The Role of Health Educators in Medical Care

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HEALTH educators anticipate a future of dynamic changes in medical care. They must be flexible and adaptive to meet the challenges and responsibilities of applying the many principles and practices of health education. The manner of delivering health care is important; the public is increasingly demanding top-quality service and striving to receive it.

Educational elements exist in every aspect of medical and health care services. This basic tenet is accepted by all health professionals but seldom fully implemented.

The Medicare and Medicaid programs specify Government standards for participating institutions related to the facility, its management, and the manner in which it provides care. The tasks of health educators are increased because of these standards; they help to educate the staffs of the institutions that are surveyed for certification.

Additional responsibilities for health educators are posed by Public Law 90–248, which requires the licensing of administrators of extended care facilities by 1970. Courses are needed to upgrade the skills of many persons now serving as administrators and formal courses of study for those who will administer the extended care facilities of the future. Public health agencies need continuing education in surveying, licensure, and consultation. Surveyor training is a top priority in many public health agencies.

Nursing homes have received the greatest impact from the standards set under Medicare and Medicaid because basic changes are required in the nature and scope of their services to certify them as extended care facilities. Health educators worked with the staffs of nursing homes that were surveyed in Montgomery County, Md., to correct deficiencies.

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Nursing Home Survey

A 1966 preliminary survey of seven nursing homes in Montgomery County applying for Medicare certification identified the following major deficiencies:

1. In many instances the nursing homes did not have written policies covering patient care. Sometimes a set of model policies had been adopted by a home without considering the particular facility. A considerable amount of confusion existed in one or two nursing homes because of inconsistent policies and procedures set forth in various manuals.

2. Increased training for virtually all nursing home personnel in supervisory positions was identified as a major need, for two basic reasons: (*a*) many people were not prepared to supervise personnel and (*b*) the change from a nursing

home to an extended care facility required many changes in administration and scope of the service.

3. Ancillary services, especially speech therapy and medical social services, were notably absent in the nursing home because of the lack of trained personnel. Other less severe manpower needs were also identified.

4. A great deal of concern existed as to what an inservice education program actually is, who can adequately direct it, and how it is implemented.

5. Nursing homes cannot always employ full time certain professional health workers, such as pharmacists and dietitians. In many instances, consultative services are adequate. But the consultants must be prepared for these services by special training.

The task of correcting institutional deficiencies can be approached in one of two ways: (*a*) An inspection of the institution may be made by noting the areas of compliance, listing the deficiencies, and sending a report to the institution and to the certifying agency or (*b*) the survey can be the beginning of helping the institution by suggesting ways of overcoming the deficiencies, recommending consultative services, and planning workshops and seminars. The health educator working with the survey staff in Montgomery County implemented an organized approach to educational experiences necessary to widespread and effective correction of deficiencies. Much more can be accomplished by the second approach because it offers the assistance that many facilities need and deserve. The second approach was used in the Montgomery County survey.

Coordinated Programs

Community coordination is a necessary component of health education in medical care. This approach stresses the importance of working together to solve problems, first by identifying health needs and resources and then forming plans of action.

A total community effort is useful in training health care manpower, not for specific institutions alone but for the entire community. Training is essential because of the increased demand for health manpower by virtually all health care facilities.

The office of institutional and medical care services of the Montgomery County Health Department, which is responsible for the surveying and licensure of medical care facilities for Medicare certification, has been investigating a total community effort for health manpower training. A health educator has been assigned the following responsibilities:

1. Identifying all community health manpower training efforts and resources.

2. Identifying training needs and problems as perceived by medical care administrators, training directors, public agency personnel from the school system and employment service commission, representatives of voluntary health associations, and hospital council education directors.

3. Searching for methods to improve the community's approach to training health manpower.

In discussing training with various groups, the health educator has found a lack of communication and coordination in a total training effort. One cause of confusion is the numerous training grants available from various sources for many different purposes. Deficiencies existing at both the national and State levels often result in fragmented service and duplicated efforts in the local community.

Often the planners of training programs do not represent all groups that are interested in health manpower. Most training programs are heavily oriented toward hospital needs, but with a growing concern for the continuity of patient care, the manpower needs of nursing homes and home health care programs also must be considered. Many needs are similar, but enough differences exist to warrant special attention.

As many relevant groups as possible should be included in the planning phase of programs because it is especially important that all health care groups—hospitals, nursing homes, home health care services, physicians, voluntary agencies, and public health agencies—work together to assure a continuum of patient care.

A number of people have expressed concern about the few experienced health professionals included when a training program is being planned. This failure often results in the poor selection of instructors and sites for courses of

study, poorly developed curriculums, and no use or misuse of available community resources. Several resource groups, such as certain divisions of the school system and voluntary health organizations, thought they could contribute more to health manpower training than they were contributing—a most unfortunate situation when training resources are at a premium. Perhaps increased communication about training efforts could create a greater awareness of local community resources.

The people in the county expressing a desire for a more centralized and coordinated approach to the training of health manpower were concerned about (*a*) centralized training sites and sources of data on recruitment, selection, and placement; (*b*) a single source for government-funded programs; (*c*) sharing facilities and resources; and (*d*) eliminating duplication of effort.

Information acquired during the Montgomery County survey of nursing homes strongly suggested the need for a more organized approach to community training efforts. Interested groups need to assume leadership in improving training of health manpower in the community. The health department can help either directly or catalytically in bringing appropriate groups together to first discuss community training needs and wants and then plan training programs to meet total community needs. The health educator can subsequently contribute to a continuing education program.

Health educators from the Maryland State Department of Health and the Montgomery County Health Department are planning sessions with the Maryland Nursing Home Association on (*a*) the mechanics of planning and scheduling workshops, stressing the concept of planning to meet local needs and (*b*) the best use of local community resources.

A health educator and a coordinator from the institutional and medical care program of the county health department helped to form an education committee to prepare written policies for patient care. Committee members are representatives of the Maryland Nursing Home Association, the Montgomery County Medical Society, and the Montgomery County and Prince George's County Health Departments. The health departments developed the guidelines for the policies. A workshop on the subject was held in Gaithersburg, Md., on May 3, 1967 (*1*).

Another major concern of the education committee is the development of formal education programs to prepare (*a*) current nursing home administrators for the 1970 licensure examinations and (*b*) formal degree courses for future administrators of nursing homes.

Inservice Education

The Montgomery County survey of nursing homes for Medicare participation revealed that one of the greatest needs in nursing homes and in many hospitals is inservice education programs. The following questions often are asked about inservice education of nursing personnel:

1. What exactly is inservice education? For example, does it have to include a formal classroom setting?
2. How does a home go about setting up an inservice education program?
3. Who will teach?
4. Where can we find the resources and teaching materials applicable to nursing homes?

The lack of educational workers is usually more acute in nursing homes than in hospitals because individual homes may not be able to afford a director of inservice education. The director of nursing may be assigned this responsibility but often does not have either the time or the experience to handle the task. Health educators and other professional health workers, such as nurses, sanitarians, and dietitians, can impart the educational principles and methodology that would help the administrators and directors of nursing plan the inservice programs applicable to their needs and capabilities.

Health educators have helped nursing homes set up inservice education programs by identifying teaching materials and resources, assisting in the establishment of dietary and housekeeping inservice programs, and participating with the education committee of the Maryland Nursing Home Association in planning a seminar on implementing an inservice education program.

Consumer Education

One factor often overlooked in planning the delivery of health care is what the people actually want and what they actually need. Ignoring

this factor often affects both their use of the services and the satisfaction they derive from them. The consumers of health care are frustrated, and many lack sophistication concerning the health care system (*2*).

One of the biggest tasks of the health educator in medical care is consumer education. After 2½ years of operation, the beneficiaries of Medicare and Medicaid still need to know a great deal about the programs. At best, most people have only a general understanding of the coverage. Calls to the health department indicate that many people do not know that Medicare is an insurance program and not a geriatric comprehensive care program.

Numerous inquiries are received about specific Medicare benefits. One feature that still is not well understood is utilization review. The Medicaid program, with a scope potentially larger than Medicare, presents an even greater challenge in consumer education.

Imaginative efforts are needed to inform Medicare and Medicaid beneficiaries about their benefits. Medigame, a simulation exercise, was developed by the Division of Medical Care Administration of the Public Health Service and is being tested as an educational technique (*3*).

Related to consumer education is the need to keep the public informed on changes in the medical care system. Most people are familiar with the general hospital, but few are familiar with such health care institutions as extended care facilities and comprehensive home health care programs. Information on these services is especially important to understand the whole concept of continuity in patient care.

The need for more consumer participation in our health care system is evidenced by the 1967 Partnership for Health legislation, Public Law 90–174. A potential activity for health education, related to consumer education, is a coordinated community approach to determine consumer wants and needs in medical care and to relay this information to professional health care workers and planners.

Our health care system is a virtual maze of agencies, facilities, and programs, making it difficult for anyone to become familiar with the system. Some type of health information referral system may become necessary to facilitate the delivery of health care in our country, especially in large urban areas. The possibilities of a referral system are limitless. The services offered by this type of system could include (*a*) an information guideline service to all the available community health facilities, services, and sources of financial assistance; (*b*) a referral system to help place patients in the appropriate health care facility; and (*c*) preventive health care information. Although the endeavor might be complex and sophisticated, it is necessary because of the great demands on our health care system.

In our growing concern about medical care, it would be most unfortunate if we neglected information on preventive health care. New approaches to educating the consumer are needed. All professional health workers must teach preventive health, not only because the prevention of disease is feasible but also because information on the rapid advances in medical research needs to be imparted to the general public. Public health agencies, voluntary health associations, and medical care facilities must collaborate in preventive health care education programs. Medical care facilities, in addition to offering service, can offer information on preventive health care. A number of hospitals are now employing health educators for this purpose.

Summary

A health educator assigned to the Montgomery County Health Department in 1966 assisted in a survey of seven county nursing homes that had applied for certification under the Medicare program. He worked with the nursing home staffs to improve deficiencies that were uncovered as a result of the survey.

The activities of the educator were largely directed toward planning group education experiences with the Maryland Nursing Home Association and county health organizations in workshops on the preparation of written patient care policies, on various aspects of inservice education, and on upgrading the skills of administrators and consultants to work in the new environment of the nursing homes. The educator also attempted to help identify training needs and methods that would bring about bet-

ter communication and coordination between agencies in the development and use of health manpower.

The health educator stressed the need of an informed citizenry to use more effectively the health care benefits of the Medicare and Medicaid programs and to become more aware of the total health care system. New and better ways of increasing the sophistication of consumers in the use and evaluation of health care also were stressed.

REFERENCES

(*1*) Maxwell, V. B., and Woodward, L. H.: A descriptive study of the characteristics and flow of ECF patients in Montgomery County, Md., Jan. 1, 1967, through June 30, 1967. Montgomery County Department of Health, Rockville, Md., May 1968. Mimeographed.

(*2*) The plight of the U.S. patient. Time 93: 53–58, Feb. 21, 1969.

(*3*) Cashman, J. W., and Galiher, C. B.: Medigame. A new consumer education tool. Public Health Rep 83: 987–989, December 1968.

Licensing Examination for Nursing Home Operators

The Professional Examination Service (PES) of the American Public Health Association has asked administrators of nursing homes throughout the country to participate in the development of a program under which they will be licensed. New Federal legislation provides that no nursing home may receive Federal funds after July 1, 1970, unless the State in which it is operating has established a program for the licensing of nursing home administrators. Persons who have been working as nursing home administrators for at least a year may be licensed by waiver until 1972. After that date, however, no waivers will be permitted. Federal funds are available during the 2-year period 1970 to 1972 to provide training for those who cannot immediately pass licensing examinations.

To assist the States in implementing the new legislation, the Public Health Service has contracted with PES to develop an examination program for the use of State licensing agencies.

The first step in this program is the construction of a basic examination which must be completed by April 30, 1969, so that it can be used to test applicants for license in time to meet the 1970 deadline. The examination will be designed to evaluate applicants' knowledge of nursing home administration and their capability to apply such knowledge to operating situations.

To insure that the examination will be practical and related to the actual problems encountered in the operation of nursing homes, 450 practicing administrators were asked to submit questions. The names of the administrators asked to participate were provided to PES by national organizations in the nursing home field.

An advisory committee, established by the PES under the terms of its contract with the Public Health Service, prepared an outline of the subject matter which a qualified nursing home administrator should be familiar with. The prepared outline is intended to guide question writers and has been sent to such persons so that they may choose the areas in which they are most interested or feel best qualified to contribute. The examination will not be constructed until all questions have been received and processed.

Questions contributed by administrators will be edited for subject matter and for conformance to psychometric principles by PES staff. They will be submitted to review panels of experts whose comments will be used in the final editing.

Education Notes

Milieu Therapy at Institute of Gerontology. Applications are being accepted for the 14-week residential institute in milieu therapy to be offered in Ann Arbor by the Institute of Gerontology, University of Michigan-Wayne State University, May 5–August 8, 1969.

Through a grant from the Administration on Aging, Department of Health, Education, and Welfare, traineeships are available to qualified personnel who give promise of the ability to design and direct programs using environmental settings as therapeutic agents in the social rehabilitation of geriatric patients in old age homes, psychiatric hospitals, and nursing homes. Formal courses in gerontology are integrated with a milieu practicum which provides experience in motivation, group process, sheltered workshop operation, and the psychology of environmental intervention in mental hospitals and other institutional settings.

For further information and application forms, write to Dr. Wilma Donahue, Institute of Gerontology, 1510 Rackham Building, University of Michigan, Ann Arbor, Mich. 48104.

Executive Development: Planning as a Community Function. Columbia University School of Public Health and Administrative Medicine in cooperation with the National Health Council's Committee on Continuing Education offers for its sixth year a noncredit institute on management at the Park Plaza Hotel, New Haven, Conn., July 13–18, 1969.

Designed for executives of voluntary and official health agencies, other professional organizations, and institutions providing health and welfare services to the community, the institute will focus on the philosophy, process, and tools of planning. Emphasis will be on stimulating self-development in managerial attitudes and concepts and sharpening skills in agency planning designed to improve community planning.

The institute will be limited to 50 persons. The $125 tuition includes all instructional and biographical material but not room and meals. A limited number of full tuition traineeships and partial cost-of-living stipends are available.

Additional information is available from the Program on Continuation Education—Public Health, Columbia University School of Public Health and Administrative Medicine, 21 Audubon Ave., New York, N.Y. 10032.

Environmental Health Sciences Graduate Programs. The Harvard School of Public Health's department of environmental health sciences has announced the availability of fellowships for graduate training in radiological health, air pollution control, and industrial hygiene for the 1969–70 academic year.

These programs lead to the degrees of master of science and doctor of science, and the fellowships provide student stipends ranging from $200 to $300 per month and $500 per year for each dependent, plus full tuition and fees. Department of environmental health sciences is a new designation replacing that of the department of industrial hygiene.

Further details may be obtained by writing to Dr. Dade W. Moeller, Head, Department of Environmental Health Sciences, Harvard School of Public Health, 665 Huntington Avenue, Boston, Mass. 02115.

Air Pollution Control Administration. A training program in air pollution control administration, funded by the Public Health Service, is being given at Pennsylvania State University from June 30 through September 4, 1969.

The course is designed to give specialized training necessary for an appreciation of all phases of the air pollution problem—scientific and engineering, administrative, and socioeconomic. The curriculum comprises lectures, discussions, laboratory experiments, fieldwork, and public administration simulation exercises.

Employees of air pollution control agencies as well as college juniors, seniors, graduates, and graduate students are eligible to apply. Stipends, registration fees, and instructional materials are awarded to qualified applicants.

Certificates will be awarded to persons completing the course, and candidates meeting all university requirements may obtain eight academic credits applicable to upper division graduate levels.

Recruiting is in progress. More information is available from Dr. R. Lee Byers, Director, Specialist Training Program, Center for Air Environment Studies, 226 Chemical Engineering II, Pennsylvania State University, University Park, Pa. 16802, or by telephoning 814–865–3479.

Air Pollution Technician Training. An air pollution technician training program, funded by the Public Health Service, will be offered at Pennsylvania State University from July 14 to September 12, 1969.

Designed to give specialized knowledge in the theory, installation, operation, and maintenance of the instruments and types of equipment used in air pollution control, the instruction will be in three phases: classroom, laboratory sessions, and fieldwork.

The program is open to employees of air pollution control agencies, associate degree students, and others who have completed their first or second year of college. Financial aid, stipends, prepaid registration, and instructional materials may be awarded to qualified persons.

Recruiting for the 1969 session has begun. Further information may be obtained by writing to Dr. R. Lee Byers, Director, Specialist Training Program, Center for Air Environment Studies, 226 Chemical Engineering II, Pennsylvania State University, University Park, Pa. 16802 or by telephoning 814–865–3479.

Community Mental Health Psychiatric Nursing. A program leading to a master of science degree in community mental health psychiatric nursing is being established at the Arizona State University College of Nursing at Tempe. The first students will be admitted in the fall of 1969.

Supported by a grant from the National Institute of Mental Health, the program is designed to train nurses in community mental health techniques and philosophy so that they can assume teaching or leadership positions in the developing community mental health programs.

The four-semester curriculum will emphasize prevention and intervention within the community rather than the more traditional patient care provided in a hospital setting. During their first year students will study concepts of health and normal interaction patterns in the family and the community. In the second year emphasis will be on the nurses' role and function in community mental health.

The basic curriculum will include courses in advanced nursing, research, human development, and in the social, biological, and behavioral sciences. Elective courses may include study in teaching, administration, or health problems related to specific groups.

In addition to classroom activities and seminars, the nurses will receive clinical experience at area hospitals, community mental health centers, and other mental health and related community service areas.

A bachelor of science degree in nursing is required.

Semester fees include $145 registration fees for residents of Arizona and for nonresidents, a $407.50 tuition fee. A limited number of stipends will be available.

Additional information is available from Ellamae Branstetter, professor of nursing, Arizona State University College of Nursing, Tempe, Ariz. 85281.

Health Planning Fellows. The University of Michigan is establishing a center for health planning to train social planners, assist governmental and voluntary organizations in planning, and improve planning methods.

Beginning in August 1969 a limited number of health planning fellowships will be available to holders of a bachelor's degree with specialization in a social science. The fellowships, including full tuition, stipend, and a $500 allowance for each dependent, are for 2 years.

The curriculum leads to a master of public health degree and includes courses such as systems analysis, operations research and statistics, social and political sciences, public health principles and methods, community mental health, medical care organization and financing, and environmental health. In addition, students will participate in public policy seminars and courses in the economics and politics of planning.

Each term fellows will work on projects assisting communities in planning solutions to significant social problems. One term will be a field assignment to a social agency.

Additional information is available from Robert N. Grosse, Professor of Health Planning, University of Michigan, Ann Arbor 48104.

phs synopses

SPIERS, PHILIP S. (University of North Carolina School of Public Health): *Hodgkin's disease in workers in the wood industry. Public Health Reports, Vol. 84, May 1969, pp. 385–388.*

Certain evidence in the literature about Hodgkin's disease suggested the hypothesis that the excessive risk of workers in the wood industry of contracting it could be explained by their exposure to pine pollen. By regression analysis involving the use of mortality and commercial statistics, it was found that the variation between States in deaths from Hodgkin's disease (all ages combined) as a proportion of the sum of deaths from Hodgkin's disease and from lymphosarcoma and reticulosarcoma could be predicted for white males in States east of, but not west of, the Rocky Mountains. As expected, no significant prediction was obtained for white females. That a prediction of risk was possible for males implied that the built-in assumption, that the etiology of Hodgkin's disease (other than for the kind caused by pine pollen) and of lymphosarcoma and reticulosarcoma is similar, was correct. However, only data from secondary sources were examined. An adequate test of the hypothesis will require examination of data from primary sources.

FARBEROW, NORMAN L. (Suicide Prevention Center, Los Angeles), and SIMON, MARIA D.: *Suicides in Los Angeles and Vienna. An intercultural study of two cities. Public Health Reports, Vol. 84, May 1969, pp. 389–403.*

Cross-cultural differences and similarities in suicide were investigated by examining 50 suicides committed in Vienna and 50 in Los Angeles. Through in-depth interviews with family and other informed survivors, information was sought on details of the suicide act, communication given and received about suicidal intent, previous history of suicide attempts, estimation of lethal intent, personality syndromes, and personal and background information about the deceased. Comparable data for the two cities were obtained by using a protocol with similar items.

In general, the Viennese seemed socially alienated and isolated and in poor communication with spouses, relatives, and close friends. Those committing suicide in Los Angeles were more often in strained or broken interpersonal relationships and under great social and occupational pressures. Communication of feelings seemed to occur more often among the Los Angeles cases than the Viennese cases. The results showed no significant differences in age, sex, and marital status for the two groups.

The Viennese used domestic gas primarily to kill himself while the Los Angelino most often used a gun. For the Viennese, the cause of the suicide was more often attributed to physical illness, for the Los Angelinos, most often to interpersonal difficulties. About two-thirds of the suicidal acts in both groups seemed intended to be lethal.

More Viennese men showed reactive depressions, more Viennese women were old and alone, and more Los Angeles men and women showed emotional instability. Alcohol was a serious problem for at least a third of the decedents in both groups. Those in Los Angeles were occupationally and residentially more mobile than the Viennese.

Ways of decreasing the suicide rate in both cities are discussed, including legal, social, and professional action. At present, increased direct intervention capabilities through more suicide prevention centers are needed. For the future, primary prevention programs to improve early identification of the suicide-prone and also to provide public education that dispels taboos hold most promise.

SCHAFFNER, WILLIAM (Vanderbilt University Hospital), and ADAIR, RITA M.: *Smallpox vaccination campaign for Rhode Island hospital personnel. Public Health Reports, Vol. 84, May 1969, pp. 425–429.*

A smallpox vaccination program for hospital employees was carried out in 13 hospitals and one children's home in Rhode Island subsequent to the announcement of an international smallpox alert during the spring of 1967. Only 25 percent of the hospital employees surveyed were found to have been vaccinated during the previous 3 years. A total of 3,473 additional employees were vaccinated during the program, increasing the percentage of personnel known to have been vaccinated within the preceding 3 years to 55 percent. No vaccinia was transmitted to patients and no major complications occurred, but three emloyees lost a total of 6 working days because of minor vaccine-related illnesses.

The hospital licensing board of Rhode Island is now considering incorporating employee immunization requirements into licensing regulations. Clearly, high-risk groups, including hospital employees and staff, should be revaccinated routinely according to a regular schedule.

phr synopses

REINKE, WILLIAM A. (School of Hygiene and Public Health, Johns Hopkins University), TAYLOR, CARL E., and IMMERWAHR, GEORGE E.: ***Nomograms for simplified demographic calculations. Public Health Reports, Vol. 84, May 1969, pp. 431–444.***

To assist public health personnel untrained in demography who must undertake population programs with important demographic features, a set of nomograms is introduced which quickly reveals the importance and interrelationships of quantitative factors that affect population growth.

The primary determinants of growth rates are family size and intergeneration span. One graph permits assessment of their importance under any current conditions of interest.

These primary forces relate to several specific factors of more direct concern to planners. Family size is based upon the number of births per family and survivorship through childhood. Intergeneration span is affected by the mother's age at birth of the first child, number of children she bears, and spacing between births. Finally, the health planner often prefers to translate growth rates into terms of relative population increase over a fixed period of years. The set of 16 nomograms is constructed so that all the above factors can be appraised simultaneously without the need for formulas or calculations.

Rules for using the nomograms are described, and their application to actual data from Costa Rican and U.S. nonwhite population is illustrated.

EDWARDS, L. D. (Presbyterian–St. Luke's Hospital, Chicago): ***Infections and use of antimicrobials in an 800-bed hospital. Public Health Reports, Vol. 84, May 1969, pp. 451–457.***

A month-long survey of hospital associated infections and use of antimicrobials at the Public Health Service Hospital, Staten Island, N.Y., revealed that 17.9 percent of 1,465 patients had infections with onset in the community and 7.8 percent had hospital-onset infections. The hospital-onset group had an average stay more than twice as long as the average stay of the community-onset group.

Infections were designated "hospital onset" if they were clinically evident 72 hours or longer after a patient's admission, if the infection was related to a procedure performed within 72 hours of admission, or if the infection was related to a previous stay at the hospital. All other infections were designated "community onset."

Antimicrobials were given to 30 percent of the patients; 13.5 percent of them were given antimicrobials for prophylaxis. The prophylactic antimicrobials were used predominantly in the surgical services where 17.4 percent of the courses administered did not prevent serious postoperative infections. Therapeutic antimicrobials were administered to 21 percent of the patients.

Surveillance was accomplished by filling out infection reports on all patients receiving antimicrobials for therapy, prophylaxis, or both. The medication index was reviewed, and all wards were visited five times a week. Charts of all discharged patients were also reviewed.