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ABSTRACT

This model, which provides tried and proven concepts and principles and which can be adapted to a health facilities services delivery system, is designed to assist the professional in planning for patient and family education and may be used with any illness regardless of its etiology or chronicity. The model presents a step-by-step procedure, representing a comprehensive and interdisciplinary approach to analyzing educational needs of patients in a variety of settings. Each of the following steps is discussed in a separate section: (1) Identify the educational needs of patient and family, (2) establish educational goals for patient and family, (3) select appropriate educational methods, (4) carry out the educational program, and (5) evaluate patient and family education. A flow chart and an outline of the model steps are included. (SH)

A Model For Planning Patient Education

An Essential Component of Health Care

Report of the
Committee on Educational Tasks
in Chronic Illness
Public Health Education Section,
American Public Health Association

U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
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Preface

The importance of patient education as an integral part of health care is increasingly recognized in the health and hospital field. The Hill-Burton program, in cooperation with the American Public Health Association and Metropolitan Life Insurance Company, presents this booklet prepared by the Committee on Educational Tasks in Chronic Illness of APHA's Public Health Education Section.

This booklet, which is the result of the experience of many persons concerned with patient education, is based on the principle of educational psychology that people will more readily accept changes if they are involved with the decision-making process. Despite our recognition of the patient's need and right to know how to further health, it is the patient who makes the final decision to accept or reject the prescribed regimen. The health educator and other health professionals must be prepared to assist the patient in arriving at the decision most beneficial to his own well-being.

This "Model," which provides tried and proven concepts and principles and which can be adapted to a health facilities service delivery system, is designed to assist the professional in planning for this vital task. The model is not the way or the answer to planning and organizing a program. But it is a method which, if modified to fit local needs, can be effective.

The Division of Facilities Development is pleased to publish this important contribution to patient education, which should enhance the health services available in our Nation, assist health facilities in reducing unnecessary readmissions, and provide for better utilization of our national health care resources.

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Introduction

This is a report of the Committee on Educational Tasks in Chronic Illness, which was appointed in 1968 by the Public Health Education Section of the American Public Health Association, to determine the educational components in caring for the chronically ill after the acute stage of the illness.

Basic Premises

The Committee accepted the following statements as a basis for its work:

1. Children and young adults as well as older people suffer with chronic illness.
2. Patient education is an integral part of patient care.
3. Target groups to be considered in educational programming include:
   a. the patients and their families;
   b. staff members (at all levels) in the health care setting; and
   c. appropriate groups in the community.
4. The team approach, with the physician serving as the team leader and coordinator, offers the most effective approach to patient education.
5. Since various disciplines—e.g., occupational therapy, physical therapy, social service—may have different educational goals, the patient education program must be carefully reviewed and coordinated.
6. Consideration should be given to an "educational prescription" that would be available in written form and would accompany the patient as he moved from one facility to another.
7. All those involved in caring for the chronically ill have need for in-service and continuing education.

Committee Assignments

Initially subcommittees were established which related to the setting in which care is provided to the chronically ill patients. Although the Committee was cognizant that this arbitrary division was not ideal, it was considered preferable to other kinds of divisions such as disease or age categories. Subcommittee chairmen were encouraged to approach the assignment creatively and to include representation from several disciplines on their committees.

The task of developing the report was further complicated by the fact that a meeting of the entire group could not be arranged. However, in October 1969 a preliminary report was circulated to the subcommittee chairmen for comment.

One subcommittee postulated a model which has been modified as presented on pages 7 to 8. This model has served as the basis for this final report.

The Model

The model, developed by the Committee, is a mechanism for defining the educational processes necessary for patient and family education and may be used for any illness regardless of its etiology or chronicity. It can be used by physicians, nurses, social workers, health educators, and others responsible for planning and organizing education programs for patients and their families.

To accomplish the educational tasks described in this booklet, the health facility administrator must provide a favorable climate, adequate manpower, resources, and time to carry out each step. An important first step would be to employ a trained and experienced educational consultant, or health educator, to serve as the coordinator of the patient education program. Other important factors include the provision of conference room space, the development of administrative mechanisms which allow for an exchange of information among staff, and the provision of specialized consultation and evaluation.

Also, there would be a need for providing opportunities for training appropriate staff to sharpen its existing skills or acquire new ones, or modify existing practices so that the patient will be helped to utilize the educational opportunities available. Some of the staff skills require an ability to:

1. Identify what the patient and family need to know and understand to carry on a prescribed program;
2. Determine through various methods the patient's attitudes, knowledge, and life style;
3. Determine a patient's perceived need for knowledge and hidden fears;
4. Perceive educational opportunities;
5. Understand and be able to use the educational techniques, including group discussion; and
6. Choose areas and methods of evaluation.

To implement the steps set forth in the model, it is suggested that consideration be given to establishing two committees to advise the educational coordinator. One, a medical advisory committee, would provide an effective communication link to those in the medical community responsible for organizing and coordinating patient care. Another, the patient education advisory committee, would serve as the bridge not only to the various departments of the facility but also to the community. In addition, a patient advocate or advisory group could provide additional feedback. Through these committees, the coordinator would be in the unique position of being able to obtain feedback and provide information relative to the educational needs of patients from the viewpoint of medicine, nursing, other allied health disciplines, and the community.

The purpose of patient education is, of course, an improved health status for the patient. The model is not an end in itself but rather it is a means by which patient and family education can be reached in a health care facility.

Sincere appreciation is expressed to the members of the Committee and its subcommittees, representing many disciplines, agencies, and organizations and working in many areas of the United States.

Joan M. Wolle, Chairman

Planning for Patient Education

An essential component of health care is the education of the patient, his family, and others concerned with his well-being. To achieve optimum results through the education process, all facets of care must be coordinated, beginning with the initial medical and social consultation and continuing through all phases of the case. This coordination, both within and among the institutions serving the patient, must be such that those involved in any one phase of care can take full advantage of the knowledge, skills, and resources of others in the health care complex. Thus, the specialized knowledge of many health professionals can be applied in a way which contributes maximally to quality total care for each patient.

In planning for the educational aspects of health care, consideration must be given to three groups:

1. Patients and their families;
2. Staffs of institutions serving the chronically ill; and
3. Target populations in the general public.

Factors to be considered in developing a plan for patient education include:

1. The patient's response to a particular disease or combination of conditions;
2. The patient's unique physiological and psychological makeup, past experiences, and physical and social environment;
3. The treatment regimen;
4. The staff and others involved in his care;
5. The environment in which the care is given.

educational plan should be developed for every patient and should reassessed periodically since the patient's educational needs ange depending upon such factors as his medical condition, his owledge, attitudes, and abilities. Similarly, the educational needs the patient's family should be diagnosed individually and assessed d modified periodically.

If education is a prerequisite to effective patient education. Plan- g for staff education is a process in which goals are set, educational thods and resources chosen, and evaluation defined. Staff educa- requirements may include training directed at rehabilitation philos- y and organization, program administration, human relations, up process, the team approach, leadership development, problem ving, decision making, consultation techniques, and communica- skills.

mmunity education is another important consideration which affects ent education. Educational efforts among target populations of general public should be directed toward:

Preventing and limiting illness;

Increasing the acceptance, support and appropriate use of facil- ities and health programs and facilities; and

Recruiting, training, and retaining needed personnel.

Model

odel was developed which presents a step-by-step procedure, esenting a comprehensive and interdisciplinary approach to yzing educational needs of patients in a variety of settings. The el delineates five steps:

dentification of the educational needs of the patient and family;

Establishment of educational objectives;

Selection of appropriate educational methods;

mplementation of the educational program; and

Evaluation.

ally every effective plan for health education includes these five cts which, of course, cannot be considered as separate distinct but as an interrelated process. To implement the model effec- , consideration must be given to:

he situations and opportunities for accomplishing the steps, in- luding the "how," "by whom," and "when";

2. The necessary staff attitude, knowledge, and skills; and
3. The required administrative arrangements, policy decisions, and resources.

This model can be adapted easily for use by various health professionals and can be used in planning for a patient or group of patients in almost any setting such as in hospitals, long-term care facilities, health centers, and in the home. The model also can be used by personnel to heighten their awareness of the educational process as it relates to patients and their families, and to help staff assess their individual in-service and continuing education needs. In addition, it can be useful in determining the activities of various levels of specialists who have responsibilities for education. The following is a discussion of each of the five steps in the process.

Step I—Identify the Educational Needs of Patient and Family

Education of the patient is an integral part of patient care, shaped by the particular illness, the needs of the individual, the nature of the prescribed treatment regimen, and skill of the personnel who are providing care. All personnel responsible for providing patient care need to understand the patient education process.

Identifying the patient's educational needs begins with a recognition of the uniqueness of the individual determined by his biological and psychological makeup, his social and physical environment, and his past experiences.

These factors account for the broad range of differences existing among patients in terms of their knowledge of medical conditions, understanding of medical terminology, their attitudes toward health and illness, the treatment regimen, the social and cultural variations in response to illness as well as attitudes toward physicians, nurses, and other health professionals who are providing care in hospitals and other medical facilities.

Patient education requires knowledge of the disease or illness, resources, and treatment regimen; an understanding of the patient, his background, and environment; and the ability to have the patient perceive ways in which he can realize his full potential.

The physician and other health professionals should determine specifically what knowledge and skills the patient and family will need to obtain maximum benefit from medical care. These goals serve to establish a common understanding of the aims of patient education for all personnel involved in his care.

As useful as these goals are, however, they do not provide the health professional with a knowledge of what the patient already knows about his illness and treatment; what misconceptions he may have that could affect his response to care; his fears and attitudes toward care; or the skills or resources he has which could help in treatment. Such information can be obtained only from the patient and those having a close relationship with him.

Sufficient information about the patient is seldom acquired during a single interview or encounter, but rather through a mutual relationship built upon understanding and trust. The educational aspects of care are a responsibility shared by all personnel who have direct or indirect contacts with the patient. A basic problem in patient care is that of obtaining his cooperation in carrying out the prescribed treatment plan.

Step II—Establish Educational Goals for Patient and Family

The treatment goals serve as a basis for a patient education plan. The health professional must determine what the patient already knows about his illness and treatment, the misconceptions he has which may affect his response to care, his fears and attitudes, or the resources he has which will help him in the treatment regimen.

In identifying educational needs, the type of information all patients need to know about a specific illness should be considered. For example, patients with congestive failure would need to know the reason for administering digitalis, the problems involved with over- or under-digitalization, and the possibility of a sodium-restricted diet. Thus, in setting goals, it is important to consider whether the patient already knows the reason for digitalization, the potential for over- or under-digitalization, and how much he already knows about a sodium-restricted diet. Information lacking in any of these areas should be provided to the patient.

Data may be obtained by having all personnel involved in the care of the patient share information in case conferences. After a decision is made regarding the deficiencies in the patient's knowledge and his potential for rectifying them, an educational prescription should be written aimed at providing information to the patient so that he can accept and carry out the treatment plan.

Patient education is a continuing and evolving process with responsibility for specific aspects delegated to appropriate personnel. Those responsible for his care need to use data from such sources as the medical history and interviews as well as from conversations and observations of the patient and the family. The patient should be asked about the care he is receiving, ways in which he feels he is advancing toward the treatment goals, and his ideas on aspects of care in which he wants special emphasis or help.

The specific educational goals must be communicated to all concerned—patient, family, and staff—and understood and accepted if change is to occur.

Step III—Select Appropriate Educational Methods

After formulating the specific educational goals based on the needs of the patient and the family, the appropriate educational methods should be selected to meet each goal. The process of selecting educational methods should not be performed by the educational consultant alone, but it should be a cooperative venture among all professional staff members.

Selecting educational methods that are appropriate for the learning content involves identifying opportunities and situations for patient education for each of the goals. In order to identify these opportunities, it is important to be cognizant of each patient's flow pattern through the facility, the different staff members who will be involved in his care, his treatment and rehabilitation plan, and the number of other patients with similar conditions who might be following a related regimen. With this information, it is possible to list the opportunities for patient education. Decisions must be made to determine which opportunities will be used, which techniques are best, and whether the methods will be individual, group, or a combination.

Generally, the personal or individual methods should be implemented by persons working directly with the patient, such as the physician, nurse, occupational therapist, recreational therapist, physical therapist, dietitian, social worker, speech therapist, medical technologist, and others providing service. Group methods can be used by health specialists from the community or from the facility serving the chronically ill.

At times, an opportunity to provide patient education may occur as a result of the patient's rehabilitation regimen; for example, a physical therapist's explanation of the necessity for a certain conditioning procedure represents an application of a personal method to an opportunity. Other times, however, the procedure becomes more involved, thus requiring special planning; for example, group instruction programs for diabetic patients.

Criteria for selecting educational methods should include effectiveness, efficiency, adequacy, and appropriateness.

Effectiveness is the extent to which an activity achieves the goal. An educational method is considered highly effective if it attains the goal.

Efficiency is the amount of resources used to attain the goal. Factors to be considered in efficiency are manpower, time, materials, and monies. The educational activity which uses the least amount of resources to attain an educational goal is considered to be the most efficient activity.

Adequacy is the degree to which an educational activity can achieve the goal. An activity by itself can be quite inadequate; however, when that activity is combined with another activity, a synergistic effect could occur which would make the combination highly adequate.

Appropriateness is the relevancy of the method toward achieving the goal with respect to the ecologic environment of the patient. It is quite possible that an educational method could be effective, but at the same time be inappropriate because of a hereditary defect or an environmental problem. For example, using a tape recorder as an educational device for persons with normal hearing can be a very effective educational method, but it is quite inappropriate for persons with impaired hearing. A pamphlet containing the same information may be more appropriate, especially if the person is an avid reader.

With respect to group methods, frequently there is greater chance for behavior change when patients with similar illnesses seek solutions to their problems together; for example, classes may be conducted for certain types of patients such as diabetic, orthopedic, ophthalmo-

logical, and cardiac. Different teaching and learning techniques may be used such as demonstration, film discussions, and role playing.

With respect to audiovisual techniques, two relatively recent innovations should be considered: closed circuit television and programmed instruction. Other audiovisual techniques and materials that could be used include posters, pamphlets, exhibits, slides, films, mass media, and newsletters.

Time and place should be determined by the patient's schedule and, when possible, his wishes. For example, a stroke patient probably will be extremely tired after a vigorous physical therapy session and probably not as receptive to educational approaches at that time. The place for imparting information also should be considered. If the environment presents too many distractions, whether visual or audible, learning is not as likely to occur. Common sense for time and place can be a fairly safe guide.

To select appropriate educational materials, the staff should possess certain basic knowledge and skills:

1. A belief in the educational method and a willingness to help people learn for themselves.
2. An ability to recognize all educational opportunities.
3. A knowledge of educational process and an ability to determine selectively the types of situations that can be used to achieve different educational goals.
4. A knowledge of strengths and weaknesses of different educational methods and an ability to apply selectively the various methods to the situations.
5. A knowledge of available community resources and the ability to use these resources effectively.

A supportive and flexible administrative structure which is conducive to using educational opportunities existing in all aspects of the institution's operation is essential in accomplishing the educational task. The educational consultant must have the educational equipment and other resources needed to carry out his responsibilities effectively. Educational tools such as films, slides, overhead projectors, tape recorders, chalkboards, and literature are important. Without such educational aids the program often cannot be carried out adequately and effectively. The educational consultant also must have the necessary time to plan and coordinate the educational activities and to follow through and evaluate their effectiveness.

The institution cannot divorce itself from its environmental setting and still maintain high quality educational programs; it should maintain good rapport with other organizations, agencies, and the general public.

Since some smaller facilities may not be able to employ a full-time educational specialist, several health facilities in a community may consider employing jointly such a specialist. The educational specialist's or health educator's functions in a hospital or other institutional setting generally are no different from those practiced in other settings; these include consultation on educational methodology, assistance in in-service education, and developing the educational component of the medical care program.

Step IV—Carry Out the Educational Program

Although this is set as the fourth of five steps, it does not start immediately after Step III and end abruptly before Step V. Rather, it is a part of a continuum; it begins at the first step and continues through evaluation, which, of course, is part of the task of carrying out the educational program.

Step V—Evaluate Patient and Family Education

Since improved patient care is the primary goal of the educational task within each setting, the major focus of evaluation should be related to the progress the patient makes as a result of the educational program.

In considering the model as a design for organization, certain commonalities exist for any institution involved in organizing an education program:

1. Early planning for evaluation through a clear definition of goals to be evaluated; and

2. Early identification of methodology for evaluation.

Certainly, if the goals cannot be identified easily, there cannot be an identification of methodology by which success or failure is measurable. For example, a goal such as "to have patients lead a happier and more productive life" is laudable, but hardly measurable since as yet there are no objective means of measuring happiness and contentment.

If, however, the goal were defined as "to reduce the amount of excess sodium excreted over dietary allowances," then there is a measurable goal which is specific and attainable. Likewise, a goal may be defined which is behaviorally oriented, such as "to prepare the patient to accept the responsibility for his self-medication program." This requires not only behavioral change among patients but also among staff who have to prepare the patient and the administration which must provide a climate for education.

Evaluation of goals must be constant and continuous lest the professional person develop routine prescription procedures for behavior change, forgetting that he is dealing with an individual patient.

Families need to be considered in any evaluation scheme in order to assure that goals once reached are maintained by the patient, the family, or both.

There should be constant evaluation about the informational content patients and family are provided. Generally, the goals progress from the simple to the more complex. Questions which should be continually asked include, "Are they being given too much information or too little?" "Are they being confused by a plethora of facts?" "Can they perform as adequately with less information and, if so, how much less?" Evaluation must be done periodically so that necessary modifications in the plan can be made.

In evaluation it is also necessary to ask if the methods chosen to provide information are those which will insure adequate performance using staff and patient time to the best advantage. Consider such questions as "Is a one-to-one approach used because historically this has been the method, or can group work do the job more ade-

quately?" "Are new techniques called for, such as programmed instruction, video tape, and single-concept films, and, if so, are they being used?"

One team member—preferably the educational specialist—should have prime responsibility for the coordination and re-evaluation of the goals. Priorities of goals set for the patient and family in the educational prescription should be determined by the team at regularly scheduled periods. Acceptance and understanding of the goals by the group enable each member of the team to pursue his own subgoals with less danger of fragmentation. Involving the team throughout in the planning process provides them with a broad and deep learning experience and will also influence their behavior and attitude.

In those instances where there is no educator on the staff, a physician, social worker, or nurse with training in educational methods may act as coordinator.

In summary, evaluation should be considered an integral aspect of planning. It should be based upon educational goals; it should be constant; it should be done by all persons involved in the program; and it should be completed in an atmosphere of administrative permissiveness and cooperation.

THE MODEL
Steps in Planning:

Step I. Identify Educational Needs of Patient and Family

A. Determine knowledge, attitudes, and skills patient and his family need from a medical point of view to:

- understand patient's illness;
- understand patient's care;
- cooperate and participate in treatment program.

HOW:

Working from the medical diagnosis, treatment plan, and prognosis, specify knowledge and skills patient and family must have to benefit from the care for which each member of health care team is responsible.

WHO:

The relevant staff.

WHEN:

Obtain basic information as soon as possible with periodic review and also at time of discharge.

B. Determine to what extent patient and his family already possess knowledge, attitudes, and skills, e.g.,

- What does patient already know about his illness, his treatment (prescriptions, meaning of instruction, etc.), his prognosis, his role in the treatment program, and resources available to him?

- What misconceptions does he have that may affect his response to care?
- What attitudes does he have that may affect his response to care, either favorably or unfavorably?
- What needed skills do patients and family already have which will help in treatment?
- What skills or present behavior may need to be relearned?

HOW:

By reviewing the patient's medical history.

By checking with medical personnel who previously cared for patient.

By interviewing patient and his family (both direct and indirect).

By listening attentively.

By observation of patient and family.

C. Determine educational goals from point of view of patient and his family.

- What would the patient and his family like to know or do?

HOW:

Interview patient and family.

Step II. Set Educational Goals for Patient and his Family

A. Review possible educational goals for patient and family as identified by health care team and by patient and family in terms of:

- deficiencies in knowledge and skills of patient's family;
- willingness and interest;
- ability to carry out assignment.

HOW:

Share and review information collected in Step I:

- by written summary;
- by case conference.

WHO:

All members of health care team.

WHEN:

As soon as possible after initial medical evaluation and decisions about medical treatment, and periodically thereafter.

B Assess difficulty in reaching each goal.

- What kinds of learning are involved for patient and his family? How long might this learning take? What personnel, materials, and other resources would be needed, and are these available?

HOW:

Analysis of each goal in terms of what must be learned, factors aiding or impeding learning, possible methods to reach goals, and cost of these methods.

WHO:

Education Specialist.

C. Determine priority of goals.

- In what sequence would goals be met to facilitate treatment?
- Which goals are essential (for both short-range and long-range treatment program)?

HOW:

Staff conference.

WHO:

All members of health care team.

D. Decide on short-range and long-range educational goals.

HOW:

Staff conference.

WHO:

All members of health care team with patient and family.

Step III. Select appropriate Educational Methods to Meet Each Educational Goal Set for Patient and Family

A. Identify opportunities and situations for patient and family education for *each* of the goals.

HOW:

Suggestions could be made by staff working with the Educational Consultant.

WHO:

All members of health care team.

WHEN:

As soon as possible after educational goals are set.

B. Review possible methods for reaching each educational goal.

HOW:

Individual instruction; group instruction; use of visual aids; self-instructional material.

C. Determine specifically what is to be taught, by whom, where, when, and how.

HOW:

Through the use of the educational prescription.

WHO:

Each member of the health care team should be involved in decisions.

Step IV. Carry out the Educational Program

(This step is part of a continuum; it starts with Step I and continues through Step V.)

Step V. Evaluate Patient and Family Education

A. In terms of the patient's progress at stated intervals, to what extent were educational methods chosen which were:

- effective?
- appropriate?
- efficient?

HOW:

Feedback from individuals and agencies involved in care.

WHO:

Public Health Nurse, family, physician, therapy personnel, and local providers of health care should be involved in follow-up after discharge.

B. To what extent were educational needs from the medical point of view adequately identified?

- What did we think was a need which really wasn't necessary?
- What patient and family educational needs did we overlook or slight?

HOW:

Set through evaluation.

Patients and their families as well as staff should be involved in evaluation.

C. To what extent were patient and family educational needs as identified by the patient correctly recognized by staff?

HOW:

Informal evaluation.

WHO:

Staff.

D. To what extent were patient and family knowledge, attitudes, and skills adequately assessed at beginning of planning?

HOW:

Through evaluation.

WHO:

Patients and their families should also be involved in evaluation.

E. To what extent were the educational goals which were set realistic, adequate, and timely?

HOW:

Feedback from all the parties and agencies involved in care, especially those working with the patient after discharge from rehabilitation extended care facility.

WHO:

All providers of health care should be involved in follow-up after discharge.

F. Were goals given the best priority?

HOW:

Same as E.

WHO:

Same as E.

G. To what extent were educational methods chosen which were appropriate, effective, and efficient?

HOW:

Same as E.

WHO:

Same as E.

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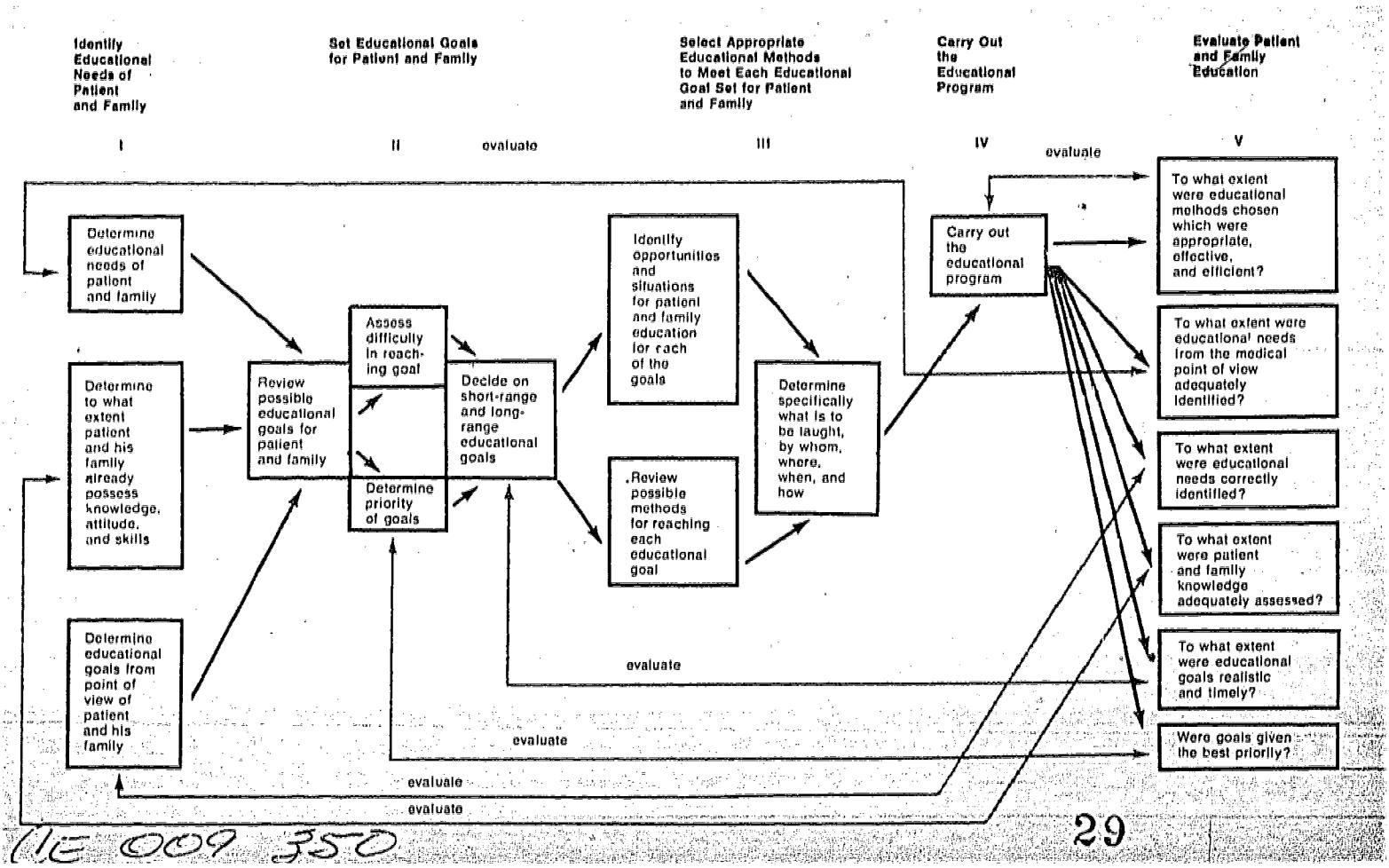
Identify Educational Needs of Patient and Family
Set Educational Goals for Patient and Family
Select Appropriate Educational Methods to Meet Each Educational Goal Set for Patient and Family
Carry Out the Educational Program
Evaluate Patient and Family Education
I
II
III
IV
V
evaluate
evaluate
Determine educational needs of patient and family
Determine to what extent patient and his family already possess knowledge, attitude, and skills
Determine educational goals from point of view of patient and his family
Review possible educational goals for patient and family
Assess difficulty in reaching goal
Determine priority of goals
Decide on short-range and long-range educational goals
Identify opportunities and situations for patient and family education for each of the goals
Review possible methods for reaching each educational goal
Determine specifically what is to be taught, by whom, where, when, and how
Carry out the educational program
To what extent were educational methods chosen which were appropriate, effective, and efficient?
To what extent were educational needs from the medical point of view adequately identified?
To what extent were educational needs correctly identified?
To what extent were patient and family knowledge adequately assessed?
To what extent were educational goals realistic and timely?
Were goals given the best priority?
evaluate
evaluate
evaluate
evaluate