

Patient Education In Primary Care

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PATIENT EDUCATION DOCUMENTATION IN CPRS

The VAMC in Wichita, KS is using clinical reminders in CPRS to provide a seamless computerized system to document patient education. This approach has multiple benefits: easy data entry; easy data retrieval; access to both ambulatory care and inpatient care; and easy access to patient education handouts and medication handouts. In addition, it addresses Chronic Disease Index and Prevention Index requirements, avoids redundancy of teaching and documentation, and facilitates entry of the learning assessment. This includes education and documentation at the time of the interview as well as timely referrals (with documentation) initiated as a result of the assessment.

Prior to implementation of the patient education documentation system, all clinical staff members were given access to CPRS GUI and the common drive. Patient education handouts were placed on the common drive so that all clinicians would have access to them; the only exceptions were selected nutrition and rehabilitation handouts which were restricted to staff with advanced training in these areas. Micromedex software was used for medication handouts to provide up-to-date handouts without requiring staff time to create or edit them. A computer handbook was developed and placed on the common drive to provide assistance to staff members learning new processes, for the orientation of new staff, and as a reference for staff.

A videotape demonstration was made to prepare staff for the new system. Each staff member received individual tutoring in the process. While learning the process, staff members were encouraged to make suggestions to improve it. Several

continued on page 2

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

WHAT IS IT?

This newsletter provides a mechanism to help meet the challenges of incorporating effective patient education into primary care.

WHO IS IT FOR?

VA Primary Care Teams, Patient Health Education Coordinators or Patient Health Education Committee chairs, VISN and VAMC decision makers.

c o n t e n t s

Patient Education Documentation in CPRS . . . Page 1

Making a Difference in Chronic Care Page 4

Current Studies That Document the Impact of Patient Education

Chronic Care Clinics for Diabetes in Primary Care . . . Page 6

Oral Anticoagulation Self-Management Page 6

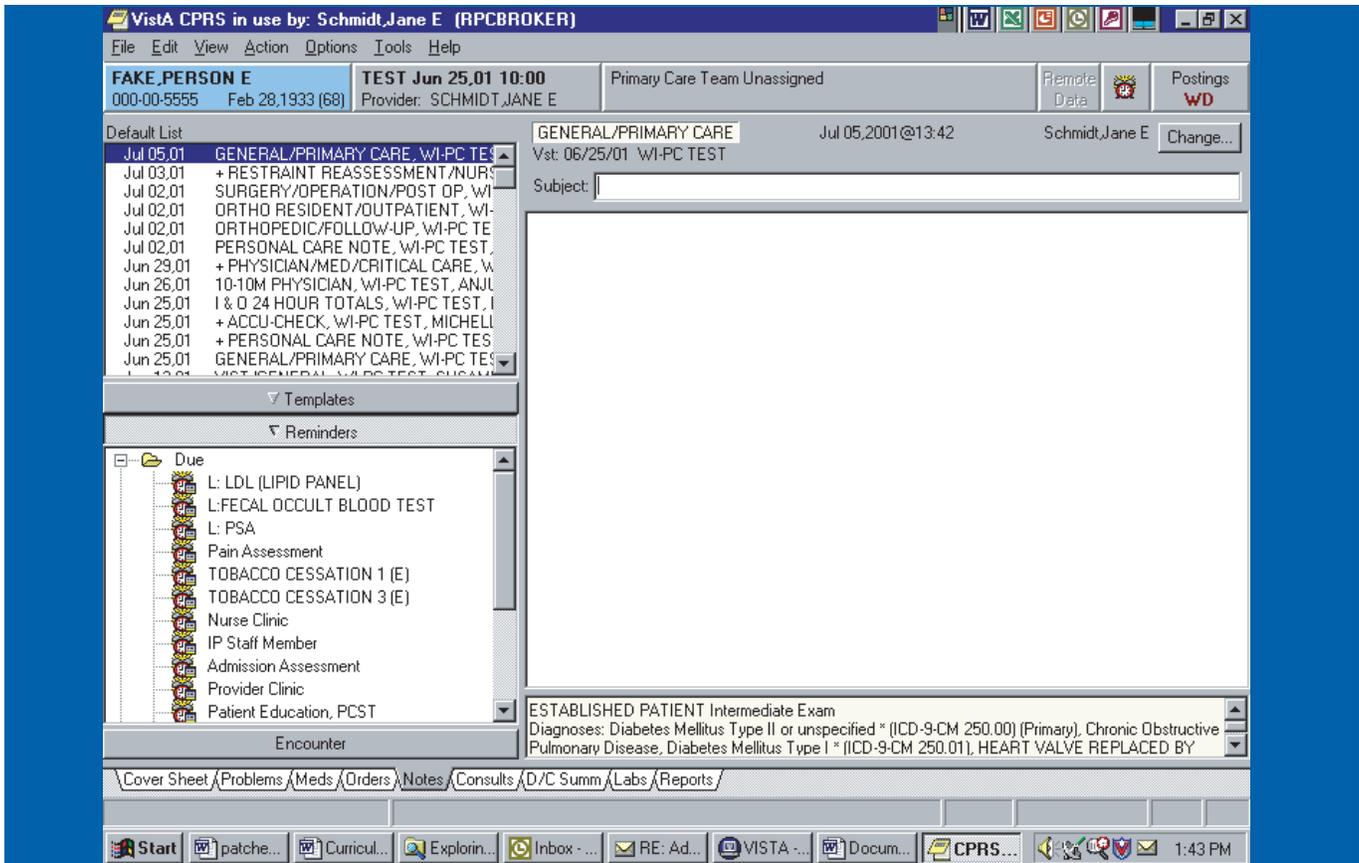
Weight Management: What Patients Want From Their Primary Physicians. Page 7

Patient Education/Primary Care Program Notes

Patient Education Prescriptions Page 7

Performance Improvement Training Page 7

1. This publication may be duplicated. It will be available soon on the VHA Primary Care website at <http://www.va.gov/med/patientcare/primary/index.cfm/>



modifications were made as a result. Chart reviews were used to provide reinforcement and to highlight areas needing attention.

CPRS Set Up

- Micromedex was loaded on the toolbar (when selecting the “Tools” option)
- Appropriate reminders were loaded onto the cover sheet for each clinical service team
- A Health Summary was developed and named “Patient Education Index” to include the Health Factors Component, the Education Component, and the Selected Progress Notes Component. This health summary has been placed on the top of the listing of Health Summaries on the Reports Tab of CPRS.
- Consults were set up as quick orders for specific referrals.

Clinical Reminder Program Set Up

- Education Topics were developed and loaded
- Health Factors were loaded, including

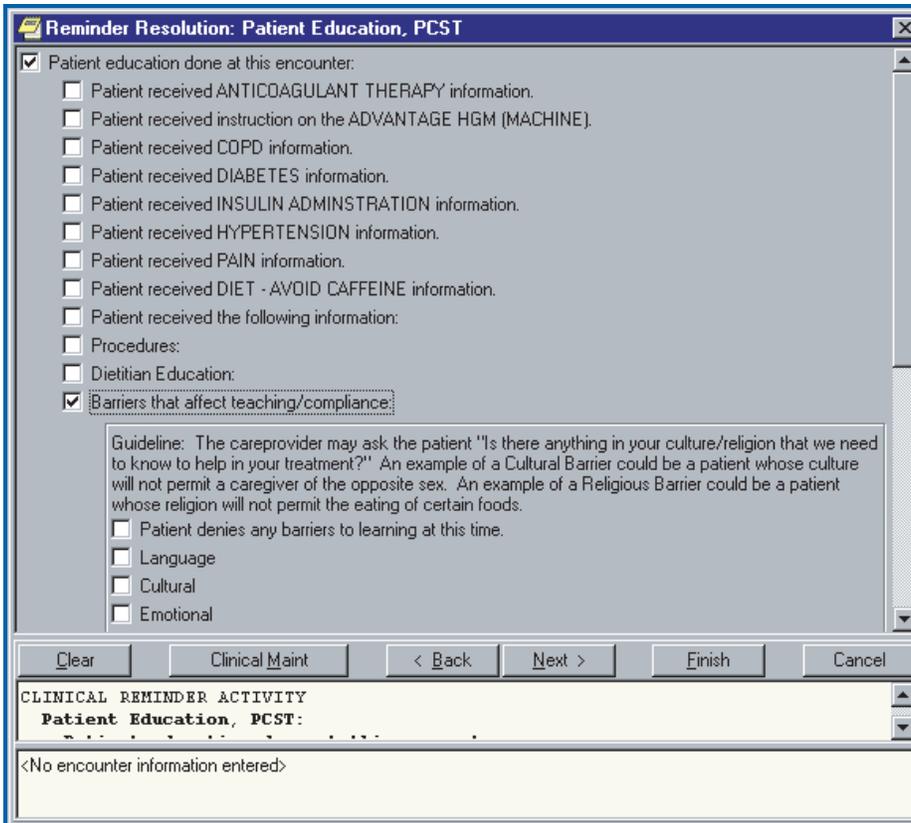
those related to patient characteristics/barriers to learning and preferred method of learning as well as CDI/PI (e.g. Lifetime Non-user of Tobacco for the Tobacco Screening Reminder)

- Clinical Reminders were set. Some were set to “Due Now” so that they always appear on the initial listing when the user selects the Reminder Drawer. The reminders included:
 - Interdisciplinary Admission Assessment—Due now for each admission (the Learning Assessment is located within the Interdisciplinary Admission Assessment)
 - Learning Assessment—Due every 2 years (per policy)
 - Service Team Education Reminders—All staff members have the reminder as “Due Now.” Separate listings were developed since each discipline has a different focus. Each education reminder listing has topics related to that area of expertise.
 - Clinical Reminders related to CDI/PI—Various due time frames.

Clinical Reminder Dialog Set Up

- The reminder elements were set to address a single aspect of the education. The elements were grouped so that the user can provide a portion of the education, and the next staff person can pick up where the other left off. Only the primary topic shows on the health summary; the listed sub-topics would only be shown on the progress note. The main topic on the health summary would refer the user back to the date of the progress note for details on the education that was done.
- The education elements were set up to have a finding item as the education topic related to that specific learning experience so it would show on the Patient Education Index.
- A level of understanding and comments section was added to each education element.
- Specific dialogs were set to initiate consults to specialists for patient education.

continued on page 3



Patient Education Documentation in Ambulatory Care

- The user selects the Notes Tab and begins the note. If reminders are due the nurse addresses the specific reminders. The education reminder is always due and will show on the listing.
- The user selects the Reports Tab and the health summary titled “Patient Education Index” to see characteristics/barriers to learning and the preferred method of learning for that specific patient.
- The user changes provider prior to addressing any reminder that may require a consult or order including education-related reminder. This not only complies with the by-laws but also gives the physician/resident/advance practice clinician more insight into the patient’s needs and adds another discipline’s input into the interdisciplinary note.
- If other education is due during any patient interview with any discipline, the education takes place and is documented via the education reminder.
- The user selects the service-specific education reminder (only the user’s service team listing appear on the reminders due listing).
- The user selects the specific education topic s/he has taught the patient. The level of understanding is selected and comments are entered as needed.
- A listing of additional characteristics/barriers to learning or additional preferred methods of learning is available at the bottom of each service team listing. This facilitates easy documentation if any are identified.
- If handouts are required, the user can print patient education handouts from the common drive or medication handouts from Micromedex within CPRS.

For further information contact:

Jane Schmidt, RN, staff nurse, VAMC Wichita; (316) 685-2221 ext. 3315.

Advantages of the Reminder Dialog:

- Only the information selected shows on the note.
- Once the education topic is selected, the information is placed on the note and the Patient Education Index Health Summary located on the Reports Tab. If the education topic is related to another reminder (for example, tobacco cessation) that reminder gets turned off until the due time frame again expires. This eliminates redundancy in charting and education by several staff members.
- The user can elaborate on the education by adding comments on the note after the reminder is processed.
- There is no need for additional progress note titles related to education. The education can be documented within the progress note. The education documentation can easily be found by reviewing the Patient Education Index, noting the date of the entry, and then reading the notes for that day.

Procedure for Referrals

The by-laws of the Wichita VAM&ROC state that only physicians and advance practice staff members are permitted to request a consult. Since the Consult Software Package which is used for all referrals tags the word “consult,” the responsible provider has to be a physician or advance practice clinician. Prior to entering the note, the nurse changes the provider to reflect either a physician or an advance practice clinician. Upon completion of any consult initiated due to any reminder, the nurse selects the action of “Hold Until Signed” and then exits the chart. The physician or advance practice clinician receives a notification (via CPRS) and processes the notification. This not only complies with the by-laws but also gives the other staff member more insight into the patient’s needs.

MAKING A DIFFERENCE IN CHRONIC CARE

In 1997, VISN 8's Sunshine Healthcare Network leaders recognized the unmet challenges and needs of veterans with chronic diseases, including over-utilization of the health care system, changes in lifestyle, loss of income, lower self-concept, and high stress levels that adversely affect the veterans' health and quality of life. Dr. Robert Roswell, VISN Director, Dr. Maria Mullins, VISN 8 Clinical Manager, and the network leadership assigned the VISN's Patient Health Education Work Group, led by Tampa VAMC's Director, Richard Silver, and Dr. Virginia Nodhturft, Associate Chief for Nursing/Education, to find a creative educational model to address these issues.

After much research and literature reviews, the work group selected the Chronic Disease Self-Management Program (CDSMP) developed by Kate Lorig, PhD, and other researchers at Stanford

VETERANS COMPLETING THE PROGRAM REPORTED THE FOLLOWING PATIENT- CENTERED OUTCOMES ACHIEVED:

- Increased performance of healthy behaviors
- Increased self-efficacy in performing self-management activities
- Improved communication with provider
- Improved management of anger
- Improved management of fatigue
- Increased use of community resources

THE CDSMP TAUGHT:

- Goal setting
- How to develop an exercise program
- Cognitive symptom management
- Relaxation and breathing exercises
- Problem solving
- Communication skills (with family, friends, and health care providers)
- Use of medications
- How to deal with the emotions of chronic illness (anger, fear and depression)

University. The VISN patient health education group had become familiar with the Stanford approach through participating in the VHA program, *Enhancing Patient Education Skills*. Lorig identified common tasks that were taught across all chronic disease courses, and modified and expanded those tasks to provide a course content that has proved valid for groups of persons with any chronic disease. These tasks include the use of cognitive symptom management techniques; dealing with fear, anger and depression; fatigue and sleep management; use of medications; communication with others, including health professionals; problem-solving and decision making; exercise; nutrition; and use of community resources.

A major innovation in this project is that specially trained lay leaders—people who have chronic diseases themselves—teach the program. The research findings from this program demonstrated positive outcomes for patients in terms of quality of life and healthier behaviors, plus cost savings for health care systems. Since Lorig's population was demographically different from the veteran population, VISN 8 decided to pilot the program to ascertain whether similar outcomes could be obtained with the veteran population.

At least two VA personnel from each participating network VA medical center

(Tampa, Bay Pines, Miami, West Palm Beach, Gainesville, Lake City, and San Juan, PR) were sent to the Stanford University Patient Education Research Center for training in the CDSMP. However, the San Juan, PR facility was not included in the research pilot program due to language and cultural variations in the veteran population. After staff training was completed, patients were recruited for the pilot program through several methods. Primary care providers at each of the participating medical centers were asked to refer patients to the program, and self-referrals were solicited through posters and flyers. Invitation letters were also sent to veterans who were identified by their clinicians as eligible for the program. Participants must have at least one chronic condition, good cognitive function, and no primary diagnosis of psychosis. Cancer patients currently receiving chemotherapy, and patients in such pain or acute disease that they could not endure the class time and length, were excluded from the pilot program.

Pairs of trained leaders taught the seven-week course (2.5 hours per week). At least one leader in each pair also had a chronic condition. Some facilities held classes in the hospital, while others used community-based sites. Small groups of six to ten veterans with chronic conditions and their significant others attended each program.

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VETERAN FOCUS GROUP RESULTS: MAJOR THEMES DERIVED FROM THE FOCUS GROUPS

| | |
|---|--|
| Mixed group of chronic diseases | Leaders developed empathy with veterans who had different chronic diseases. When one leader saw a patient with severe arthritis making progress with his walking despite terrible pain, she felt guilty and started walking. Another leader started to eat better since she had so many more choices than the veteran with diabetes, who was struggling with her diet. |
| Service Connected vs. Non service Connected | This made no difference meeting goals. All patients increased healthy behaviors. |
| Teaching protocol | Veterans had initial difficulty in identifying specific action plans, despite the modeling by the leaders. An additional 30 minutes would help patients to accomplish this extremely important activity. |
| Highlight of experience | Comments from participants: <p>“To feel valued was the highlight for me. To think just meeting with veterans once a week and listening to their stories about their chronic disease problems made me realize I was not the only one coping.”</p> <p>“The whole experience was just wonderful. I liked listening to the conversations and enjoyed the laughter that the other veterans brought.”</p> <p>“The great feeling of connecting with other veterans was a highlight for me.”</p> <p>“Just recognizing that I’m responsible for managing my own chronic condition was a highlight for me. Half way through the program I suddenly realized that my doctor can’t exercise for me, he can’t manage my stress, he can’t eat for me. I have to do all that.”</p> |
| Recommend to other veterans | All participants agreed that they would recommend this experience to other veterans with chronic disease. |
| Ideas for improvement | Market the program to all primary care providers, so they can refer as many veterans as possible. |

Each participant received a copy of the book, *Living a Healthy Life With Chronic Conditions*, and an audiocassette, *Time for Healing: Relaxation for Mind and Body*, to use during the program and for personal use later. The sessions were highly interactive, with emphasis on efficacy-enhancing strategies and frequent group problem-solving sessions. Recent studies indicate that the most effective way to help patients change toward healthier behaviors is to strengthen self-efficacy rather than teach particular facts and information. The conceptual basis for this innovation is self-efficacy theory: the belief in one’s ability to do a specific task or to achieve a certain result is a good predictor of motivation and behavior.

Sessions addressed the following self-efficacy techniques:

Formulating action plans: Many patients were so overwhelmed by the daily effects of their disease that they had lost the ability to set and accomplish long-term goals. Leaders demonstrated goal-setting techniques through action plans, which taught patients how to break long-term goals into incremental, achievable steps. At the end of

each class, participants devised their personal action plans. Patients reported on achievement of their action plans at the beginning of the next class.

Skills mastery: Participants were asked to try new behaviors every week and add to these gradually. Each session included time for feedback on progress and discussion of problems.

Modeling: Leaders served as models to the participants by demonstrating desired behaviors as a part of the class, especially in the formulation of action plans, communication skills, and goal setting.

Reinterpreting symptoms: Patients were taught that physical and emotional problems, often attributed to the chronic condition, follow a cycle that is frequently unrelated to the disease. Poor nutrition or physical condition, stress, lack of sleep, etc. may cause the symptoms rather than the disease process. As each symptom was discussed, multiple possible causes were identified and a set of symptom management techniques within the patient’s cultural belief system was suggested.

Persuasion: Leaders encouraged participants to do more to help themselves than

they had done in the past. For example, if participants were walking less than three times per week, the leader might suggest walking one more time or a little farther each time, with the approval of the health care provider.

Results were measured with validated tools developed by the Stanford University researchers. The program was extremely successful at each of the six participating medical centers. Data from the pilot of 53 patients showed increases in healthy behaviors, increased self-efficacy in performing self-management activities, improved communication with providers, improved management of anger and fatigue, and increased use of community resources. Focus group data indicated that the veterans benefited through an increase in good health behaviors, better health, and feelings of empowerment about managing their chronic conditions. The action plans were the mainstay of the program and allowed the veterans to accomplish enjoyable tasks every week by learning to set reasonable goals. This approach helped the participants focus on what they could accomplish

continued from page 5

rather than on what they could no longer do. The veterans who participated in the program found their military training to be an additional bond to other group members, although that background was also strongly reflected in the discussion and guided imagery portions of the program.

Due to the success of the pilot, the Sunshine Healthcare Network has received a two-year funded grant to expand the program. The research study focuses on patients with Type II diabetes who also have other chronic conditions. Co-investigators for the study are Virginia Nodhturft, EdD, Associate Chief for Nursing/Education at VAMC Tampa, and Pamela Hebert, DrPH, Project Manager at the Employee Education Resource Center in Birmingham, AL. Janet Schneider, MLS, Patient Education Librarian at VAMC Tampa, is the assistant investigator for the study. The program was also selected as one of the top ten Best Practice Models in VHA in 1998. Results of the pilot were published in the June 2000 issue of *Nursing Clinics of North America*. The program is easily adaptable to other VA medical centers.

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Janet Schneider, MLS, Patient Education Librarian, VAMC Tampa; (813) 972-2000 ext. 6571.

HOW DO WE KNOW PATIENT EDUCATION WORKS?

CHRONIC CARE CLINICS FOR DIABETES IN PRIMARY CARE

Participants in this study at Group Health Cooperative of Puget Sound in Seattle, WA included patients with diabetes who were

30 years old or older and who were selected at random from an automated diabetes registry. Primary care practices were randomized within clinics to either a chronic care clinic (intervention) group or a usual care (control) group. The intervention group conducted periodic one-half day chronic care clinics for groups of approximately 8 patients with diabetes in their respective doctor's practice. The clinics consisted of standardized assessments; visits with the primary care physician, nurse, and clinical pharmacist; and a group education/peer support meeting.

Investigators collected self-report questionnaires from patients and data from administrative systems at baseline and at 12 and 24 months. Variables included the process of care received, the satisfaction with care, and the health status of each patient.

In an intention to treat analysis at 24 months, the intervention group had received significantly more recommended preventive procedures and helpful patient education. Of five primary health status indicators examined, two (general health and bed disability days) were significantly better in the intervention group. Compared with control patients, intervention patients had slightly more primary care visits, but significantly fewer specialty and emergency room visits. Among intervention patients, consistently positive associations were found between the number of chronic care clinics attended and a number of outcomes, including patient satisfaction and HBA1c levels. The authors conclude that periodic primary care sessions organized to meet the complex needs of patients with diabetes improved the process of diabetic care and were associated with better outcomes.

Wagner EH, Grothaus LC, Sandhu N, Galvin MS, McGregor M, Artz K, Coleman EA. (2001) Chronic care clinics for diabetes in primary care: a system-wide randomized trial. Diabetes Care 24(4):695-700.

ORAL ANTICOAGULATION SELF-MANAGEMENT

In a randomized cross-over study, small portable devices that enable patient self-monitoring of anticoagulation and self-adjustment of the dose were compared with conventional management by a specialist anticoagulation clinic. Fifty patients were self-managed or were managed by the anticoagulation clinic for a period of 3 months, then the alternative strategy was followed for each patient. Prothrombin times (expressed as international normalized ratio [INR]) were measured at intervals of 1-2 weeks during both periods. Measurements were blinded to type of management.

There was no significant difference in the overall quality of control of anticoagulation between the two study periods. The proportion of patients who spent most time in the therapeutic target range was larger during self-management than during anticoagulation clinic-guided management. A patient satisfaction assessment showed superiority of self-management over conventional care.

The authors concluded that self-management of INR in the study population is feasible and appears to result in control of anticoagulation that is at least equivalent to management by a specialist anticoagulation clinic, and it is preferred by patients. They caution that larger studies are required to assess the effect of this management strategy on the incidence of thromboembolic or bleeding complications.

Crombeecke ME, Levi M, Colly LP, deMol BJ, Prins MH, Hutten BA, Mak R, Keyzers KC, Buller HR. (2000) Oral anticoagulation self-management and management by a specialist anticoagulation clinic: a randomized cross-over comparison. Lancet 356(9334):97-102.

WEIGHT MANAGEMENT: WHAT PATIENTS WANT FROM THEIR PRIMARY PHYSICIANS

A total of 410 consecutive adult patients in 2 primary care practices at the University of California, San Francisco, were approached to participate in this study. 366 (89%) completed a survey in the waiting room; afterward they were measured for body mass index (BMI). Primary outcomes measured were patient attitudes about weight loss, previous weight management experiences with their current physicians, and patient preferences for weight management in the future within the primary care relationship.

97% of the obese patients, 84% of the overweight patients, and 39% of the non-overweight patients thought they needed to lose weight. 49% of the obese patients, 24% of the overweight patients, and 12% of the non-overweight patients had discussed weight with their current physicians. The types of weight management assistance that patients most wanted from their physicians were: 1) dietary advice; 2) help with setting realistic weight goals; and 3) exercise recommendations.

The authors suggest that most patients, especially those who are obese or overweight, want more help with weight management than they are getting from their primary care physicians.

Potter MB, Vu JD, Croughan-Minihane M. (2001) *Weight management: what patients want from their primary physicians.* *Journal of Family Practice* 50(6):413-518.

PATIENT EDUCATION/PRIMARY CARE PROGRAM NOTES

PATIENT EDUCATION PRESCRIPTIONS

Clinical staff at VAMC Lebanon, PA now have another tool to help them provide patient education. Prescriptions for patient education can be written for any of the major diagnoses at that medical center, for pain management, or hepatitis C. Barbara Snyder, Patient/Family Education Coordinator, presented the plans to the patient/family education committee which determined the diagnoses to be included in the patient education "formulary." Barbara Deaven, Librarian, compiled a teaching module for each of the diagnoses. Each module contains a large explanatory chart or poster, usually highlighting anatomy and pathology, or a model to provide that information. Each module has at least one film, information about pertinent internet sites, and educational materials. When the patient and family arrive in the library with their prescription, they are given all the time they need and a choice of materials to use.

The prescription pads were distributed recently to clinicians during inservices about the new program. The number of patients and/or families using this service is increasing weekly. The librarians report that patient and family satisfaction with the program has been very high.

For further information contact:

Barbara Snyder, RN, BSN, Patient/Family Education Coordinator, VAMC Lebanon, PA; (717) 272-6621 ext. 4435

Barbara Deaven, MLS, AHIP, Librarian, VAMC Lebanon, PA: (717) 272-6621 ext. 4749.

PERFORMANCE IMPROVEMENT TRAINING

Every quarter, Patient Education in Primary Care will offer 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 entire July 2001 newsletter and provide brief answers to the questions below. Turn these in to your supervisor along with a copy of the newsletter

OR

Organize a one-hour brown bag journal club or set aside time during a staff or team meeting to read the newsletter and discuss the questions below. Turn in a master list of participants along with a copy of the newsletter.

Questions:

1. How is patient education currently documented at your facility? What suggestions would you make to improve patient education documentation at your facility?
2. How is patient education for chronic conditions designed and delivered at your facility? To what extent are self-efficacy enhancing elements included in these activities?
3. How could veterans be directly involved in providing patient education services at your facility?
4. Would prescriptions for patient education be a useful tool in your facility?



**To Be Filled In
Veterans' Library
17-5A**

Name: _____ SS#: _____
Friend/Family: _____

Please check appropriate line.

**The Library has resources including videos or written materials.
Please visit the Veterans Library on 17-5A to learn more about:**

() Cholesterol/Fats

() Chronic Obs. Pulm. Disease: ASTHMA BRONCHITIS EMPHYSEMA PNEUMONIA

() Dementia

() Diabetes: TYPE I TYPE II

() Heart Problems: ANGINA MI CAD VALVE MYOPATHY CHF

() High Blood Pressure: MILD SEVERE

() Pain Control: HEADACHE NECK BACK LEG OTHER

() Hepatitis C

() Peripheral Vascular Disease

() Posttraumatic Stress Disorder (PTSD)

() Smoking Cessation

() Other _____

Provider Signature: _____ Filled by: _____

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

Contact any of the following with your input:

Barbara Hebert Snyder
(216) 691-9393
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Carol Maller
(505) 265-1711 ext. 4656
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**TELL US
ABOUT THE
TOPICS
YOU WOULD
LIKE TO SEE
COVERED IN
FUTURE
ISSUES.**

**PATIENT HEALTH
EDUCATION IN
PRIMARY CARE TASK
FORCE:**

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