Patient Education in Primary Care

Volume 10 Issue 3 2007

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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 and Patient Health Education Committee members, VISN and VAMC decision makers.

Helping Patients with Traumatic Brain Injuries in Primary Care

"It would be nice if rehabilitation from traumatic brain injuries (TBI) was simple, but so much depends on the type, site and severity of the injury, the complexity of the trauma, and the kind of personality and lifestyle the patient had before the injury. The same deficit in different people produces different responses," said Dr. Treven Pickett, neuropsychologist at the VA Polytrauma Rehabilitation Center in Richmond, VA. "So one of the most important principles we follow in treating these patients is tailoring their regimens to their unique characteristics, and that holds for all TBI patients whether their injuries are mild or severe," he said.

"We've developed a family education manual for TBI, and we offer weekly education programs for families. The manual helps them become familiar with some of our clinical vocabulary, and it explains the rehabilitation process. We've learned that it's best to offer opportunities, but not mandate participation in counseling or education. The more we can empower families, the better the patients seem to cope," he said.

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1. This publication may be duplicated.

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"The neurobehavioral symptom inventory (NSI) is a useful tool for primary care clinicians," he said. "It lists twenty-two symptoms, each sorted into categories (mild, moderate, or severe), and the recommended treatment approach for each symptom." Dr. Joel Scholten, VA Polytrauma Network Site Director in Tampa, FL, also encouraged use of the NSI but cautioned primary care clinicians about medications they may prescribe for TBI patients. "Any medication with potential cognitive side effects (pain medications, anti-seizure medications, etc.) can affect TBI patients; they're sensitive to side effects," he said. "Less is more, so start low and go slow," he advised. Dr. Elaine Date, medical director of the VA Polytrauma Rehabilitation Center in Palo Alto, CA, suggested that primary care clinicians familiarize themselves with the medications used at the polytrauma centers to treat cognitive, emotional, and pain problems.

"The most important thing primary care clinicians can do for patients with mild to moderate TBI is to shape positive expectations for recovery," said Dr. Pickett. "The patient's symptoms may improve over time if he follows the treatment plan and doesn't engage in potentially harmful activities such as contact sports or alcohol or other drug use. Giving patients hope and helping them normalize their situations is a very valuable service," he said.

The Day Program Treatment Team at the VA Polytrauma Rehabilitation Center in Tampa, FL offered a number of suggestions to help primary care clinicians who are working with TBI patients:

- Provide information in small chunks, and repeat messages numerous times
- Use a variety of educational modalities—verbal, print, video, audio
- TBI patients need more frequent follow-up than many other primary care patients; they're not likely to initiate a call to the clinician if they have a problem, so the treatment team needs to take more initiative with them
- Many TBI patients have memory deficits so they're likely to forget to take their medications and keep their appointments; provide assistive devices (timers, alarms, calendars, pill reminders, PDAs), and make a reminder phone call the day before a scheduled appointment
- Encourage a caregiver to accompany the patient to all appointments
- Encourage physical therapists to make a video of the patient doing prescribed exercises so he can use it at home as a visual cue
- Patients may have route-finding skill deficits; don't verbally tell a patient how to get to the pharmacy or the lab, instead escort the patient there yourself
- Local facility policies may need to be adjusted for TBI patients—e.g. requiring that no-shows get another consult before being seen; patients may need longer visits than usual schedules permit; patients may need more visits with physical and occupational therapists than usually ordered
- Offer TBI patients and families assistance in accessing vocational rehabilitation services and veterans benefits representatives
- Consider the family's health—the patient may be more irritable than previously or have impaired interpersonal skills as well as memory deficits, and the family may be adjusting to new burdens, roles and responsibilities; provide assistance as needed in obtaining counseling, education, or other supportive services
- Be patient and understanding—most of the behavioral problems are a direct consequence of the brain injury, not volitional non-compliance with treatment.

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Jack Avery, speech-language pathologist at the VA Polytrauma Rehabilitation Center in Minneapolis, MN, encouraged primary care clinicians to be aware of their role in helping patients access rehabilitation services through the polytrauma/TBI continuum of care.

The most severely injured patients typically enter the VA's rehabilitation system of care via one of the four Polytrauma Rehabilitation Centers after transfer from a military treatment facility and are eventually discharged to a polytrauma network site or polytrauma clinical support team for follow-up. "But for many patients with mild TBI, the problems may not be identified until months after their homecoming, and their first point of contact with VA health care will be a primary care team," he said. "That's why it's important for primary care clinicians to conduct screening for TBI, to understand the hierarchy of TBI treatment services provided by VHA, and to work with the patients to manage their treatment," Avery said. "One thing I've learned is never to be caught by surprise by how pervasive and devastating memory problems can be," he said. "These problems are also variable; one day a patient may be able to rely on his memory, but the next day he can't."

"The Palo Alto site was one of the first to incorporate clinical reminders for TBI screening into the electronic medical record," said Dr. Date. "We often do a secondary screen over the telephone to see how we can best help the patient," she said.

"The VA has invested heavily in providing the full spectrum of care to patients with TBI," she said. "It's important for primary care clinicians to understand that there are clinicians and resources within the VA health care system that are available to help them and their patients." As Dr. Pickett noted, "This system of polytrauma rehabilitation services in VHA, which grew out of the VA TBI lead centers, is really excellent. I'm proud to work here, and I look forward to coming to work each day."

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RESOURCES ON TRAUMATIC BRAIN INJURY

For Patients

- http://www.polytrauma.va.gov/index.asp (home page for the VA polytrauma system of care)
- http://www.biausa.org/ (home page of the Brain Injury Association of America which offers a wide variety of resource materials for patients and families on living with brain injuries)

For Clinicians

- http://www.polytrauma.va.gov/index.asp
- http://www.hsrd.minneapolis.med.va.gov/PTqueri (home page for the Polytrauma and Blast-Related Injuries (PT/BRI) QUERI Coordinating Center)
- http://dvbic.org/ (home page for the Defense and Veterans Brain Injury Centers)
- http://vaww1.va.gov/rehab4veterans/page.cfm?pg=31 (contains the 22-item Neurobehavioral Symptom Inventory)
- http://www1.va.gov/VHI/page.cfm?pg=33 (EES continuing education program on TBI)

Making the Most of iMedConsent Patient Education Resources

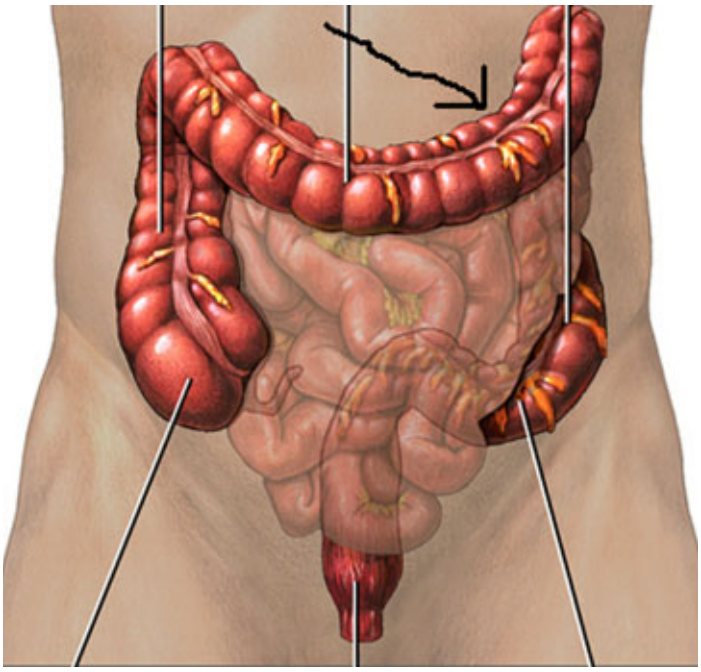
Recently, VA launched the Electronic Support for Patient Decisions (ESPD) initiative to develop new and innovative ways to use technology to create a comprehensive, standardized approach to informed consent and related patient decision-making processes. In support of this initiative, VA completed the national rollout of iMedConsent, a software package that supports electronic access, completion, signing, and storage of such documents as informed consent forms and advance directives. The software also includes an extensive library of patient education documents, drug information, and a wide selection of anatomical pictures and diagrams. These materials greatly improve the ability of staff members involved in patient education to access and distribute consistent and thorough information to patients.

The iMedConsent content library covers 28 clinical specialty areas in English and Spanish including the following categories:

- Procedure-specific informed consent documents
- Patient education documents written in both standard and easy reading (6th grade) formats
- Pre- and post-procedure patient instructions
- Gallery of anatomical and procedure-specific images (may be annotated by the practitioner and saved to the patient record)
- Patient information sheets for prescription and over-the-counter medications.

According to Ray Frazier, program analyst in the VA National Center for Ethics in Health Care, over 22,500 patient education documents were printed for patients in the first three months of 2007. However, usage of the patient education materials varies widely among VHA health care facilities. "At some sites, clinicians frequently use the materials with patients and at other sites, they may think the software package focuses only on informed consent and may not even be aware of the patient education materials," he said.

Several sites have tailored the software to meet local needs. At the Cleveland, OH VAMC, nurses on the surgical floors use the materials with patients and their families. "We've created our own local pre-operative instructions for patients which we store within iMedConsent," said Joanne Rimac, Clinical Applications Coordinator. "The software automatically generates a note to the patient's chart that the instructions were given, and we also capture the patient's signature that he received the instructions. We also added the iMedConsent patient education note title to our patient education health summary," she said.



At the VA Northern Indiana Healthcare System, inservice training for clinicians on the patient education features of iMedConsent is incorporated within the required annual education programs for physicians and nurses. "We created a self-study poster presentation explaining how to access and use the iMedConsent patient education materials," said Dana Cole, Patient Health Education/ Prevention Coordinator. "I also go out to the units to show the nurses how to use iMedConsent for

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patient education. Most staff weren't aware of this resource, but once they see it they want to use it with patients," she added.

"At the VAMC in Grand Junction, CO our patient education committee goal is to increase the use of the iMedConsent patient education materials," said Sylvia Barton, primary care nurse and chair of the Patient Education Committee. "Within the past twelve months, printers have been placed in each exam room, and each computer has been loaded with the iMedConsent software to make it easier for clinicians to give various materials to patients. We've done inservice sessions for staff and spread the word about the iMedConsent resources through local email. We also created a tutorial to show staff how to use the materials and placed it in the patient education category of CPRS tools. The response has been positive. The surgeons really like using the full-color anatomical and procedural drawings with patients, and clinicians like the fact that they can edit and customize the materials for particular patients." "Our biggest concern," she said, "is that the software doesn't delineate the JCAHO-mandated elements for patient education, so that documentation must still be done separately from the automatic 'save to chart' option."

The most extensive use of the iMedConsent patient education software is at VAMC Fargo, ND. "Even though we had access to other electronic sources of patient education materials, we decided to make iMedConsent our primary source for all patient education materials," said Charlotte Feldman, Clinical Applications Coordinator. "We did this for several reasons:

- The software makes documentation of patient education easier
- Clinicians can customize and print any item for an individual patient
- We don't have to store hard copies of patient education pamphlets as we used to
- It's easy to update materials, which is a cost savings over our former approach of purchasing materials; when they became dated they had to be discarded
- It's easy to create, store, and access new documents."

"With leadership support, we initiated a process to convert all our current patient education materials into iMedConsent. Beginning in February 2006, we conducted inservices for all clinical staff on documentation in the medical record. Part of the inservice was devoted to patient education. Clinical staff were asked to volunteer as a patient education champion for their areas/units. The champions' tasks were to review all patient education materials currently in use in their areas, to eliminate outdated or ineffective materials, and to research a wide range of existing sources (MicroMedex, Outlines, etc.) for new materials they would like to add to the iMedConsent library. The champions were given administrative authority to create new documents or edit existing documents for the master library. If the champion chose not to have this functionality, I offered to create the documents they needed," Feldman said.

"We added Fargo as a file extension for each locally-created document, and we were careful to credit sources for all the materials we imported," she said. "For several clinical areas, we also created packages for the most frequently used patient education materials so clinicians wouldn't have to scroll through the entire library to find what they wanted. That's been very well-received," she said. "We also created packages to hold all the patient signature forms and all the procedure prep instructions we use here."

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"In the inpatient areas, we edited the physician discharge orders to include giving iMedConsent patient education materials to the patient. It's also part of our local discharge template," she said.

"The response has been very positive. In October 2006, 527 patient education documents were printed and given to patients. In April 2007, that number had increased to 863. This approach works well for us," she said.

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Patient Education Resources

Multicultural Consumer Health Resources

The VHA Consumer Health Library Panel (CHLP) issued Library Tip #31 in January, 2007. It lists a wide variety of multicultural consumer health resources available to clinicians through the Internet and their professional librarians to address the JCAHO standard that written information provided to patients is in the language of the patient.

MedlinePlus (http://medlineplus.gov/) allows users to toggle from English to Spanish for authoritative, current information. While not everything available in English is also in Spanish, the format allows English-speakers to easily select from the categories of overviews, treatments, etc.

The National Network of Medical Libraries (NNLM) "Other Language Resources" (http://nnlm.gov/outreach/consumer/multi.html#A7) lists resources with items in multiple languages

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including Cambodian/Khmer, Chinese, French, German, Hmong, Korean, Laotian, Russian, Somali, Spanish, Thai, and Vietnamese.

HealthFinder (http://www.healthfinder.gov/) was developed by the U.S. Department of Health and Human Services, together with other Federal agencies, to serve as a portal to government and nonprofit organizations' health information on the Internet. Users can toggle from English to Spanish.

The New South Wales Multicultural Health Communication Service of Australia (http://www.mhcs.health.nsw.gov.au/) was established in 1997 as a result of NSW Health's Plan "Health Services for a Culturally Diverse Society" (1995). It features a 36-page catalog of multicultural health resources with links to online PDF documents on a wide variety of health topics.

The 24 Languages Project (http://library.med.utah.edu/24languages/) is sponsored by the Spencer S. Eccles Health Sciences Library in Salt Lake City, Utah, in partnership with the Utah Department of Health and others. It provides electronic access to over 200 health education brochures in 24 different languages.

South Texas College Library Services (http://www.southtexascollege.edu/library/guides/medicalspanish.htm) has compiled a listing for those wishing to improve their own medical Spanish for use in interviewing Hispanic patients, increasing vocabulary, cultural competency skills, and more.

Healthy Roads Media (http://www.healthyroadsmedia.org/) is an alliance of organizations that provides print and non-print (audio, multimedia, and video) materials in eleven languages: English, Spanish Vietnamese, Amharic, Arabic, Somali, Bosnian, Russian, Hmong, Khmer, and Liberian English. Information is geared primarily to refugee populations.

¡BIEN! The Border Health Information and Education Network (http://www.bienhealth.org/) is a community-based network that provides access to reliable health information in English and Spanish to the public, health providers, researchers, faculty, and students along the United States/Mexico border. Not all materials are available in both English and Spanish.

Among the other topics in the Library Tip series are these:

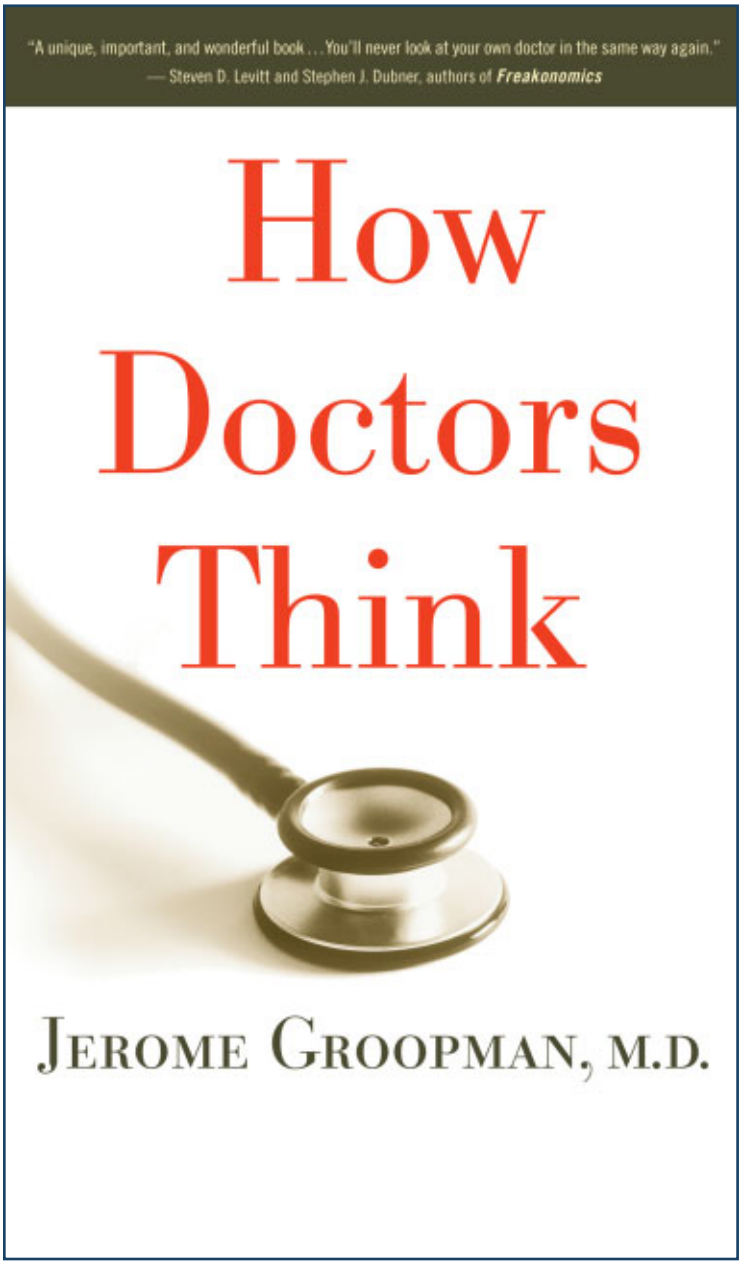
- Consumer health websites
- Core consumer health books
- Health literacy resources
- Information therapy
- Librarian-led patient education resource centers internet and print resources
- My HealtheVet tutorial
- Library services for primary care standards
- Polytrauma consumer health books, pamphlets, multimedia/audiovisuals, journals, and internet sites
- Post-traumatic stress disorder consumer health books, audiovisuals and internet sites.

For further information, contact your local librarian.

How Doctors Think

By Jerome Groopman, MD. Houghton Mifflin Company, New York, 2007
ISBN-10: 0618610030

Jerome Groopman, MD, holds the Dina and Raphael Recanati Chair of Medicine at Harvard Medical School and is chief of experimental medicine at Beth Israel Deaconess Medical Center in Boston. He has published more than 150 scientific articles. He is also a staff writer at The New Yorker and has written editorials on policy issues for the New Republic, the Washington Post, and the New York Times.



Excerpts from two editorial reviews indicate why this book may be of interest to VA clinicians and patients:

Perri Klass, MD, professor of pediatrics and journalism at NYU, writing in *Publishers Weekly* said, "Every reflective doctor will learn from this book—and every prospective patient will find thoughtful advice for communicating successfully in the medical setting and getting better care."

David Brown, writing in the *Washington Post Book World* said, "His book contains all kinds of smart, often selfless, occasionally heroic doctors making good decisions and sometimes saving lives. But it is far from a narcissistic paean to his profession. It is an effort to dissect the anatomy of correct diagnosis, successful treatment and humane care—and also of diagnostic error, misguided therapy and thoughtless bedside manner. His task is to offer practical advice to both patients and physicians. He succeeds at both….Groopman notes that having adequate time to think helps (but of course doesn't guarantee) good decision making. Much of medicine, however, is practiced with the consumer waiting for the product to be delivered, whether it's the proposed work-up, the diagnosis, the treatment options or the long-term prognosis. This expectation of instant knowledge and service is something few people would consider reasonable for tasks such as having a will drawn up or even getting a pair of skates sharpened. This is perhaps worth keeping in mind as doctors are increasingly asked to do more in shorter appointments for the same or less money."

The last section of the book contains a series of questions patients can ask their doctors to understand and discuss how the doctor is thinking about their health problem.

Teach Tip

Using Graphic Materials with Patients

The adage that a picture is worth a thousand words holds true for patient education. Research on visuals and graphics shows that the memory systems in the brain favor visual storage, so when a message is visualized it's easier to remember than one just read or heard.

Here are some strategies for getting the maximum impact from graphics and other visual patient education materials, such as those found in the IMed patient education library:

- Call up the visual to the computer screen in the exam room so you can go over it with the patient
- Explain the purpose of the graphic
- Explain the diagrams and key messages in lay terms; many patients are unfamiliar with anatomical drawings or abstract concepts, so help the patient decode what he's seeing
- Get feedback from the patient on the information to assure that he understands—e.g. What does this diagram tell you?
- Use the computer's drawing tools to underline, circle or highlight key information; enlarge diagrams and fonts as needed to help the patient see the images
- Print the visual for the patient and highlight key information with a pen or marker
- Write the patient's name on the handout
- Write in the name and phone number of someone who can answer questions
- Encourage the patient to share the resource with family members.

Current Studies That Document the Impact of Patient Education

Computers in the Exam Room

This study, conducted in the primary care clinic of VA New York Harbor Healthcare System, was designed to assess whether physician experience affected the impact of computers in the exam room. Participants included 115 patients being seen for scheduled visits, eleven faculty internists, and twelve internal medicine residents practicing at that site for at least one year.

Physicians completed a baseline questionnaire and a post-visit survey immediately following a visit with a study patient. Participating physicians saw between 6-10 study patients over a 4-month period. Patients completed a questionnaire while waiting to be checked out following the visit.

Both physicians and patients were asked whether use of the computer: reduced the time spent talking to, looking at, and examining the patient; interfered with the doctor-patient relationship; and made the visit feel less personal.

Patients seeing residents, compared to those seeing faculty, were significantly more likely to say that the computer reduced the time the physician spent talking to, looking at, and examining them. They also were significantly more likely to say that the computer made the visit feel less personal. Only 8% of all patients thought that the computer interfered with the doctor-patient relationship. Residents were more likely than faculty to report the same effects, but the differences were smaller and not statistically significant.

The authors conclude that additional research is needed to identify specific computer-related behaviors that positively and negatively impact communication in the exam room. They suggest that communication skills training can be developed to optimize the physician-patient relationship when computers are used in the exam room.

Rouf E, Whittle J, Lu N, Schwartz M. (2007) Computers in the exam room: differences in physician-patient interaction may be due to physician experience. Journal of General Internal Medicine, 22(1):43-8.

Use of a self-assessment tool to prevent diabetic foot ulcers

This randomized, multi-center trial conducted by researchers at the Texas A&M University Health Science Center was designed to evaluate the effectiveness of a temperature monitoring device on the incidence of foot ulcers in diabetic patients at high risk for lower extremity complications.

Participants included 173 patients with a previous history of diabetic foot ulceration who were assigned to one of three groups: standard therapy, structured foot examination, or enhanced therapy. Each group received therapeutic footwear, diabetic foot education, and regular foot care. Patients in the structured foot examination group performed daily inspections and recorded the results in a logbook. Participants in both the standard therapy and structured foot examination groups were instructed to call the study nurse immediately if they identified any foot abnormalities. Patients in the enhanced therapy group used an infrared skin thermometer to measure daily temperatures on six foot sites, and were instructed to call the study nurse and reduce activity if differences between left and right corresponding sites were greater than 4 degrees F.

Patients in the enhanced therapy group had significantly fewer foot ulcers than did patients in either of the other groups. Patients in these groups were more than 4 times more likely to develop ulcers than patients in the enhanced therapy group.

The authors conclude that use of this home monitoring tool appeared to be a simple and useful approach to preventing foot ulcers.

Lavery LA, Higgins KR, Lanctot DR, et al. (2007) Preventing diabetic foot ulcer recurrence in high-risk patients: use of temperature monitoring as a self-assessment tool. Diabetes Care, 30(1):14-20.

Physician-Patient Communication about Medication Non-adherence

This cross-sectional national survey was conducted in 2003 by researchers at Tufts-New England Medical Center to describe the dialogue between physicians and elderly patients about medication costs and adherence. Participants included 17,000 (from a starting sample of 36,901) community-dwelling Medicare beneficiaries 65 years and older in all fifty states, over-sampling Medicaid enrollees and seniors in low-income neighborhoods.

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Among these respondents, 41% reported taking five or more prescribed medications. More than half the respondents reported two or more prescribing physicians. Among those with three or more chronic conditions, 24% reported having no communication with their doctors about all their medications in the previous twelve months, as did 32% of the whole respondent group.

Twenty-seven percent of the respondents who reported skipping doses or stopping a medication because of side effects or perceived non-effectiveness had not talked with their doctors about it. Among those reporting cost-related non-adherence, 39% had not talked with their doctors about it. Cost-related non-adherence was identified as not filling a prescription because of cost, skipping doses to make a prescription last longer, and taking smaller doses than prescribed to make a prescription last longer. However, having had a discussion with their physicians about drug cost was significantly associated with switching to a lower priced drug.

The authors conclude that the communication gap between physicians and elderly patients about medications is an important quality and safety issue, and that more attention should be directed to medication management in all patient visits.

Wilson IB, Schoen C, Neuman P, et al. (2007) Physician-patient communication about prescription medication nonadherence: a 50-state study of America's seniors. Journal of General Internal Medicine, 22(1):6-12.

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 this entire issue 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. What approaches are used in your facility to help patients with traumatic brain injury and their caregivers manage their treatment regimens? What suggestions would you make to enhance these efforts?
2. What educational and administrative supports are provided in your facility to help clinicians take advantage of the patient education resources within the iMedConsent software? What can you do to help?
3. What approaches are used in your facility to help patients and/or caregivers whose primary language is not English? What suggestions would you make to enhance these efforts?

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

Contact any of the following with your input:

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This newsletter is transmitted electronically to VHA staff. To add colleagues to the distribution list, contact your local patient education coordinator or committee chairperson.

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