

RESOURCE COLLECTION ON A BUDGET: Establishing a Patient Education Library

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Introduction

Few health providers will argue against the importance of patient education.

The development of a patient education resource library should be and can be developed at all sites - regardless of clinic or hospital size, or staffing. Sites with total Contract Health Services should also develop a Patient Education File/Library. Too often Contract Health Service sites assume that the private physician or provider is providing adequate patient education services. The truth is private providers usually offer random patient education services -- incorrectly assuming that the Indian Clinic or Hospital has educated the patient before they came to their office or assuming that someone at the Indian Clinic or Hospital will talk to them after they leave their private office.

There are many commonly voiced concerns by the Health providers prior to commencement of a patient education library project -- most concerns and objections will center on money. This section of the Manual provides some guidelines to meet the challenge of funding.

Common concerns of the staff:

- *"Where will we do patient education? There is no patient education "room," - therefore, there is no "convenient area" in which to provide patient education."*
- The Clinic or Hospital does not have an empty room or unused area near the examining rooms - *"We will need more space."*
- *"There is no place for privacy or confidentiality."*
- There is no audio-visual equipment (such as VCR's) or projectors or staff requests expensive new equipment. *"No audio-visual equipment."*
- Staff estimates that they will need several thousand dollars to purchase printed patient education materials and videos. *"Money!"*
- Staff points out that printed pamphlets, brochures and other information is conveniently placed in the waiting area for patients to freely take. Perhaps a video is also shown on the waiting room TV. *"Isn't this patient education?"*
- And last, but not least, in importance is the often heard refrain that there are *no "Indian -specific "* materials available.

Often the barrier to the provision of comprehensive patient education is not rooms, pamphlets nor money. The largest barrier to the provision of patient education is time. Commitment to the importance of patient education, the management of time through the development of policies and procedures to govern patient education and the organizational structure of the health clinic or hospital are just some of the obstacles to overcome in order for patient education to become a reality.

Administrators' commitment to patient education will most assuredly be tested.

Purpose

Patient Education is a planned learning experience, which can be achieved by using a combination of three methods that influence patient knowledge and health behavior:

- teaching and demonstrating,
- counseling, and
- behavior modification.

This process demands time and effort that can be difficult to manage in a busy hospital or clinic. Many health professionals attempt to shorten the teaching process by providing written materials to patients so they can educate themselves on their own time. Although printed and non-printed materials are important tangible supplements, they should not be construed as a substitute for planned education.

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Comprehensive patient education is more than handing a prenatal client a plastic bag "stuffed" with various printed pamphlets and materials on pregnancy and childbirth.

The abundance and variety of educational materials can be overwhelming. It is not possible to collect, organize and store *all* teaching resources. A patient education library or file for a hospital or clinic must contain those materials that will yield the greatest benefit for the teacher and learner alike. In addition, without a financial grant or unlimited financial resources there is a need to be fiscally responsible.

Education resource collections can be developed to serve different purposes. One such purpose is to assemble a limited variety of education materials about a prevalent health problem. For example, a clinic that has large numbers of hypertensive patients may choose to focus on resources dealing with the nature, diagnosis, and therapy of hypertension. The materials may include video tapes, pamphlets, and audio tapes.

Another purpose is to assemble a comprehensive set of all available materials dealing with a particular subject that is common to Native Americans - such as diabetes.

It can be frustrating to health professionals and patients alike when there is a scarcity of information on file concerning a patient's medical problem. The physician or Health Provider can consult a medical journal or personal files -- where and what is available to the patient to help them understand their condition? This may be another reason for develop resource collection -- to provide ready access to educational materials during patient visits. This allows the practitioner to take advantage of the "teachable moment" and the opportunity to link clinical and educational information. Learning impact is lost if the materials are not immediately accessible. In addition, having multiple and varied resources on hand avoids duplication of the practitioner's time and effort in developing educational media.

Process

A resource collection can be solicited, collected, organized and sorted more easily if the process boundaries are specific enough. Goals and objectives should reflect the intent, extent and specificity of purpose, and a time frame defined for resource collection and library completion.

Unfortunately, there is not an abundance of Indian-specific educational materials available. Studies have shown that Native Americans react more favorably when educational materials such as videos, posters, or pamphlets include Native Americans in the content.

An individual health professional can establish a resource collection, but the team approach provides benefits from collective expertise, discussion, and task delegation. A higher quality product is often the result. Each team member should have specific duties. Among the staff, for example: who contacts potential contributors, who reads and evaluates the material, who determines the classifications, who is responsible for storing the resources?

Many materials are free and a wealth of materials can be collected from many sources. The common ones include:

- government agencies,
- pharmaceutical companies,
- commercial vendors,
- self-help support organizations,
- non-profit organizations,
- professional peer organizations,
- consumer magazines
- newspapers,
- health publications
- and, physicians and nursing journals,

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There are many excellent diagrams, illustrations, models, posters, audio and video sources, though most materials are print media. One material source often will lead to others, which then contributes to the beginning of a collection.

Appropriately defining and classifying resource materials is a critical process. Definitions may be arbitrary, and for our purpose, materials are defined as "information," "instruction," and "comprehensive." Classifications may be by author, title, publisher, key word, anatomical organ, disease, procedure, operation, therapy, media type or language. Others may be CPT or ICD codes, NLM or LC classification or listings according to the Index Medicus.

Items should be defined, analyzed, rated, then catalogued. Again, these parameters can be arbitrary, but must be consistent throughout.

The reading level should be determined by applying readability formulas. Most computers come with a readability program included in the software or you can purchase these software programs for \$50-\$75 extra. These work only on material already in the computer so anything you write yourself can be analyzed. The Fry Readability formula is accurate at lower reading levels. One can use the FRY formula on material not in the computer. The Word Perfect 6.0 package contains *Grammatik - Interactive Check*. For additional information on how to use the FRY formula, contact your local health educator or check with your local elementary school reading teacher.

This process can be simplified by using a computer scanner and a software package of readability formulas. This determination is important because it is preferable to communicate at the sixth to eight grade reading level.

It may not be enough to provide information and assume the learner will absorb it with a resultant change in behavior. Therefore, it is necessary to determine if the learner understands and assimilates the contents. Sample questions can be written for the patient to answer in order to determine his level of understanding. The addition of questions and the patient's response (verbal and written) can be included in the patient's record and serves as evidence of informed consent. Many current education materials include questions accompanying the resource. This may be adapted to audio and video as well. Interactive videos already employ this concept.

At larger sites, a data software program can be used for cataloging. Resources are then easily indexed and retrieved by key words. Catalog citations can be changed using the same program. Reproduction of citations can be generated on the computer for distribution to patients to select materials. A checkoff sheet indicating resources provided to a patient can be filled in the patient's chart. Filing actual materials in the library or filing cabinet should be set up for ease of retrieval. The catalog and collection should be frequently updated to stay current and weed out resources made obsolete by new medical advances.

Budget

Developing a specialized library can be cost effective. All of the team member tasks can be accomplished during ordinary working hours. Equipment cost can be minimized as most hospitals and clinics have access to a Xerox machine, computer and printer. One useful software program to consider purchasing includes a database and a scanner to decrease the time needed to determine the educational reading level. Usually a filing cabinet and folders can house the accumulated materials.

In summary, a patient library is feasible and beneficial to patients and health professionals alike. Setting goals, objectives, and determining the process at the beginning expedites development and leads to an appropriate and useful library collection.

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ASSESSMENT OF PATIENT EDUCATION MATERIALS

- I. Who are the professional clinicians and what is their interest and dedication to patient education?
- II. Staff Profile:

| | | |
|------|----------------|---------------------------------------|
| Name | Title/Training | Special Area of Interest/or expertise |
|------|----------------|---------------------------------------|
- III. Patient Profile:
 - A. Number of patients
 - B. Age/sex distribution
 - C. Morbidity report (20 most common diagnoses)
 - D. Past years' history of services
 1. Health maintenance visits (including OB-Gyn, Yearly PE)
 2. Laboratory/procedures (EKG, Pulmonary function, blood sugar, Cholesterol.)
 3. Facility health maintenance procedures (flex. sign. etc.)
- IV. Community Resource Profile
 - A. Agencies or professionals to whom patients are referred
 - B. Community involvement by facility personnel for HPDP
- V. Facility Resources
 - A. Personnel currently involved in various aspects of education:
Responsibilities
 - B. Space in the office being used for patient education
 - C. Types of materials currently being used now, or would like to add for patient education
 - D. Primary sources of educational materials
 - E. Criteria used for selecting materials
 - F. Personnel responsible for selecting materials
 - G. Storage arrangement for materials
 - H. Audio-visual teaching aids available
 - I. Availability of computer, copier, word processor, document storage
 - J. Budget available for education
 - K. How to recover cost of education
- VI. Setting practice goals
 - A. Assessment
 - B. Planning/development
 - C. Staff orientation
 - D. Evaluation
- VII. Identify constraints