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PATIENT EDUCATION PROGRAMS IN MICHIGAN NURSING CARE FACILITIES

By

Donald John Breckon

A DISSERTATION

Submitted to
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ABSTRACT

PATIENT EDUCATION PROGRAMS IN MICHIGAN
NURSING CARE FACILITIES

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Donald John Breckon

It was the purpose of this study to describe, in an analytical fashion, the status of patient education in Michigan's 455 nursing care facilities. Program existence and their principal components were identified, and their relationship to institutional type, size, geographical location, and age were determined. The stage of development of these programs was assessed and likewise related to institutional type, size, geographical location, and age.

A questionnaire was designed, sent to a jury of experts, revised, and then pilot tested on administrators of twelve Michigan nursing care facilities. It was then refined, printed, and mailed to the administrators of all the 455 nursing care facilities in Michigan. A response rate of sixty-nine percent was obtained, with sixty-five percent being usable. The data were then computer analyzed, and displayed.

It was determined that two hundred of the 294 institutions (sixty-nine percent) have an operational patient education program. It was most common for an institution to have a general education

program (sixty-one percent do), and less common for an institution to have a health education program (thirty percent do).

Institutional size was more frequently related to the extent and nature of patient education than were institutional type, location, or age. Large institutions were more likely to have operational programs of patient education, more likely to have a patient education center, more likely to have a patient education coordinator, more likely to have a wider range of offerings available, and more likely to have family education available. While the difference between medium-sized and large institutions was not always large, the difference between small institutions and large institutions was typically large. The commonly held belief that small institutions have a restricted patient education program was validated by this survey.

The stage of program development was measured and related to institutional type, size, age, and location. No significant findings resulted.

Seventy-three percent of the 294 responding institutions had a specific department or coordinator responsible for patient education. Sixty-two percent of the institutions had an area designated as a patient education center.

The general education programs most commonly offered arts and crafts, reality orientation, current events, and music, with many other activities being available. Group instruction was the common mode. Several outside groups were typically included in the program.

The health education programs most commonly offered were instruction about the facility, nutrition, diabetes, and hearing and visual disorders. Individual instruction was the common mode. Several groups were involved in the program.

Combinations of methods were used to get a patient involved in the program. Most commonly used was the patient conference, followed by patient requests, doctor-issued prescriptions, and standing orders.

Evaluation of learning was reported in sixty-five percent of the programs. Program evaluation was reported in fifty-nine percent of the institutions.

Both patient health education and general education were considered legitimate functions of nursing care facilities. Eighty-five percent of the administrators indicated they would be willing to develop or expand a patient education program if free consultant help were available.

DEDICATION

This dissertation is dedicated to Dr. Elizabeth Wheeler Anspach, who more than anyone else is responsible for my being a college-level teacher, and therefore a Ph.D. candidate. Her warm, outgoing, student-centered ways continue to be the ideal toward which I strive. I count it a privilege to follow in her footsteps as a public health education faculty member at Central Michigan University.

D.J.B.

ACKNOWLEDGMENTS

The researcher wishes to thank his doctoral committee for their excellent guidance and support during the development of this dissertation. These members are Donald Tavano, Russell Kleis, Sheldon Cherney, William Sweetland, and Joseph Dzenowagis, all of the Michigan State University faculty. Special thanks are extended to Professor Tavano, who served as Research Director for the project, and whose insights into planning the research project were extremely valuable, and to Professor Kleis, who provided major editorial support in addition to his input into the research design.

The researcher wishes to acknowledge the continued support and encouragement given by his wife, Sandra Biehn Breckon, and expresses appreciation for her many hours of patient typing on this project. It must be acknowledged that her assistance far exceeded that typical of typists, and was more typical of a "research assistant."

Finally, the researcher acknowledges the continued encouragement and inspiration provided by his father, R. Joseph Breckon, and his deceased mother, Margaret Wade Breckon, who always encouraged him to "get as much education as you can."

D.J.B.

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CHAPTER I

PURPOSE AND ORGANIZATION

Introduction

The term patient education is a concept that traditionally applies to educational programs on health topics, and is also called patient health education. The term is sometimes used in a broader sense to apply to all educational programs provided for patients in the belief that education about non-health topics may be therapeutic. Both patient health education and other patient education activities are the focus of this investigation.

Patient education has recently become a major concern among public health educators and other adult educators. While it existed in many forms prior to then, it has burst on the consciousness of many who were previously unaware of its existence.

This expanded awareness is partly due to the increasing concern about reducing the costs of health care, and partly due to the concern about better informed consumers in all aspects of life. It is also part of a long existent concern among health care personnel to prevent as much illness as possible. As a result, patient education programs are developing all over the country. Concurrently, these programs are being studied to determine what kind of programs are emerging.

There has also been increasing concern about the needs of the aging citizens in the last decade. Their needs have been studied,[1] a state plan developed for Michigan,[2] and many programs developed to help meet some of the needs identified.

Focus has also been centered on that segment of Michigan's aging population living in nursing care facilities. Better standards for facility construction and maintenance, and for patient care have evolved in the last decade. The concerns for patient care for the aging in Michigan have resulted in an activity programming rule: "A patient shall be provided diversional activities suited to his needs, capabilities, and interests as an adjunct to treatment to encourage him to return to self-care and normal activities insofar as possible."[3] This rule is broad enough to include health education activities, general education activities, and recreational activities planned as part of the patient's therapy.

A major obstacle to expanded patient education programming has been lack of financial support for educational activities. While lack of finances remains a problem in nursing care facilities, the situation is changing. Third party reimbursement for limited patient health education is already occurring. For example, Medicare

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[1]Michigan Office of Services to the Aging, Michigan's Aging Citizens: Characteristics, Opinions, and Service Utilization Patterns (Lansing: Michigan Office of Services to the Aging, 1975), p. 44.

[2]Michigan Office of Services to the Aging, The Michigan Comprehensive Plan on Aging (Lansing: Michigan Office of Services to the Aging, 1975), p. 182.

[3]Rule 97, Michigan Skilled and Basic Nursing Home Rules, p. 25.

and Medicaid regulations that apply to most of these institutions include some provision for reimbursement for patient health education. Government funding programs currently being proposed as national health insurance will presumably also apply to nursing care facilities as well. Concern about patient health education in Michigan's nursing care facilities is developing concurrently with that of other sectors of the health care delivery system.

It is apparent that social policy is evolving that encourages patient education. Institutions are currently being given incentives which favor comprehensive human concerns, rather than the narrower treatment concerns of the past. This study has been, to a small degree, a case of social policy under study with the major focus being on the effects of that evolving social policy.

Statement of the Problem

It was the purpose of this study to describe, in an analytical fashion, the status of patient education in Michigan's 455 nursing care facilities. The principal components of patient education programs in these facilities were identified, and their relationship to institutional type, size, geographical location and age was determined. The stage of development of these programs was assessed and likewise related to institutional type, size, geographical location, and age. Specifically, an attempt has been made to answer the following questions: (1) What elements of organized patient education programs exist in Michigan's nursing care facilities? (2) Are there patient education programs in more of Michigan's nursing

homes, medical care facilities, or hospital long-term care units? (3) Are there more patient education programs in larger institutions, medium-sized, or smaller institutions? Are there more patient education programs in some Health Service Areas (HSA's) than in others? (5) Are newer nursing care facilities more apt to have established patient education programs than older facilities? (6) Are patient education programs more developed in nursing homes, medical care facilities, or hospital long-term care units? (7) Are patient education programs more developed in larger institutions, medium-sized institutions, or smaller institutions? (8) Are patient education programs more developed in some HSA's than in others? (9) Are patient education programs more developed in newer nursing care facilities than in older facilities?

The answers to these questions provide an indication of the current level of an emerging policy that favors meeting all the needs of patients rather than primarily the treatment needs. This is not to suggest that what is current practice is the ultimate in programming efforts. Instead, it is to assume that as policy continues to emerge, other as yet unidentified concerns will be incorporated. It is important to get a sense of direction, to ascertain where the current level of programming is, and where it seems to be going. This study, hopefully, has contributed to that goal.

Significance of the Study

Patient education is as old as the doctor-patient relationship, but the significance of such education is just recently being

recognized and emphasized. Subsequently, patient education programs are developing in many sectors of the health care system in the United States. Several studies have investigated or are investigating the extent of patient education programming in acute care hospitals both nationally and in Michigan. No one has previously studied the extent of patient education programming in Michigan's nursing care facilities.

It is important for university-based patient education consultants and other proponents of patient education to know what kind of patient education programs exist in nursing care facilities. It is important for administrators and boards of nursing care facilities to know what kinds of programs exist in sister institutions.

It is important that those charged with developing a state plan on aging know what kind of education the aged residents of nursing care facilities are receiving. Indeed, The Michigan Comprehensive Plan on Aging points up health education deficiencies of the aged both within and without institutions, and recommends expansion of educational programming for the aged.[4]

Finally, it is important that those planning for the health education of the public know what health education is being delivered to this increasingly significant segment of the general public. A Task Force on Health Education of the Public has been appointed by the State Health Planning Advisory Council. They have reviewed health education programming in health care institutions. They

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[4]Michigan Office on Services to the Aging, Michigan Comprehensive Plan on Aging, p. 182.

stated "various institutions have proven effective and efficient."[5] They went on to state:

> Associations representing health care institutions should encourage and assist their members to plan, implement and evaluate health education activities in the institutions and the communities served by these institutions. These institutions are considered by many to be centers for health care in the community. Therefore, health care institutions have a role to play, not only within their facilities but by reaching outside their walls to address community needs.[6]

This State Health Planning Advisory Council task force went on to recommend:

> It is recommended that the Michigan Hospital Association, the Michigan Osteopathic Hospital Association, the Health Care Association of Michigan, the Michigan Non-Profit Homes Association and the Michigan Association of County Medical Care Facilities develop policies and procedures for planning, implementation, and evaluation of health education in health care institutions as an integral part of the health care services within the institutions and in communities.[7]

This project has undertaken a survey of patient education in Michigan's nursing care facilities, as a preliminary step toward the policies and procedures called for in the recommendation.

Definition of Terms

The term patient education traditionally applies to educational programs on health topics provided for hospitalized patients. However, nursing care facilities frequently have general education

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[5]Governor's Office of Health and Medical Affairs, Preliminary Recommendations, State Health Planning Advisory Council, Task Force on Health Education of the Public (Lansing: Governor's Office of Health and Medical Affairs, 1976), p. 92.

[6]Ibid., pp. 92-93.

[7]Ibid.

activities available as part of their diversional therapy programs. These activities are extremely important if patients are to continue to be persons, rather than be reduced to objects that need restoration. It is important for people to resume or sustain learning activities whether they are patients or not. It is likewise important that patients engage in learning activities which have interest and meaning to them, whether related to their disorder or not. This continuity of personhood must be recognized in any comprehensive program of patient education. Therefore, for the purpose of this investigation, the following definitions are used as working definitions:

Patient Education Program: An organized program of educational services to patients which may include (1) orientation to the facilities and services available, (2) explanation of diagnostic and treatment procedures, (3) access by patients to educational leadership, materials, or facilities for individual or group learning.

Patient Health Education: That part of the patient education program that provides educational activities on topics that are directly intended to improve patients' understanding of the diagnostic and treatment procedures, and the nature of their disorders.

Patient General Education: That part of the patient education program that provides self-improvement activities to facilitate continuing learning in areas not directly related to their disorders.

For operational purposes, a positive response to question one of the survey instrument indicating a person or department has been designated to coordinate general patient education indicated a Beginning Program of General Education for Patients. A positive response to question one, and two or more elements of both questions three and four of the survey instrument indicating that people are actually conducting educational activities indicated an Operational Program of General Education for Patients. A positive response to question five of the instrument indicated a Beginning Patient Health Education Program. A positive response to questions five, and to two or more elements of both seven and eight of the instrument, indicated an Operational Program of Patient Health Education. These definitions were considered by the "jury of experts," and were judged as appropriate.

Nursing Care Facility: An institution that provides long-term professional nursing service. It may be a nursing home, a county medical care facility, or hospital long-term care unit.[8] The major difference between these insitutions and acute care hospitals is the length of stay. Patients in these institutions may stay several days, weeks or months, until they are well enough to be discharged. The length of stay may be long enough that patients in these institutions may be referred to as residents. Specifically not included in this category are Homes for the aged, which provide

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[8]Directory of Hospitals, Nursing Care Facilities, Homes for the Aged, Bureau of Health Facilities (Lansing: Michigan Department of Public Health, 1974), p. 13.

room and board and supervised personal care to elderly people who generally do not need nursing care. Most patients in nursing care facilities are aged. While there may be an occasional young adult or child enrolled, they are the exception rather than the rule.

Nursing Home: An institution, other than a hospital having as one of its functions the rendering of healing, curing, or nursing care for periods of more than twenty-four hours to individuals afflicted with illness, injury, infirmity, or abnormality.[9]

County Medical Care Facility: An institution that is county-owned and operated and which provides nursing care. Such facilities are approved by the State Department of Social Services and certified by the State Department of Public Health for participation in the Medicaid and Intermediate Care Programs.[10]

Hospital Long-Term Care Unit: A separate unit of a hospital which is designed, equipped and staffed to provide nursing care for inpatients who are suffering from chronic disease or who are convalescing.[11]

Small Institution: An institution having a capacity of fifty beds or less.

Medium-Sized Institution: An institution having a capacity of fifty-one to two hundred beds.

Large Institution: An institution having more than two hundred beds.

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[9] Ibid.

[10] Ibid.

[11] Ibid.

Old Institution: An institution started prior to 1966.

New Institution: An institution started in 1966 up through July of 1976.

Health Service Area: A county or group of counties designated by Public Law 93-641, The National Health Planning and Resources Development Act, to do comprehensive health planning. The state of Michigan is divided into eight such regions.

Development Level Score: A score computed for a group of programs that indicates (1) the number of patient education topics being offered and (2) the number of groups of staff involved in providing patient education. These factors are combined with equal weight to form the development level score.

Limitations

The investigation has been limited to the 455 nursing care facilities in Michigan that appear in the most current listing by the Bureau of Health Facilities, Michigan Department of Public Health. Acute care hospitals and licensed homes for the aged have been specifically excluded. The data accumulated have been limited to self-reports on the questionnaire.

Judgment on the quality of the programs identified is outside the scope of this study. This study has attempted to quantify components of existing programs, and to provide insight into some of the quantifiable aspects of quality.

Overview of the Dissertation

All 455 nursing care facility administrators in Michigan have been surveyed. A response rate of sixty-five percent was obtained. The questionnaire used was designed by the researcher, evaluated by a jury of experts, and field tested on a sample of Michigan nursing care facility administrators. The results were computer analyzed, to look at patient education programs in relationship to institutional type, size, age, and location. The specific elements examined included: the number of institutions reporting general education, health education, or a combination of the two programs; the stage of development of such programs; designated patient education coordinators and centers; the frequency of various topics, instructional methods, personnel groups, personnel functions, methods of initiating involvement of patients and evaluation employed in the reported programs; and administrators' judgments as to the legitimacy of patient education as a function of their institutions and their interest in developing or expanding the function.

Chapter I introduces the topic, states the problem, describes its significance, and defines the appropriate terms. The nature and boundaries of the study are stated.

Chapter II reviews the relevant literature. The historical background of patient education is reviewed to show that social policy is evolving in both the governmental and private sector that favors more patient education programming. The background of educational programming for the aged is also reviewed, with special attention being given to health education for the aged. Studies

dealing with the extent of patient education programming are also reviewed.

Chapter III presents the strategies used in this project. Attention is given to the sources of data, selection of an instrument, and organization and presentation of the data.

Chapter IV presents the display and analyses of the data. Attention is focused on the research questions posed in Chapter I. The data are displayed and analyzed in such ways as to obtain the answers to these questions.

Chapter V presents a summary of procedures, a summary of results, conclusions, and recommendations. A discussion section is included that incorporates certain of the author's views.

CHAPTER II

REVIEW OF THE LITERATURE

Introduction

The patient education movement is a classic example of social policy development. It began with preliminary position-taking by interested agencies, and progressed to studies and experiments by voluntary agencies. Such experiments were followed by formal recommendations, governmental studies, and governmental action. This chapter illustrates through literature review not only the evolution of a program but also the evolution of a major social policy.

Evolution of Institutional and Governmental Policy

Patient education is not a new development but rather is as old as the doctor-patient relationship. Most doctors have long recognized the importance of the patient understanding what needs to be done to regain and retain his health. While some physicians have emphasized this more than others, the doctor-patient relationship has always had an educational component. Likewise, the nurse-patient relationship has always had an educational component. Frequently, the role of the nurse in teaching was even greater than that of the doctor, including at minimum the answering of a myriad of questions from patients.

As the knowledge explosion increased, patients became more sophisticated, and demanded to know more about their problems than before. More explanations and justification were required of medical staff than in previous years. Yet physicians had less time to spend with their patients because they now were seeing more patients than before. This widespread "health consciousness" was bringing more people to the doctors' offices with a greater desire to know. Concurrently, physicians were coming to realize that it was not enough to merely deal with the acute phase of an illness, without stressing follow-up activities of the patient that would prevent recurrence. Yet the increased patient load did not readily permit this needed attention in many cases.

One of the apparent factors responsible for increasing patient education was the development of prepaid health care groups such as the Health Insurance Plan of Greater New York, the Kaiser Permente Plan, and the Group Health Cooperative Program. For a monthly fee, families were entitled to complete medical care, both in and out of the hospital. When such groups were faced with the necessity of paying the total cost of medical care, it became apparent that prevention and informed self-care could be profitable. Hence, these early groups were among the first to implement hospital-based patient education programs.

References to patient education began to appear in the literature in the 1950s. Some articles appeared in the publications of

Veteran's Hospitals.[12] These hospitals, like the prepaid groups mentioned above, were committed to provide total medical care. They thus were more willing to reduce long-range patient care costs through educational efforts.

Other references appeared in the publications of the health education profession such as in The Health Education Journal,[13] Health Education at Work,[14] and The International Health Education Journal.[15] Yet other references appeared in the primary journal for all public health workers, The American Journal of Public Health.[16] Still others appeared in the publications of the medical profession such as Journal of the American Medical Association,[17] and The Bulletin of the History of Medicine.[18] These attempts at "spreading the word" among health care professionals were largely

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[12]George E. Beauchamp, "Patient Education and the Hospital Program," V.A. Technical Bulletin (January 1953): 88.

[13]Alice M. Johnson et al., "Health Education in Hospitals," Health Education Journal (October 1952): 175.

[14]Luciel E. Brownell, "Progress in Patient Education," Health Education at Work (May 1975): 4.

[15]John Burton, "Doctor Means Teacher," International Journal of Health Education (January 1958): 4.

[16]George Rosen, "Health Education and Preventive Medicine, New Horizons in Medical Care," American Journal of Public Health (June 1952): 687.

[17]H. F. Dowling et al., "Time Spent by Internists on Adult Health Education and Preventive Medicine," A Journal of the American Medical Association (June 1952): 628.

[18]Bruno Gebhard, "Historical Relationships Between Scientific and Lay Members for Present Day Patient Education," Bulletin of the History of Medicine (January 1958): 32.

responsible for a growing acceptance of patient education as a necessary and integral part of health care.

Representatives of several prepaid health care programs have met annually since the 1950s. The Tenth Annual Group Health Institute in 1960 was especially significant. The proceedings were published and widely distributed, further spreading the concept.[19]

Ross Laboratories, publishers of a monthly newsletter directed toward hospital administrators, devoted its entire August 1963 issue to "Health Education in a Hospital Setting." They concluded the issue by stating:

> The hospital has the opportunity to teach constructive health habits. The effectiveness of a hospital's health education efforts can be measured by the number of persons it succeeds in rehabilitating to useful lives and the number of readmissions it succeeds in preventing.[20]

In 1964, the American Hospital Association held a conference in Chicago entitled "Health Education in the Hospital." The proceedings of that conference were published the following year, and became an important reference point.[21]

> The participants agreed that: (1) The hospital has a responsibility in patient education, (2) the ability of a hospital to fulfill this responsibility varies, (3) the extent of the program will be determined by staff readiness and ability, the population served, and by types of services

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[19]Group Health Association of America, Proceedings, Tenth Annual Group Health Institute (Chicago: The Association, 1960), p. 30.

[20]Ross Laboratories, "Health Education in a Hospital Setting," Currents in Hospital Administration (August 1963): 4.

[21]American Hospital Association, Health Education in the Hospital, Proceedings of the May 1964 AHA Conference (Chicago: The Association, 1965), p. 74.

> rendered; (4) there needs to be recognition of the fundamental changes an education approach may require of and bring to the traditional program procedures; (5) carefully planned demonstration programs should be encouraged; (6) staff must be prepared for the new undertaking; (7) there is a need for continued investigation into the effect and meaning of illness to the patient and into ways for meeting the patient's need for information and assurance.[22]

In addition to reaching fundamental conclusions about patient education, the conference recognized that the American Hospital Association was the nationwide agency most likely to stimulate hospitals to develop programs of patient education. Therefore, the conference recommended that the American Hospital Association should:

1. Act as a repository and clearinghouse of studies and research in health education in hospitals . . . .
2. Stimulate demonstration projects and research, and assist in finding resources to finance these activities.
3. Identify existing health education programs in hospitals and stimulate more hospitals to initiate such programs.
4. Disseminate conference proceedings to interested parties.
5. Explore the possibilities of similar conferences at regional and state levels, and to suggest implementation of such conferences.
6. Extend the explorations begun at the Chicago conference on the definitions and goals of health education, and on the role of the health educator.
7. Document areas of need.[23]

Clearly, the acceptance of an advocacy role by this organization was an important milestone in the evolution of patient education progress. It is also significant that this conference was funded by the Metropolitan Life Insurance Company. Thus,

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[22]Ibid., p. 66.

[23]Ibid., p. 67.

private insurance companies entered the scene to implicitly endorse the concept.

Yet another major institution, the Russell Sage Foundation, entered the struggle to help patient education gain acceptance. This organization, long committed to health and social welfare, commissioned the writing and publication of a series of three monographs entitled Newer Dimensions of Patient Care. Frequent reference is still being made to these monographs, indicating somewhat the importance of this effort. They were subsequently published in book form.[24]

In 1966, the American Hospital Association produced a leaflet entitled Hospitals As Educational Institutions. It was a policy statement approved by the American Hospital Association endorsing patient education.

The AHA followed in 1967 with a statement on the Role and Responsibility of the Hospital in Providing Clinical Facilities for a Collaborative Educational Program in the Health Field. While the chief thrust of this policy statement was directed towards relationships with medical schools, it further established the role of the hospital as educator.

Another professional society officially expressed interest in 1968, when the Public Health Education Section of the American Public Health Association appointed a Committee on Educational Tasks

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[24]Esther Brown, Newer Dimensions of Patient Care (New York: Russell Sage Foundation, 1965), p. 74.

in Chronic Illness. They quickly concluded that patient education was an integral part of patient care and that:

> Target groups to be considered in educational programming include: (a) the patients and their families, (b) staff members in the health care setting, (c) appropriate groups in the community.
>
> The team approach with the physician serving as the team leader and coordinator offers the most effective approach to patient education.
>
> 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.[25]

The committee developed a five-step model which included (1) identify the educational needs of the patient and family, (2) establish educational goals for the patient and family, (3) select appropriate educational methods, (4) carry out the educational program, and (5) evaluate the patient and family education.[26] The elaboration on each step gave specific "how to do it" information. The monograph was the first "cookbook approach" for those who wanted to do patient education.

Finally, there was produced during the 1960s an important review of the research to date on patient education.[27] The Society of Public Health Education undertook this task, and thus produced the most comprehensive review of the literature to date.

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[25]American Public Health Association, A Model for Planning Patient Education: An Essential Component of Health Care (New York: American Public Health Association, 1968), p. 3.

[26]Ibid., pp. 9-24.

[27]Society for Public Health Education, "Review of Research and Studies Related to Patient Education," Health Education Monograph (1968): 64.

In September, 1971, President Richard Nixon officially appointed "The President's Committee on Health Education" to study health education across the country and report its recommendations to him. The committee consisted of sixteen people who represented very diverse and very special interests both in and out of the health care field. The charge to the committee was to:

> First, assess what was being done in health education throughout the country; second, try to find a way to evaluate the effectiveness of the effort; third, on the basis of that evaluation to recommend if necessary a new national approach to health education; fourth, to devise a strategy to implement whatever was recommended.[28]

The President's Committee on Health Education held hearings around the nation about health education, including but not limited to patient education. Specifically, in reference to patient education:

> Most of the physician groups told us that with the possible exception of pediatrics and obstetrics, and gynecological specialists, most doctors do not have the time, inclination, incentive, or belief in health education to do much of a job in patient education. We found very little effective health education of patients in hospitals, and yet we found that this might be one of the really teachable moments, when both the patient and his family are more susceptible to advice . . . . Several studies show what effective health education might do . . . . readmission rates are substantially reduced where there is effective health education. . . . Of the 7,000 hospitals in the United States we could find no more than four that were doing what we would consider an acceptable job of patient education.[29]

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[28]Victor Weingarten, "Report of the Findings and Recommendations of the President's Committee on Health Education," Health Education Monographs (1974): 11.

[29]Ibid., p. 15.

The Committee made its report in 1973 and recommended that:

1. The government prepayment plans and insurance companies which pay for health care services be willing to adjust premium rates to include in their services the cost of health education for the patients involved.
2. The nation's hospitals be strongly encouraged to offer health education programs to patients and families, both on an inpatient and outpatient basis.
3. A major new educational program be undertaken among medical and health professionals and administrators, to prepare them psychologically and professionally to accept and respond creatively to increasingly expressed concerns for consumer participation in the design of health education programs and even of health care facilities.
4. Skill in providing health education be an essential part in the training and continuing education of all health workers.
5. Systematic research and evaluation be a part of all health education programs within the health care delivery system.
6. Various health educational approaches among patients be tested to determine which ones appear to bring about the best results in patient improvement and in reduction of need for health services.[30]

This committee gave a new level of credibility to health education. It certainly gave a "big boost" to patient education.

The American Hospital Association followed the developments of the President's Committee on Health Education closely, and responded to it. In March of 1973, the AHA appointed a Special Committee on Health Education to study the role of hospitals in educating the consumers in matters of health, and the role of the AHA in helping hospitals to achieve that objective. Specifically, the hospital was charged to:

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[30]"Summary of Findings and Recommendations of the President's Committee on Health Education" (Washington, D.C., 1973), p. 25. (Mimeographed.)

1. Identify the categories of health education.
2. Make recommendations concerning the extent of the AHA's involvement in each category.
3. Identify appropriate goals for AHA programs in health education programs.
4. Identify appropriate working relationships and liaison efforts with professional groups and associations and agencies involved in health education.
5. Clarify the legal implications inherent in the presence of or in the absence of patient education programs in the hospitals.
6. Make recommendations concerning the financing of health education programs in which hospitals are involved.
7. Draft a policy statement on the role of the hospitals in health education.[31]

The policy statement called for was approved in May of 1974 and is significant enough to warrant excerpts.

> Health education is an integral part of high quality health care. Hospitals and other health care institutions, as focal points of community health care, have an obligation to promote, organize, implement and evaluate health education programs. As a part of this process, hospitals should plan with other health care institutions and community agencies to define each organization's role and responsibilities in meeting the health education needs of the populations they serve . . . .
>
> Hospitals and other health care institutions should recognize the opportunity to exercise a role of leadership in the health education of three specific audiences: the patient and his family; personnel, including employees, medical staff, volunteers, and trustees; and the community at large.
>
> The major emphasis of health education is health promotion, which includes health maintenance, disease and trauma management, and the improvement of the health care system and its utilization. Through health education programs, hospitals and other health care institutions can contribute to important health care goals, such as improved quality of patient care, better utilization of outpatient facilities, shorter lengths of stay, and reduced care costs . . . . A significant corporate commitment, including staff and financial resources, is essential if hospitals and other

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[31]"AHA Appoints Special Committee," Journal of the American Hospital Association (March 1973): 59.

> health care institutions are to fulfill their leadership role in health education . . . .
> . . . health education that is integral to treatment . . . is a legitimate part of the cost of caring for the patient.[32]

Another significant step occurred when the Health Maintenance Organization Act of 1973 passed by the national Congress required each HMO to "encourage and actively provide for its members' health education, education in the appropriate use of health services, and education in the contribution each member can make to the maintenance of his own health."[33]

Steps are being taken to implement this requirement, and patient education programs are being developed in HMO's all over the country as a result.

Both the President's Committee on Health Education and the American Hospital Association's Special Committee on Health Education indicated that it would require significant financial commitment to do the job. Insurance companies had to become involved if the tasks were to be implemented. Partially in response to the recommendations of these two committees, the Committee on Health Education of the Health Insurance Benefits Advisory Council issued a report. They prefaced their comments by stating:

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[32]American Hospital Association, The Role of Hospitals and Other Health Care Institutions in Personal and Community Health Education (Chicago: American Hospital Association, 1974), p. 1.

[33]Health Maintenance Organization Act of 1973, Title XPII, Sec. 1301, (9).

> If health education is to achieve its potential and accomplish the goals of the President's Committee . . . it must establish itself as an effective component of the health care team, with defined goals, criteria, and methodology for evaluation of progress toward these goals.[34]

They went on to state:

> The general thrust of a national health education policy at this time, should be along two complementary lines:
> 1. encouragement, by means of financial, technical, informational, political, moral, or other assistance, of new programs and demonstration projects . . . especially in settings where meaningful evaluation can be carried out; and
> 2. encouragement by the same means . . . of training, evaluation, and other activities designed to improve the quality and quantity of personnel . . . and programs being offered.[35]

They went on to quote the recommendations of the President's Committee, that called for insurance companies to "be willing to adjust premium rates to include in their payments the cost of health education to the patients involved," and responded by stating, "We strongly urge private carriers to implement these recommendations as soon as possible."[36]

On yet another front, the government Medicare program also moved to provide coverage of the costs of patient education. The 1974 Medicare Guidelines for Reimbursement of Patient Education read as follow:

> While the law does not specifically identify patient education programs as covered services, reimbursement may be made under Medicare for such programs furnished by providers of services (i.e., hospitals, skilled nursing facilities, home health agencies, and outpatient treatment

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[34]"Report of the Committee on Health Education to Health Insurance Benefits Council" (New York, 1974). (Mimeographed.)

[35]Ibid., p. 2.

[36]Ibid.

> providers) to the extent that the programs are appropriate, integral parts in the rendition of covered services which are reasonable and necessary for the treatment of the individual's illness or injury. For example, educational activities carried out by nurses--teaching patients to give themselves injections, follow prescribed diets, administer colostomy care, administer medical gases, and carry out other inpatient care activities--may be reimbursable as a part of covered routine nursing care. Also, the teaching by an occupational therapist of compensatory techniques to improve a patient's level of independence in the activities of daily living may be reimbursable as a part of covered occupational therapy. Similarly, the instruction of a patient in the carrying out of a maintenance program designed for him by a physical therapist may be reimbursed as a part of covered physical therapy.
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> However, where the educational activities are not closely related to the care and treatment of the patient, such as programs directed toward instructing patients or the public generally in preventive health care activities, reimbursement cannot be made since the law limits Medicare payment to covered care which is reasonable and necessary for the treatment of an illness or injury. For example, programs designed to prevent illness by instructing the general public in the importance of good nutritional habits, exercise regimens, and good hygiene are not reimbursable under the program.

Thus, another segment of society has moved to endorse the concept of patient education.

The concept of patient education has been evolving for at least twenty-five years. It has been significantly influenced thus far by the professions, the institutions, foundations, presidential committees, and private and governmental reports and conferences. It has also been influenced by social, political, and economic conditions. With the prospects of a national health insurance program being implemented, the prospects of patient education look even better. It appears to be "an idea whose time has come."

The Effectiveness of Patient Education

Most of the literature to date has dealt with the needs for patient education and the effectiveness of programs in meeting those needs. It has been established that patients do have needs that indicate educational programming.

1. All patients have a need for reassurance. Illness requires many adjustments. A patient's emotional well-being demands reassurance that a normal life will be possible, and what the anticipated rate of progress toward that goal will be.

2. Even if patients aren't going to recover fully, or aren't going to recover at all, evidence is mounting that they also need to know that. Adjustments and arrangements may need to be made. Such adjustments and arrangements need to be based on the best information available. When it is judged not medically advisable to give such information to the patient, the information should be made available to an appropriate person in his behalf.

3. The patient also has a right to know, in addition to his need to know. Many court decisions in recent years have revolved around the doctrine of informed consent. But the scope of litigation in this general area has dealt not only with informed consent, but also with the patient's right of access to information in his medical record, and his right to adequate self-care procedures upon discharge from the hospital. This right to know has also been emphasized in "A Patient's Bill of Rights" accepted by the American Hospital Association in 1972. Five of the twelve statements deal directly with the patient's right to know.

4. Patients need full and thorough explanations of procedures they are to follow, both verbally and in writing.

Many patients simply do not follow their doctor's orders. Scott Simonds summarized the situation thus:

> Studies of compliance with medical regimens are difficult to compare one with the other, but when you add them all up, it would appear that indeed patients do not comply with at least one-half to two-thirds of the recommendations made by their physicians.[37]

Michael Lesparre likewise summarizes these studies by stating: "The range of non-compliance described in the literature is from 15 to 93 percent, a gap that ought to make very health professional uncomfortable."[38]

Much of the responsibility for this situation goes back to a lack of complete understanding of what should be done and why. As Lesparre says in another article: "The hospital environment with its technical environment and professional expertise, is generally intimidating to the patient, and hardly conducive to learning."[39]

Problems that contribute to this phenomenon include language difficulty, cultural variations, education levels, and age differentials between patient and provider. Studies indicate that a

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[37]Scott K. Simonds, "Patient Education As One Criterion for Quality Care," paper presented at the Fifth Annual Interdisciplinary Conference on Health Records, Ann Arbor, Michigan, June 24, 1974, p. 4.

[38]Michael Lesparre, "The Patient As Health Student," Hospitals (March 1970): 4.

[39]Michael Lesparre, "The Role of the Hospital Organization in Patient Education," Health Education Monographs (Spring 1974): 74.

patient who is sufficiently fearful and anxious may become virtually unable to function mentally.[40]

It has been established through demonstration projects that have been carefully evaluated that patient education programs can and do meet the needs just outlined. Further, it has been established that:

> Substantial reduction in re-admission for patients with congestive heart failure have been found among patients who have participated in educational programs; reductions in the use of emergency rooms with asthma patients have been found when they had the opportunity to learn about their self-care in specially organized groups; reductions in broken appointments and increased compliance in self-care have been obtained through a variety of educational programs. We have found more cooperation in the taking of laboratory tests when patients are given the opportunity to learn about them. We have found patients can be taken off administered injections and placed on self-administered or oral medication after they are given an opportunity to hear more about self-care.[41]

Lesparre states: "It is very likely in the long run that patient education contributes to the most economical use of health facilities and services. And it is an excellent--perhaps the best--means to better community relations."[42]

Lawrence Green concludes his review of seventy-nine articles on this topic by stating:

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[40]George Reader, "The Physician As Teacher," Health Education Monographs (Spring 1974): 34.

[41]Simonds, p. 6.

[42]Lesparre, "The Role of Hospital Organization in Patient Care," p. 45.

> The potential benefits far outweigh the costs, and the ratio of benefits to costs is almost certain to be greater than the corresponding ratios for most medical and surgical procedures directed toward the same problems. This is not to suggest that health education should be in direct competition with medicine and surgery for health care dollars. The two sets of services must be cast in a complementary framework in which health education prevents unnecessary medical and surgical procedures, whereas medicine and surgery are an essential back up to unsuccessful health education. Health education is also shown to have undeveloped potentials for improving the outcomes of medicine and surgery.[43]

The Extent of Patient Education Programming

The literature on the nature and extent of patient education which is actually being conducted is much more restricted. Peters' study entitled "A Survey of Health Education Programs in the United States, with a Proposed Model for a Comprehensive Health Education Program in a Hospital Setting"[44] is one such study, and is important to this investigation because of the methods she employed. Peters contacted the American Hospital Association and the Resources Development Division of the United States Department of Health, Education and Welfare for a list of hospitals with health education programs. She also used lists that had been published in the Journal of the American Hospital Association from 1967 to 1973, and a list of hospitals that sent representatives to a workshop on hospital health

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[43]Lawrence Green, "Cost Containment and the Economics of Health Education in Medical Care," paper presented at the American Health Congress, Chicago, August 14, 1974.

[44]Susan J. Peters, "A Survey of Health Education Programs in the United States, with a Proposed Model for a Comprehensive Health Education Program in a Hospital Setting" (Ph.D. dissertation, Southern Illinois University, 1974), p. 223.

education held in Maryland in the spring of 1973. From these lists she compiled a single list of 113 hospitals likely to have hospital health education programs, which she then surveyed.

Her primary purpose was to describe the nature and extent of hospital health education programs in these selected hospitals. More specifically, she wanted to answer the following ten basic questions: (1) Who coordinated the health education programs and what are the educational qualifications for these coordinators? (2) Where in the hospital structure does the health education program belong? (3) What types of health education programs are most common, and for what conditions? (4) What methods are used most frequently? (5) Are educational prescriptions written, and for what? (6) Is there a planned evaluation of the program, and if so, what methods and criteria are used? (7) What kinds of inservice training are provided, and for whom? (8) What personnel are most active in the patient education programs? (9) What type of community education is sponsored? (10) What stumbling blocks were encountered in program development?

Socha's study entitled "A Survey of Patient Education Programs in Michigan Hospitals"[45] was another such study. Even though it was done on acute care hospitals, it is significant to this investigation because it was done in Michigan. The presence of patient education programs in large hospitals is an indication of

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[45]Marvin P. Socha, "A Survey of Patient Education Programs in Michigan Hospitals" (M.A. thesis, Central Michigan University, 1975).

the stage of development of patient education in Michigan. Socha surveyed hospitals in Michigan that had 200 beds or more, because of the contention by the American Hospital Association that hospitals with 200 beds or more are more likely to have a patient education program.[46] His study attempted to determine how many of these hospitals had patient education programs. In addition, he wanted to find out (1) which hospital personnel are involved with patient education, (2) which learning resources are being utilized for patient education, (3) the extent to which patient education has developed in specific areas of medicine, and (4) what attitudes and factors have deterred the implementation of a patient education program.

His results pertinent to this study indicated that 90% of these hospitals were involved in patient education activities of some kind. It must, however, be remembered that the data were obtained by self-report. Socha categorized these hospitals, and concluded that there were well-organized and effective programs in only 13% of the hospitals surveyed. There were some definite patient education activities accomplished in 60% of the hospitals surveyed, while another 17% attempted to do patient education. The remaining 10% did not attempt to do any patient education.

Neff[47] also surveyed hospitals with 200 beds or more, using a nationwide sample. She also attempted to find out who coordinated

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[46]"AHA Research Capsule #7," Hospitals 46 (1972): 102.

[47]Martha S. Neff, "A Survey Concerning the Role of the Health Educator in Selected Hospitals Throughout the United States" (Ph.D. dissertation, Indiana University, 1975).

the patient education program, and what their qualifications were. Then, specifically, she listed functions of patient educators, and asked the practicing patient educators whether they thought each function was (1) very appropriate, (2) appropriate, or (3) inappropriate. She also asked whether the educational activity is currently actively practiced in the hospital patient education program. Her study is significant to this investigation in that it provides a profile in defining the parameters of a well-organized patient health education program.

The American Hospital Association is currently under contract with the Bureau of Health Education to survey all 5,829 community hospitals registered with the American Hospital Association. The focus is on inpatient educational programs, specifically excluding outpatient or ambulatory care programs. Data are being sought which will determine (1) the extent that patient education is integrated into the programs and policies of member hospitals, (2) the differences and similarities of programs among hospitals of various sizes and types, (3) patient education activities in hospitals by states, and (4) the outcomes and benefits of patient education.[48]

The AHA study is by far the most comprehensive one undertaken to date. The report was due to the Bureau of Health Education in the Department of Health, Education and Welfare in August, 1976.

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[48]Personal correspondence, Elizabeth Lee, Staff Associate, American Hospital Association, October 15, 1975.

The study is, however, considerably behind schedule and is not completed as of this writing.

Much has been written justifying patient education programs in the health care system. Data are being assembled on the response of the hospitals and on the extent of their patient education programming. The review of the literature has revealed no attempt to analyze the response of nursing care facilities to this movement.

Education for the Elderly

The concept of lifelong learning or life span education is one that has had a significant increase in its advocates during the current decade. One of the implications of this movement is that educational programming should occur for persons in the later years of life. This is beginning to happen.

> Educational institutions as well as other community agencies are beginning to get involved in the development and conduct of educational programming for the middle and later years of life. A real interest in providing life span education within existing community institutions is being fostered in numerous locations.[49]

However, there is a myth still prevalent that older people cannot learn, or that they at least suffer a serious decline in mental abilities. Yet, as a survey sponsored by the Department of Health, Education and Welfare indicated: "Common sense observation should dispel this notion for hundreds of thousands of older adults are learning in programs reported in our survey, and millions have learned every imagined subject in adult education programs over the

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[49]David A. Peterson, "Lifespan Education and Gerontology," The Gerontologist (October 1975): 436.

years and decades."[50] This myth has fortunately been challenged by research in the past decade. It is true that when the aged as a group are examined, they perform more slowly than young people. Furthermore, it has been established that the poorer performance by some may be due to noncognitive factors such as poor motivation, lack of confidence, or poor conditions of learning.[51] Other researchers report that physical factors are not a major variable: "Slight decline in various mental abilities, especially those related to speed are persistently detected, but they are not of the type or magnitude to have much practical significance in learning in real life situations."[52] Apparently, what older people need is more time than is usually allowed for learning. The concept of self-paced learning seems critical for the aged.

The relevance of the material to be learned is also critical, in that it affects motivation. Some of the research on learning tasks have involved meaningless and trivial tasks which have little or no interest for older Americans. Being under no compulsion to learn they often shun learning such irrelevant tasks. When the relevance is apparent, however, the older learner is often the best learner. DeCrow offers an explanation of this:

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[50]Roger DeCrow, New Learning for Older Americans: An Overview of the National Effort (Washington, D.C.: Adult Education Association of the U.S.A., 1975).

[51]Diana Woodruff and David A. Walsh, "Research in Adult Learning: The Individual," The Gerontologist (October 1975): 425.

[52]DeCrow, p. 17.

> In general, older people have more and better organized experiences which provides a meaningful context into which new information can be assimilated. They know themselves better and more clearly perceive what new learning will be truly useful to them.[53]

In short, "Most older adults living in the community can learn what they need and desire to learn if given suitable opportunity."[54]

Despite all this, Jack London, writing in The Handbook of Adult Education, suggests that on only a very few occasions have educational opportunities been directed at real needs and goals of the elderly. He states:

> While society expresses concern about improving their physical and material condition, the aged are seldom provided with the resources they need for relevance and a sense of worth. We tend to place them in "playpens" by providing recreation and similar endeavors while doing almost nothing to furnish them with the means to keep mentally alert. We strip them of most of their meaningful roles on the assumption they are incapable of carrying them out effectively with the rationalization that they deserve the right to rest and take it easy. Recreational activities are not sufficient to maintain mental abilities, identity, and a sense of significance as a person.[55]

That this is important is indicated by the 1971 White House Conference on Aging: They stated: "Education is a basic right for all persons of all age groups. It is continuous and henceforth one of the ways of enabling older people to have a full and meaningful life,

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[53]Ibid., p. 17.

[54]Ibid., p. 6.

[55]Robert M. Smith et al., Handbook of Adult Education (New York: Macmillan Company, 1970), p. 15.

and a means of helping them develop their potential as a resource for the betterment of society."[56]

As a result of the attitudes that were developing and which were confirmed in the White House statement, educational programs for the elderly have developed rapidly. DeCrow's national study, aimed at the uncovering of the extent of learning opportunity, indicated that about 3,500 different programs existed. These came from all parts of the educational system and from a variety of non-school agencies as well. The study revealed that 58% of these agencies had begun new activities within the past year (1974).[57] This is a powerful indicator of the rapid growth in opportunity and in the fluidity of the entire situation.

Peterson indicates that these programs have a positive effect on the elderly in a non-cognitive dimension. He indicates that while older persons need education on a great many subjects, what the learner feels is often of more importance than the data or skills the learner learns: "Loneliness is a prime aspect of aging. It induces depression and other forms of mental illness. The sociability and excitement of learning go far to change the daily outlook of older persons."[58] Heimstra gives credence to "the activity theory." The main assumption of the theory is that an

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[56]1971 White House Conference on Aging, Toward a National Policy on Aging (Washington, D.C.: U.S. Government Printing Office, 1973), p. 6.

[57]DeCrow, p. 58.

[58]James A. Peterson, "Frontiers in the Education of the Elderly," Adult Leadership (January 1976): 170.

elderly person's morale will be high as long as he or she is able to stay active, even if faced with role reductions and changes. This would mean replacing lost roles with new areas of interest and activities. Heimstra concludes: "This suggests that there is even a greater need for continuing education in the elderly years than in the younger years."[59] This seems to be supported by a study of senior citizens in Minnesota, which concluded that senior citizens have a positive attitude toward learning and, in fact, enjoy it.[60]

Health Education for the Elderly

A decade ago, isolated programs of health education for the elderly flourished. The director of one such program wrote:

> Health programming for the aged is urgently needed, and the health educator can utilize existing data, can influence program policy, can stimulate interest in others to seek further knowledge, and can prepare himself for effective action when the opportunity presents itself.[61]

This position is still supported by many health educators today. Elwood especially advocates a strong relationship between health education and gerontology.[62] He suggests that there is a great potential for health education to offset the problems of the

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[59]Roger Heimstra, The Older Adult and Learning (Lincoln: University of Nebraska Press, 1975), p. 5.

[60]Bruce M. Hauer, "A Model of Continuing Education for Older Adults" (Ph.D. dissertation, University of Minnesota, 1975), p. 188.

[61]B. J. Gardiner and I. L. Webber, "Health Education Programming for the Aged," Health Education Monograph (1964): 3.

[62]T. W. Elwood, "Relationship of Health Education to Gerontology," International Journal of Health Education (July-September 1972): 3.

aged, and urges coordinated planning of more effective health education for the aged.

Peterson advocates education for the elderly and specifically advocates health education. He states:

> They would like to feel better, have more vigor, but unless there are those who will share with them practical methods of exercise, diet, life style, they stumble along. Most of their great needs are precisely those that a relevant adult education program can answer.[63]

Also speaking to this point was DeCrow who urged health education of the aged.

> National health insurance, for example, however, it may be financed, will be costly, and will lay the health care professions under tremendous strain. There is no way quite regardless of costs, that these programs can succeed without massive programs of training for self care and mutual assistance among the older population.[64]

Heimstra concluded his study of older people's learning by recommending in the third of twenty-two recommendations that "health educators find means to make learning opportunities more available to the older person with health problems."[65]

Education in Nursing Homes

The concept of education for the aged in nursing homes is relatively new. It must be remembered that:

> The beginnings of the institutions now known as nursing homes are a result of the poor house tradition and philosophy. Following the enactment of the Social Security Act of 1935, Public Assistance funds were made available

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[63]James A. Peterson, p. 171.

[64]DeCrow, p. 16.

[65]Heimstra, p. 73.

> for care of the needy aged in proprietary boarding and nursing homes. Due to these beginnings and the inability or possible lack of desire of the public sector of society to provide care for nonhospitalized but ill aged persons, private proprietary institutions met the need and have become predominant in the nursing home field.[66]

From this meager beginning, the last forty years has seen a great deal of attention focused on nursing homes, in an attempt to upgrade facilities and programs. Consumer action groups have often advocated expansion of services. Both federal and state regulations currently require activity programming. Michigan's Skilled and Basic Nursing Home Rules specifically state: "A patient shall be provided diversional activities suited to his needs, capabilities and interests as an adjunct to treatment to encourage him to resume self care and normal activities insofar as possible."[67]

A governmental publication published to help consumers pick a good nursing home states:

> The most successful program reduces a patient's isolation --from other patients in the home and from life outside the home. For those who can go out, activities should include trips to places such as theaters, museums, and parks, and visits to the homes of friends and family. Community institutions such as libraries should bring their services to the home. People from the community should be encouraged to serve as volunteers who work or visit with the patients. Each patient should have an activity schedule geared to his interests and abilities.[68]

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[66] C. H. Ross, "Gero Education," Journal of American Geriatric Society (April 1975): 184.

[67] The Michigan Comprehensive Plan on Aging, p. 171.

[68] U.S. Department of Health, Education and Welfare, Nursing Home Care (Washington, D.C.: Government Printing Office), p. 19.

Such educational programming is occurring. A check of the various state nursing home associations and state health departments by staff of the Department of Health, Education and Welfare revealed "some activities and a great deal of interest."[69] The ten Regional Long-Term Care Education Coordinators are including patient and family education as an integral part of patient care in the patient care planning courses funded by the federal government.[70] Two such workshops in patient and family education in long-term care units have been completed.

Senator Frank Moss's Subcommittee on Long-Term Care reviewed nursing homes around the country looking for good things that were happening. One of the innovations they recommended for widespread dissemination was educational and training programs that were developing for patients, especially classes in reality orientation and sensory training, but including a wide range of other educational services for patients.[71]

The Institute of Gerontology that is cosponsored by the University of Michigan and Wayne State University also advocates health education programs for the residents of nursing care facilities as part of Milieu Therapy. They have reproduced a handbook for

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[69]Personal correspondence, Mr. Stanley Rosenberg, Health Education Consultant, Division of Long-Term Care, USDHEW, March, 1976.

[70]Ibid.

[71]U.S. Senate, Subcommittee on Long-Term Care, What Can Be Done in Nursing Homes: Positive Aspects in Long-Term Care (Washington, D.C.: Government Printing Office, 1975), p. 584.

those who facilitate such experiences that provides detailed lesson plans for classes that are conducted daily, extending over several weeks. Topics for these classes include understanding medication, diet, exercise, vision, hearing, dental care, personal hygiene, psychological needs, etc.[72]

Health education for elderly persons who are residents of nursing homes has gained a level of respectability it had not previously enjoyed. Programs are developing around the nation. It now remains to maximize the creative input and to describe and disseminate the good program ideals that evolve, so that they can be replicated.

Summary

Patient education programming is not new, but rather is in a period of rapid development. Experiences in hospitals, government programs, and professional associations have all had impact on this movement.

It is now apparent that the governmental units are about to take action which will formalize and legitimize patient education. A Michigan governmental appointed Task Force on Health Education of the Public has called for such a study to be done, that would be used as the basis for policy development regarding planning, implementation, and evaluation of health education in nursing care facilities. This investigation will in part meet that need.

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[72]Frank E. Grant, Catawba Hospital Handbook for Facilitators (Ann Arbor: Institute of Gerontology, 1976), p. 57.

Furthermore, this investigation will determine if nursing care facility administrators are aware of and part of the developing national trend toward patient education programming. Program existence will reflect in part administrator awareness of the cost effectiveness of patient education. Similarly, it will reflect awareness of the needs of the elderly to remain mentally alert, to receive self-fulfillment and social recognition from learning relevant material, which all, in turn, affect morale. Most specifically, it will reflect awareness of the trend toward increased educational programming in Michigan nursing care facilities.

CHAPTER III

METHODOLOGY

The Evolutionary Stages of the Investigation

The purpose of this project was to determine what elements of patient education programs exist in Michigan's nursing care facilities. Consideration was given to what factors might influence the composition of such programs. It was determined that the type of institution, the age of the institution, the size of the institution, and the location of the institution all could affect program. Other factors that were considered include the attitudes of the governing board, the attitude of the administrator and other facility staff, and the attitudes of the patients. These were excluded, as being outside the scope of this study, but are recommended for further examination by other researchers.

The project then was limited to determining existence of patient education programs, specific elements of those found to exist, and the relationships between these variables and the size, location, age and type of nursing care facility. It was decided that a measure should be made of the stage of development of the programs that were identified. Initially, an attempt was made to define three stages of developing as beginning, operational, and well developed. However, as attempts were made to delineate these categories, it was realized that it was difficult, if not impossible,

to define the categories so as to be mutually exclusive. Specifically, difficulty was encountered in determining a measure of a well-developed program that might not also be often found in a beginning program. The third category was accordingly dropped. It was tentatively decided that if a program had a coordinator whose duties included doing patient education, that program was judged to be in the beginning stages. A program was judged to be operational if, in addition to a coordinator, at least two other groups were involved in planning or teaching in the program, and if at least two educational offerings were available.

It was recognized that more programs was not the equivalent of better programs, and likewise that bigger programs was not necessarily the equivalent of better programs. After much thought and discussion with members of the dissertation committee, it was decided that measurements of the quality of the programs observed were outside the realm of this study. Such measures would involve, at minimum, some subjective measures by participants, with some internal and external evaluation measures also included. Standards for comparison would also have to be identified to which the members of the profession would agree. Qualitative measures were, therefore, eliminated, and the focus remained on determining program existence and stage of development.

The project was discussed with the administrator of the Isabella County Medical Care Facility, Mr. John Verway. He suggested that the regional field representative of the Division of

License and Standards of the Michigan Department of Public Health would also be a good person to contact to discuss the project.

Accordingly, the matter was discussed with Mr. Elwood McCleod. He indicated that it would be helpful to also discuss the project with someone from the Division of Long-Term Services of the U.S. Department of Health, Education and Welfare. The matter was, therefore, discussed with Mr. Stanley Rosenberg, who indicated a national survey was not feasible because of the large differences in agencies, and in terminology, from state to state. His agency had investigated such a study and found it unfeasible. Thus, the focus returned to Michigan programs in patient education.

A directory was obtained from the Michigan Department of Health. It listed 455 nursing care facilities in Michigan. At this time, it was thought that operational programs of patient education were scarce, an opinion that was shared by the administrator, the representatives of the state and federal agencies, and the respective professional associations. There was some concern that if the population were sampled, some innovative programs could easily be missed. It was thus determined to study the entire population.

The problem now was delineated to studying patient education programs in 455 nursing care facilities scattered widely throughout Michigan. Personal visitations were judged unfeasible. Telephone surveys were ruled out because of the time required to discuss the program. There was also concern that the interviewer might not be able to reach the most knowledgeable respondent, and that the questions would perhaps be answered by a secretary or

receptionist. It was felt that the administrator was the single most likely person to know what kinds of patient education were occurring in an institution, and that if he was not, he would know who was in such a position. Further, administrators were in a position to influence program development. It was thus established that a mailed questionnaire to nursing care facility administrators would be the best means of gathering the desired data.

A questionnaire was developed, after carefully reviewing an instrument used by the American Hospital Association in a study reviewed in Chapter II. A request was granted to use or modify any parts of that questionnaire.

The questionnaire as developed was submitted to a jury of experts to be critiqued. The jury included an administrator of a nursing care facility, a university-based patient education consultant, a practicing patient educator, the current president of the Society of Public Health Education, a field representative of the Division of Standards and Licensing of the Michigan Department of Public Health, a field representative of the Division of Long-Term Care Services of the Health Resources Administration of the Department of Health, Education and Welfare, the executive director of the Michigan Non-Profit Homes Association, and the executive director of the Michigan Health Care Association. Their review represented their personal opinions, and did not reflect any official agency action.

Each of the eight people had experience in patient education or nursing care facility programming, yet from a slightly different

perspective. Further, it was judged that each had a major interest in patient education in nursing care facilities and should have an opportunity for input.

Major revisions were suggested at this stage and there was unanimous agreement that the questionnaire was too long. The jury also seemed to agree that nursing care facility administrators were ultrasensitive regarding requests for financial information, and would discard the questionnaire if these questions were included. There were many comments regarding the wording of specific questions as well. After carefully reviewing their response with the dissertation committee, a decision was made to shorten the questions and to avoid inquiry about finances, so as to increase the probable return rate. The questionnaire was revised accordingly, and shortened from nine pages to four. This was done by more judicious use of the space of each page, by the elimination of some questions, and by the restructuring of others. Two jurors predicted a response rate of around thirty percent, based on previous experience with some rather informal surveys of the agencies they represented.

The questionnaire was then field tested on administrators of twelve nursing care facilities, taking care to have large and small facilities in both urban and ural areas represented. Four of the twelve administrators returned the questionnaire as requested, without any follow-up attempt, resulting in a thirty-three percent return. The four responses were from two nursing homes and two medical care facilities. Three of the responding institutions were

classed as large, while one was small. Three were classed as rural, while one was urban.

All four of the respondents filled out the questionnaire. There were eight marginal comments, all of which were elaborations on answers or additional opinions of administrators. There were no criticisms of the questionnaire and no changes in it were suggested.

A cover letter signed by the investigator as a Central Michigan University faculty researcher was sent to six of the twelve administrators. A cover letter signed by the investigator as a Michigan State university doctoral student was sent to the other six. Three of the four responses were received from the first of these two cover letters. It was, therefore, decided to use the legitimate faculty title and university letterhead stationery.

The questionnaire was reviewed by Dr. Robert DeBruin, a research consultant in the Computer Services Center at Central Michigan University. The data obtained from the field tests were coded for computer printouts.

Minor revisions were made on the basis of these reviews and pretests. The questionnaire and cover letter were reviewed one more time by the dissertation committee, revised slightly, and approved for distribution.

On May 26, 1976, the revised questionnaire was mailed to administrators of all 455 nursing care facilities in Michigan, in order to provide a complete profile or a "census" of existing programs. A stamped return envelope was provided. (See Appendix for a copy of the questionnaire and the letter.) There were 160

questionnaires returned, for an initial response rate of twenty-five percent.

On June 8, 1976, a follow-up letter was mailed to the non-respondents. (See Appendix for a copy.) A concluding sentence urged the administrators to call the researcher collect if they needed another copy of the questionnaire. Fourteen administrators did call collect, and another questionnaire was mailed to each. As a result of this follow-up letter, seventy-three more questionnaires were returned, making the new total 233, resulting in a new response rate of fifty-one percent.

On June 28, 1976, another follow-up letter was sent to non-respondents. The letter included a statement from Mr. Gary Hooyenga, president of the Michigan Health Care Association, urging member institutions to cooperate in this research project. (See Appendix for a copy of this letter.) Another questionnaire was included this time, as was another stamped return envelope. Eighty-two more questionnaires were returned, resulting in a new total of 315 and a combined response rate of sixty-nine percent. Of the 315 questionnaires returned, 294 or sixty-five percent were usable. The remaining twenty-one trickled in after the computer analysis had been completed.

Members of the jury had predicted a thirty percent response rate. The usable response rate of sixty-five percent is extremely high in comparison to that prediction.

Analysis of the Data

The Univac 1106 Computer at Central Michigan University was used to do the analysis. The program was written by Dr. Robert DeBruin and Ms. Joyce Abler using elements of the Statistical Package for the Social Sciences,[73] and elements of the Biomedical Computer Programs.[74] Statistical procedures used extensively were frequency counts, percents, ranges, standard deviations, and measures of central tendency. The existence of patient education programs was determined. Summary data were provided, after which the programs were grouped by the independent variables of institutional type, size, location, and age, and then displayed. A program development score was computed and likewise grouped and displayed.

The principal components of patient education programs were then analyzed. Summary data were provided, after which the data were grouped according to institutional type, size, age, and location. An attempt was made to determine if any of the following items were related to the independent variables identified above: existence of patient educaton coordinators and centers; the frequency of various topics, instructional methods, personnel groups, personnel functions, methods of initiating patient involvement, and the evaluation methods employed; and administrators' judgments as to the legitimacy of patient education as a function of their

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[73]Norman Nie et al., Statistical Package for the Social Sciences, 2d ed. (New York: McGraw-Hill, 1975), p. 675.

[74]W. J. Dixon, Biomedical Computer Programs (Los Angeles: University of California Press, 1975), pp. 729.

institutions, and their interest in developing or expanding this function.

Specific questions to be answered included the following: (1) What elements of organized patient education programs exist in Michigan's nursing care facilities? (2) Are there patient education programs in more of Michigan's nursing homes, medical care facilities, or hospital long-term care units? (3) Are there more patient education programs in larger institutions, medium-sized institutions, or smaller institutions? (4) Are there more patient education programs in some Health Service Areas than in others? (5) Are newer nursing care facilities more apt to have established patient education programs than older facilities? (6) Are patient programs more developed in nursing homes, medical care facilities, or hospital long-term care units? (7) Are patient education programs more developed in larger institutions, medium-sized institutions, or smaller institutions? (8) Are patient education programs more developed in some Health Service Areas than in others? (9) Are patient education programs more developed in newer nursing care facilities than in older facilities?

Summary

A questionnaire was designed, sent to a jury of eight experts, and pilot tested on administrators of twelve Michigan nursing care facilities. It was then refined, printed, and mailed to administrators of all 455 nursing care facilities in Michigan. A response rate of sixty-nine percent was obtained, with sixty-five

percent being usable. The data were organized and then analyzed by the computer at Central Michigan University, using frequency distributions, percents, ranges, standard deviations, and measures of central tendency. The data were then interpreted so as to answer the research questions. Findings are reported in Chapter IV and conclusions are reported in Chapter V.

CHAPTER IV

ANALYSIS OF DATA

Introduction

This study was undertaken to identify and analyze patient education programs as they existed in nursing care facilities in Michigan in 1976. The first task was to locate such programs by area of the state, and to describe their distribution by type, size, bed capacity, and age of nursing care facility. Once located, the programs were analyzed to learn about three major factors: (1) extent of development; (2) principal components, which included (a) program coordination, (b) educational center designation, (c) educational offerings for patients, (d) education for the patient's family, (e) principal participants, (f) initiation of patient involvement, (g) evaluation; and (3) whether administrators, with consultant help, would initiate or expand such programs. Analysis of each of these factors was in terms of location, type, size, and age of facility.

Distribution of All Michigan Nursing Care Facilities

Michigan, in 1976, had 455 nursing care facilities as defined and listed by the Bureau of Health Care Administration of the Michigan Department of Public Health. They are generally classified into three categories: (1) nursing homes, of which

there are three hundred ninety, (2) medical care facilities, of which there are thirty-nine, and (3) hospital long-term care units, of which there are twenty-six. Nursing homes can be further classified as to whether they are proprietary homes operated for profit, or public or private homes oprated on a not-for-profit basis. The vast majority are operated for profit. Of the three-hundred ninety nursing homes, three-hundred twenty-seven are operated as for-profit ventures.

Michigan is divided into eight Health Service Areas (HSA) (see Figure 1) for comprehensive health planning purposes. These are federally created and stress local participation in the planning process. Local HSA's prepare plans for their areas. These plans are blended into a state plan and eventually into a national plan. These health service areas are used as the basis for analysis by geographic regions in this study.

HSA 1, composed of seven southeastern Michigan counties and including the Detroit metropolitan area, has fifty-three percent of Michigan's population and forty-eight percent of the nursing care facility beds. HSA 4, composed of twelve West Michigan counties and including Grand Rapids, is a distant second in these respects, with ten percent of the population and thirteen percent of the beds. The fewest beds are in HSA 7, composed of eighteen counties in northern Michigan, and in HSA 8, the entire Upper Peninsula. However, because the population is so much lower, the beds per thousand population is highest in the Upper Peninsula, and second highest in HSA 7 located in northern lower Michigan. The number of

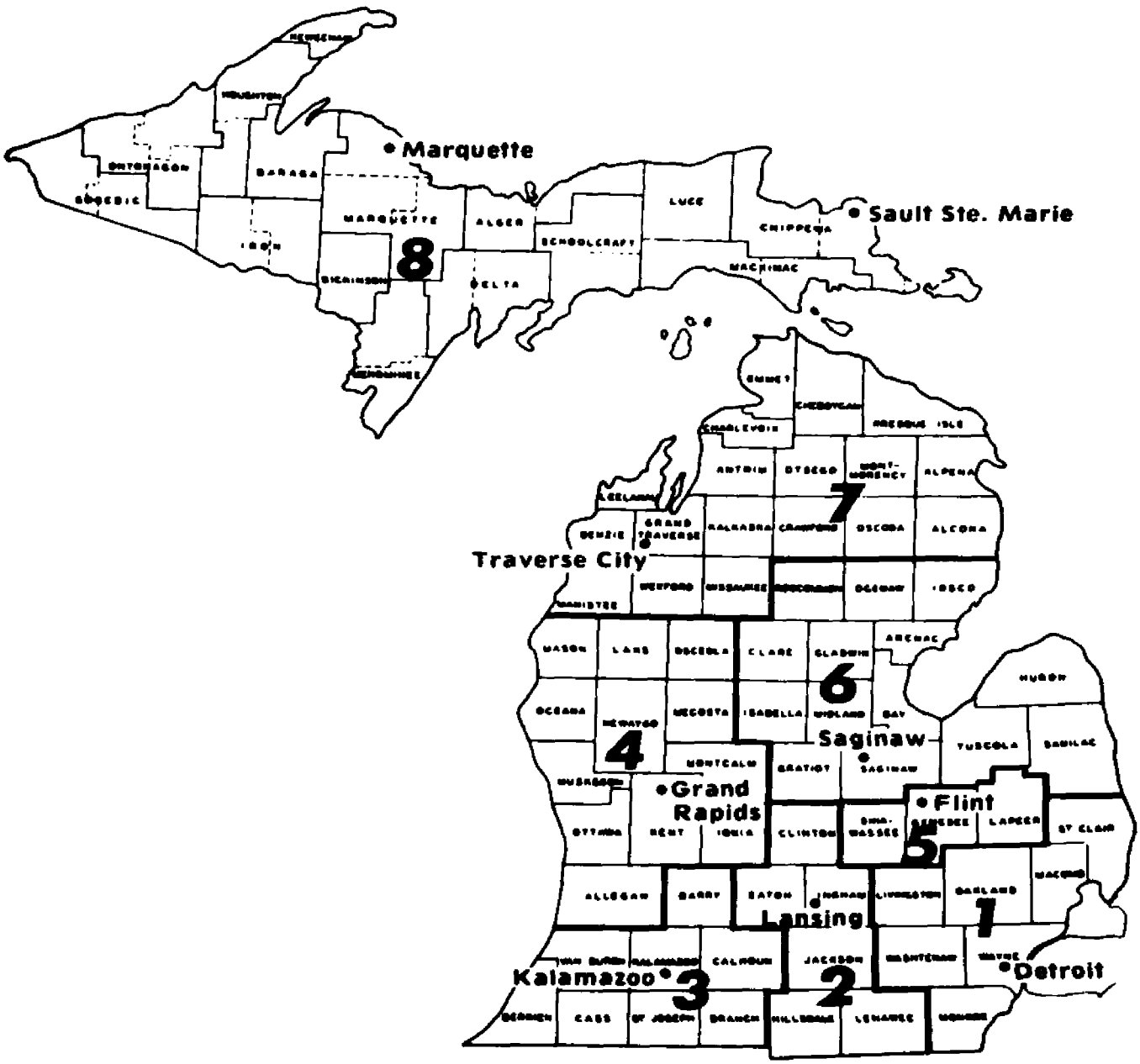

Figure 1.--Health Service Areas for the State of Michigan.

beds per thousand population for the entire state of Michigan is 5.14, with a range in the HSA's from 3.51 in the Shiawassee, Genesee, Lapeer area to 10.15 in the Upper Peninsula. The highest rates are in the norther HSA's with lowest population density, while the lowest beds per thousand rates are in the metropolitan areas of southern Michigan. The distribution of nursing care facility beds, general population, and beds per thousand among these HSA's are displayed in Table 1.

Distribution of Respondents

As detailed in Chapter III, a statewide survey was undertaken. Questionnaires were mailed to administrators of all 455 of the state's nursing care facilities. A total of 294 questionnaires were returned and usable. Thus sixty-five percent of all facilities are represented in the analysis.

The response rate was greatest among administrators of medical care facilities (ninety percent), followed by administrators of nursing homes operated on a not-for-profit basis (eighty-three percent), and administrators of hospital long-term care units (sixty-two percent). Among the large number of administrators who operated nursing homes for profit, the response rate was fifty-eight percent. This below average response rate was concentrated in two areas, HSA 1 in southeastern Michigan where the response rate was forty-six percent, and HSA 3 in southwestern Michigan where the response rate was fifty-six percent. Except for slight underrepresentation of the large number of for-profit nursing homes in

TABLE 1.--The distribution of population, nursing care facility beds, and beds per thousand population among Michigan's eight Health Service Areas.

	Population	Nursing Care Beds					
		Nursing Home		Medical Care Facility	Hospital Long-Term Care Unit	Total	Beds per Thousand
		For Profit	Not for Profit				
HSA 1	4,990,994	18,541	3,199	282	1,197	23,219	4.65
HSA 2	683,415	1,726	307	776	--	2,809	4.11
HSA 3	769,617	2,841	362	474	672	4,349	5.65
HSA 4	1,017,143	4,452	802	523	945	6,722	6.61
HSA 5	608,929	1,823	--	313	--	2,136	3.51
HSA 6	736,253	2,049	624	673	815	4,161	5.65
HSA 7	265,770	911	--	599	508	2,013	7.59
HSA 8	263,886	1,245	171	736	518	2,607	10.15
Total	9,336,007	33,588	5,465	4,376	4,650	48,079	5.14

SOURCE: Population Projections of the Counties of Michigan by Age and Sex for Each Year 1970-1980, Bureau of Program and Budget, Executive Office, State of Michigan, December 1972, p. 16.

these two areas and the small number of hospital long-term care units, approximately three-fourths of all nursing care facilities in all areas of Michigan are represented in the study. These data are displayed in Tables 2 and 3.

Respondents from HSA 1 represent the largest number of beds (12,875), and the largest number of institutions (ninety-eight). Their institutions also have the largest mean bed size (131). HSA 4, which includes the twelve counties around Grand Rapids, has nearly twice as many beds (5,398) represented as the next closest HSA, and fifty percent more institutions (fifty-four). There are several HSA's clustering near third place. HSA 7 in northern Michigan has the fewest beds represented in the study (996). It also has the fewest number of institutions represented (fifteen), and the smallest mean number of beds (sixty-six). Table 4 displays these data.

TABLE 2.--Capacity of responding Michigan nursing care facilities, by number of beds and type of institution.

	Number of Beds	Mean	Std. Dev.	Range	Number Inst.
Nursing homes for profit	19,502	102.10	58.06	12-325	191
Nursing homes not for profit	5,520	106.15	92.19	5-473	52
Medical care facilities	3,958	113.09	55.70	36-206	35
Hospital long-term care units	1,422	88.86	132.06	17-524	16
Entire population	30,402	103.40	70.31	5-524	294

TABLE 3.--Number and percent of responding Michigan nursing care facility administrators, by type of institution and Health Service Area.

	Nursing Home				Medical Care Facility		Hospital Long-Term Care Unit		Total	
	For Profit		Not for Profit							
	N	%	N	%	N	%	N	%	N	%
HSA 1	70	46.0	24	80.0	2	100	2	50.0	98	52.1
HSA 2	14	70.0	4	80.0	4	80.0	-	--	22	73.3
HSA 3	18	56.2	4	80.0	4	80.0	2	50.0	28	60.8
HSA 4	33	75.0	11	78.6	5	100	5	100	54	79.4
HSA 5	16	84.0	--	--	2	100	-	--	18	85.7
HSA 6	19	63.0	7	100	7	100	2	40.0	35	71.4
HSA 7	8	72.7	--	--	5	83.3	2	40.0	15	68.1
HSA 8	13	68.4	2	100	6	85.7	3	100	24	77.4
Total	191	58.4	52	82.5	35	89.7	16	61.5	294	64.6

TABLE 4.--Distribution of Michigan nursing care facility beds represented in this study, by Health Service Area.

	Total Number of Beds	Mean	Std. Dev.	Range	Total Number Inst.
HSA 1	12,875	131.38	85.43	5-473	98
HSA 2	2,167	98.50	47.93	24-194	22
HSA 3	2,338	86.59	43.81	12-196	27
HSA 4	5,398	99.96	75.67	27-524	54
HSA 5	1,925	106.94	58.22	26-230	18
HSA 6	2,898	80.50	44.61	25-206	36
HSA 7	996	66.40	43.69	25-181	15
HSA 8	1,805	75.21	42.16	29-197	24
Total	30,402	103.41	70.31	5-524	294

Approximately two-thirds of the responding institutions are in the medium-sized class having from fifty-one to 200 beds. Approximately one-fourth of the institutions are in the small-sized group, with fifty beds or less. Only one in twelve are in large-sized institutions of more than 200 beds.

While one-fourth of the institutions are small, only eight percent of the total beds represented are in small-sized institutions. Sixty-eight percent of the institutions are medium-sized, and a similar sixty-nine percent of the total beds represented are in medium-sized institutions. However, while eight percent of the institutions are large, these twenty-six institutions have twenty-three percent of the beds represented in this study.

A very large percentage (eighty-one percent) of the hospital long-term care units are small, proportionally more than any of the other three types of institutions. Marginal notations on three of the sixteen questionnaires indicated that hospital long-term care units are being phased out.

For-profit nursing homes and not-for-profit nursing homes have a strikingly similar distribution in size groups, with both types having about one-fifth of their institutions in the small-size group, about seventy percent in the medium-size group and about nine percent in the large-size group. Responding medical care facilities are more commonly between fifty-one and two-hundred beds (seventy-seven percent), with both fewer large institutions and fewer small institutions than other types of facilities. Table 5 displays these data.

TABLE 5.--Number and percent of responding Michigan nursing care facilities, by type and size of institution.

		Nursing Home		Med. Care Facil.	Hospital Long-Term Care Unit	Total
		For Profit	Not for Profit			
Small institutions	N	40	11	5	13	69
	%	20.9	21.2	14.3	81.3	23.5
Medium-sized institutions	N	135	36	27	1	199
	%	70.7	69.2	77.1	6.3	67.7
Large institutions	N	16	5	3	2	26
	%	8.4	9.6	8.6	12.5	8.8
Total	N	191	52	35	16	294
	%	65.0	17.7	11.9	5.4	100

The respondents are evenly divided into the newer and the older groups. A newer institution was defined as one that started in the past ten years, through July, 1976. Forty percent of the responding institutions are classified as older, i.e., more than ten years old, while forty-five percent are newer. Age of institution was not reported by fifteen percent of the respondents. Table 6 displays how the four types of institutions are distributed by age.

Approximately half the beds (14,666) in the responding institutions are in institutions reported as older, meaning more than ten years old. Another 10,492 beds are in institutions reported as newer, those less than ten years old. Age was not reported for the remaining insitutions whose total bed capacity is 5,244.

TABLE 6.--Distribution of responding Michigan nursing care facilities, by type and age of institution.

		Nursing Home		Med. Care Facil.	Hospital Long-Term Care Unit	Total
		For Profit	Not for Profit			
Older institutions	N	73	21	17	7	118
	%	38.2	40.4	48.6	43.8	40.1
Newer institutions	N	96	15	13	8	132
	%	50.3	28.8	37.1	50.0	44.9
No indication	N	22	16	5	1	44
	%	11.5	30.8	14.3	6.3	15.0
Total	N	191	52	35	16	294
	%	65.0	17.7	11.9	5.4	100

In summary of this section, sixty-five percent of the 455 administrators of the state returned a usable questionnaire. Administrators of medical care facilities were considerably above average in response, as were administrators of nursing homes operated on a not-for-profit basis. Administrators of hospital long-term care units were near the average. Administrators of nursing homes operated on a profit-making basis constitute the largest group, and had a below average response rate. The return was especially low in the southeastern and southwestern areas of the state, where approximately half the administrators returned the completed questionnaire.

Approximately two-thirds of the institutions represented are between fifty and 199 beds in size, nearly one-fourth of the represented institutions have less than fifty beds, and approximately

nine percent of the respondents have more than 200 beds. The responding institutions are fairly evenly divided into those of ten or less years of age and those of more than ten years of age.

Nearly two-thirds of the patient beds represented in the study are in for-profit nursing homes, while the other third are distributed in not-for-profit nursing homes, medical care facilities, and hospital long-term care units. More than a third of the institutions and beds represented are in HSA 1. Slightly less than half the beds are in institutions less than ten years old.

Distribution of Patient Education Programs

One of the basic objectives of this investigation was to determine how many of Michigan nursing care facilities are presently operating programs of patient education and what is the general character of those operating programs. A program was defined to be operational if the following three conditions were met: (1) a coordinator was appointed, (2) two or more educational activites were offered, and (3) two or more different categories of staff members were involved. The educational programs were classified as patient general education, patient health education, or both. If either a general education or a health education program were operational, a patient education program was said to be in existence.

It was found that 200 of the 294 nursing care facilities (sixty-nine percent) had operational programs. These programs were then categorized by institutional type to ascertain if patient education programs were more likely to exist in the two types of

nursing homes, medical care facilities, or hospital long-term care units. Analysis was made in an earlier section of the total number of nursing care facility beds in Michigan, and of the number of beds represented in this study. These data provide the context for subsequent analyses. No attempt was made to analyze the number of beds in institutions with operational programs of patient education. The unit of analysis used in the following sections of this report is the institution.

A patient education program was defined for this study as consisting of either a general education program or a health education program. The percentage of institutions with either program in existence was examined first.

For-profit nursing homes and medical care facilities were found to have an almost identical percentage of operational programs, at seventy-two and seventy-one percent, respectively. Not-for-profit nursing homes were a distant third at fifty-eight percent, whereas hospital long-term care units had operational programs in half the institutions. These data are displayed in Table 7.

Another way of looking at the distribution of programs in Table 7 is to examine the distribution of patient general education programs separate from patient health education programs. Institutions with these specific programs were categorized to permit comparison. There were 178 operational general education programs in the 294 responding institutions (sixty-one percent). Sixty-five percent of the for-profit nursing homes had general education programs, while sixty percent of the medical care facilities,

TABLE 7.--Number and percentage of nursing care facilities providing patient education programs, by type of institution.

		Nursing Home		Med. Care Facil.	Hospital Long-Term Care Unit	Total
		For Profit	Not for Profit			
		N=191	N=52	N=35	N=16	N=294
Operational general education program	N	125	25	21	7	178
	%	65.4	48.1	60.0	43.8	60.5
Operational health education program	N	59	10	16	3	88
	%	30.9	19.2	45.7	18.8	29.9
Either program in existence	N	137	30	25	8	200
	%	71.7	57.7	71.4	50.0	68.0

forty-eight percent of the not-for-profit nursing homes, and forty-four percent of the hospital long-term care units had such programs.

Eighty-eight (thirty percent) of the 294 responding institutions reported operational patient health education programs. Forty-six percent of the medical care facilities had operational health education programs, while thirty-one percent of the for-profit nursing homes had such programs. Not-for-profit nursing homes and hospital long-term care units were considerably behind, with nineteen percent of the two types of institutions offering patient health education programs.

Patient education programs were then categorized by institutional size to test the accuracy of the popular belief that large institutions have more programs than medium-sized or small institutions. A greater percentage of the larger institutions did have

patient education programs (eighty-eight percent) than did the medium-sized institutions (seventy-four percent) or the smaller institutions (forty-two percent). This was especially true for general education programs. Health education programs, however, are most common in medium-sized institutions. A partial explanation for this phenomenon is the fact that fifty-nine of the eighty-eight health education programs are in for-profit nursing homes. Table 5 earlier revealed that seventy-one percent of such facilities are in the medium-sized category. The 200 programs are displayed by institutional size in Table 8.

The distribution of patient education programs by HSA is also of interest in view of the planning roles of HSA's. The percentage of institutions with operational patient education programs ranged from forty-eight percent in HSA 3 to eighty percent in HSA 7, with sixty-eight percent of all responding institutions having

TABLE 8.--Number and percentage of nursing care facilities providing patient education programs, by size of institution.

		Small N=69	Medium N=199	Large N=26	Total N=294
Operational general education program	N	23	134	21	178
	%	33.3	67.3	80.8	60.5
Operational health education program	N	14	66	8	88
	%	20.3	33.2	30.8	29.9
Either program in existence	N	29	148	23	200
	%	42.0	74.3	88.4	68.0

programs. The two HSA's with the largest number of institutions offering programs are HSA 1 and HSA 4. They both reported operational programs in seventy-four percent of the institutions, well above the average for Michigan. The proportions of institutions offering general education programs range from a low of thirty-six percent in HSA 6 to a high of seventy-three percent in HSA 7, with an average of sixty-one percent for all HSA's. Operational health education programs occurred in as few as nineteen percent of the instututions in HSA 4, as high as forty percent in HSA 7, and an average of thirty percent for all HSA's. These data are displayed in Table 9.

An attempt was also made to test the hypothesis that newer institutions were more likely to have operational patient education programs than older institutions. Accordingly, the 200 programs were aggregated by age, with those started in the last ten years being classified as newer institutions.

Of the newer institutions seventy-two percent had patient education programs, while sixty-six percent of the older institutions had programs. The proportion for patient health education was almost identical, with thirty percent of both the new and older institutions offering health education. There are both a larger number of institutions and a large percentage of institutions that have patient general education programs in the newer group. These data are displayed in Table 10.

In summary of this section, it should be pointed out that only sixty-six institutions or twenty-two percent have both general

TABLE 9.--Number and percent of nursing care facilities providing patient education programs, by Health Service Area.

		HSA 1 N=98	HSA 2 N=22	HSA 3 N=27	HSA 4 N=54	HSA 5 N=18	HSA 6 N=36	HSA 7 N=15	HSA 8 N=24	Total N=294
Operational general education program	N	67	14	11	39	12	13	11	11	178
	%	68.4	63.6	40.7	72.2	66.7	36.1	73.3	45.8	60.5
Operational health education program	N	31	8	7	10	7	10	6	9	88
	%	31.6	36.4	25.9	18.5	38.9	27.8	40.0	37.5	29.9
Either program in existence	N	73	15	13	40	13	21	12	13	200
	%	74.4	68.1	48.1	74.0	72.2	58.3	80.0	54.1	68.0

TABLE 10.--Number and percent of nursing care facilities providing patient education programs, by age of institution.

		Older Inst. N=118	Newer Inst. N=132	No Data N=44	Total N=294
Operational general education program	N	69	87	22	178
	%	58.4	65.9	50.0	60.5
Operational health education program	N	35	39	14	88
	%	29.7	29.5	31.8	29.9
Either program in existence	N	78	95	27	200
	%	66.1	71.9	61.3	68.0

education and health education programs operational. It is most common for an institution to have a general education program (sixty-one percent do), and less common for an institutuion to have a health education program available (thirty percent do). Two hundred of the 294 institutions (sixty-nine percent) had one or the other or both categories of programs available.

State of Development of Patient Education Programs

Another of the basic objectives of this study was to determine the stage of development of patient education programs. Specifically, it was of interest to find if patient education programs were more developed in some types of institutions than others, in older or newer institutions, in large, medium, or small-sized institutions, or in some HSA's more than in others.

It was initially thought that a good indicator of development would be the number of institutuions with a beginning program compared to the number of institutions with operational programs. However, it was discovered that there are very few programs in the beginning stages. Most institutions have either a fully operational program or none at all. It was, therefore, decided to devise a more discriminating "patient education development stage score" which would permit comparison of the development stage of the operational programs. After much deliberation and discussion, it was decided that the best patient education devlopment score would consist of a combination of the number of general education offerings and health education offerings, with the number of groups of staff involved in general education and health education. These sets of data were each standardized on a ten-point scale, and then combined with equal weight to form a patient education development score.

The first step was to examine patient education program development stage by institutional type. For-profit nursing homes were found to have a very slightly higher development score with a mean score of 4.16, and a range of .21 to 7.09. Medical care facilities were almost as high, with a mean score of 4.07 and a range of .52 to 6.66. Not-for-profit nursing homes were relatively close with a mean score of 3.86, with hospital long-term care units being almost identical at 3.71. There appeared to be almost no difference in program development stage among the four types of institutions. These data are displayed in Table 11.

TABLE 11.--Mean patient education development scores displayed by Institutional type.

	Number	Mean Patient Educ. Devel. Score	Standard Deviation	Range
Nursing homes for profit	137	4.16	1.66	0.21-7.09
Nursing homes not for profit	30	3.86	1.90	0.21-7.25
Medical care facilities	25	4.07	1.68	0.52-6.66
Hospital long-term care units	8	3.71	1.73	1.46-7.16

When programs were aggregated according to size, large-sized institutions did have a somewhat higher mean program development score of 4.37, with medium and small-sized institutions being close behind at an almost identical mean score of 4.0. This information is displayed in Table 12.

TABLE 12.--Mean patient education development scores displayed by institutional size.

	Number	Mean Patient Educ. Devel. Score	Standard Deviation	Range
Small institution	29	3.96	1.65	0.21-6.97
Medium-sized institution	148	4.06	1.69	1.25-7.16
Large institution	23	4.37	1.80	0.21-7.98

When program scores were grouped according to HSA's, it was interesting to note that HSA 8 in the Upper Peninsula had the greatest degree of development. The mean patient education development scores in the eight HSA's ranged from a high of 4.84 to a low of 3.40. These data are displayed in Table 13.

Virtually no difference was detected when patient education development scores were compared in older and new institutions. The mean scores were nearly identical, both rounding off at 4.0.

In retrospect, none of the independent variables seemed to make any difference in the stage of development of patient education programs. This was also true when a separate development score was computed for patient health education. There were no significant variations when grouped by type, size, age, or location. However, this was not true when a separate program development score was computed for patient general education. Type and size of institution appear to be related to patient general education development scores, while age and location appear not to be. Hospital long-term care units and medical care facilities had low mean scores at 3.27 and 3.47, respectively, with not-for-profit nursing homes having the highest mean development score at 4.28. Data on institutional type are displayed in Table 14.

Large institutions had a higher general education development mean score (4.64) than did medium-sized institutuions (3.94) and small institutions (3.76). These data are displayed in Table 15 (page 74).

TABLE 13.--Mean patient education development scores displayed by Health Service Area.

	Number	Mean Patient Educ. Devel. Score	Standard Deviation	Range
HSA 1	73	4.17	1.74	0.21-7.25
HSA 2	15	4.73	1.51	0.21-6.35
HSA 3	13	4.23	1.51	0.21-6.00
HSA 4	40	3.64	1.69	0.21-7.98
HSA 5	13	4.07	1.73	0.21-6.99
HSA 6	21	3.40	1.34	0.21-5.07
HSA 7	12	3.67	1.37	0.80-5.76
HSA 8	13	4.84	1.48	0.21-6.83

TABLE 14.--Mean patient general education development scores displayed by institutional type.

	Number	Mean General Educ. Devel. Score	Standard Deviation	Range
Nursing homes for profit	125	4.08	1.15	0.42-8.54
Nursing homes not for profit	25	4.28	1.08	0.42-6.46
Medical care facilities	21	3.47	.90	0.31-5.42
Hospital long-term care units	7	3.27	.46	0.63-6.25

TABLE 15.--Mean patient general education development scores displayed by institutional size.

	Number	Mean General Educ. Devel. Scores	Standard Deviation	Range
Small institution	23	3.76	1.27	0.42-6.04
Medium-sized institution	134	3.94	1.05	0.31-8.54
Large institution	21	4.64	1.22	2.50-6.25

In summary of this section, nothing much has been established about the relationship of patient education program development stage to institutional type, size, age, or location. When development scores were computed for health education programs, no significant relationships were found. When development scores for general education were computed separately, type and size were very modestly related factors. Nursing homes and larger institutions more frequently reported general education programs than did medical care facilities, hospital long-term care units or medium or small facilities.

Principal Components of Patient Education Programs

One of the basic objectives of this study was to determine what elements of patient education exist in Michigan nursing care facilities. Several major components were identified and will be described in this section.

Program Coordination

The first issue investigated in each of the 294 institutions was whether or not the institution had a specific department or coordinator that was responsible for general education programs offered. There were 214 institutions, or seventy-three percent, that responded positively. This was an interesting finding. On the one hand the number of program coordinators was larger than the number of operational programs (178) as defined; on the other hand, since state licensure rules demand "diversional activities," the twenty-seven percent that reported no such designated coordinator was surprising. Either general education of patients was not considered part of this program of diversional activity, or else such activities were coordinated by staff members with other principal duties and without designation as coordinators.

Eighty-six percent (thirty of thirty-five) of the medical care facilities had coordinators for general education, while only fifty percent of the sixteen hospital long-term care units had such positions. Nursing homes were in between these two extremes. Seventy-five percent of the one hundred ninety-one for-profit nursing homes and sixty-two percent of the fifty-two not-for-profit nursing homes had coordinators.

Those 214 institutions that did have coordinators responsible for general education typically assigned this duty to a division or department called the Patient Activities (ninety-eight) or Diversional Therapy (sixty-four) Department. Seven mentioned a social service director, while six allowed an external agency such

as the community school program, the intermediate school district, or the mental health activities center to coordinate their general education programs.

There were 106 institutions (thirty-six percent) that indicated that they had coordinators of patient health education, eighteen more than had a fully operational program. Medical care facilities were above the mean (thirty-six percent), having such coordinators in half of their institutions. Thirty-seven percent of for-profit nursing homes had coordinators while twenty-nine percent of not-for-profit nursing homes and nineteen percent of hospital long-term care units had coordinators for patient health education.

In thirty of the 294 institutions (ten percent) there were designated coordinators who coordinated both general and health education programs. Looked at differently, thirty of the 214 general education coordinators (fourteen percent) also coordinated health education, or thirty of the 106 health education coordinators (twenty-eight percent) also coordinated general education. These data are displayed in Table 16.

Four of the eight hospitals without general education coordinators were reportedly planning to designate one, as were a third of the for-profit nursing homes, fifteen percent of the not-for-profit nursing homes and twenty percent of the medical care facilities who did not have coordinators for general education. A much smaller proportion of the institutions planned to add patient health education coordinators, however. Only about ten percent (twenty of 188) of

TABLE 16.--Distribution of institutions having designated education coordinators, by program and by institutional type.

		Nursing Home		Med. Care Facil.	Hospital Long-Term Care Unit	Total
		For Profit	Not for Profit			
		N=191	N=52	N=35	N=16	N=294
Have general education coordinator	N	144	32	30	8	214
	%	75.4	61.5	85.7	50.0	72.8
Have health education coordinator	N	70	15	18	3	106
	%	36.6	28.8	51.4	18.7	36.0
Same person coordinates both programs	N	21	4	4	1	30
	%	11.0	7.7	11.4	6.2	10.2

TABLE 17.--Number and percent of institutions without patient education coordinators who are planning to designate one, by institutional type.

		Nursing Home		Med. Care Facil.	Hospital Long-Term Care Unit	Total
		For Profit	Not for Profit			
No general education coordinator	N	47	20	5	8	80
Planning for a general education coordinator	N	15	3	1	4	23
	%	31.9	15.0	20.0	50.0	28.8
No health education coordinator	N	121	37	17	13	188
Planning for a health education coordinator	N	14	4	0	2	20
	%	11.6	10.8	0	15.4	10.6

nursing care facilities were planning to add such a staff designation. These data are displayed in Table 17 (page 76).

There was no significant difference in the frequency of education departments or coordinators among institutions by region or age. There was, however, when institutions were examined by size. The larger institutions, as might be expected, provided departments or coodinators of education with much greater frequency.

Only forty-four percent of the sixty-nine small institutions employed such a coordinator for patient general education, while eighty percent of the one hundred ninety-nine medium-size institutions and ninety-two percent of the twenty-six large institutions did so. Small institutions were substantially below the average of all nursing care facilities (seventy-three percent) in providing coordinators of patient general education.

Only a fourth of the small institutions had coordinators of health education. This was well below the average for all nursing care facilities (thirty-six percent). Medium-size and large institutions were nearly identical with almost forty percent providing coordinators for such programs.

In five of the twenty-six large institutions (nineteen percent), the same person coordinated both programs. In twenty-two of the 199 medium-size institutions (eleven percent) there were single directors for both general and health eduation. In only three of the sixty-nine small institutions (four percent) was this true. These data are displayed in Table 18.

TABLE 18.--Distribution of institutions having designated patient education coordinators, by size of institution.

		Small N=69	Medium N=199	Large N=26	Total N=294
Have general education coordinator	N	30	160	24	214
	%	43.5	80.4	92.3	72.8
Have health education coordinator	N	17	79	10	106
	%	24.6	39.7	38.5	36.0
Same person coordinates both programs	N	3	22	5	30
	%	4.3	11.1	19.2	10.2

Medium-sized institutions without general education coordinators often indicated they were planning to designate such coordinators. This was true in fifteen of the thirty-nine institutions. Among small institutions without general education coordinators, eight of thirty-nine (twenty-one percent) reported planning to designate them. Neither of the two large institutions indicated any immediate plans to designate one.

Size was not a significant variable when plans to designate a health education coordinator were examined. Eleven percent of all nursing care facilities without such a coordinator were planning to add them. All three size groups were strikingly close to that average. These data are displayed in Table 19.

In summary of this section, there were coordinators of general education in 214 institutions and coordinators of health education in 106 institutions. The same persons coordinated both

TABLE 19.--Number and percent of institutions without patient education coordinators who are planning to designate one, by institutional size.

		Small N=69	Medium N=199	Large N=26	Total N=294
No general education coordinator	N	39	39	2	80
Planning for a general education coordinator	N	8	15	0	23
	%	20.5	38.4	0.0	28.8
No health education coordinator	N	52	120	16	188
Planning for a health education coordinator	N	5	13	2	20
	%	9.6	10.8	12.5	10.6

programs in thirty institutions. Stated differently, approximately twice as many institutions had coordinators of general education as had coordinators of health education. Twenty-three of eighty, nearly a third, of the institutions without general education coordinators were planning to create such positions, while twenty of one hundred eighty-eight, just over one-tenth, of the institutions without health education coordinators were planning to create such a position.

Educational Center Designation

Another issue investigated was whether or not the facilities had space designated as educational centers for patients. Sixty-two percent of the 294 institutions, according to respondents, had centers. Another nine percent were in the planning stages. No

significant differences were revealed when looking at the data by age, region, or type. Again, however, size of institution was a significantly related factor.

While thirty-three percent of the small institutions had patient education centers, seventy percent of the medium-sized institutions and seventy-seven percent of the larger institutions had such centers. Another nine percent of all institutions were planning to provide centers. These data are displayed in Table 20.

Patient General Education Offerings

The next concern of the study was to determine what general education topics were covered and the method in which they were presented. Respondents were specifically asked about literature, arts and crafts, music, creative writing, theater, reality orientation, and current events. (See questionnaire, Appendix.) An open-ended

TABLE 20.--Distribution of Michigan nursing care facilities patient education centers, by size of institution.

		Small N=69	Medium N=199	Large N=26	Total N=294
Have center	N	23	139	20	182
	%	33.3	69.8	76.9	61.9
No center	N	37	40	3	80
	%	53.6	20.1	11.5	27.2
Planning stage	N	8	15	2	25
	%	11.6	7.5	7.7	8.5
No report	N	1	5	1	7
	%	1.4	2.5	3.8	2.4

question encouraged respondents to "please list others." Horticulture, physical fitness, religious instruction, films, and high school completion or GED classes were listed.

Sixty-one percent or 178 of the 294 institutions offered some form or combination of general education. These operational programs were then examined to determine the frequency of education offerings. The topics most commonly offered in order of frequency were arts and crafts, literature, reality orientation, current events, and music. Table 21 presents comparative data on the frequency of all such offerings. The topics have been arranged in descending order, according to the frequency of their occurrence.

Some comments on the five most commonly listed general education topics are appropriate. Again, these include arts and crafts, literature, reality orientation, current events, and music.

Arts and crafts were offered by ninety-eight percent of the institutions, and were available to patients as part of the diversional therapy program. Such instruction was provided in every instance except for three of the for-profit nursing homes. Group instruction was provided by ninety-six percent of the institutions while individual instruction was also provided by seventy-four percent of the facilities. Very little self-instructional media or printed material was reportedly used. Data on methods used appear in Table 22.

Literature was offered by eighty-two percent of the institutions but in only fifty-seven percent of hospital long-term care units. The most common method used was simply the providing of

TABLE 21.--Frequency of offering various topics in patient general education programs, by type of institution.

		Nursing Home		Med. Care Facil.	Hospital Long-Term Care Unit	Total
		For Profit	Not for Profit			
Number having no program		N= 66	N=27	N=14	N=9	N=116
Number having operational program		N=125	N=25	N=21	N=7	N=178
Arts and crafts	N	122	25	21	7	175
	%	97.6	100	100	100	98.3
Literature	N	103	20	18	4	145
	%	82.4	80.0	85.7	57.1	81.5
Reality orientation	N	105	18	15	6	144
	%	94.0	72.0	71.4	85.7	80.9
Current events	N	98	22	15	5	140
	%	78.4	88.0	71.4	71.4	78.7
Music	N	93	21	15	5	134
	%	74.4	84.0	71.4	71.4	75.3
Creative writing	N	20	7	6	0	33
	%	16.0	28.0	28.6	0	18.5
Theater	N	20	5	4	1	30
	%	16.0	20.0	19.0	14.3	16.9
Religious instruction	N	18	3	0	0	21
	%	14.4	12.0	0	0	11.8
Physical fitness	N	11	4	2	0	17
	%	8.8	16.0	9.5	0	9.6
High school completion	N	7	2	0	0	9
	%	5.6	8.0	0	0	5.1

TABLE 22.--Methods used in selected topic areas of patient education in the one hundred seventy-eight general education programs in Michigan nursing care facilities.

		Group Instruc.	Individ. Instruc.	Self Instruc.	Printed Material
Arts and crafts	N	170	132	39	36
	%	95.5	74.2	21.9	20.2
Literature	N	78	58	50	109
	%	43.8	32.6	28.1	61.2
Reality orientation	N	121	106	19	34
	%	68.0	59.6	10.7	19.1
Current events	N	116	62	31	68
	%	65.2	30.8	17.4	38.2
Music	N	122	35	21	14
	%	68.5	19.7	11.8	7.9
Creative writing	N	12	22	9	7
	%	6.7	12.4	5.1	3.9
Theatre	N	28	3	3	0
	%	15.7	1.7	1.7	0
Religious instruction	N	21	8	3	7
	%	11.8	4.5	1.7	3.9
Physical fitness	N	17	10	3	3
	%	9.6	5.6	1.7	1.7
High school completion	N	9	3	3	5
	%	5.1	1.7	1.7	2.8

printed material for optional use of patients (sixty-one percent). Subscriptions to several magazines and newspapers were common. Reading printed material may be educational, and is an easy way to make education available to the patients. A number of institutions have worked out relationships with local libraries to rotate a supply of books. No data were gathered with respect to utlization of such reading materials. (The incidence of this relationship will be spelled out in a later section of this analysis.) Group instruction was provided in literature by forty-four percent of the institutions. These included but were not limited to book reviews by both patients and non-patients. Self-instructional media was provided by twenty-eight percent of the institutions. Examples given were records, tape recorded literature, and filmed versions of books. Some institutions provided a library of large print books and books in Braille. Others provided reading programs for the blind and near-blind. One institution provided reading improvement classes.

Reality orientation was provided by eighty-one percent of the institutions, most frequently in for-profit nursing homes and hospital long-term care units. Reality orientation is a series of activities designed to maintain or reestablish a patient's contact with reality. A lot has been said about this in the journals and conferences for nursing care facility staff. Some of the basic elements are making patients aware of what day and date it is, what events have been planned for patients and how they can participate in them. The importance of daily grooming, and the importance of

eating a varied diet are also included. Regular reading of a newspaper is encouraged, as is listening to or watching the newscasts. Individual instruction in this area was listed in sixty percent of the institutions.

Getting patients out of their rooms and into group activities was stressed. Group instruction was listed in sixty-eight percent of the institutions. Birthday parties were held, as were bingo, bowling, cards, popcorn, and patio parties. Periodic trips were made to nearby shopping centers or other places of interest. On other occasions trips were made to restaurants to "eat out." Occasional home visits were likewise encouraged. Patient involvement in planning and conducting these activities was stressed. Resident councils existed in some institutions.

Reality orientation was obviously an important part of the daily routine of the staff. Certainly, it falls within the scope of education, and is a good example of fitting educational programs to the needs of the learners.

Current events was also mentioned by seventy-nine percent of the institutions, with group instruction being the most common method used. Inasmuch as the questionnaire was distributed in May and June of the bicentennial year 1976, it is not surprising that numerous classes were reported on national, state, and local historical topics. "Oral history" of local communities was common. Films were likewise shown on historical topics and other items of current interest.

Another series of sessions mentioned specifically was "Know Your Candidates" nights, to both prepare and encourage the patients to vote. Weekly discussion groups were held in some institutions on topics of current interest.

Printed material was the second most common means of providing education about current events, and as mentioned above, involves provision of newspapers and magazines. Individual instruction was mentioned by thirty-one percent of the respondents. It was presumed that his involved staff interaction with patients about the events of the outside world but that it was also stressed as part of the more formal aspects of reality therapy, occurring as part of the daily routine of interpersonal communication.

Music was likewise important in nursing care facilities and was provided in seventy-five percent of the institutions, varying little among types of instruction. Group instruction was provided by sixty-nine percent of the institutions. Most commonly mentioned were music appreciation classes. Group musical activities with an educational component included "sing-alongs," "rhythm bands," and the more formal "choirs." Concerts were held for patients by these groups and by outside groups as well. Individual instruction was available in twenty percent of the institutions. Self-instructional media were used in twelve percent of the facilities. Specifically mentioned were record and tape libraries.

The remainder of the topics were offered by less than twenty percent of the institutions. Four of these topics warrant some comment.

Creative writing sessions were held in nineteen percent of the institutions. Twenty of these thirty-three programs were in for-profit nursing homes, which represented sixteen percent of such institutions. While the actual numbers of programs were smaller, both the not-for-profit nursing homes and the medical care facilities had such activities. In some places they involved writing short stories, plays, and poetry. Formal readings were held, with other patients invited. In others, patients prepared a weekly or monthly newspaper or newsletter. This required that they be involved with other patients and staff in order to know what news to report.

Study of religion was provided for in eighteen (fourteen percent) for-profit and three (twelve percent) not-for-profit nursing homes. It was not provided in any of the medical care facilities or hospital long-term care units.

Physical fitness was not listed on the original list, but was a "write-in" by ten percent of the institutions, especially in not-for-profit nursing homes. Physical fitness classes were held regularly in some institutions, and were called by such names as "Gerigymnastics" and "geriatric exercises." Another closely related activity often written in was dancing. Certainly, part of the advantage of dancing for elderly people is in the movement and resultant increased function of many parts of the body.

Finally, high school completion courses or GED tutoring were offered in five percent of the institutions. The nine institutions having such programs were all nursing homes. Classes in history, sociology, English, speech, mathematics, botany, and

typing were offered. These were usually offered by either the local community school programs or the local intermediate school districts. While the numbers offering such courses weren't large, the experience of those who did so had been positive. Comments were made like "we've been turned on to adult education here, and it's fantastic." Two other institutions expressed interest in this area but reported that they had not been given the necessary help or encouragement from the local community school programs. One nursing care facility administrator said, "They are not interested in us." Another said, "They have to have fifteen students to offer a class here, and we usually can't make that minimum." Not all nursing care administrator's, however, were so favorably inclined. One stated, "When patients are in their 80s, what kind of education would do any one any good?" Nonetheless, high school completion programs did exist in five percent of the institutions.

Yet another way of looking at this issue is to compare the mean numbers of general education offerings by institutional type. When this was done it was apparent that only minor type related differences existed. The two types of nursing homes provided slightly more general education opportunities showing means of nine offerings each. The medical care facilities and hospital long-term care units both had means of eight offerings each. Table 23 compares these aggregate scores.

There was a wide range in numbers of offerings within each of the four types, however. Some of the for-profit nursing homes provided as many as twenty-eight different educational offerings,

TABLE 23.--Range and mean numbers of general education offerings in Michigan nursing care institutions, by type of institution.

	Mean	Std. Dev.	Range
For-profit nursing homes	9.43	4.96	3-28
Not-for-profit nursing homes	9.48	5.58	2-20
Medical care facilities	7.86	3.95	3-20
Hospital long-term care units	7.86	4.34	3-14

whereas in every category some institutions offered only three, and one of the not-for-profit nursing homes reported only two. Region 5, in which Flint is located, had a high average number of offerings (eleven) as did Region 2 in which Lansing is located (eleven).

There was nothing significant to be reported when the number of offerings were examined by institutional age or location. Again, however, the number of offerings was correlated with institutional size. Though the range in numbers of offerings was wide for all three categories, and widest for large institutions, patients in larger institutions generally found more offerings available to them (mean, 10.95). Unfortunately, in all size categories, even among those reporting programs, some institutions provided sharply limited choices. Other institutions in each size category offered much more choice. Table 24 presents these data.

In general, group instruction was used most frequently as the method of teaching. The mean score of 4.03 indicates that it was used as a teaching method in an average of four of the offerings

TABLE 24.--Range and mean numbers of general education offerings in Michigan nursing care institutions, by size of institution.

	Mean	Std. Dev.	Range
Small institution	8.91	5.62	3-21
Medium-sized institution	8.96	4.55	2-21
Large institution	10.95	6.16	4-28

in the responding institutions. Individual instruction (mean = 2.50) is also used more often than either printed material (mean = 1.61) or self-instructional material (mean = 1.03). Classes and individual instruction were clearly the most popular methods of teaching in general education programs. These data are displayed in Table 25.

TABLE 25.--Frequency of use of various educational methods in the one hundred seventy-eight general education programs in Michigan nursing care facilities.

	Group Instruc.	Individ. Instruc.	Self Instruc.	Printed Material
Reported frequency of use	719	446	184	287
Mean number of uses per institution	4.03	2.50	1.03	1.61

In summary of this section, it was determined that the 178 institutions with operational general education programs typically offered eight or nine general education activities but they ranged from as few as two to as high as twenty-eight such offerings per institutions. Those most commonly offered were arts and crafts, literature, reality orientation, current events, and music. Group instruction was used most with individual instruction, printed material, and self-instructional media following in that order.

Patient Health Education Offerings

Eighty-eight of the 294 institutions (thirty percent) have operational programs of patient health education. These operational programs were examined to determine the frequency of educational offerings and the methods in which they were presented. Topics listed include cancer, death and dying, diabetes, hearing or visual disorders, heart disease or hypertension, nutrition, orientation to the facility, orthopedic disorders, and respiratory disorders. Personality changes, discharge planning, dental hygiene, and colostomy care were occasional write-in responses.

When the topics were examined according to the frequency of occurrence, they tended to fall into two groups. The group of topics covered most often include orientation to the facility, nutrition, and diabetes. This group of topics was covered in eighty-three to ninety-four percent of the programs. There was some overlap with the nutrition item and the diabetes item, inasmuch as diet regulation is an important part of diabetes education.

However, nutrition also is a factor in cardiovascular disease, and may be critical in normal functioning of the elderly. Hospital long-term care units were considerably below average in their provision of education about their facility, nutrition, and diabetes.

The second group of topics included hearing and visual disorders (sixty-eight percent), death and dying and orthopedic disorders (both at sixty percent) with the major killers, heart disease (fifty-seven percent), respiratory disorders (fifty-two percent) and cancer (forty-eight percent), being offered in about half the institutions. Again, hospital long-term care units were below average in all the categories except for education about heart disease and respiratory disease. Table 26 presents comparative data on the frequencies of such offerings. The topics have been arranged in descending order, according to the frequencies of their occurrence.

Nothing significant was apparent when the mean number of health educational offerings was examined by institutional size, age or location. It was, however, useful to look at the mean number of health education offerings by institutional type. Hospital long-term care units had the highest average number of offerings. Even though some institutions offered as few as four, others offered as many as twenty-two fields of instruction with the mean being eleven. For-profit nursing homes had a comparable mean at ten offerings, but a wider range. Some of these institutions offered as few as two educational activities while others offered as many as thirty-six. Not-for-profit nursing homes and medical care

TABLE 26.--Frequency of offering various topics in patient health education programs, by type of institution.

		Nursing Home		Med. Care Facil.	Hospital Long-Term Care Unit	Total
		For Profit	Not for Profit			
Number having no program		N=132	N=42	N=19	N=13	N=206
Number having operational programs		N= 59	N=10	N=16	N= 3	N= 88
Orientation to facility	N	58	8	15	2	83
	%	98.3	80.0	93.8	66.7	94.3
Nutrition	N	51	9	15	2	77
	%	86.4	90.0	93.8	66.7	87.5
Diabetes	N	50	9	12	2	73
	%	84.7	90.0	75.0	66.7	83.0
Hearing or visual disorders	N	39	9	11	1	60
	%	66.1	90.0	68.8	33.3	68.2
Death and dying	N	37	7	7	1	52
	%	62.7	70.0	43.8	33.3	59.1
Orthopedic disorders	N	34	6	11	1	52
	%	57.6	60.0	68.8	33.3	59.1
Heart disease hypertension	N	33	7	8	2	50
	%	55.9	70.0	50.0	66.7	56.8
Respiratory disorders	N	29	5	10	2	46
	%	49.2	50.0	62.5	66.7	52.3
Cancer	N	30	4	7	1	42
	%	50.8	40.0	43.8	33.3	47.7

facilities had similar means of nine offerings. These data are displayed in Table 27.

TABLE 27.--Range and mean numbers of health education offerings in Michigan nursing care institutions, by type of institution.

	Mean	Std. Dev.	Range
For-profit nursing homes	9.69	6.20	2-36
Not-for-profit nursing homes	8.90	5.02	3-21
Medical care facilities	8.62	4.35	2-17
Hospital long-term care units	10.67	9.87	4-22

Individual instruction was by far the most widely used method in all topic areas, with group instruction being the second most common method. The use of printed material was a close third, with self-instructional materials being a distant fourth. This sequence was true in all topical areas except education about cancer. There, individual instruction was most common, but the use of printed material occurred more frequently than did group instruction. Table 28 presents some illustrated data on this concern.

When the comparative frequencies of the use of the four methods of instruction were computed, it was determined that the most common method used was individual instruction. The mean score of 4.8 indicated that it was used as a teaching method in an average of five offerings in the responding institutions. Group instruction was the second most common method, used on an average of two

TABLE 28.--Methods used in selected topic areas of patient education in the eighty-eight health education programs in Michigan nursing care facilities.

		Group Instruc.	Individ. Instruc.	Self Instruc.	Printed Material
Orientation to facility	N	34	75	13	25
	%	38.6	85.2	14.8	28.4
Nutrition	N	39	61	11	24
	%	44.3	69.3	12.5	27.3
Diabetes	N	26	59	7	25
	%	29.5	67.0	8.0	28.4
Hearing or visual disorders	N	23	45	4	16
	%	26.1	51.1	4.5	18.2
Death and dying	N	25	33	3	18
	%	28.4	37.5	3.4	20.5
Orthopedic disorders	N	11	43	3	10
	%	12.5	48.9	3.4	11.4
Heart disease hypertension	N	17	39	5	15
	%	19.3	44.3	5.7	17.0
Respiratory diseases	N	10	37	2	9
	%	11.4	42.0	2.3	10.2
Cancer	N	12	30	3	18
	%	13.6	34.0	3.4	20.5

offerings per institution (mean = 2.23). Printed material ranked third (mean = 1.72), while self-instructional media was a distant fourth (mean = .54). These data are displayed in Table 29.

In summary of this section, the eighty-eight institutions with operational health education programs offered orientation to the facility, nutrition, and diabetes in eighty-five to ninety-four percent of the institutions. Education was offered about hearing

TABLE 29.--Frequency of use of various educational methods in the eighty-eight health education programs in Michigan nursing care facilities.

	Group Instruc.	Individ. Instruc.	Self Instruc.	Printed Material
Reported frequency of use	197	423	48	151
Average number of uses per institution	2.23	4.80	.54	1.72

and visual disorders, death and dying, orthopedic disorders, heart disease, respiratory disorders and cancer in half to two-thirds of the institutions. The mean number of educational offerings per institution ranged from nine in not-for-profit nursing homes and medical care facilities to eleven in hospital long-term care units. In all four types of institutions, the range of educational offerings varied from a low of two to a high of thirty-six. The most common method used was individual instruction with group instruction and printed material being also commonly used while self-instructional media ranked a distant fourth.

Education for the Patient's Family

An attempt was made to analyze the 294 institutions in terms of programs provided for the patients' families. About a third of these 294 institutions offered such a program. Slightly more than half of the sixteen hospital long-term care units (fifty-six percent) provided education for the family, while thirty-one percent of both the 191 for-profit nursing homes and the thirty-five medical care

facilities offered such programs. The fifty-two not-for-profit nursing homes were a distant fourth, with only seventeen percent of them offering such programs. These data are displayed in Table 30.

No significant findings were apparent when these data were analyzed by institutional age or location. Institutional size, however, did appear to be significantly related. Family education was provided in twenty-one percent of the small institutions, in thirty-one percent of the medium-sized institutions, and in half of the large institutions. Thirty of the 164 institutions (eighteen percent) reporting no family education programs indicated they were planning such programs. These data are displayed in Table 31.

Most respondents did not give examples of what program offerings were provided, but the most common example among the few that were cited was discharge planning. Most often, discharge planning was geared to the individual patient and family, and included patient daily care, rehabilitation exercises, diet, and medication. Some institutions dealt with the mental and emotional aspects of having a sick or dying person in the family's home. Others dealt with the financial demands, and with the kinds of assistance that could be anticipated from social service agencies.

Principal Participants in Planning and Conducting Patient Education Programs

The next major concern was to discover what kinds of personnel were represented in planning, group teaching, or individual instruction of patients. Specifically listed were facility staff

TABLE 30.--Distribution of educational programs for patients' families in Michigan nursing care institutions, by type of institution.

		Nursing Home		Med. Care Facil.	Hospital Long-Term Care Unit	Total
		For Profit	Not for Profit			
		N=191	N=52	N=35	N=16	N=294
Family education provided	N	60	9	11	9	89
	%	31.4	17.3	31.4	56.3	30.3
No family education	N	103	37	20	4	164
	%	53.9	71.2	57.1	25.0	55.8
In planning stages	N	21	4	3	2	30
	%	11.0	7.7	8.6	12.5	10.2
No report	N	7	2	1	1	11
	%	3.7	3.8	2.9	6.3	3.7

TABLE 31.--Distribution of Michigan nursing care institutions offering programs for patients' families, by size of institution.

		Small	Medium	Large	Total
		N=69	N=199	N=26	N=294
Family education provided	N	14	62	13	89
	%	21.3	31.2	50.0	30.3
No family education	N	46	107	11	164
	%	66.7	53.8	42.3	55.8
In planning stages	N	7	22	1	30
	%	10.1	11.1	3.8	10.2
No report	N	2	8	1	11
	%	2.9	4.0	3.8	3.7

such as educational specialists or nurses, patients, local school personnel, college personnel, educational television personnel, and library or museum personnel.

As might be expected, facility staff were most widely represented, being involved in ninety-six percent of the programs. They participated about equally in planning (eighty percent), group teaching (eighty percent), and in individual instruction (seventy-seven percent) of all programs. Patients were the next most widely involved in planning and conducting programs. They were included in seventy-one percent of the programs. They participated in planning in fifty-one percent of the programs, in group teaching situations in thirty-four percent of the programs, and in individual instruction in thirty percent of the programs.

Local school personnel were involved in one way or another in fifty-four percent of the programs. In eighty-one programs (forty-six percent) they participated in group teaching, but they participated in planning in only thirty-one percent of the programs. Apparently, community school personnel were asked to do specific tasks, but were not widely included in broad-based planning of programs.

As mentioned in an earlier section, local library and museum personnel were involved in forty-two percent of the programs. Interestingly, they served as planning consultants in twenty-eight percent of the institutions, which approximated the frequency of such participation by local school personnel. They were involved in group instruction in twenty-two percent of the programs.

There was considerably less frequent involvement of local college personnel. The staff of local colleges made contributions in twenty-eight percent of the institutions. They contributed primarily by making group presentations. Some comments were made by respondents to the effect that they had tried to get help from local colleges, but found little evidence of willingness to help.

Volunteer groups were written in as being involved in fifteen percent of the programs, with volunteers from religious groups written in by five percent of the respondents. Volunteers came from local schools and colleges, men's and women's clubs, scouting groups, 4-H groups, and as mentioned above, religious groups. They participated in planning, group teaching, and individual instruction with approximately equal frequency.

It is interesting that educational television personnel were not more widely involved. With only five institutions (three percent) using this medium, it is apparent this resource remains relatively untouched. Data on personnel involvement appear in Table 32.

No significant insights emerged when this issue was examined by institutional age, size, or location. However, when staff involvement was examined by institutional type, several striking items emerged. Local school personnel were involved in fifty-four percent of the institutions. Approximately sixty percent of the two largest groups of institutions, nursing homes, involved them. However, only one hospital long-term care unit involved local school personnel, and only a third of the medical care facilities included such staff. Similar, though not as striking, differences appeared

TABLE 32.--Number and source of personnel involved in the 178 patient general education programs, by educational function.

		Planning	Group Teaching	Individual Instruction	Total N=178
Facility staff	N	143	142	137	171
	%	80.3	79.8	77.0	96.1
Patients	N	91	60	53	126
	%	51.1	33.7	29.8	70.8
Local school personnel	N	55	81	51	96
	%	30.9	45.5	28.7	53.9
Library or museum personnel	N	49	39	33	74
	%	27.5	21.9	18.5	41.6
College personnel	N	27	41	27	49
	%	15.2	23.0	15.2	27.5
Individual volunteers	N	15	23	18	27
	%	8.4	12.9	10.1	15.2
Religious group representative	N	6	8	7	9
	%	3.4	4.5	3.9	5.1
Educational TV station personnel	N	2	2	1	5
	%	1.1	1.1	0.6	2.8

regarding involvement of college personnel. These data are displayed in Table 33.

When one looks at the comparative frequency of involvement by various personnel groups in the three staff functions listed, it can be observed that more groups were involved in group teaching (mean = 2.22) and planning (mean = 2.17) than in individual instruction (mean = 1.83). It is interesting to note that the mode in each of the three cases is two, indicating that two groups or points of view were typically represented in planning and conducting educational programs. These data are displayed in Table 34 (page 105).

An aggregate score was computed for each institution, taking total number of groups involved and the number of the three functions in which each was involved. For example, eight groups were listed with three possible functions for each one. If an institution included all eight groups in all three functions it would have had an aggregate score of twenty-four. The highest aggregate score computed was seventeen. The two types of nursing homes both had mean scores that were somewhat higher and maximum scores that were much higher than the other two types of nursing facilities. The widest choice of offerings and methods was reported by a for-profit nursing home in HSA 4, in the Grand Rapids area. No significant insights resulted when the issue was examined by age, size, or HSA. The widest range of aggregate scores was by institutional type. These data are presented in Table 35 (page 105).

TABLE 33.--Number and source of personnel involved in planning and operating general education programs in Michigan nursing care facilities, by type of institution.

		Nursing Home		Med. Care Facil.	Hospital Long-Term Care Unit	Total
		For Profit	Not for Profit			
		N=125	N=25	N=21	N=7	N=178
Facility staff	N	121	25	19	6	171
	%	96.8	100	90.5	85.7	96.1
Patients	N	92	15	14	5	126
	%	73.6	60.0	66.7	71.4	70.8
Local school personnel	N	72	15	8	1	96
	%	57.6	60.0	38.1	14.3	53.9
Library or museum personnel	N	51	15	6	2	74
	%	40.8	60.0	28.6	28.6	41.6
College personnel	N	34	10	4	1	49
	%	27.2	40.0	19.0	14.3	27.5
Individual volunteers	N	21	4	0	2	27
	%	16.8	16.0	0	28.6	15.2
Religious group representatives	N	9	0	0	0	9
	%	7.2	0	0	0	5.1
Educational TV station personnel	N	3	0	1	1	5
	%	2.4	0	4.8	14.3	2.8

TABLE 34.--Frequency of involvement in general education programs of various personnel groups, by educational staff functions.

	Planning	Group Teaching	Individual Instruction
Reported frequency of involvement	388	396	327
Mean number of groups per institution	2.17	2.22	1.83

TABLE 35.--Range and mean number of groups involved in planning and teaching in general education programs.

	Mean	Std. Dev.	Range
For-profit nursing homes	6.54	3.27	2-17
Not-for-profit nursing homes	6.64	3.07	2-13
Medical care facilities	4.52	1.89	2- 9
Hospital long-term care units	4.71	2.21	2- 8

Inquiry was also made to discover what kinds of staff were involved in planning, group teaching or individual instruction in the health education program. Nursing staff, dieticians, administrators, and therapists were all commonly involved.

Nursing staffs were the most widely involved in educating patients, verifying what is commonly perceived. They were involved in eighty-seven of the eighty-eight programs. They did individual instruction in eighty-three percent of the programs, were involved in planning in seventy-one percent, and did group instruction in fifty-seven percent of the programs.

Dietitians were involved in eighty-nine percent of the programs, again primarily in individual instruction (sixty-eight percent) and planning (sixty-four percent).

Administrators were involved in eighty-three percent of the health education programs. As might be expected, administrators in all types of institutions played more of a role in planning educational programs (sixty-eight percent) than in individual instruction (forty-six percent) or in group teaching (twenty-seven percent). A slightly larger percentage of the programs had nurses involved in planning (seventy-one percent) than administrators (sixty-eight percent).

The fourth most widely involved group was the therapists, the most common of which were occupational, physical, respiratory, and speech therapists. They were involved in eighty-two percent of the programs. Again, a common perception was verified by this study in that they did individual instruction in seventy-three percent of the programs. They also were heavily involved in planning and group teaching. They performed these functions in a larger percent of hospital long-term care units (sixty-seven percent) and medical care facilities (fifty-six percent) than in for-profit nursing homes (forty-six percent) or not-for-profit nursing homes (thirty percent). This presumably was a result of their more frequent employment by hospitals and hospital-like medical care facilities than in nursing homes. Whether or not they were involved in this capacity was presumably a function of their availability more than of their job description.

Physicians were involved in health education programming in seventy-six percent of the programs. They were involved in the planning process in sixty-three percent and in individual instruction in forty-three percent of the programs. They were involved in group instruction in only seventeen percent of the institutions. Apparently, the "team approach" with the physician a member of the team that plans and sometimes conducts the learning experience is being applied in these nursing care facilities.

Some comments are appropriate regarding the role of education staff. The statistics indicate they were involved in only forty-seven percent of the institutions. Presumably, this was a function of labeling. Many of the institutions assigned educational tasks to other staff members, who were not labeled primarily as education staff. Education staff were reported to be involved in planning in thirty-eight percent, in group teaching in thirty-six percent, and in individual instruction in thirty-two percent of the programs. This apparently low level of involvement presumably reflects the concept that the patient educator should be primarily a coordinator leaving the actual planning and teaching up to others.

Staff from public health departments and voluntary health agencies were the least frequently involved of the nine groups listed. The data on the frequency of involvement of various groups of personnel are displayed in Table 36. The personnel groups have been arranged in descending order according to the frequency of their participation.

TABLE 36.--Number and source of personnel involved in the patient health education programs, by educational function.

		Planning	Group Teaching	Individual Instruction	Total N=88
Nursing staff	N	62	50	73	87
	%	70.5	56.8	83.0	98.9
Dietitians	N	56	29	60	78
	%	63.6	33.0	68.2	88.6
Administrators	N	60	24	40	73
	%	68.2	27.3	45.5	83.0
Therapists	N	51	41	64	72
	%	58.0	46.6	72.7	81.8
Physicians	N	55	15	38	67
	%	62.5	17.0	43.2	76.1
Social workers	N	45	32	56	67
	%	51.1	36.4	63.6	76.1
Clergy	N	31	40	46	61
	%	35.2	45.5	52.3	69.3
Education staff	N	33	32	28	42
	%	37.5	36.4	31.8	47.7
Health agency staff	N	27	16	21	40
	%	30.7	18.2	23.9	45.5

Nothing significant was revealed when these data were examined by institutional age, size, or HSA. However, when examined by institutional type, one item of interest was revealed. Hospital long-term care units were consistently below average in the numbers and types of personnel involved in patient health education programs as well as in actual numbers of institutions. Only three such institutions had health education programs, and only one of these reported involvement of any staff except nurses in those programs. Medical care facilities were usually slightly above the averages for all institutions in the range of personnel involved. This presumably reflects the greater incidence of health education programs in such facilities. These data are displayed in Table 37.

When one looks at the comparative frequency of the involvement of the three staff groups listed, it can be observed that the groups were most often involved in individual instruction and planning. The institutions involved a mean of 4.84 groups in individual instruction, a mean of 4.77 groups in planning, and a mean of 3.17 groups in group teaching. Again, however, the modal scores reveal that eight groups were typically involved in planning, five groups were involved in individual instruction, while four groups were involved in group instruction. These data are displayed in Table 38 (page 111).

An aggregate group involvement score was computed for each institution having a health education program. The highest aggregate score computed was twenty-six, meaning several groups were involved in one or more of the three functions listed. Nothing

TABLE 37.--Number and type of personnel involved in planning and operation of patient health education programs in Michigan nursing care institutions, by type of institution.

		Nursing Home		Med. Care Facil.	Hospital Long-Term Care Unit	Total
		For Profit	Not for Profit			
		N=59	N=10	N=16	N=3	N=88
Nursing staff	N	58	10	16	3	87
	%	98.3	100	100	100	98.9
Dietitian	N	55	8	14	1	78
	%	93.2	80.0	87.5	33.3	88.6
Administrators	N	52	6	14	1	73
	%	88.1	60.0	87.5	33.3	83.0
Therapists	N	47	6	16	3	72
	%	79.7	60.0	100	100	81.8
Physicians	N	46	7	13	1	67
	%	78.0	70.0	81.3	33.3	76.1
Social workers	N	45	6	15	1	67
	%	76.3	60.0	93.8	33.3	76.1
Clergy	N	39	7	14	1	61
	%	66.1	70.0	87.5	33.3	69.3
Education staff	N	29	5	7	1	42
	%	49.2	50.0	43.8	33.3	47.7
Health agency staff	N	27	5	7	1	40
	%	45.8	50.0	43.8	33.3	45.5

TABLE 38.--Involvement in health education programs of various personnel groups, by educational staff functions.

	Planning	Group Teaching	Individual Instruction
Reported frequency of use	420	279	426
Average number of uses	4.77	3.17	4.84

significant was revealed when the issue was examined by institutional age, size, or location. The widest disparity was when the aggregate scores were grouped by institutional type. For-profit nursing homes and medical care facilities had identical mean scores of thirteen, while hospital long-term care units were lowest (mean = 10.33). The range for all groups was extensive (range = 2-26). These data are displayed in Table 39.

In summarizing this section it is apparent that representatives of several groups were typically involved in some aspect of the general education programs. The groups most likely to be

TABLE 39.--Range and mean number of groups involved in planning and teaching in health education programs.

	Mean	Std. Dev.	Range
For-profit nursing homes	13.07	5.54	2-26
Not-for-profit nursing homes	10.90	7.48	4-26
Medical care facilities	13.37	4.38	6-22
Hospital long-term care units	10.33	11.15	2-23

involved were facility staff, patients, local school personnel, and library or museum personnel, with a variety of other groups being involved occasionally. They were involved with approximate equal frequency in planning, group teaching, and individual instruction. Representatives of several groups were also involved in some facets of health education programs. Nursing staff, dieticians, administrators, therapists, physicians, social workers, and clergy were involved in more than two-thirds of the programs. They were involved most commonly in individual instruction and planning, though they were also often involved in group teaching.

Initiation of Patient Involvement

Eighty-eight or thirty percent of the 294 institutions reported that they provide patient health education programs. These included only three of the sixteen hospital long-term care units, sixteen of the thirty-five medical care facilities, ten of fifty-two not-for-profit and fifty-nine of the 191 for-profit nursing homes. There were four methods for initiating patient involvement in patient education: patient conferences, patient requests, physician prescriptions, and standing orders.

The patient conference was the most commonly employed method for initiating patient health education, reported in eighty-two or ninety-three percent of the programs. It was rarely, however, the only method used. Patient requests might have initiated health education programs in fifty-nine or sixty-seven percent of the cases. In only one institution, a for-profit nursing home, was it reported as the only method. Doctor-issued prescriptions were another means

of initiating health education in forty-seven or fifth-three percent of the institutions; but in only one institution, a not-for-profit nursing home, was it the only means. Standing orders were employed in thirty-eight or forty-three percent of the institutions, but in only two for-profit nursing homes and one medical care facility was it the only means.

A combination of methods was reportedly employed for initiating patient health education in most institutions. Twenty reported using all four methods; twenty-five reported three; twenty-eight reported two; and only fifteen reported a single method for initiating them. These data are displayed in Tables 40 and 41. Analysis of the data revealed no apparently significant differences in means of initiating patient involvement in health education programs by size, age, or location of institution.

TABLE 40.--Frequency of employment of each of four methods to initiate patient participation in health education programs, displayed by institutional type.

		Nursing Home		Med. Care Facil.	Hospital Long-Term Care Unit	Total
		For Profit	Not for Profit			
		N=59	N=10	N=16	N=3	N=88
Patient care conference	N	55	9	15	3	82
	%	33.2	90.0	93.7	100	93.1
Patient requests	N	43	6	10	0	59
	%	72.8	60.0	62.5	0	67.0
Educational prescription	N	36	5	6	0	47
	%	61.0	50.0	37.5	0	53.4
Standing orders	N	23	5	8	2	38
	%	38.9	50.0	50.0	66.6	43.1

TABLE 41.--Methods and combinations of methods used to initiate patient participation in health education programs, displayed by institutional type.

		Nursing Home		Med. Care Facil.	Hospital Long-Term Care Unit	Total
		For Profit N=59	Not for Profit N=10	N=16	N=3	N=88
Patient conference only	N	4	2	3	1	10
	%	6.8	20.0	18.8	33.3	11.4
Patient request only	N	1	0	0	0	1
	%	1.7	0	0	0	1.1
Conference and request	N	12	1	1	0	14
	%	20.3	10.0	6.3	0	15.9
Education prescription only	N	0	1	0	0	1
	%	0	10.0	0	0	1.1
Prescription and conference	N	7	0	0	0	7
	%	11.9	0	0	0	8.0
Prescription and request	N	1	0	0	0	1
	%	1.7	0	0	0	1.1
Conference, request, and prescription	N	11	1	4	0	16
	%	18.6	10.0	25.0	0	18.2
Standing orders only	N	2	0	1	0	3
	%	3.4	0	6.3	0	3.4
Standing orders, and conference	N	1	1	2	2	6
	%	1.7	10.0	12.5	66.6	6.8
Standing orders, conference and request	N	3	1	3	0	7
	%	5.0	10.0	18.0	0	8.0
Standing orders, conference and prescription	N	2	0	0	0	2
	%	2.3	0	0	0	2.3
All four methods	N	15	3	2	0	20
	%	17.0	3.4	2.3	0	22.7

Evaluation of Health Education Programs

Considerable evaluation of patient learning was being done in health education programs, as was indicated by positive responses to the question by fifty-seven (sixty-five percent) of the eighty-eight respondents, with an additional ten (eleven percent) planning to do evaluation. Evaluation of patient learning was apparently considered important and was being done. It was done in approximately two-thirds of the for-profit nursing homes, the medical care facilities, and the hospital-long term care units and in five of the ten not-for-profit nursing homes. These data are displayed in Table 42. No significant insights were gained by analyzing the data by institutional size, age, or location.

TABLE 42.--Number and percent of nursing care institutions in which evaluation of patient learning was done or being planned, by type of institution.

		Nursing Home		Med. Care Facil.	Hospital Long-Term Care Unit	Total
		For Profit	Not for Profit			
		N=59	N=10	N=16	N=3	N=88
Do evaluate	N	39	5	11	2	57
	%	66.1	50.0	68.8	66.7	64.8
Do not evaluate	N	11	3	4	1	19
	%	18.6	30.0	25.0	33.3	21.6
Planning to evaluate	N	9	0	1	0	10
	%	15.3	0	6.3	0	11.4
No data	N	0	2	0	0	2
	%	0	2.3	0	0	2.3

Surprisingly, fifty-two of the eighty-eight institutions (fifty-nine percent) reported that they did evaluations of their total health education programs, with another fourteen percent reporting that they planned to do it. Program evaluation was slightly more prevalent in for-profit nursing homes than in other institutional types. This prevalence is likely to increase as another seventeen percent of the for-profit nursing homes were planning to do program evaluation. Program evaluation has been stressed in the health education field for the past several years. Nursing care facilities seem to be in step with the rest of the agencies in this regard. Table 43 presents additional data on this issue. No significant insights were gained by examining the data by institutional size, age, or location.

TABLE 43.--Number and percent of nursing care institutions in which evaluation of patient health education programs was done or being planned, by type of institution.

		Nursing Home		Med. Care Facil.	Hospital Long-Term Care Unit	Total
		For Profit	Not for Profit			
		N=59	N=10	N=16	N=3	N=88
Do evaluate	N	36	5	9	2	52
	%	61.0	50.0	56.3	66.6	59.1
Do not evaluate	N	10	3	5	1	19
	%	16.9	30.0	31.3	33.3	21.6
Planning to evaluate	N	10	0	2	0	12
	%	16.9	0	12.5	0	13.6
No data	N	3	2	0	0	5
	%	5.0	2.3	0	0	5.7

In summarizing this section, patient health education programs existed in less than a third of the institutions. These operational programs offered a variety of activities, most commonly through individual instruction or group instruction. There was substantial involvement of facility staff and less, though still significant, involvement of outside resource people. A combination of methods was used to get patients started in the programs, but the most common method was the patient conference. Physicians were involved through educational prescriptions in nearly half of these programs, and through standing orders in more than one-third of them. Finally, there was evaluation of individual patient learning and of total programs in a majority of the programs.

Administrators' Opinions Concerning Patient Education

Another objective of this study was to solicit the opinions of administrators regarding the legitimacy of patient health education and patient general education as functions of nursing care facilities. Administrators were asked to respond to statements indicating that health education and general education are legitimate functions of nursing care facilities. They were asked to check the response most closely expressing their own judgment, selecting from strongly agree, agree, neutral, disagree, and strongly disagree.

Patient health education was considered a legitimate function of nursing care institutions by three-fourths (75.8%) of the administrators. Forty-eight percent agreed and twenty-eight percent

strongly agreed that it is. It can be observed when looking at Table 44 that this is consistent across the four types of institutions with especially strong support expressed by the small group of hospital long-term care unit administrators and the large group of for-profit nursing home administrators. Looking at the same question from the other end of the spectrum, only four percent of the administrators expressed judgment that patient health education is not a legitimate function. Out of 294 administrators, only twelve expressed disagreement, one expressing strong disagreement, with the statement. Clearly, there was little disagreement among

TABLE 44.--Responses of administrators concerning the legitimacy of patient health education as a function of Michigan nursing care facilities, by type of institution.

		Nursing Home		Med. Care Facil.	Hospital Long-Term Care Unit	Total
		For Profit	Not for Profit			
		N=191	N=52	N=35	N=16	N=294
Strongly agree	N	57	13	7	6	83
	%	29.8	25.0	20.0	37.5	28.2
Agree	N	91	21	20	8	140
	%	47.6	40.4	57.1	50.0	47.6
Neutral	N	26	6	4	0	36
	%	13.6	11.5	11.4	0	12.2
Disagree	N	5	3	2	1	11
	%	2.6	5.8	5.7	6.3	3.7
Strongly disagree	N	1	0	0	0	1
	%	0.5	0	0	0	0.3
No response	N	11	9	2	1	23
	%	5.8	17.3	5.7	6.3	7.8

administrators that nursing care institutions can and should do patient health education. No significant insights were gained by analyzing the data by institutional size, age, or location.

Another way of examining the data is to look at responses when administrators are grouped according to the programs offered in their institutions. As might be anticipated, those administrators who had patient health education programs more frequently expressed judgments that it is a legitimate function than did those who did not have such programs. More significantly, while there was a mild difference, sixty-three percent of those without either program agreed or strongly agreed that such programs are legitimate functions, and only seven percent disagreed. Of course, it is also interesting, and perhaps significant, that fourteen percent were neutral and sixteen percent "passed." It appears that while there was perhaps thirty percent apathy there was only seven percent opposition and sixty-three percent endorsement for the principle of patient health education. The data seem to reveal that administrators who had patient health education programs differed from others primarily in strength of agreement. These data are displayed in Table 45.

Patient general education was also considered a legitimate function of nursing care facilities. Only nine percent of the facility administrators were opposed to the concept, while two-thirds (66.3%) endorsed it. Forty percent of the respondents agreed, and twenty-seven percent strongly agreed that it is a

TABLE 45.--Responses of administrators concerning the legitimacy of patient health education as a function of Michigan nursing care facilities, by type of patient education program operated.

		All Resp. N=294	Those With Neither Program N=94	Those With Only Health Education N=22	Those With Only Gen. Education N=112	Those With Both N=66
Strongly agree	N	83	16	12	20	35
	%	28.2	17.0	54.5	17.9	53.0
Agree	N	140	43	5	66	26
	%	47.6	45.7	22.7	58.9	39.4
Neutral	N	36	13	4	16	3
	%	12.2	13.8	18.2	14.3	4.5
Disagree	N	11	7	0	4	0
	%	3.7	7.4	0	3.6	0
Strongly disagree	N	1	0	0	1	0
	%	0.3	0	0	0.9	0
No data	N	23	15	1	5	2
	%	7.8	16.0	4.5	4.5	3.0

legitimate function. Again, this support was fairly consistent across institutional types. These data are displayed in Table 46.

Nothing significant was revealed when these data were examined by institutional age or location. However, when looked at by size, considerably stronger support came from large institutions. Fifty-four percent of the administrators of large institutions strongly agreed and another twenty-seven percent agreed that general education programming should be a function of nursing care facilities. Medium-sized institutions were near the average, while administrators of small institutions were much less likely to see such programming as legitimate. It is significant to note that

TABLE 46.--Responses of administrators concerning the legitimacy of patient general education as a function of Michigan nursing care facilities, by type of institution.

		Nursing Home		Med. Care Facil.	Hospital Long-Term Care Unit	Total
		For Profit	Not for Profit			
		N=191	N=52	N=35	N=16	N=294
Strongly agree	N	54	11	8	5	78
	%	28.3	21.2	22.9	31.3	26.5
Agree	N	75	23	15	4	117
	%	39.3	44.2	42.9	25.0	39.8
Neutral	N	29	10	6	4	49
	%	15.2	19.2	17.1	25.0	16.7
Disagree	N	17	2	3	2	24
	%	8.9	3.8	8.6	12.5	8.2
Strongly disagree	N	1	0	0	0	1
	%	0.5	0	0	0	0.3
No data	N	15	6	3	1	25
	%	7.9	11.5	8.6	6.3	8.5

while support was less strong among administrators of small institutions, it was still present in half the cases. These data are displayed in Table 47.

Again, the predictable occurred. Those with both programs, or with general education programs, more frequently expressed judgments that general education is a legitimate function of nursing care facilities. More than three-fourths of such administrators expressed either agreement or strong agreement. Only six percent disagreed.

TABLE 47.--Response of administrators concerning the legitimacy of patient general education as a function of Michigan nursing care facilities, by size of institution.

		Small N=69	Medium N=199	Large N=26	Total N=294
Strongly agree	N	10	54	14	78
	%	14.5	27.1	53.8	26.5
Agree	N	25	85	7	117
	%	36.2	42.7	26.9	39.8
Neutral	N	17	29	3	49
	%	24.6	14.6	11.5	16.7
Disagree	N	9	14	1	24
	%	13.0	7.0	3.8	8.2
Strongly disagree	N	0	1	0	1
	%	0	0.5	0	0.3
No data	N	8	16	1	25
	%	11.6	8.0	3.8	8.5

Again, it is significant to note that forty-one percent of the administrators of institutions without a patient education program of any kind either agreed or strongly agreed that such programming is appropriate. Thirty percent were neutral on the issue, and only thirteen percent of such administrators disagreed. These data are displayed in Table 48.

The administrators were asked if they would be interested in developing a patient education program at their facility if free consultant help were available. The overwhelming majority (eighty-five percent) indicated that they would. Only eight percent indicated that they would not, although another seven percent did not

TABLE 48.--Responses of administrators concerning the legitimacy of patient general education as a function of Michigan nursing care facilities, by type of patient education program provided.

		All Resp. N=294	Those With Neither Program N=94	Those With Only Health Education N=22	Those With Only Gen. Education N=112	Those With Both N=66
Strongly agree	N	78	8	6	33	31
	%	26.5	8.5	27.3	29.5	41.0
Agree	N	117	31	8	55	23
	%	39.8	33.0	36.4	49.1	34.8
Neutral	N	49	28	4	11	6
	%	16.1	29.8	18.2	9.8	9.1
Disagree	N	24	11	3	7	3
	%	8.2	11.5	13.6	6.3	4.5
Strongly disagree	N	1	1	0	0	0
	%	0.3	1.1	0	0	0
No data	N	25	15	1	6	3
	%	8.5	16.0	4.5	5.4	4.5

respond to the question. Qualifying statements were written in occasionally indicating that the respondent was a staff member rather than the administrator and could not anticipate what the administrator's opinion might be. Interest in consultant assistance for initiating programs was quite consistent in the four types of institutions, as displayed in Table 49.

Nothing significant was revealed when these data were examined by institutional size, age, or location. When the responses were examined according to program existence, several interesting items emerged. It was evident that the majority of administrators, including nearly three-fourths (71.3%) of those who had no program,

TABLE 49.--Administrator interest in developing a patient education program if free consultant help were available.

		Nursing Home		Med. Care Facil.	Hospital Long-Term Care Unit	Total
		For Profit	Not for Profit			
		N=191	N=52	N=35	N=16	N=294
Yes	N	169	37	31	12	249
	%	88.5	71.2	88.6	75.0	84.7
No	N	10	8	3	3	24
	%	5.2	15.4	8.6	18.8	8.2
No data	N	12	7	1	1	21
	%	6.3	13.5	2.9	6.3	7.1

would utilize consultant assistance to establish or expand patient education programs. Only eight percent of all administrators and sixteen percent of those with no programs indicated they would not do so. These data are displayed in Table 50.

A few administrators were apparently reluctant to commit themselves to such programs. A few believed it to be a waste of time. Comments such as the following were written in:

> The average age in this facility is 75 and any education program would be a waste of time.

> Patients do not understand and are not interested.

> We are at least ten years too late for my people.

> I question the motivation of a patient to learn something never sought before becoming a patient.

Other comments centered on the financial aspects of providing the service:

TABLE 50.--Administrator interest in developing a patient education program if free consultant help were available.

		All Resp. N=294	Those With Neither Program N=94	Those With Only Health Education N=22	Those With Only Gen. Education N=112	Those With Both N=66
Yes	N	249	67	18	103	61
	%	84.7	71.3	81.8	92.0	92.4
No	N	24	15	2	4	3
	%	8.2	16.0	9.1	3.6	4.5
No data	N	21	12	2	5	2
	%	7.1	12.8	9.1	4.5	3.0

> We are not interested in doing more than we are when no one is interested in the patient enough to even underwrite present costs.

> I strongly disagree that tax money should be spent to enlarge the responsibilities of nursing homes when the state is unwilling and/or unable to reimburse nursing homes for ever-expanding requirements.

> We simply do not have the funds.

> We would love the idea if the staff were paid for by someone. The State of Michigan does not.

> Only if the state pays the full cost.

Many institutions have programs, however, and had found ways of financing them. Comments were made such as the following:

> We are really into education and have discovered some absolutely fascinating things about it.

That comment came from a small nursing home that offers classes in English, mathematics, history, music, and Biblical studies, plus the traditional arts and crafts and reality orientation. Another administrator said:

> We have been trying to set up some form of educational programs, but don't know how to start or where to get help. We need HELP, we want HELP.

In summarizing this section, it should be noted that there was considerable support for the legitimacy of both health education and general education programming for patients. Three-fourths of the administrators endorsed patient health education programming while two-thirds of them endorsed patient general education. Four percent either disagreed or strongly disagreed that health education was a legitimate function of nursing care facilities, while nine percent expressed similar judgment about patient general education. Further, eighty-five percent of the responding administrators indicated they were interested in developing or expanding a program in patient education at their institution if free consultant help were available.

Summary

More than two-thirds of the institutions were found to have one or the other or both forms of education programs available for patients. It was more common for an institution to have a general education program (nearly two-thirds did) than a health education program (less than one-third did), and even less common for an institution to have both programs avaiable (one-fifth did). Coordinators were available in about three-fourths of the institutions, and they typically coordinated both kinds of programs when both were provided. Educational centers were available in about two-thirds of the institutions.

General education offerings that were most common included arts and crafts, literature, reality orientation, current events, and music. The health education offerings most typically were orientation to the facility, nutrition, diabetes, and hearing and visual disorders. There were many other interesting offerings available in both groups.

Group instruction was used most frequently in general education, while individual instruction was used most frequently in health education. Reliance solely upon printed material was very rare and similar reliance upon self-instructional material was even more rare in both kinds of programs.

Facility staff, patients, and local school personnel were most commonly involved in providing general education programs, with many others being involved occasionally. Nurses, dietitians, administrators, therapists, physicians, and social workers were all commonly involved in the health education programs.

Educational programs were most commonly initiated by patient care conferences and by patient requests. Educational prescriptions and standing orders were commonly used in about half of the institutions.

Patient learning was evaluated in two-thirds of the institutions. Program evaluation occurred in almost that many institutions.

Administrators expressed agreement that both health education and general education are legitimate functions of nursing care

facilities. Less than ten percent disagreed. Eighty-five percent expressed a willingness to develop or expand a program in patient education if free consultant help were available.

CHAPTER V

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

Summary of Procedures

It has been the purpose of this study to describe in an analytical fashion the status of patient education in Michigan's nursing care facilities. An attempt was made to identify the principal components of patient education programs in these facilities and relate them to institutional type, size, geographical location and age. The stage of development of these programs has been assessed and likewise related to institutional type, size, geographical location, and age.

A review of the literature revealed that patient education programs have been in existence for approximately twenty-five years, and that such programming is supported in official statements by representatives of many health agencies. They have recently become more prominent for a variety of reasons including the very great growth in the nursing care enterprise and a series of studies that have shown patient education to be cost effective. Educational programming for the elderly has likewise become more common in the recent past, as research reveals that elderly people can learn, want to learn, and are learning. The literature suggested that health education programming for the elderly is of more recent vintage, and that such programming in nursing homes is still in its infancy.

A questionnaire was designed and sent to a jury of experts for input, after which it was revised and field tested. In May of 1976, it was sent to all 455 nursing care facilities in Michigan. Two follow-up letters were sent at appropriate intervals. A usable response rate of sixty-five percent was obtained which was called exceptionally good for studies of that population, by members of the jury of experts. The responses were analyzed to determine the proportions of the various types, regions, sizes, and ages of institutions they represented.

Administrators of medical care facilities were considerably above average in response, as were administrators of nursing homes operated on a not-for-profit basis. Administrators of hospital long-term care units were near the average. Administrators of for-profit nursing homes constituted the largest group, both in number of responses and the total number of institutions, but they had a below average response rate. The return was lowest in two Health Service Areas, HSA 1 in southeastern Michigan and HSA 3 in southwestern Michigan, where approximately half the administrators returned the completed questionnaire.

Approximately two-thirds of the institutions represented were between fifty-one and 199 beds in size, nearly one-fourth of the represented institutions had less than fifty beds, and approximately nine percent of the respondents had more than 200 beds. The responding institutions were fairly evenly divided into those of ten or less years of age and those of more than ten years of age.

Nearly two-thirds of the patient beds represented in the study were in for-profit nursing homes, while not-for-profit nursing homes, medical care facilities, and hospital long-term care units were a distant second, third, and fourth in that order. More than a third of the institutions and beds represented were in HSA 1. Approximately half the beds were in institutions less than ten years old. About two-thirds of the beds represented were in institutions with fifty to 199 beds.

The resultant data from the 294 usable questionnaires were analyzed by the computer at Central Michigan University. A program from Statistical Packages for the Social Sciences[76] and another from Biomedical Computer Programs[76] were adapted by Dr. Robert DeBruin and Ms. Joyce Abler for use on Central Michigan University's Univac 1106 Computer. Statistical procedures used extensively were frequency counts, percents, ranges, standard deviations, and measures of central tendency. The existence of patient education programs was determined. Summary data were provided, after which the programs were grouped by the independent variables of institutional type, size, location, and age, and then displayed. A program development score was computed and likewise grouped and displayed. The principal components of the patient education programs were then analyzed. Summary data were provided, after which the data were grouped according to the independent variables identified above.

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[75]Nie, p. 429.

[76]Dixon, p. 729.

In all cases, an attempt was made to determine if the existence of any of the dependent variables were related to the independent variables.

Specific factors analyzed were: existence of patient education coordinators and centers, the frequency of various topics, methods of instruction, personnel groups and their functions, methods of initiating patient involvement and evaluation methods employed; and administrators' judgments as to the legitimacy of patient education as a function of their institutions and their interest in developing or expanding this function.

Summary of Findings

It was determined that two hundred of the 294 institutions (sixty-nine percent) had an operational patient education program of some type available. It was most common for an institution to have a general education program (sixty-one percent did), and less common for an institution to have a health education program available (thirty percent did).

For-profit nursing homes and medical care facilities were more likely to have patient education programs of either the general education or health education type (seventy-two percent did) than were not-for-profit nursing homes (fifty-eight percent) or hospital long-term care units (fifty percent).

Size was an important variable. Eighty-eight percent of the large insitutions had such programs, compared to seventy-four percent of the medium-sized institutions and fifty-two percent of the smaller institutions.

There was also much variance by location. HSA 7 in northern lower Michigan reported the highest incidence of institutions having such programs (eighty-eight percent), while HSA 3 in southwestern Michigan, including Kalamazoo, reported the lowest incidence of such programs (forty-eight percent). HSA 1 in southeastern Michigan, including Detroit, and HSA 4 in west central Michigan, including Grand Rapids, are the two HSA's with the largest number of nursing care facilities. They both reported operational programs in seventy-four percent of the institutions, well above the average for Michigan.

There was less variance by age of insitution. Seventy-two percent of the institutions that were ten years old or less had such programs. There were both a larger number of institutions and a larger percentage of institutions that had patient education programs in the newer group.

There were 178 operational general patient education programs in the 294 responding institutions (sixty-one percent). For-profit nursing homes more frequently provided general patient education than did the other types of institutions. Sixty-five percent of them reported such programs. Medical care facilities were slightly below average, at sixty percent. Not-for-profit nursing homes were substantially below average (forty-eight percent), as were hospital long-term care units (forty-four percent). A larger percentage of the large institutions (eighty-one percent) had programs available, than did medium-sized institutions (sixty-seven percent) or small institutions (thirty-three percent). Such programs of general

education were most frequent in HSA 7 in northern Michigan and HSA 4, the Grand Rapids area (both at more than seventy-two percent), and least frequent in HSA 4, the Kalamazoo area (forty-one percent), and HSA 8, the Upper Peninsula (forty-six percent). General education programs were also slightly more common in newer institutions (fifty-nine percent) than in older institutions (fifty percent).

Eighty-eight (thirty percent) of the institutions reported operational programs of patient health education. Forty-six percent of the medical care facilities had operational programs, while not-for-profit nursing homes and hospital long-term care units were considerably less likely to have such programs available to patients (nineteen percent do). Health education programs were most frequent in medium-sized institutions (thirty-three percent) as compared to large institutions (thirty-one percent) and small institutions (twenty percent). They were again most frequent in HSA 7 (forty percent) and least frequent in HSA 3 (twenty-six percent). They were equally prevalent in newer and older institutions.

An education program development score was computed, which consisted of a combination of the number of general education offerings, the number of health education offerings, the number of groups of staff involved in the general education programs, and the number of staff involved in the health education programs. This score was found not to be related significantly to any of the independent variables, type, size, age or location of facilities. This was also true when a development score was computed for patient

health education separate from patient general education. There were no significant differences when grouped by institutional type, size, location, or age. However, when a development score was computed for patient general education alone, type and size of institution were moderately related variables. The two types of nursing homes were somewhat higher than other institutional types though the differences were not large. A somewhat higher development score was computed for large institutions than for medium-sized or small institutions, though again the differences were not large. Nothing conclusive was established about the relationship of patient education development stage to type, size, location or age of institutions.

It was determined that most of the 294 responding institutions (seventy-three percent) had designated specific departments or coordinators to be responsible for general education. Medical care facilities more frequently reported such designations (eighty-six percent) than did for-profit nursing homes (seventy-five percent), not-for-profit nursing homes (sixty-two percent) or hospital long-term care units (fifty percent). There were 106 of the 294 respondents (thirty-six percent) who had coordinators of patient health education. Medical care facilities again more frequently reported such coordinators (fifty percent) than did for-profit nursing homes (thirty-seven percent), not-for-profit nursing homes (twenty-nine percent), and hospital long-term care units (nineteen percent). In thirty of the 294 institutions, the same person coordinated both programs.

There was no significant difference in the frequency of designated coordinators when the data were grouped by institutional location or age. However, size of institution did seem to be related. Medium-sized (eighty percent) and large institutions (ninety-two percent) were above the institutional average of seventy-three percent, while small institutions reported general education coordinators exist in forty-four percent of the institutions. This was similarly true when the existence of health education coordinators was examined. Medium-sized and large institutions, at thirty-nine percent, were above the institutional average of thirty-six percent, while the sixty-nine small institutions reported such coordinators in only twenty-five percent of the cases.

Most of the 294 institutions (sixty-two percent) had established patient education centers, while another nine percent were planning them. No significant variance was revealed when this item was examined by institutional type, age, or region. Again, however, size was a highly related factor. While thirty-three percent of the small institutions had patient education centers, seventy percent of the medium-sized institutions and seventy-seven percent of the larger institutions had such centers.

Topics most frequently offered in the 178 general education programs were arts and crafts (ninety-eight percent), literature (eighty-two percent), reality orientation (eighty-one percent), current events (seventy-nine percent), music (seventy-five percent), creative writing (nineteen percent), theater (seventeen percent),

religious instruction (twelve percent), physical fitness (ten percent), and high school completion courses (five percent).

The two types of nursing homes reported an identical mean number of nine offerings per institution. The medical care facilities and hospital long-term care units both offered a mean of eight offerings. Large institutions had a mean of eleven offerings, compared to nine in the small and medium-sized institutions. There is in all groups a wide range in the number of offerings, with some programs providing as few as two offerings, and others as many as twenty-eight.

Group instruction was the most frequently used mode of instruction in general education programs. Its mean score of 4.03 indicated it was used in an average of four of the eight to eleven offerings in the 178 general education programs. Individual instruction was used less often (mean = 2.50), as was printed material (mean = 1.61), or self-instructional material (mean = 1.03). Classes and individual instruction were clearly the most popular method of teaching in general education programs.

Topics most frequently offered in the eight-eight programs of patient health education included orientation to the facility (ninety-four percent), nutrition (eight-eight percent), diabetes (eighty-four percent), hearing or visual disorders (sixty-nine percent), death and dying (sixty percent), orthopedic disorders (sixty percent), heart disease (fifty-seven percent), respiratory disease (fifty-two percent), and cancer (forty-eight percent).

Hospital long-term care units reported the highest mean number of offerings (eleven), with for-profit nursing homes reporting ten, and not-for-profit nursing homes and medical care facilities reporting nine such offerings. No significant variance was revealed where these data were grouped by insitutional size, age, or location. Again, a wide range in the number of offerings existed in all groups, with some reporting as few as two and others as many as thirty-six.

Individual instruction (mean = 4.8) was reported to be more than twice as common as group instruction (mean = 2.23) or printed material (mean = 1.72) as the dominant mode of instruction in the nine to eleven offerings of patient health education topics. Self-instructional media was reported much less often (mean = .54).

Eighty-nine of the 294 (thirty percent) responding institutions reported the availability of educational activities for patients' families or family members. It was available in fifty-six percent of the hospital long-term care units, thirty-one percent of both the for-profit nursing homes and medical care facilities, and seventeen percent of the not-for-profit nursing homes. No significant information was revealed when these data were grouped by institutional age or location. Size, however, was a significant variable. Small institutions provided family education in only twenty-one percent of the cases, compared to thirty-one percent of the medium-sized institutions, and fifty percent of the larger institutions. Thirty of the 164 institutions (eighteen percent) reporting no family education program indicated such programs were in the planning

stages. Most respondents did not provide examples of what was offered, but the most common example that was cited was discharge planning.

Groups most frequently involved in general education programs were facility staff (ninety-six percent), patients (seventy percent), local school personnel (fifty-four percent), library or museum personnel (forty-two percent), college personnel (twenty-eight percent), individual volunteers (fifteen percent), religious group representatives (five percent), and educational television station personnel (three percent).

More groups were involved in group teaching (mean = 2.22) and planning (mean = 2.17) than in individual instruction (mean = 1.83). These differences were not large; the computed means all round off to two.

A mean number of seven of these groups were involved in the two types of nursing homes, while a mean of five such groups were involved in hospital long-term care units and medical care facilities. There were no significant differences revealed when these means were grouped by institutional size, age, or location. As many as seventeen groups were involved in some programs.

Groups of staff most frequently involved in the health education programs were nursing staff (ninety-nine percent), dietitians (eighty-nine percent), administrators (eighty-four percent), therapists (eighty-two percent), physicians (seventy-six percent), social workers (seventy-six percent), clergy (seventy percent),

education staff (forty-eight percent), and health agency staff (forty-six percent).

More groups were involved in individual instruction (mean = 4.84) and in planning (mean = 4.77) than in group teaching (mean = 3.17). Again, these differences were not large.

The eighty-eight health education programs were further examined to determine how patient education was initiated. The patient conference was the most commonly employed method, reported in ninety-three percent of the programs. Patient requests sometimes initiated programs in sixty-seven percent of the institutions. Doctor-issued prescriptions were among the initiating options in fifty-three percent of the institutions, while standing orders were used in forty-three percent of the institutions. Combinations of methods of initiation were reported in most institutions. Twenty of the eighty-eight institutions reported using all four methods, twenty-five reported using three, twenty-eight reported two, and only fifteen reported use of only a single method.

Evaluation of patient learning was reported in sixty-five percent of the health education programs, with an additional eleven percent planning to do evaluation. Program evaluation occurred in fifty-nine percent of the institutions, with another fourteen percent planning to do so. No significant variations were revealed when the data were grouped by institutional type, size, age, or location.

Patient health education was considered a legitimate function of nursing care facilities by seventy-six percent of the

administrators, who either agreed (forty-eight percent), or strongly agreed (twenty-eight percent), as to its legitimacy. Out of the 294 administrators, eleven disagreed, and one strongly disagreed. Thirteen percent were neutral, while sixteen percent did not respond to the question. Sixty-three percent of the administrators without a patient eduation program either agreed or strongly agreed that such programs are legitimate functions of nursing care facilities.

Patient general education was also considered a legitimate function of nursing care facilities by the administrators; only nine percent were opposed to the concept, while sixty-six percent endorsed it. Again, it is significant to note that forty-one percent of the administrators without a patient education program of any kind either agreed or strongly agreed that such programming is appropriate. Only thirteen percent disagreed, while thirty percent were neutral and sixteen percent did not respond to the question.

When asked if they would be interested in developing or expanding a patient education program if free consultant help were available, the overwhelming majority (eighty-five percent) of responding administrators indicated that they would. Only eight percent indicated they would not, although another seven percent did not respond to the question. Nothing significant was revealed when these data were examined by institutional type, size, age, or location. However, this was not true when the data were grouped according to program existence. The majority of the administrators, including seventy-one percent of those who have no program now, would utilize consultant assistance to establish or expand patient

education programs. Only eight percent of all administrators and sixteen percent of those with no programs indicated they would not do so.

Conclusions

There were more patient education programs in existence than anticipated. There were operational programs in approximately two-thirds of the institutions. General education programs were twice as common as health education programs. While health education was relatively new and undeveloped in this population, the concept of patient education was not. Administrators were supportive of the concept of patient health education, presumably due in part to previous experience with patient general education.

The efforts at assessing the development stage of patient education programs in this study were ineffective. The attempt to determine which programs were operational and which programs were in the beginning stages did not produce useful information, since very few institutions were in the beginning stages. The more sophisticated effort to compute a patient education development score was likewise not productive as no significant differences were revealed. It is still assumed that there are measurable differences in the development stage of patient education programs, but that appropriate indices of these differences were not measured in this investigation.

Institutional size was more frequently related than were institutional type, location, or age to the extent and nature of

patient education. Large institutions were more likely to have operational programs of patient education, more likely to have patient education centers, more likely to have coordinators of patient education, more likely to have wider ranges of educational offerings available. While the differences between medium-sized and large institutions were not always great, the differences between small institutions and large institutions were typically large. The commonly held belief that small institutions have restricted patient education programs was validated by this survey.

Institutional type was the next most significant variable. For-profit nursing homes and medical care facilities more frequently provided patient education of some type than did not-for-profit nursing homes and hospital long-term care units. For-profit nursing homes were most likely to provide general education, second most likely to provide patient health education, second most likely to have designated patient education coordinators, had the highest mean number of offerings in both general education and health education, and were second most likely of the four institutional types to provide family education. These institutions comprise the largest group of nursing care facilities and the leading type of institution in the various categories of patient education measured in this survey.

Medical care facilities were tied with for-profit nursing homes in being most likely to provide patient education, were second in providing general education, and were considerably above average in providing general education, and were considerably above

average in providing health education. They were most likely to have patient education coordinators. When mean offerings were compared, even though they ranked third with a mean score of eight general education offerings, they ranked only slightly below the two types of nursing homes with their mean offering of nine each. They were ranked fourth in health education offerings, with a mean of nine but the difference between first and fourth was again not large.

Not-for-profit nursing homes generally ranked third among the four types of institutions in the extent and nature of patient education programs provided. They were below average in availability of programs, designation of coordinators, mean number of health education offerings, and availability of family education. They had a higher than average mean number of general education offerings.

Hospital long-term care units reported the highest mean number of health education offerings. In most of the categories of this investigation, however, they ranked last among the four institutional types. There are only sixteen such institutions. Their patient education programs understandably emphasize health education.

Institutional age was also a significant variable in some aspects of this study. There were both a larger number of institutions and a larger percent of institutions that had patient education programs among those established in the last ten years than among older institutions. While age appeared to be a factor in

determining the existence of a program, it appeared not to be a factor in determining the characteristics of programs.

Institutional location was not generally a significant variable, though wide variations existed from HSA to HSA. HSA 7 in northern lower Michigan was consistently most likely to offer patient education, while HSA 3 in southwestern Michigan, including Kalamazoo, was consistently least likely. HSA 1 in southeastern Michigan, including Detroit, and HSA 4 in west central Michigan, including Grand Rapids, have the largest number of institutions, and both are above average in the provision of patient education.

The mean numbers of educational offerings in the two types of patient education programs were similar. Mean numbers of health education offerings were also remarkably close.

In general education programs, group instruction was the most frequent method of instruction, followed in order by individual instruction, printed material, and self-instructional media. Classes and other group activities were clearly the most common means of instruction in general education programs.

This sequence was not true of the health education programs. Individual instruction was the most commonly used method, followed by group instruction and printed material. Self-instructional media were seldom used in health education programs. One-to-one instruction was clearly the most common method used in health education programs.

Family education was not commonly avaiable. It was more frequently available in large institutions than in medium-sized or

small ones. A significant number of institutions without such programs were planning to initiate them.

Health education programs tended to involve a larger number of groups in their planning and operations than did general education programs. However, the differences were not large.

Health education programs most frequently used patient care conferences to initiate patient involvement in patient education programs. Patient requests, doctor-issued prescriptions, and standing orders were all commonly used as well. Institutions most often used a combination of the above mentioned methods to get a patient into a program.

Evaluation of patient learning was usually done, as was program evaluation. Administrators appeared to be in tune with the trend toward more evaluation in health education.

Perhaps the most striking of all conclusions was that administrators were ready to develop or expand such programs if consultant help were available. A large majority of the 294 responding administrators indicated that they would be interested in developing or expanding a patient education program if free consultant help were available.

Patient general or health education programs existed in about two-thirds of the institutions. Yet, in addition, there was registered a strong amount of support for the idea of expanding such programming, especially to include health education. Patient education in Michigan nursing care facilities appears to be an idea whose time has come.

Discussion of Findings and Conclusions

Patient education in a nursing care facility must of necessity be defined so as to include both general education and health education. It is arbitrary and counter-productive to limit the term to health education. While that may be traditional and appropriate for acute care institutions, it is clearly unacceptable in the nursing care setting. The longer term of residency combined with the fact that many residents have learned to live with their condition make both kinds of education beneficial. Educational activities may be varied in nature. They may also be directed at the staff or at the patient. However, those activities prepared for direct patient involvement must be labeled as patient education, regardless of the content.

Further, the patient involvement and resultant effect on mind and morale may be at least as therapeutic as the information transmitted. The patient must continue to find something to look forward to in life which can, when achieved, produce self-fulfillment and recognition by others. Either general education or health education meets these conditions.

Having so defined patient education, this investigation revealed more organized programs than anticipated. Slightly more than two-thirds of the institutions have programs of one type or the other. This fact produced feelings of pleasant surprise in the investigator until the other side of the situation came into focus. Nearly a third of the institutions do not have programs of any type.

More than a third do not have general education programs and more than three-fourths do not have health education programs.

Particularly distressing is the fact that printed material is not commonly used in either type of program. Such materials abound. Many pamphlets are prepared and distributed free of charge, especially by voluntary health agencies. Further, they can be locally developed to meet specific needs, and inexpensively prepared. A great reservoir of potential education remains untapped.

Likewise, it is distressing to this investigator to discover that little use is made of professionally trained educators. Those currently employed as educational specialists in community agencies are seldom called upon for input in program planning. Much expertise is going untapped.

It is also disturbing to note that little use of educational television is occurring. The possibilities of closed circuit television have been explored in public school and university settings. It is being adapted to patient health education in acute care hospitals with much locally prepared and commercially prepared material being available. It yet remains for some creative people to adapt the media to patient education in nursing care facility settings.

Recommendations

Administrators appear ready to develop or expand patient education programming. They appear receptive to consultant help. Yet where should they turn? Where is there expert staff with adequate time and budget to provide the needed help? Where can

administrators find trained staff available to develop or expand programs? Where can inservice training be obtained for the existing staff? How will the staff training and development of programs be financed?

Certainly, the following questions ought to be addressed: (1) What should be the role of the Michigan Department of Public Health? (2) What should be the role of the Michigan Department of Social Services? (3) What should be the role of the Michigan Department of Education? (4) What should be the role of the relevant professional associations? (5) What should be the role of the HSA's? Whether or not these questions are answered quickly and adequately will help determine the future of patient education in Michigan nursing care facilities.

Recommendations for Further Research

This study, or an improved but similar version of it, should be repeated in three to five years. The direction of change and the rate of change will then come more clearly into focus.

As mentioned earlier within this report, the concept of program development stage needs refining. Other characteristics of program maturity need to be identified and tested.

The dimension of patient education program quality remains untested. An investigation of variables that affect program quality is in order. Among those that should be examined are (1) the attitudes of the administrator and the staff toward patient education, (2) the attitudes of the board of directors of the facility,

(3) the community mores regarding education, (4) budget, (5) adequacy of facilities, (6) patient enrollment trends, (7) institutional membership in professional associations, (8) general institutional commitment to excellence, (9) selection and training of staff, and (10) time and timing of instruction.

Strong evaluation models of patient education need to be developed and applied to nursing care facilities. While this study counted how many administrators attempted to do program evaluation, no attempt was made to determine the adequacy of such evaluation. What constitutes adequate program evaluation yet remains a nebulous question. What such an evaluation would show when done on the programs identified in this study is unpredictable, yet an important next step. Special emphasis needs to be given to comparing the effectiveness of inexpensive programs to expensive programs. Even further, the required intensity of a program necessary to produce a desired effect demands to be investigated. But perhaps the most basic research should be done first, with an investigation of the real needs of the residents of Michigan nursing care facilities, and a determination if patient education programs actually relate to the developmental needs of people approaching senility or death.

A Concluding Statement

This investigation was not intended to be a definitive study of the population, but rather an exploratory, descriptive investigation. While much has been learned, as usual, more questions have

been raised. Both more programming and more research yet need to occur.

It is the hope of this researcher that this investigation has or will raise the consciousness of some people in positions of influence so that ultimately elderly patients will find more meaning in the final months of their lives. With this hope, this investigation is terminated.

APPENDIX

CENTRAL MICHIGAN UNIVERSITY

May 26, 1976

Dear Administrator:

Organized programs of patient and family education are beginning to develop in nursing care facilities all over the country. This has occurred in response to the Patient's Bill of Rights, the issue of informed consent, and the potential for reimbursement of costs from federal funds. Have you thought about doing more in patient education in your institution? Have you wondered what your fellow administrators are doing about this?

To obtain the answers to these questions, and to determine the extent of patient education, we have begun a study of such programs in the nursing care facilities of Michigan. Enclosed is a questionnaire that has been critiqued by representatives of the Michigan Non Profit Home Association, the Michigan Health Care Association, and six other agencies. The questionnaire has also been field tested in Michigan nursing care facilities. We now need your assistance.

Please take five to ten minutes now to fill in the enclosed questionnaire. Your individual responses will be kept confidential. The survey results will be sent to each administrator who completes the questionnaire.

All responses should be returned by June 4, 1976. A stamped, self-addressed envelope is enclosed for your convenience. Thank you in advance for your important contribution to this project.

Sincerely,

Donald J. Breckon
Associate Professor
Health Education Dept.

MOUNT PLEASANT, MICHIGAN 48859

CENTRAL MICHIGAN UNIVERSITY June 8, 1976

Dear Administrator:

On May 26, a questionnaire was sent to you asking about educational programs you have available for patients. Approximately 150 of your fellow administrators responded. Your response is yet needed to present a complete picture of the presence or absence of patient education in Michigan.

You can be assured that your individual response will be treated with confidentiality. All reporting will be done by categories only.

I realize how busy you are, and that you haven't got to the questionnaire yet. Please be assured that your response is valuable to this study, regardless of whether or not you offer any patient education. Please take the ten minutes now to fill in the questionnaire. Ten minutes of your time today will result in you receiving the most current report available on patient education programs in Michigan nursing care facilities.

Please respond by June 16. If you need another questionnaire, please call collect 517-773-7151.

Sincerely,

Donald J. Breckon
Associate Professor
Health Education Department

MOUNT PLEASANT, MICHIGAN 48859

CENTRAL MICHIGAN UNIVERSITY June 28, 1976

Dear Administrator:

You may recall that on May 26 I sent you a questionnaire asking about any educational activities you have available for patients, either on an individualized or group basis. To date, I have received 218 completed questionnaires, for a 48% response. A response rate of 60% is desirable to establish the validity of this study. Will you reconsider and take ten minutes to fill out the questionnaire.

I have discussed this project with Gary Hooyenga, President of the Michigan Health Care Association, and with their executive staff. They have endorsed the study, and urge your cooperation.

Remember, it is just as important to this study to get a questionnaire with all "No" answers as one with all "Yes" answers. Please don't hestiate to fill it out merely because your educational program is limited or nonexistent.

You can be assured that your individual response will be treated with confidentiality. All reporting will be done by categories only.

I will send the survey results to all who complete the questionnaire. You, too, will know what your fellow administrators are doing in this area.

I need ten minutes of your time today to successfully complete this study. Please assist me in this important matter. Please respond by July 2, 1976.

Sincerely,

Donald J. Breckon
Associate Professor
Health Education Dept.

MOUNT PLEASANT, MICHIGAN 48859

A SURVEY OF PATIENT EDUCATION PROGRAMS FOR THE AGED IN MICHIGAN NURSING CARE FACILITIES

Part One: Identifying Data

Name of Facility_____ Telephone_____

Street and number_____

City and state_____ Zip_____ County_____

Type of Facility (check one):

____ Profit-making nursing home ____Non-profit nursing home

____ Medical care facility ____Hospital long-term care unit

Number of beds_____ Year facility opened_____

Name of respondent_____ Title_____

Part Two: General Educational Program for Patients

Note: For this section, please consider any general educational programs offered to patients in your institutional diversional therapy program, such as music, crafts, or any educational activity that does not directly cover a health topic.

1. Does your facility have a specific department or coordinator that is responsible for general education programs offered? ___Yes ___No ___In planning stages
   If yes, identify the department_____

2. Does your facility have a space designated as an educational center for patients? ___Yes ___No ___In planning stages

3. Please indicate which of the following topics are provided for patients and check the columns that describe them. Please list others.

	Group Instruction	Individual Instruction	Self-Instructional Media	Printed Material
Literature	___	___	___	___
Arts and crafts	___	___	___	___
Music	___	___	___	___
Creative writing	___	___	___	___
Theater	___	___	___	___
Reality orientation	___	___	___	___
Current events	___	___	___	___
_____	___	___	___	___
_____	___	___	___	___
_____	___	___	___	___

4. Please indicate which of the following people are involved in your general education program for patients. Check as many columns as appropriate. Please list others.

	Planning	Group Teaching	Individual Instruction
Facility staff	___	___	___
Patients	___	___	___
Local school personnel	___	___	___
College personnel	___	___	___
Educational TV personnel	___	___	___
Libruary or museum personnel	___	___	___
_____	___	___	___
_____	___	___	___

Part Three: Health Education Programs for Patients

Note: For this section, the focus of your answers should be on patient health education programs, rather than general educational activities. For example, think of educational activities provided for patients and families that deal with specific health problems such as diabetes, colostomy care, etc.

5. Does your facility have a specific department or coordinator that is responsible for patient health education programs offered? ___Yes ___No ___In planning stages

   If yes, is this the same department or coordinator that is responsible for patient general education? ___Yes ___No

6. Do you provide any educational programs for families of patients? ___Yes ___No ___In planning stages

   If so, in what areas?_____

   _____

   _____

7. Please indicate which of the following topics are covered in your patient education programs. Check as many columns as appropriate. Please list others.

	Group Instruction	Individual Instruction	Self-Instructional Media	Printed Material
Cancer	___	___	___	___
Death and dying	___	___	___	___
Diabetes	___	___	___	___
Hearing or visual disorders	___	___	___	___
Heart disease, hypertension	___	___	___	___
Nutrition	___	___	___	___
Orientation to facility	___	___	___	___
Orthopedic disorders	___	___	___	___
Respiratory disorders	___	___	___	___
_____	___	___	___	___
_____	___	___	___	___

8. Which of the following persons help plan or teach patients and families in your health education program? (Check as many columns as appropriate.) Please list others.

	Planning	Group Teaching	Individual Instruction
Physicians	___	___	___
Nursing staff	___	___	___
Dietitians	___	___	___
Social workers	___	___	___
Administrators	___	___	___
Occupational, physical, respiratory, or speech therapists	___	___	___
Clergy	___	___	___
Education staff	___	___	___
Staff from health department or voluntary health agency	___	___	___
_____	___	___	___
_____	___	___	___

9. How is the health education program initiated for individual patients? (Check as many as appropriate.) Please list others.

___ Standing orders
___ Educational prescription by physician
___ Patient request
___ Discussed during patient care conference

_____

_____

10. Does your facility evaluate the learning of individual patients? ___Yes ___No ___In planning stages

11. Does your facility evaluate its total educational program? ___Yes ___No ___In planning stages

Part Four: Administrator Opinions on Education of Patients

Note: Please indicate your views on patient education programs by checking the response that most clearly represents your opinion.

12. Health education of patients and/or their families is a legitimate function of nursing care facilities.
___Strongly agree
___Agree
___Neutral
___Disagree
___Strongly disagree

13. General educational programming is a legitimate function of nursing care facilities.
___Strongly agree
___Agree
___Neutral
___Disagree
___Strongly disagree

14. If consultant help were avilable at no charge, would you be interested in developing a patient education program in your facility? ___Yes ___No

Thank you for your assistance. Please return the questionnaire promptly in the enclosed envelope. Feel free to add any additional information you think appropriate on the bottom or back of this sheet.

Donald J. Breckon
Health Education Dept.
Central Mich. University
Mt. Pleasant, MI 48858

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