to veteran callers. Follow-up is emphasized here, also, as any patient who calls is re-contacted one or two days later to make sure there is no continuing problem.

Nurse managed clinics at Durham are viewed as key to meeting more in-depth patient education needs. New diabetics, for example, may be scheduled for the meter clinic to learn how to use a glucometer. Nurses and other providers may refer diabetics for individual appointments in the foot clinic where the nurse will screen for foot problems and implement approved interventions regarding foot care, callous treatment and nail cutting. The Risk Reduction clinic is targeted to patients with hyperlipidemia and hypercholesterol-emia and also involves a dietitian. Finally, the Wellness clinic is a two hour class for new patients and yearly return visits that meets JCAHO and EPRP requirements for preventive care and assessments such as the alcohol or depression screen. Patient satisfaction surveys in the primary care and nurse managed clinics are mailed out after the visit; one change that was recently implemented in the Wellness clinic based on survey results was the invitation of spouses to the class.

Staff at the Boston Outpatient Clinic cite low turnover, the long experience with collaborative practice (physicians and nurse practitioners) and primary care, and the integration of patient education into the clinical visit as major reasons for their low problem scores. However, Sheila Poswolsky, an adult nurse practitioner and the patient education liaison for the outpatient clinic also believes that a formalized telephone health advice program(TAP) has responded to the need for improved telephone communication between providers and veterans. "We found that patients were not getting through, or they were calling their providers directly for things like scheduling or pharmacy matters." Now there is an RN who coordinates TAP using both RNs and secretaries (with protocols for what gets transferred to a nurse) to answer calls. Staff can get veterans into clinics, reinforce teaching, give normal lab data, refer to pharmacists, and contact the primary care provider if necessary. Communication is enhanced since nurses forward progress notes by to the chart and to the provider who can review and decide on further action. Laurel Bailey Ghose, staff nurse and TAP coordinator believes that "the program communicates to veterans that there is someone concerned about their health. Especially for those patients who are homebound and may have no family in the area it is also reassuring to have someone to talk with when a problem arises."

"THE PROGRAM COMMUNICATES TO VETERANS THAT THERE IS SOMEONE CONCERNED ABOUT THEIR HEALTH..."

Melanie Swims, PharmD, Clinical Pharmacist, and chair of the Patient Education Committee at the Memphis VA Medical Center believes that the strong support at the service level for patient education and the development of a decentralized patient education liaison program has encouraged everyone to accept at least some responsibility for patient education. Each of the 20+ liaisons are asked to assess how patient education needs are being met in their area, develop plans to meet those needs, coordinate teaching materials for specific service area, and serve as a contact between the individual service and the institution wide patient education committee. Strong leadership by this committee over the past two years has resulted in the development and dissemination of hospital-wide resource lists, new guidelines for the development or selection of materials, the establishment of a computerized mail group for quick communication about education-related matters, and multiple in-service programs on documentation, teaching strategies, and literacy issues. Yearly patient satisfaction survey results have shown improvements in patients' perceptions of the adequacy of information received; interest in the broad topic "how to get further care" has doubled in the past year.

The Patient Education Committee at the VA Puget Sound Healthcare System has also sponsored quarterly education programs for staff that have drawn broad multidiscipliary response. For example, one all day participatory workshop is planned on motivational interviewing while the next will address accessing Internet resources for patient education. However, Connie Browne, nurse practitioner and Co-Chair of the Patient Education Committee at the Seattle Division concludes that it is the coordinated team approach to care and, as in Boston, the physician/nurse practitioner collaborative model, that makes the biggest difference.

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At Seattle, there are four primary care teams each with 4 physicians, 10 residents, 6-7 nurse practitioners, 2 RNs, 1 LPN, a psychologist, social worker, pharmacist and a team coordinator. Separate front desk assistants are used for each team. Browne notes that with this arrangement, "it's a little bit cozier. Patients feel more connected, they know their team members' names." Nurses man the phone all week so patients have easy access to their team - either they are given advice immediately or providers are alerted to call the patients back. There is also a satellite pharmacy in the primary care area with individual booths so that patients can get their questions answered in a more personal way. All of this, says Browne, makes patients feel involved in the health care team. It establishes a trusting relationship which makes people more receptive. Getting the same message from multiple providers also helps reduce confusion."

Having access to appropriate teaching materials is also an asset! In Seattle, Health TV is an invaluable resource. For example, if a provider orders occult blood screening, at the end of the visit the clerk gives the patient a test kit and a prescription for Health TV, and the LPN or a volunteer sets them up with the video program at one of the three TV sets in the patient education area. In Durham, Wylie estimates that 85% of the education pamphlets available in the clinic were developed by outpatient nurses. They follow recommendations to write at the 6th-8th grade reading level and must have materials approved by the patient education committee, but the involvement upfront seems to encourage more consistent use of these materials.

While there are a plenty of other factors that could affect the scores - including size of facility, stability of the veteran population, physical accessibility, and other regional issues - primary care team structures, telephone protocols, exit interviews, and teaching resources that increase system responsiveness to patient questions seem to be making a difference.

For further information on the four sites contact:

Connie Browne, RN, ARNP, Nurse Practitioner, Seattle Division, VA Puget Sound Healthcare System, FTS 700/762-1010; COM 206/762-1010, Ext. 61908 (MF) and 63879 (T-Th).

Laurel Bailey Ghose, RN, Staff Nurse, VAOPC of Boston; COM 617/248-1334.

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Melanie Swims, PharmD, Clinical Pharmacist, VAMC Memphis, FTS 700/222-7363; COM 901/523-8990 Ext 7933.

Ida Wylie, Manager, Primary Care and Telephone Care, Durham VAMC, FTS 700/671-6011; COM 919/286-0411 Ext 7986.

FIGURE 1

CUSTOMER SERVICE STANDARDS - PATIENT EDUCATION QUESTIONS

- When you asked questions did you get answers you could understand?
- Did the provider explain why you needed tests in a way you could understand?
- After tests were done, did the provider explain the results in a way you could understand?
- Did someone explain the purpose of any prescribed medicines in a way you could understand?
- Did someone tell you about side effects of your medicines in a way you could understand?
- Did the provider explain what to do if problems or symptoms continued, got worse or came back?
- Did you get as much information about your health and/or treatment as you wanted from the provider?

Patient Education on the Run

Use a clip board for patients to complete forms or self-assessments. Equip each with a laminated information sheet - for example with information on where flu shots will be given or a list of suggested questions to ask their primary care provider. The laminated sheets wear well and can be rotated weekly or monthly.

HOW DO WE KNOW PATIENT EDUCATION WORKS?

HEART FAILURE

A needs assessment survey was conducted with 113 heart failure patients referred to a new heart failure clinic. Of the patients interviewed, 60% had NY Heart Association class III or IV status. Two-thirds of the patients reported receiving information or advice about self-care from health care providers. However 37% reported that they knew "little or nothing about the disease," 49% "some" and only 14% said "a lot." Approximately 40% of patients did not recognize the importance of weighing themselves daily and 36% believed that they should drink a lot of fluids. Knowledge was related to being married, prior hospitalization, and having received advice from health providers. A poor adherence score was associated with being unmarried, lower perceived self-efficacy, a lack of knowledge about self-care, and no prior hospitalization. Among other recommendations, the authors conclude that more emphasis on patient education during outpatient visits is warranted.

Ni, H. et al. (1999) Factors influencing knowledge of an adherence to self-care among patients with heart failure. Archives of Internal Medicine. 159: 1613-1619.

PROSTATE CANCER/SHARED DECISIONMAKING

The purpose of this study was to evaluate a patient education approach to shared decisionmaking for prostate cancer screening. In a randomized control trial, 160 men with no history of prostate disease were assigned to either a control group or an experimental group which viewed a 20 minute videotape (from the Foundation for Informed Medical Decision-Making, Inc., Hanover, NH) on the advantages and disadvantages of PSA testing. While all patients' knowledge at baseline was poor, experimental patients showed a 78% improvement at two-week follow-up in the number of knowledge questions answered correctly while there was no overall change for control patients. At follow-up, 48 (62%) of 78 intervention patients planned to have the PSA tests compared with 64(80%) of 80 control patients. This represents a statistically significant 18.5% reduction.

Volk, R.J., Cass, A.R., Spann, S.J. (1999) A randomized controlled trial of shared decision making for prostate cancer screening. Archives of Family Medicine. 8: 333-340.

HEPATITIS C WEBSITE

Veterans Health Administration - **http://www.hepatitisc.gov**

This new resource includes disease specific information on the disease course, screening techniques, treatment, and prevention. The site also has "downloadable" patient education materials including Frequently Asked Questions about Prevention, Treatment and Counseling Guidelines, Managing Side Effects of Hepatitis C Treatment and others.

The website is sponsored by the Centers of Excellence in Research and Education for Hepatitis C at the Miami (FLA) and San Francisco VAMCs.

PATIENT EDUCATION/ PRIMARY CARE PROGRAM NOTES

TAI CHI PROGRAM OFFERS MULTIPLE HEALTH BENEFITS

As part of a series of relaxation activities offered to veterans enrolled in the PTSD program, Sharon Morrison, CSW - PTSD therapist, Coordinator of the Ex-POW Program, and Tai Chi instructor in the community - began offering a weekly Tai Chi class four years ago, initially limited to the PTSD Program at New York Harbor Health Care System. It was later expanded to include any interested veteran and significant other. With increasing numbers of scientific articles documenting the fitness and fall prevention benefits of Tai Chi - an ancient Chinese exercise and form of martial arts characterized by a series of gentle coordinated movements - this program appears to have caught the interest of older veterans as well as those with disabilities and/or serious chronic

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conditions. For example, the original class has been adapted for visually impaired patients by focussing on movements that can be done from a chair, using touch to demonstrate positions, and emphasizing verbal communication and voice inflection rather than silent exercise. Other adaptations for chronic conditions such as arthritis and multiple sclerosis have also been considered. For example, Tai Chi includes a variety of finger exercises and fanning of the wrists that would be helpful to include in a program for those with arthritis.

While not currently able to evaluate results formally, Ms. Morrison sees a variety of positive changes among those who participate regularly. For example, older patients, in particular, learn how to walk in a steadier way by shifting their weight from one side of their body to the other - they are then less likely to fall. The emphasis on learning how to breathe properly helps those with heart disease conserve energy while doing simple things like waiting for a bus or taking a shower. Psychiatric patients say Tai Chi helps reduce their anxiety; they also like having a technique that they can use almost anywhere when they are stressed. Veterans who use walkers often become less dependent on this support as they participate in the program.

For those interested in starting Tai Chi programs at their medical center, Ms. Morrison suggests checking with local community organizations including senior centers, health and fitness centers and YMCAs to identify qualified instructors. There is currently no national Tai Chi credentialing organization so that advice from agencies who have found instructors with appropriate teaching experience, years of practice and personal recommendations can be time saving. Other than the instructor, only a room and word-of mouth/posters informing veterans and primary care clinicians about the class are necessary to launch the program.

For more information contact:
Sharon Morrison, CSW, New York Harbor Health Care System, NYC; FTS 700/662-3500; COM 212/686-7500 Ext.7589.

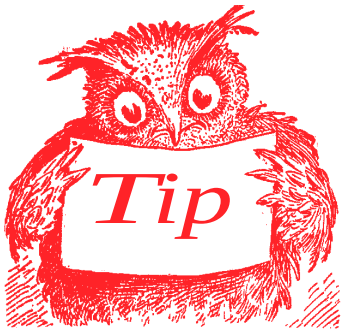
PRACTICAL EDUCATION STRATEGIES USING ANALOGIES TO ENGAGE YOUR PATIENTS[2]

Health care is full of complicated medical terms which are imperative for patients to understand. Through analogies, patients can relate to a familiar object or idea and use this as a basis for understanding a more complicated medical concept. For example, if you need to explain to a patient that he has heart disease, it may be helpful to start by explaining that his heart is like a pump. This analogy compares his heart (a complex organ) to a pump (a simple item that most everyone is familiar with). Once the initial connection is made, you can work from the analogy to explain other pertinent parts of his anatomy as they relate to his heart disease. For instance, you could go on to explain that his arteries and veins are like pipes that lead in and out of the heart. These pipes take blood, oxygen, and nutrients to other parts of his body. If the pipes get clogged with plaque, the heart cannot pump blood through them like it needs to.

Some suggestions for ensuring the effective use of medical analogies include:

1. An analogy works best when the concept being taught is new. If the patient already has some understanding of the topic, try to build on existing knowledge.
2. Analogies should only be used if the concept is hard to grasp.
3. It is very important to make sure the patient understands the analogy. If the patient has never understood a pump, this analogy will not help him understand his heart.
4. Explain the specific similarities between the two concepts. Simply stating that the heart is like a pump does not focus the patient's attention on how it is similar. Make sure to take it a step further and explain how the action of a pump is relevant to the action of his heart
5. Make the analogy as visual as possible. Helping the patient to visualize similarities will increase the likelihood of him understanding the new concept.

2. This article was adapted with permission from PEN (#1, 1999) published by Pritchett & Hull Associates, Inc., Atlanta Georgia. The content was based on a presentation by Dr. Terry Ruhl of Mid-Michigan Medical Center, Midland, MI.



Performance Improvement Tip

Clinicians lacking a few hours of the required 30 hours of continuing education? Provide staff with a copy of "New Feature: Performance Improvement Training" in this issue or one of the previous issues with a note to answer the questions and return to their supervisor. This can then be recorded as one hour of training.

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6. Be aware of misconceptions the analogy may leave. For instance, if the patient's experience with a pump includes a reservoir overflowing, he may incorrectly assume that congestive heart failure will cause his lungs to rupture. It may be helpful to have the patient explain his understanding of the analogy to make sure you have accomplished your goal.

7. After the target concept is learned, the patient can be weaned from the analogy. This will allow the medical professional to build on the patient's knowledge and easily explain other necessary, related information.

While use of medical analogies can be very effective, they can also be fun. Here are some examples you may want to try with your patients:

- The spinal cord is like a telephone cord that can't send messages to your brain if it is damaged or cut.
- Using antibiotics to treat a virus is like using an umbrella to stay warm on a cold day.
- A normal stool is the consistency of a banana.
- Stress is like a runaway car. Unmanaged stress races out of control until it is stopped, often with a bang (like a heart attack).
- When you are having a heart attack, the pressure can feel like an elephant is standing on your chest.
- Your invertebral discs are like shock absorbers or cushions that let you bend and twist your spine without causing damage.
- Having neuropathy makes your legs and feet feel like your mouth does after the dentist has given you novocaine. They can be tingly and/or numb.

NEW FEATURE: PERFORMANCE IMPROVEMENT TRAINING

Shared Decision Making - Opportunities and Challenges for VHA

Every quarter, Patient Education in Primary Care offers the opportunity to earn one hour of performance improvement training credit for a patient education topic of importance to primary care clinicians. To earn this credit choose one of the following two options:

Read the following summary "Shared Decision Making" and provide brief answers to the following questions. Turn these in to your supervisor along with the content description. OR

Organize a one hour brown bag journal club or set aside time during a staff or team meeting to read the entire position paper and discuss the following questions. Turn in a master list of journal club participants along with the content description.

QUESTIONS:

1. How can the clinician assess the extent to which patients want to participate in shared decisionmaking?
2. What are small ways that primary care staff can support more active involvement by patients in decisionmaking?
3. What are barriers to clinician participation in shared decisionmaking?

SUMMARY: Shared Decision Making - Opportunities and Challenges for VHA[3]

Shared decision making is a process of communication between a clinician and a patient regarding the patient's health. Key elements of the process include mutual sharing of knowledge and expertise and building a consensus about the preferred treatment. The ideal outcome is a plan that is mutually agreeable both to the clinician and the patient. This process is embedded in the relationship that develops between the clinician and patient, and is expressed through the multitude of decisions that they make over time in managing the patient's health. Like dancing, shared decision making is smoothest when both the clinician and the patient value it and want to engage in it, and when both bring some energy and skills for it to the encounter.

A number of studies have demonstrated substantial benefits to both clinician and patient when this partnership approach to care is used. These benefits include improved health outcomes, greater adherence to treatment regimens, reduced exposure of clinicians to malpractice litigation, higher levels of clinician and patient satisfaction, and more effective use of health care resources.

It is important to remember, however, that shared decisionmaking is not a single, uni-dimensional intervention. It occurs as a cluster of clinician and patient behaviors (See Figure 2) along a continuum from no patient participation to maximum patient control. It is situationally specific in that it varies across diagnoses, from acute to chronic conditions, and over time within the same clinician-patient relationship. It also reflects a continuum of skills on the part of both clinician and patient to communicate effectively with each other.

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3. This information is adapted from a position paper - Shared Decision Making: Opportunities and Challenges for VHA, released as part of an educational package entitled "Shared Decision Making" in September 1999 and distributed to all medical center education contacts. For further information on this project contact Carol A. Craft, Ph.D., R.N., Chair, VA Learning University Shared Decision Making Task Force at 314/894-5736 or electronically on MS Outlook.

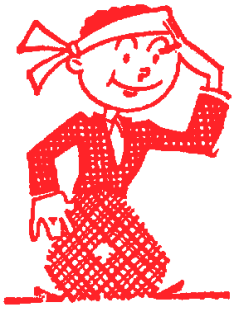
FIGURE 2

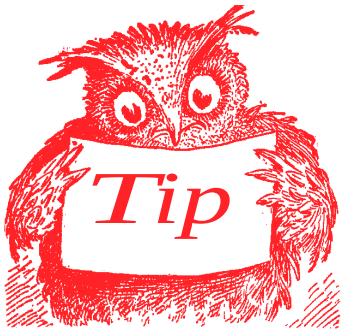
CLINICIAN BEHAVIORS THAT PROMOTE SHARED DECISION MAKING

- Establish an atmosphere so that the patient feels his/her views about treatment options are valued;
- Encourage the patient to discuss concerns in detail and express concerns about the patient;
- Elicit patient preferences so that treatment options discussed are compatible with his/her lifestyle;
- Inform patients in a clear and simple way about treatment options, risks and probably benefits. Check to see if the information was understood;
- Help the patient think about and implement the process of weighing risks and benefits;
- Focus first on the goals of therapy, not technical options of management;
- In the face of disagreements, initiate a process of mutual exchange to explore areas of agreement as well as disagreement;
- Acknowledge that final choices belong to fully informed patients;
- Ask patients to take some responsibility for care;
- Work to refine clinician's own communication skills, especially in direct and honest dialogue and negotiation.

PATIENT BEHAVIORS THAT PROMOTE SHARED DECISION MAKING

- Identify relevant medical decisions in their care and management issues warranting discussion with the physician;
- Share beliefs about the health problem, and disclose preferences;
- Discuss topics not related to the current visit, including interpersonal relations or one's emotional state;
- Ask questions;
- Weigh and evaluate treatment alternatives and formulate a treatment preference;
- Negotiate decisions with physicians.





Joint Commission Tip

Standard PF 1.1 "The assessment considers cultural and religious practices...." Tap into a web site sponsored by the University of Indiana that provides a wide array of information on different cultural, ethnic, religious and other special groups and links to their specific sites. Go to: <http://www.lib.iun.indiana.edu/trannurs.htm>

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Within the Veterans Health Administration (VHA), shared decisionmaking in the context of clinician-patient partnerships is explicitly encouraged as a strategy to achieve VHA's goals of improving quality and accessibility of care and meeting its customer service standards. The task for VA clinicians and patients is to assess needs, preferences, and skills for shared decision making and to find ways to respond that enhance the relationships and the desired health outcomes. The task for VHA is to sustain policy and program commitment for shared decisionmaking and to support additional initiatives to promote shared decision making in the VA health care system.

DO YOU HAVE ANY SUCCESSFUL PATIENT EDUCATION STRATEGIES THAT YOU WOULD LIKE TO SHARE WITH US?

Contact Barbara Giloth (773/743-8206 or email bgilot1@uic.edu), Carol Maller (700/572-2400, ext 4656 or email carol.maller@med.va.gov) or Charlene Stokamer (700/662-4218 or email charlene.stokamer@med.va.gov) with your input!

TELL US ABOUT THE TOPICS YOU WOULD LIKE TO SEE COVERED IN FUTURE ISSUES.

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COMING IN APRIL -

A NEW LOOK AT PAIN MANAGEMENT

Office of Primary and Ambulatory Care