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A STUDY TO DESIGN A FUNCTIONAL
PATIENT HEALTH EDUCATION PROGRAM
FOR IMPLEMENTATION AT THE UNITED STATES
ARMY MEDICAL DEPARTMENT ACTIVITY,
FORT BENNING, GEORGIA

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A Problem Solving Project
Submitted to the Faculty of
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In Partial Fulfillment of the
Requirements for the Degree
of
Master of Health Administration

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By

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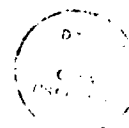


TABLE OF CONTENTS

ACKNOWLEDGEMENTS	i
LIST OF TABLES	v
LIST OF ILLUSTRATIONS.	vii
CHAPTER	
I. INTRODUCTION	1
Background	1
Statement of the Problem	4
Objectives	4
Assumptions.	6
Limitations and Obstacles to Optimum Research. . .	7
Required Standards and Criteria.	9
Literature Review.	9
Research Methodology	11
Footnotes.	14
II. DISCUSSION	15
Ascertaining Program Goals and Methodologies . . .	15
Identifying Existing Endeavors	18
Evaluating Existing Programs	19
The Patient Beneficiary Survey	21
The Staff Questionnaire.	24
Data Analysis.	26
Alternatives and Alternative Analysis.	31
Footnotes.	38
III. CONCLUSIONS AND RECOMMENDATIONS.	40
Conclusions.	40
Recommendations.	44
Footnotes.	48

APPENDIX

A. Definitions.	49
B. Patient Health Education Opinion Survey Questionnaire for Selected Staff Members	52
C. Patient Health Education Opinion Survey Questionnaire for Patients	56
D. Ambulatory Care Workload by Patient Category	59
E. MEDDAC Staffing Levels	60
F. Methodologies in Patient Health Education.	61
G. Frequently Addressed Subject Matter in Health Education.	62
H. Role and Functions of the Consumer Health Education Committee.	64
I. Identified Health Education/Patient Education Endeavors.	69
J. Locally Developed Printed Health Education Literature	77
K. Results of Patient Questionnaire	78
L. Results of Staff Questionnaire	81
M. Manhour Expenditure Estimates for Existing Health Education Programs	87
N. Options for Consideration.	89
O. Proposal for the Community Health Education and Health Promotion Committee	93
SELECTED BIBLIOGRAPHY.	94

LIST OF TABLES

1. Ambulatory Care Workload by Patient Category, January 1979 - December 1979	59
2. Staffing Levels by General Category (as of 31 December 1979).	60
3. Identified Health Education/Patient Education Endeavors.	69
4. Identification of Health Education Endeavors by Target Population.	75
5. Data Recapitulation-Patient Survey Question- naire: Part I - Patient Health Education Sub- jects.	78
6. Data Recapitulation-Patient Survey Question- naire: Part II - Desired Methods for Health Education Delivery	79
7. Data Recapitulation-Patient Survey Question- naire: Part III - Administrative Data from Respondents.	80
8. Data Recapitulation-Staff Survey Question- naire: Part I, Section A - Patient Health Education Delivery Methods	81
9. Data Recapitulation-Staff Survey Questionnaire: Part I, Section B - Patient Health Education Subjects	82
10. Data Recapitulation-Staff Survey Questionnaire: Part II, Section A - Patient Beneficiaries	83
11. Data Recapitulation-Staff Survey Questionnaire: Part II, Section B - Program Shortcomings.	84
12. Data Recapitulation-Staff Survey Questionnaire: Part III - Administrative Information (Rank/Rating). . .	85
13. Data Recapitulation-Staff Survey Questionnaire: Part III - Administrative Information (Career Field/Job Setting)	86

14. Manhour Expenditure Estimates for Existing Health Education Programs (FY 1979)	87
15. Options for Consideration	89

LIST OF ILLUSTRATIONS

- Figure 1. Major Stages in Designing a Functional Patient
Health Education and Health Promotion Program
at Martin Army Hospital 13
- Figure 2. Model for Implementation of Recommendations 47

I. INTRODUCTION

Background

The continuing disparity between the demand for health care and the number of qualified health care providers within the United States Army suggests the need to involve the patient, his family and the community as active participants rather than passive consumers of health care. Health care has progressively become more complex as the technical knowledge base underlying it has grown at explosive rates. It is no longer realistic to expect users of health care to learn their role by word of mouth or any other disorganized approach to the dissemination of information. Instead, a vigorous, organized community health education effort, tailored to the needs of the population served, is necessary to gain the fullest cooperation from health care consumers and to capitalize on their contribution to an effective health care delivery system.¹

The above stance represents the general position of United States Army Health Services Command (HSC) with regard to the responsibility imposed on its subordinate organizations to launch and maintain an effective health education program. First published in late 1973 as a result of high level directives calling for sweeping changes in the methods of ambulatory patient care delivery, directives required that Army medical

treatment facilities be taxed with the responsibility to meet this challenge.²

In its initial form, this guidance lacked specificity and left many of the recommendations for implementation to the discretion of the Medical Treatment Facility (MTF) Commander. With essentially no additional assets provided to support these recommendations, commanders in general, afforded only limited attention to meeting HSC's target dates for the accomplishment of suggested objectives. With little formal health education expertise available at most installations, some rather amateurish (but commendable) efforts eventually appeared.³ Many of these programs were fragmented, reflected duplications of already existing civilian programs, and were seen as infringing on areas of responsibility traditionally managed solely by preventive medicine activities. In many cases, these initial efforts also met with the animosity of the professional staff.⁴

In the years that followed, authority was given to the local Medical Center (MEDCEN) or Medical Department Activity (MEDDAC) for the management and coordination of health education programs. Successive revisions of Ambulatory Patient Care⁵ (APC) Model #14 called for the establishment of a "Community Health Education Program (CHEP) Committee," whose major function would be the routine

surveying of community needs and the establishment of local program objectives. Additionally, a multitude of "spin-off benefits" were hoped to be realized, and ranged from increased levels of patient satisfaction to effecting a higher economy of medical resources.⁶

Through feedback already received, the Fort Benning MEDDAC Commander presently feels that the health education programs that have been implemented locally have met with favorable responses from patients, staff and the Fort Benning installation cadre. There remains concern, however, regarding the following key questions:

1. Are the needs and interests of the community being adequately surveyed in order to channel CHEP resources accordingly?
2. Are those administrative and medical areas that (in the opinion of the staff and patients) need consistent emphasis being adequately addressed?
3. How can existing CHEP efforts be evaluated to determine program effectiveness?
4. Within resource constraints, what alterations (and innovations) should be made to effect improvement in patient health education?
5. How can various subprograms or education efforts within CHEP be better coordinated and supervised? Should a committee continue

to be the instrument employed to manage this program, for example, or should an activity, section, or individual be duly appointed and provided appropriate responsibility for the overall discharge of the CEHP responsibilities?

Statement of the Problem

The problem is to design a health education program for implementation at the Medical Department Activity, Fort Benning, Georgia.

Objectives

The primary objectives of this study will be to:

a. Identify present staff contributors to the MEDDAC patient health education program, and analyze their efforts in terms of scope, specific goals, resource expenditures, subjects addressed, target populations and evaluative procedures presently employed.

b. Through questionnaires, solicit opinions of staff members by random sample, addressing (Appendix B):

1. Methods of patient health education that should be employed.

2. Patient health education subjects that should be addressed.

3. Sectors within the patient beneficiary population that should receive emphasis.

4. Shortcomings with existing patient health education programs.

c. Through questionnaires, solicit opinions of patient beneficiaries by random sample, addressing (Appendix C):

1. Patient awareness of existing patient health education resources and efforts.

2. Methods preferred by patients for dissemination of health education (or for those that they would prefer to see utilized).

d. Establish resource requirements in terms of manpower, money and material that are supporting the present patient health education efforts.

e. Determine resource requirements in terms of manpower, money and material to support/suggest future program components.

f. Accomplish a descriptive analysis of various patient health education programs in order to determine which program components will have the most desired return (based upon available resources), and as a result, the greatest potential for success. This will require the Command to identify the desired goals of the health education

program.

g. Recommend the most appropriate design for a functional patient health education program for implementation at the United States Army Medical Department Activity, Fort Benning, Georgia.

Assumptions

In order for this study to be accomplished, the following assumptions are made:

a. Staff reaction to a restructuring of a patient education program will be supportive, cooperative and generally favorable.

b. There will be no significant changes in the composition of health care services presently offered through facilities under the jurisdiction of the Fort Benning Medical Department Activity.

c. There will be no significant changes in the composition of the patient beneficiaries (in terms of overall numbers, as well as categorial classifications) that are eligible to seek health care services at facilities under the jurisdiction of the Fort Benning Medical Department Activity.

d. Support services presently being provided by the installation of Fort Benning and other local agencies in the civilian community will remain essentially as they are at the present.

Limitations and Obstacles to Optimum Research

The following limitations and obstacles to optimum research in the preparation of this proposal are identified:

- a. The focus of this study will concentrate on patient health education subjects only.
- b. Patient health education subjects that are presently endorsed by higher echelons of command will be addressed with avoidance of research-related subjects and others not presently noted within the mission template of the Fort Benning Medical Department Activity.
- c. Although innovative ideas in the field of patient health education will be solicited from both civilian and military institutions, no attempt will be made to conduct either a quantitative or descriptive comparative analysis of the Fort Benning MEDDAC and other facilities.
- d. Specific design of an individual patient health education Standing Operating Procedure (SOP), or the design of specific written or other audiovisual material, etc., will not be addressed.
- e. The percentage distribution of patient questionnaires and the determination of sample size will not be based upon the percentage distribution of patient beneficiaries who potentially could seek care at Martin Army Hospital (known as "estimated patient population"). Such a calculation would serve little purpose in enhancing this study,

as to a significant degree, such figures are arrived at by utilizing numerous coefficients and multiplying these coefficients against selected base factors (which also may be simply estimates). In essence, accurate patient population statistics are not available. As a more accurate alternative, the percentage distribution of questionnaires and sample size will be calculated utilizing the average ambulatory care workload during the calendar year (January through December 1979). Such a display of outpatient workload is included in Appendix D. It should be noted that the typical monthly ambulatory care workload indicated also has a major shortcoming. Such totals are not composed of many distinctly different patients. For example, on many occasions, the same patient(s) may return to use the clinical facilities of the Fort Benning MEDDAC a second time (or more) and therefore be counted as an additional clinic visit. Subsequently, some bias must be accepted in selecting the ultimate patient sample that is generated. In summary, there is a lack of data available to substantiate how many of the outpatients are repeaters. Nonetheless, outpatient workload, as recorded, serves as the best available data base for defining the population and arriving at appropriate patient sample size and sample composition. Hospital

inpatients, unless they sought outpatient care while hospitalized, will not otherwise contribute to defining the patient questionnaire sample.

f. The distribution of staff questionnaires will be based upon staffing levels as of 31 December 1979 (Appendix E).

Required Standards and Criteria

The required standards and design of an acceptable patient health education program will include:

- a. The ability to effectively acquaint all patient beneficiaries with the services and policies employed in health care delivery within the Fort Benning MEDDAC. Because of the high mobility and short tours of duty realized by most trainees and infantry school students, this particular aspect of patient education must be responsive and timely.
- b. The requirements for personnel resources, money and materials must be reasonably available within existing budgetary limitations.
- c. The recognition of demands that the program will have on responsible staff members in terms of available duty time.
- d. The determination of the possibility of achieving the prescribed goals for which the patient health education programs were designed.

Literature Review

Most authorities agree that the purpose of health education, in

general, is to help people make appropriate decisions and to carry out behaviors that are necessary for optimum health. It is also viewed as a process that bridges the gap between health information and health practices. Its scope frequently encompasses education relating to the utilization of the health system and community resources, while addressing consumer habits and the management of health problems.⁷

Historically, such a perspective represents a significant advance when compared to the disjointed and poorly planned programs of the 1930's. Following World War II, however, the major thrust of health education endeavors shifted from one of a basic "disease-prevention" orientation to one which recognized that rational man does not necessarily behave with respect to his health as his intellect might dictate.⁸

The deluge of health and health related legislation of the late 1960's and early 1970's recognized health education as one of the nation's top ten health priorities. Many of these laws taxed government agencies with greater responsibilities with respect to providing individuals with the information to advance and protect their own health.⁹

As a general result, hospitals and medical facilities must now

assume a greater role in health education. This must be accomplished while also trying to satisfy the health consumer's demands that health education is an "intrinsic right," not purely a privilege. Further, it must not significantly contribute to the spiralling costs of health care.¹⁰ In this same vein, advertising used in conjunction with public education, whether to promote a health class or desirable health practices, is now officially endorsed by the American Hospital Association¹¹ as being in the best interests of society and patient care.

The literature demonstrates that the field of health education is surprisingly expansive with many potential facets. Appendix F represents a sampling of the methodologies which could be included in a modern, hospital-based, patient-oriented, health education program.

Further, Appendix G represents a display of frequently addressed subject matter in which many of these methodologies are routinely employed.

Research Methodology

The following research methods were utilized to gather data relative to this study:

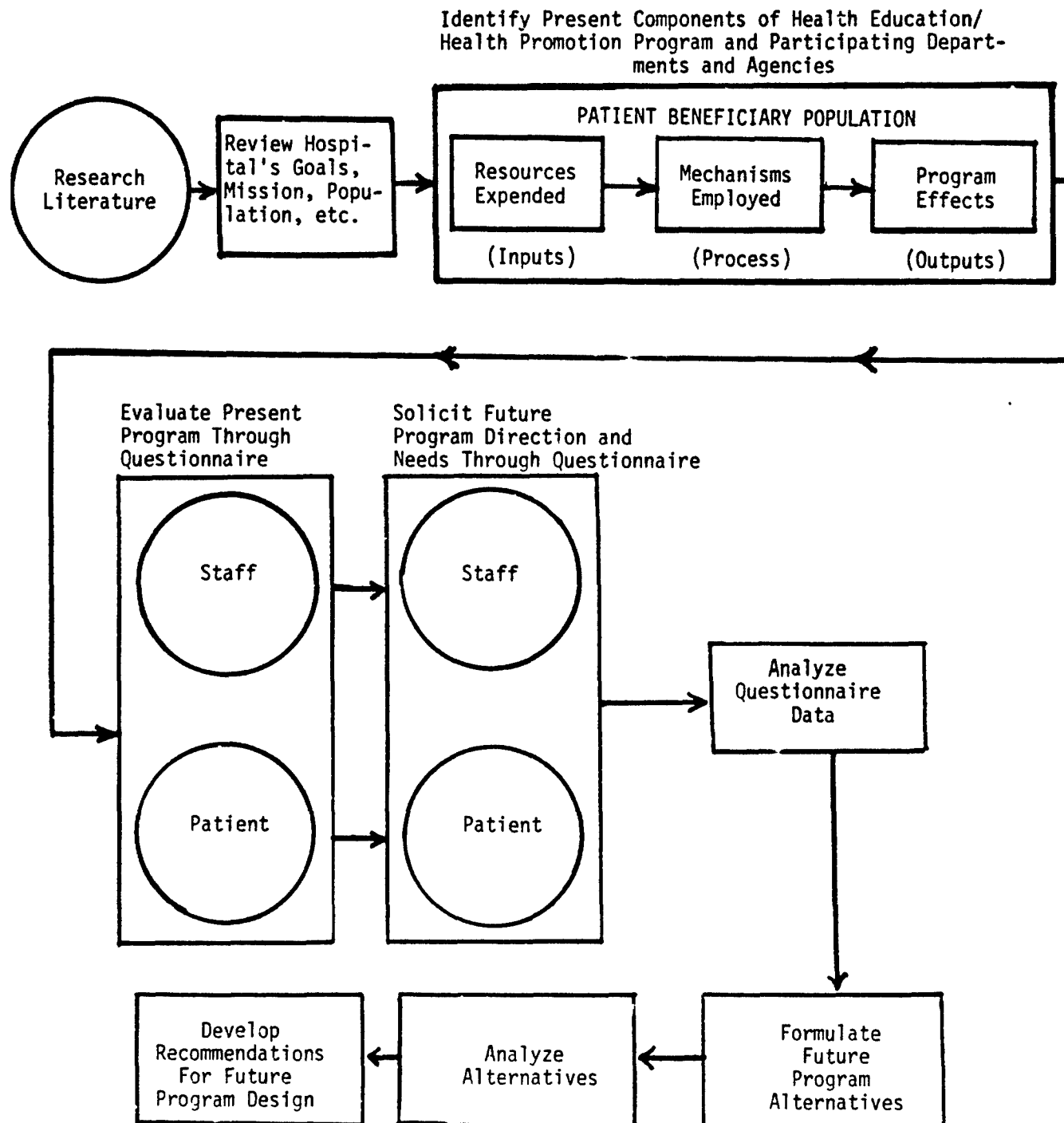
- a. Review and analysis of selected statistical records and reports, particularly those documents oriented toward measuring

workload accomplished.

- b. Literature review.
- c. Modeling.
- d. Personal interviews.
- e. Patient and staff questionnaires.
- f. Direct site analysis.
- g. Decision theory.

A model utilizing a general systems approach and identifying the major stages that will be employed within this study to design a functional patient health education program at Martin Army Hospital is included as Figure 1.

FIGURE 1. MAJOR STAGES IN DESIGNING A FUNCTIONAL PATIENT HEALTH EDUCATION AND HEALTH PROMOTION PROGRAM AT MARTIN ARMY HOSPITAL, FORT BENNING, GEORGIA



FOOTNOTES

¹United States Army Health Services Command, "Community Health Education Program," Ambulatory Patient Care Model #14 (July 1977): 1.

²United States Army Health Services Command, Ambulatory Patient Care Program Document, FY 1974, Fort Sam Houston, Texas (July 1974): 10-11.

³Telephonic Interview with LTC Thomas C. Christie, MSC, Chief, Clinical Support Division, Letterman Army Medical Center, Presidio of San Francisco, California, 12 September 1979.

⁴Ibid., 12 September 1979.

⁵"Ambulatory Patient Care Models," Published as Guidance by Headquarters, Health Services Command, Contain Individualized Program Goals and Objectives for a Sizeable Inventory of Innovations Required in Outpatient Care Delivery Mechanisms.

⁶APC Model #14: 2-3.

⁷Elizabeth A. Lee, "Health Education," Hospitals, J.A.H.A. 48 (April 1, 1974): 133-134.

⁸Horace G. Ogden, "Health Education: A Federal Overview," Public Health Reports 91 (May-June 76): 199-200.

⁹Anne R. Somers, "PL 94-314: Opportunity for Health Education, Promotion." Hospital Progress (October 1976): 6-7.

¹⁰E. C. Johnson, "Health Education Not Feelin' Good," Modern Healthcare 2 (December 1974): 60.

¹¹American Hospital Association, "Advertising By Hospitals," Guidelines, AHA (1977): 1.

II. DISCUSSION

Ascertaining Program Goals and Methodologies

Health education is an organized process of behaviorally-based learning so structured as to lead to changes in health behavior. While such an endeavor encourages positive health practices, a secondary motive aims toward improving overall health care delivery.¹

Patient health education can address an expansive array of subject matter, theoretically limited only by the "resource constraints and ideology composing the organization platform."² The goals of the program can range from improving individual (or collective) health status to assisting in the accomplishment of the overall goals of the organization. Such programs will routinely consist of a broad group of activities which may include those more commonly referred to as "patient education, health information and health promotion endeavors."³

As required through Army regulations,⁴ military medical treatment facilities must consider their organizational goals as being similar to the goals of consumer health education. Such institutions must also have strong ties to the communities that they serve and must be prepared to comfortably recognize and deal with change.

The nine-story, main chassis portion of Martin Army Hospital

was constructed in 1958 and designed to accommodate 500 inpatients. In 1976, an ambulatory facility wing was added and now houses most of the clinics supporting the hospital. Rounding out the direct patient care facilities are eight troop medical clinics located at selected points throughout the installation. These clinics are tasked with providing the bulk of the primary medical care for the largely infantry and infantry-oriented servicemember and, in some cases, his dependents. The organizational structure of the Fort Benning MEDDAC is not unusual and is similar to most CONUS Medical Department Activities. With a mission template calling for fulfilling the health care needs of the patient beneficiaries residing on or near the installation of Fort Benning, the Fort Benning Medical Department Activity utilizes basically only its authorized health services delivery sites to disseminate health care information.

Whether or not to embark upon a health education program is a question which has not been delegated to local command levels. Ambulatory Patient Care Model #14 mandates that subordinate commands develop a plan for Community Health Education which specifies goals and objectives and includes immediate, intermediate and long-range educational activities and educational methodologies.⁵ It is

further stipulated by the model that this plan be reviewed on a regular basis and revised as necessary.

As with most programs, selected goals must be clearly and precisely defined during the early stages of project planning in order for the organization to expect such goals to be orderly and effectively accomplished. At the Fort Benning Medical Department Activity, the health education effort has been vested by the organization commander in which is now known as the "Consumer Health and Education Committee (CHEC)." As defined by the implementing directive,⁶ the committee's purpose is, "(1) to provide a communication means for transmittal of information, suggestions, and expressed concerns of the Army community about health services; (2) to provide consumer education and information services; (3) to provide a means of conveying concerning regarding health entitlements, benefits, and changes thereto; (4) to increase the effectiveness with which the Medical Treatment Facility and its supported population interact and (5) to formulate objectives, policies, and guidance concerning the MEDDAC's Community Health Education Program." An extract of a portion of MEDDAC Regulation 15-1, which delineates the functions, membership, and special instructions governing the role of the CHEC is included within Appendix H.

In that the hospital has assigned the responsibility to formulate

the goals and objectives of the health education effort to the CHEC, the available minutes of the CHEC were reviewed as a part of this study in an attempt to ascertain what goals and objectives have, in fact, been formulated.

All available records of proceedings for the CHEC were reviewed from July 1976 to the present. It was found that the committee's title and composition have changed several times during that period. The committee's mission and functions were found to have been formulated; however, specifically defined goals and objectives were not clear. Numerous problem areas had been identified by the committee as requiring attention (in terms of patient educational efforts). In some cases, the problems noted were accompanied by specific guidance as to how the committee recommended resolution. Observations assessing program success or failure only rarely appear in the minutes, and where identified, are based purely upon the subjective opinion of committee members.

Identifying Existing Endeavors

A second attempt to identify health education and health promotion program elements, goals and methodologies was made through the distribution of a command letter to all organizational staff elements during the fall of 1979. The letter solicited input regarding program

components that sections sponsor in total or components to which they partially contribute resources. The results of this solicitation are depicted in Table 3, Appendix I.

The identified educational endeavors address the patient beneficiary population both in terms of major categorial segments and in terms of the unique characteristic effecting a portion of the total population. For example, Table 4, Appendix I cites the number of programs identified within Table 3, in relation to that segment of the population to which the program focuses.

As the final phase in identifying existent health educational endeavors, a listing included within Appendix J depicts those items of printed literature presently available to the patient population and organization staff. As can be noted, a total of forty-seven readily identifiable programs are presently being executed within the command.

Evaluating Existing Programs

In addition to the Community Health Education Committee's general lack of short and long term goals as a working body, there is no identifiable written evaluation or evaluative mechanism which could attempt to indicate how effective or ineffective the existing

programs have been. In the broadest sense, for example, the solicitation of patient opinion should be considered as a feedback mechanism, and as such, it is an identifiable element which may be utilized in conducting an evaluation effort of existing programs.

An evaluation of a health education program theoretically should certify its appropriateness and its effectiveness.⁷ Basically, evaluation is nothing more than the comparison of an object of interest against a standard of acceptability.⁸ In the case of this study, an "object of interest" is considered as one or more of the elements of a health education program.

The literature offers numerous hypothetical designs to conduct evaluations of health education programs and levels where evaluation efforts can be focused. Unfortunately, however, as is found most often, the dilemmas⁹ such techniques offer pose significant obstacles for the administrator and the practitioner, and are therefore not accomplished. For example, standards in research procedures have been formulated. There are problems in measuring outcomes of health education that require policy decisions on whether benefits are to be expected to accrue rapidly or slowly, temporarily or permanently, in the general population or in high-risk groups, and in what relationship to the economy. Finally, there is the dilemma posed by the

questions both the administrator and the practitioner must address in the absence of an adequate data base. Avoidance of conducting effective evaluation, therefore, frequently becomes easier than overcoming these obstacles.

The Patient Beneficiary Survey

In the broadest sense, the solicitation of patient opinion should be considered as a feedback mechanism, and as such, it is an identifiable element which may be utilized in conducting an evaluation effort of existing programs. The extent of this patient-based "evaluation" however, consists only of gaining a subjective appraisal of patient awareness relating to a selected portion of existing services, while also soliciting insight regarding patient utilization of these same services. The vehicle employed was Part I of the Patient Health Education Opinion Survey Questionnaire for patients (Appendix C). Part II of the questionnaire was developed in an attempt to surface guidance to the command from the health care recipient, with particular emphasis centered upon which direction(s) the health education programs of the future should take.

The questionnaire underwent several revisions following two field tests within hospital clinics. Samples of thirty patients were

utilized during the testing and the presence of surveyors allowed for an open discussion regarding respondents questions.

Major modifications that resulted included, (1) an overall simplification of language throughout the questionnaire, tailoring the narrative in order that it be understandable to the average high school graduate;¹⁰ (2) development of "judgmental-desirability" rank order¹¹ in Part II, versus a less discrete "positive-negative"¹² solicitation mechanism; (3) and the recognition that a surveyor need be available at the time of questionnaire administration in order to display copies, photographs, etc. and provide explanations of the listed educational endeavors. It was felt that the presence of a surveyor would insure that respondents had a better understanding of educational mechanisms noted and thereby would furnish more dependable responses.

The sample size for the patient beneficiary survey was arrived at using inferential manipulation. As noted earlier in the study, the average daily workload, which is representative of those patients who more frequently utilize the health care facilities, was chosen as the basis for defining the target population. The population standard deviation (σ) was estimated ($\sigma \approx R/6$), with the percentage of average daily workload utilized to serve as the polar values of the

range. Invoking the Central Limit Theorem, with a confidence coefficient of .95 (reliability coefficient of 1.96), a maximum allowable error or $d = 2$, the sample size (n) was calculated at 60. Breaking down n according to percentage of average daily clinic workload, the appropriate number of questionnaires per major status of patient was determined as follows:

Active Duty Military Patients	29 Questionnaires
Retired Military Patients	6 Questionnaires
Dependents of Active Duty Members	17 Questionnaires
Dependents of Retired/Deceased Members	7 Questionnaires
Others	<u>1 Questionnaire</u>

$n = 60$ Questionnaires

The results of the survey are delineated within Appendix K.

A complete inventory of clinical settings was then assembled, and utilizing a random numbers table, gross numbers of patient questionnaires per clinic were determined. After recognizing those clinics which do not offer services to all beneficiaries, a second series of random numbers was employed to delineate which classes of beneficiary within each selected clinic would be asked to complete the questionnaire. The questionnaires were numbered for control purposes; however, no patient identification was solicited in order to insure bias levels were kept to the minimum.

The Staff Questionnaire

It can be argued that those responsible for existing programs are in the best position to judge the effectiveness of their specific program(s). To gain data which was as objective as possible, however, random sampling techniques similar to those utilized in the patient survey were employed with the staff survey.

The staff survey has two major areas of interest. Part I of the questionnaire is designed to gather input regarding subject matter and methodologies that staff members feel should be employed in the command's health education program. Part II solicits staff opinions relating to target patient populations toward which health education programs should be aimed.

Inferential statistical manipulation was also used to determine staff survey sample size. The population standard deviation was again estimated, with the percentage of major personnel category utilized to serve as the polar values of the range. Invoking the Central Limit Theorem, with a confidence coefficient of .95 (reliability coefficient of 1.96), a maximum allowable error of $d = 2$, the sample size (n) was calculated at 34. Breaking down n according to percentage of major personnel category, the appropriate number of questionnaires per major category was determined as follows:

Officers/Warrant Officers	6 Questionnaires
Enlisted Personnel	10 Questionnaires
Civilian Personnel:	
Wage Grade	3 Questionnaires
General Schedule	<u>15</u> Questionnaires
n = 34 Questionnaires	

Similar to the patient survey, the staff survey underwent two revisions following field testing within the MEDDAC. Two major modifications included, (1) development of "judgmental-desirability" rank order in Section A and B, Part I and Section A, Part II, versus a less discrete "positive-negative" solicitation mechanism; and (2) the elimination of a numerical evaluation placement scoring mechanism in favor of a program shortcoming identification exercise. Samples of 30 staff members were utilized during the testing episodes, and the presence of surveyors allowed for an open discussion regarding any questions.

Utilizing a random numbers table, a series of 34 random numbers were selected and utilized to draw names of staff members to be surveyed from computerized civilian and military personnel rosters. Those staff members who refused to complete the questionnaire or were not available to complete the questionnaire within a reasonable period were dropped. In their place, alternate names were drawn from the appropriate rosters using random numbers.

The results of the staff survey are delineated within Appendix L.

Data Analysis

The patient questionnaire was administered to a randomly chosen cross-section of patient beneficiaries who were utilizing the clinical and inpatient facilities of Martin Army Hospital over a five-day period. The majority of the sixty patients (65 percent) in the sample consisted of active duty military personnel or their dependents. Thirty-two of the thirty-seven servicemembers were in the pay grade of E-1 through E-7. Sixty percent of all sampled patients indicated that they used the hospital facilities 1-3 times during the past year, while 10 (16.7 percent) indicated they used the services seven or more times. The age distribution of those sampled indicates that over 43 percent were between the ages of 14 and 25. Coupled with an additional 30 percent within the 26-39 year old age group, the majority (73 percent) of those patients canvassed were under the age of forty.

Because of the potentially wide diversity of educational levels that could be encountered by a survey of this nature, only two central motives were hoped to be accomplished by administering the patient questionnaire. Firstly, patient knowledge of existing educational programs or services was solicited. This included utilization rates by sampled patients of those resources noted in Part I of the patient

questionnaire. Secondly, patient opinion regarding which mechanisms of health education they felt was most beneficial to them was solicited via Part II.

The survey results revealed that many of the existing health education programs are not well known to the patient beneficiaries. Logically, data generated relating to utilization rates of existing resources by these same patients was also low. For example, only one of the seven educationally-oriented services listed on the questionnaire was known to at least 50 percent of the patients canvassed. Most of the services were known only to between 20 and 33 percent of those solicited. Correspondingly, most of the services were noted to have been utilized by the patients in less than twenty-five percent of the cases (Tables 5, 6, and 7 of Appendix K).

Three particular methodologies of health education delivery proved to attract the support of the canvassed patients. "Closed Circuit Television," "Dial-A-Message" and "printed brochures" were those methodologies drawing the heaviest support. However, closed circuit television demonstrated a wide confidence interval which alludes to the variance in the numerical scores received.

The staff questionnaire was distributed to a randomly selected sample of 34 staff members, sixteen of whom were active duty service-members, with the remaining eighteen questionnaires completed by

civilian employees of either the General Schedule (GS) or Wage Grade (WG) classification. Of the military members included within the sample, eleven were enlisted personnel, four were commissioned officers, and one was a warrant officer. Those surveyed within the civilian workforce included sixteen with a GS classification, and two with a WG classification. The majority of those canvassed identified themselves in a career field other than the several selected career fields specifically noted on the questionnaire. A review of the input, however, revealed that nearly all such respondents were of a medical military occupational specialty being either 91B, 91C or 91D, or of the nursing aid job series. In terms of job-setting, two-thirds of those sampled indicated they were either in direct patient care or the direct support of patient care.

Section A of Part 1 of the staff questionnaire attempted to solicit staff opinion regarding methodologies that should be employed within the Fort Benning Medical Department Activity in conducting health education program efforts. The utilization of printed brochures as a distinct methodology proved to be the most popular by those canvassed. Two other mechanisms, namely the utilization of the "Dial-A-Message" system and closed circuit television, ranked second and third in desirability. The width of the "closed circuit television"

confidence interval, however, raise a question regarding the solidarity of staff consensus with this mechanism. Although the highest ratings offered using the judgmental rank-order mechanism (score of 10) were received by this choice in the greatest number of cases (mode), the median of seven reinforces this very point. Those methodologies which drew the least support were the "mailed reminder notices," and the "radio and television spot announcements." Solidarity in the solicited opinions is demonstrated by the considerably lower σ_x calculated for the responses.

Section B of Part I to the staff questionnaire was intended to draw opinions as to those broad subjects which should receive emphasis in health education. Several of the subject areas received recognizable agreement from staff members, to include "medical-administrative informational areas;" "chronic disease management;" "psychiatric problems" and the continued use of "medical advisor reference booklets." Although "emergency medical services and first aid subjects" drew high ratings from some staff members solicited, these ratings were not consistent, and this lack of consistency is noticeable in the rather expansive confidence interval that resulted.

Seeking staff opinion as to which segment of the patient beneficiary population needs more attention was the purpose of Part II, Section A

of the staff questionnaire. Overwhelmingly, the solicited staff members recognized the lower enlisted population as that segment which should receive greater attention. Similarly, the staff demonstrated surprising agreement in identifying the remaining order of priority for the other seven beneficiary groups, with the allied military members and their dependents receiving the lowest rating.

Identifying possible reasons for previous health education program component shortcomings was the intent of Part II, Section B of the staff questionnaire. Five possible causes drew more positive responses than negative, while another five drew more negative responses than positive. One possible cause, namely "past poor execution" drew an identical number of positive and negative responses. Opinion could then be considered as split, with "lack of interdepartmental coordination," "lack of adequate monetary and materiel resources" receiving the highest number of positive responses respectively. The "lack of pre-implementation planning," "lack of ability to evaluate the effectiveness of programs," and "command" and "staff apathy" received the greatest number of negative responses from solicited staff members. Data recapitulation of the staff survey results are included within Tables 8 through 13, Appendix L.

Alternatives and Alternative Analysis

How far reaching the parameters of a health education program should extend is a difficult question facing an administrator in any type of a health oriented organization. A first step toward an answer, however, is to attempt to determine the quantity of resources, in terms of personnel and monies, that are presently being expended.

An analysis of the forty-seven identified programs at the Fort Benning Medical Department Activity reveals that twenty-one are delivered during normal duty hours. The remaining twenty-six are provided the patient beneficiaries after normal duty hours, essentially through the services of active duty military providers.

In terms of monetary resources, health education programs are not recipients of budgeted funds. What funding is necessary is drawn from operating funds of the sponsoring section or activity. This, however, was found to be the rule with only four of the twenty-one programs. For example, four program components realized expenditures from operating funds. Such expenditures consisted of film and filmstrip rental and the procurement of printed educational literature and amounted to \$156.37 for all of fiscal year 1979. Printing support

supplied normally from facilities of the Fort Benning installation are provided at no charge to the hospital. Therefore, it can be concluded that the element of materiel expenditures to support existing programs is negligible.

In terms of manhour expenditures, it was found that no reasonably accurate records reflecting dedicated support to health education endeavors are being maintained. During interviews, each staff section sponsoring a program offered rather liberal manhour estimates for accomplishing each program. Without a definitive mechanism which could accurately accomplish this task on a continuing basis, however, such estimates should be considered of only marginal value. If utilized, such utilization should be limited to broad planning actions only. These manhour expenditure estimates are depicted in Table 5, Appendix M. Each program corresponds to the identified existing programs noted in Table 3, Appendix I. The estimates represent manhours dedicated to the planning, teaching and other related phases necessary to accomplish each program.

Additionally, it should be recognized that these manhour requirements are probably inflated to some degree, but nonetheless represent a tremendous expenditure of resources. The 4,673 hours which are estimated to be expended annually represent a considerable cost to

the MEDDAC, whether the programs are delivered during normal duty hours or after duty hours. For example, if the average hourly wage of those involved were \$9.00 per hour (approximately comparable to that of an active duty captain with over six years of service), the cost in manhours would be \$42,203.03.

The development of specific alternatives which will reflect definitive personnel and materiel costs then can be calculated accurately only after specific goals and objectives are determined by the command and definitive mechanisms, over a specified period, are established to capture necessary data. Therefore, the alternatives that are delineated herein are relatively general in nature. They are presented in terms of options (Table 6, Appendix N) with each of the options depicting a varying level of intensity that the health education program could assume. For example, Option A includes all goals and objectives identified by this study and logically amasses the largest dedication of resources if that option were adopted. Because Option A includes the largest array of possible program components, the time frame requirements to effect the complete list of components is also the greatest of the three options.

The general goals and objectives depicted in Appendix N can be separated into two major categories. Goal 1 relates to improving control, direction, and management of the overall Health Education

Program. Objectives 1A through 8A relate to more specified actions that can be accomplished in an attempt to satisfy this goal. Goal 2 pertains to selecting the program components themselves and the delivery mechanisms for accomplishing the requirements of those components.

Estimated time frame requirements were assigned in realistic terms, following interviews with selected staff section chiefs. In most cases, those interviewed were the same section chiefs who would logically be assigned the responsibility to accomplish the respective objective, within the parameters defined. In most cases, the estimated time frames of some objectives interrelate sequentially with the time frames assigned to others. Additionally, the time frames pertaining to each of the two major goals are inclusive of each of the specific objectives assigned to each respective goal.

A similar interview methodology was employed to arrive at the estimated general resource requirements. These requirements were awarded utilizing any one of three general classifications: (1) "Minimal" if the objective was estimated to require an expenditure of less than \$500 per annum. This was calculated on the hourly wage of active duty Captain (with over four years of service) and the estimated cost expenditures in terms of funds and material necessary,

- (2) "Moderate," if the cited objective was estimated to require an expenditure of more than \$500, but less than \$1,000 per annum, and
- (3) "Considerable," if the cited objective was estimated to require an expenditure of more than \$1,000.

As can be noted in Table 6, Appendix N, Option A includes 28 individual objectives. Option B includes 22, while Option C consists of 10 objectives. Assigning point values to the estimated general resource requirement classifications ("minimal," one point; "moderate," two points; and "considerable," three points), a quantification can be made regarding the average resource requirements per option. Employing this technique, Option A amassed a total of 58 points, which when divided by the 28 program objectives contained within that option, averages 1.85 points. Descriptively, this option should be considered overall as demanding a moderate expenditure of resources, even though selected objectives contained within the option would require considerable resources. Option B, which represents a less intense overall program, amassed a total of 36 points which, when divided by the 22 program objectives contained within that option, averaged 1.64 points. This option, then, is considered as demanding a minimal-to-moderate expenditure of resources. Finally, Option C consists of 10 objectives amassing 12 requirement points.

This calculates to an arithmetic mean of 1.2, which can be classified as the least involved program and demanding only a minimal level of resources.

All three options are designed to fulfill the general goals established by the study. The major differences, then, relate to the level of intensity with which these goals are fulfilled. Option A represents the "complete" program as defined by the author and based upon input gained through the patient and staff questionnaire and through personal assessment. Much improved control and direction would allow the command to better monitor the program and evaluate its effectiveness. Program objectives are expansive and cover a full spectrum of subjects which could employ numerous delivery modalities. All segments within the patient beneficiary population are also addressed. Option B, on the other hand, is somewhat more limited in terms of program components than is Option A. All objectives which demand "considerable" expenditures of resources are excluded from Option B. With this exclusion withstanding, no segments of the population are totally avoided by the overall educational effort. Finally, Option C is the most restrictive, and as a result, the command and direction elements are not as inclusive as with Options A and B. Additionally, all special program components dedicated to handicapping and chronic medical problems

are avoided, with concentration only on minimal expenditure efforts that deal with basically general health promotion subjects. Once again, the scope and delivery mechanisms appropriate to each objective must be defined by the command once the option packages are evaluated and a strategy adopted.

FOOTNOTES

¹Elizabeth Arvidson, et. al., "A Health Education Model for Ambulatory Care," Journal of Nursing Administration 9, (March 1979): 16-17.

²Jeanne A. Coombs, Mathew J. Skinner, and Diane Chapman Walsh, "A Systematic Approach to Community Education." American Journal of Health Planning 2 (July 1977): 14-15.

³Donald M. Vickery, "Is it a Change For the Better?" Hospitals 53 (October 1, 1979): 87-88.

⁴United States Department of the Army, Regulation 40-2, Army Medical Treatment Facilities - General Administration (Washington, D. C.: 8 March 1978): 1-1 through 1-3.

⁵United States Army Health Services Command, Ambulatory Patient Care Model #14, Community Health Education Program (July 1977): 3-4.

⁶United States Army Medical Department Activity, Fort Benning, Georgia, MEDDAC. Regulation 15-1, MEDDAC Committees, Subcommittees, Conferences, Boards and Councils, Fort Benning, Georgia, 1 July 1979, Page F-1 through F-3.

⁷Lawrence W. Green, "How to Evaluate Health Promotion," Hospitals, J.A.H.A. 53, (October 1, 1979): 106.

⁸Lawrence W. Green, "Toward Cost-Benefit Evaluation of Health Education: Some Concepts, Methods and Examples," Health Education Monographs 2 (Supplement, 1974): 34.

⁹Lawrence W. Green, "Evaluation and Measurement: Some Dilemmas for Health Education," American Journal of Public Health 67, (February 1977): 155-161.

¹⁰Guidance was Solicited and Received in these Revisions from the Community Mental Health Activity, Fort Benning, MEDDAC, and the Directorate of Personnel and Community Activities, United States Army Infantry Center, Fort Benning.

¹¹Green, "Toward Cost-Benefit Evaluation of Health Education: Some Concepts, Methods and Examples," pp. 34-6.

¹²Combs, Skinner, and Chapman, p. 15.

III. CONCLUSIONS AND RECOMMENDATIONS

Conclusions

After reviewing the programs presently being accomplished by the MEDDAC, coupled with impressions gained through personal interviews with staff members and responses received through the staff questionnaires, it becomes quite apparent that considerable enthusiasm does exist at all managerial levels toward providing health education efforts. A sizeable array of program components has evolved. These components are aimed at most of the major segments of the patient beneficiary population, while addressing a well balanced inventory of subject matter.

In addition to this staff enthusiasm, the hospital commander and his immediate cadre are equally as enthusiastic about fulfilling the needs of the patient beneficiaries. Amidst a climate of continuing resource austerity, the preventive medicine advantage that such a program offers is an attractive incentive to the health promotion of these potential care recipients. Health education has become rightfully viewed as a professional obligation and unquestionably necessary for satisfying the accreditation and legal pressures being exerted through numerous channels. The distinguishing characteristic of the contemporary patient educational effort is that it must be a

deliberate and systematic effort, with specific and meaningful content, and undergoing regular monitoring and evaluation.¹

Several significant problem areas, however, are exerting influence in retarding these efforts from realizing their maximum potential. Each of these problems are indeed correctable, and rectification lies fully within the purview of the Medical Department Activity.

These problems include:

1. The command has formulated general functions for the health education program. These functions were intended to serve as general guidance to the Consumer Health Education Committee. A regular review of the committee's effectiveness to fulfill these functions, however, is not being routinely accomplished. Therefore, although the committee meets at the prescribed intervals, it serves as little more than a communication vehicle on hospital services and problems, and operates basically between the hospital leadership and representatives of selected patient beneficiary groups. With this lack of function fulfillment by the committee, and a similar lack of direction by the command, the overall command health education program has become somewhat disjointed, with many outstanding program components being delivered basically independently of each other.

2. A considerable duplication of educational efforts has developed. Appropriate planning, reviewing, and direction can prevent a needless expenditure of valuable resources which could be advantageously channeled elsewhere. The initiation and conducting of the majority of the programs, however, appear to be based on a bona fide need existing within the patient population. But all too often, the scope and limitations of these programs are not outlined, and thereby, these programs become helplessly subject to a multitude of objective and subjective variables. Such variables, which include the personal motivation, dedication and convictions of the responsible staff members who are directing the program components, frequently serve to steer the program in whatever direction it eventually assumes. For example, there are at least two separate program components presently being conducted that deal with the subject of diabetic management. Similarly, four programs deal with diet therapy and physical fitness; seven programs deal with expectant parents and post partum subjects, and five program components address dental and oral hygiene. It is recognized that many of these programs are structured to address different facets within the broad categories of subject matter listed. Additionally, such programs may be tailored differently for their respective target audiences. However, a portion of the programs

appear amenable to consolidation.

3. A definitive awareness of those efforts presently being sponsored within the command has not been accomplished. The staff survey results, as well as information conveyed during personal interviews with selected key staff members, substantiate the fact that many staff members are not fully aware of what others are doing. Further, those administrative and professional personnel who serve in roles which could either channel perspective education recipients to the appropriate resource or provide for the general dissemination of information regarding these programs are not fully able to accomplish this function. In many cases, this disparity is again related to the staff's lack of knowledge of those services provided by other staff members.

4. Generally, no formal means of evaluating past and present programs has been established. Evaluative efforts examining program effectiveness, timeliness, methodologies, scope, and content, regardless of the precise evaluative strategy utilized, could identify the worthiness of resource expenditure.

5. In addition to the lack of definitive guidance regarding health education, the apparent lack of goal and objective formulation persists. Further, a review and reassessment function of the program

goals and objectives on a regular basis has not been accomplished.

6. Record keeping procedures have not been instituted to allow for the command to accurately identify the material and personnel resource requirements involved in the existing and proposed educational efforts. If such requirements were identified, newly proposed education efforts could be submitted for command evaluation and scrutiny prior to implementation. Additionally, cost-benefit analysis and other techniques might be employed as a component to a formally structured evaluative mechanism.

Recommendations

Based upon the findings noted within this study, it is recommended that the following actions be taken by the Commander, Fort Benning Medical Department Activity:

1. That a Community Health Education and Health Promotion (CHEHP) Committee be established as soon as possible. The suggested membership, purpose and general functions delineated by the MEDDAC Commander to this committee are included within Appendix O. Specific functions and objectives can be developed by the committee and forwarded to the Commander for approval.
2. That the CHEHP Committee or other body conduct a complete

assessment of the existing health education endeavors. The appraisal should solicit similar information as noted in Table 3, Appendix I. Additionally, it should require sufficient justification for the respective program's continuance, to include budgetary and staffing requirements, proposed mechanisms for evaluation, and the objectives each program is intended to accomplish.

3. That the evaluation of the provisions of Options A, B, and C be accomplished in conjunction with the goals and objectives formulated and approved by the Commander. That option which promises to be the most compatible with these goals should be the option adopted.

4. That a comparative analysis be conducted between existing program components and the selected option. This analysis will identify duplications, shortfalls and areas for consolidation.

5. That a health education program document be formulated, dictating the goals and objectives to be accomplished pursuant to a particular period of time (fiscal year).

6. That formal evaluation mechanisms be adopted through which each program component can receive evaluation on at least an annual basis. Numerous designs^{2,3,4} can be adopted to satisfy process, impact and outcome evaluation levels.⁵ These include the (a) historical (or record-keeping) approach, (b) inventory approach, (c) comparative

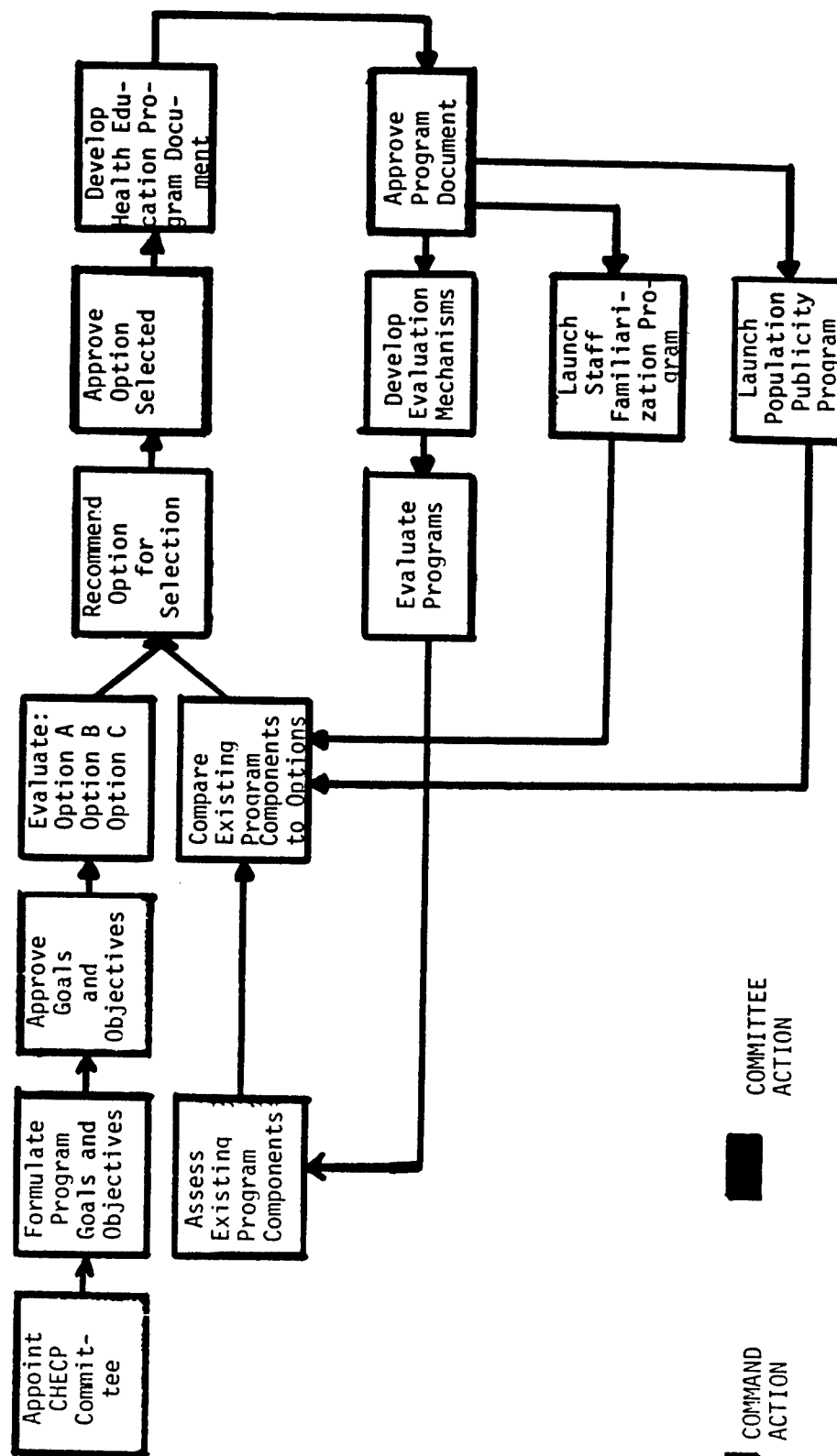
approach, (d) quasi-experimental approach, and the (e) controlled experimental approach.

7. That a program familiarizing the hospital staff with the educational endeavors available be conducted. This effort will allow for a greater dissemination of information regarding health education resources to the patient beneficiaries.

8. That a large scale publicity effort promoting the program components be launched. This will allow for those patient beneficiaries who do not regularly use the medical facilities of the Fort Benning MEDDAC to receive information regarding what health education and health promotion endeavors are available for their use.

A model highlighting the implementation of these recommendations is included as Figure 2 indicated on the following page.

FIGURE 2. Model for Implementation of Recommendations



FOOTNOTES

¹Maryann F. Fralic, "Developing a Viable Inpatient Education Program - A Nursing Director's Perspective," Journal of Nursing Administration VI (September 1976): 30-31.

²Lawrence W. Green, "Evaluation and Measurement: Some Dilemmas for Health Education," American Journal of Public Health 67 (February 1977): 155-160.

³Kathryn Lee Kelly, "Evaluation of a Group Nutrition Education Approach to Effective Weight Loss and Control," American Journal of Public Health 69 (August 1979): 813-14.

⁴Peter Lacouture, et. al., "Evaluation of a Community-Based Poison Education Program," Clinical Toxicology 13 (December 1978) 623-29.

⁵Lawrence W. Green, "How To Evaluate Health Promotion," Hospitals, J.A.H.A. 53 (October 1, 1979): 106-108.

APPENDIX A
DEFINITIONS

DEFINITIONS

Ambulatory Patient Care (APC) Models: Written guidance developed by Health Services Command, addressing a wide variety of subjects which relate to various aspects of Ambulatory Patient Care delivery and facilities within subordinate medical treatment facilities.

Ambulatory Patient Care (APC) Program: A Health Services Command directed program, composed of a series of goals and objectives, designed to upgrade the quality of ambulatory patient care delivered in subordinate medical treatment facilities.

Central Limit Theorem: The theorem of statistical inference which states that given a population of any functional form with a mean, μ , and finite variance, σ^2 , the sampling distribution of $\bar{x}$, computed from samples of size n from this population, will be approximately normally distributed with mean, μ , and variance, σ^2/n , when the sample size is large.

Clinic Visit: A contact between a patient and a provider of medical care, and includes at least one of the following: treatment, examination, evaluation, or consultation.

Community Health Education Program (CHEP) Committee: A committee consisting of selected medical treatment facility staff members, which fulfills a wide parameter of functions regarding health education as defined by the local commander.

Community Health Education Program (CHEP): A program established at all Medical Centers and Medical Department Activities under the control of Health Services Command, with the purpose of gaining full cooperation from health care consumers and to capitalize on their contribution to an effective health care delivery system.

Computer Assisted Health Education: An Automated Data Processing (ADP) System which allows for patients to interact with ADP equipment in receiving answers to questions, etc.

Discharge Planning: A series of functions accomplished during the course of a patient's hospitalization, in order that appropriate care continuity is not interrupted.

Health Education: Those educational efforts designed to acquaint patient beneficiaries with necessary information, in order that they may better manage their health problems.

Health Promotion: Those educationally oriented efforts designed to encourage patient beneficiaries to maintain a good health status and avoid unnecessary illness.

Home Health Instruction: A wide variety of health education and health promotion presented by qualified personnel, to patients and their families within the home setting.

Judgemental-Desirability Rank Order: An opinion solicitation mechanism allowing respondents to affix a numerical ranking order to given statements.

Mailed Reminder Notices: A mechanism whereby the hospital sends mailed notices to patient beneficiaries, reminding them of recommended medical services that should be accomplished within a given period of time.

Medical Center: A large military medical treatment specialty center offering all levels of primary, secondary and tertiary care.

Medical Department Activity: A military medical organization normally consisting of a hospital, satellite troop/health clinics, veterinary activities and other subordinate facilities.

Medical Treatment Facility: Any medical facility, regardless of size, which provides direct patient care.

Patient Beneficiary: All personnel who, through their status in relation to the military service, have been declared by public law as eligible to receive routine medical care at Uniformed Services Medical Treatment Facilities.

Patient Education: Those educational efforts designed to acquaint patient beneficiaries with generally administrative information regarding health service procedures, policies, and services.

Phone-In Educational Tapes: A communication-electronic apparatus which allow for patients to telephonically call for health education instruction and information.

Positive-Negative Solicitation Mechanism: An opinion solicitation technique whereby those surveyed can respond negatively or positively to a question or statement.

Screening Booths: The establishment of a normally small station at a selected location where beneficiaries may have elements of their health state measured and appropriate guidance and advice provided.

Standing Operating Procedures: Written protocols developed by sections within an organization, delineating actions that should be taken under certain circumstances.

United States Army Health Services Command (HSC): A major military command under the direct control of the Office of the Surgeon General, and is responsible for the supervision of most Army medical treatment facilities located in the Continental United States, Alaska and Panama.

APPENDIX B

PATIENT HEALTH EDUCATION OPINION SURVEY
QUESTIONNAIRE FOR SELECTED STAFF MEMBERS

Patient Health Education Opinion Survey Questionnaire for Selected Staff
Members

Dear Staff Member:

Thank you for sparing a few minutes to complete this questionnaire. Its purpose is to evaluate the Patient Health Education efforts at the Fort Benning Medical Department Activity as seen through your eyes. The opinions you render will be analyzed with all other completed questionnaires, and may be used in planning our Patient Health Education Program of the future.

This questionnaire contains three basic parts. Part I is designed to gather input regarding subject matter and methodologies that you feel should be employed in our patient health education effort. Part II solicits your opinions regarding target patient populations that the health education should be focused toward, as well as those identifiable shortcomings effecting the present program. Part III is simply designed to gather administrative data which will aid us in compiling our results. There is also a short section where you can add any additional comments.

PART I

Section A - Methods

Instructions: Of the ten below listed types of patient health education delivery methods, please rank them in order (from 10 to 1) for the method you feel "most desirable" (by inserting the number "10" next to the respective item), down to the "least desirable" (by inserting the number "1"). Please do not leave any items blank.

10 = Most Desirable
1 = Least Desirable

1. Closed-circuit health education television within the hospital facilities. ☐
2. Printed brochures and handouts available at hospital, clinics, and at selected locations on post. ☐

- 3. Guest speakers to groups, clubs, etc. ☐
- 4. Home health visits. ☐
- 5. "Dial-A-Message" telephone services (where patients can call a selected number for a certain health subject and listen in the privacy of their own home.) ☐
- 6. Radio and television spot announcements. ☐
- 7. "The Benning Bulletin" notices. ☐
- 8. Articles in the post newspaper (Bayonet). ☐
- 9. Mailed reminder notices. ☐
- 10. Orientation folders and briefings to new members of the military community. ☐

PART I

Section B - Patient Health Education Subjects

Although it is realized that the below listed subjects are all important, gaining your opinion as to where the Command should place its emphasis with its limited resources will be helpful.

Instructions: Please rank these subjects according to your opinion of their importance. Insert "10" for that subject area you feel most important (and should therefore get priority), down through "1" for that subject you feel is the least important. You may add to this listing (and appropriately rank) two additional areas not specifically identified.

- 1. Medical-administrative information such as clinic services, telephone numbers, hours of operation, etc. ☐
- 2. Chronic disease management (i.e., guidance for the coronary patient, diabetic patient, etc.). ☐
- 3. "Home Medical Advisors" containing information on treatment of minor illnesses in the home, poison antidotes, etc. ☐
- 4. Subjects relating to psychiatric or psychological problems (i.e., stress management, depression, loneliness, etc.). ☐
- 5. Preventive-oriented subjects such as the importance of proper diet and exercise, how to reduce risk of heart disease, etc. ☐
- 6. Public health subjects such as good personal hygiene, pest and rodent control, importance of immunizations, etc. ☐

7. Emergency lifesaving and first aid (i.e., CPR, Heimlich maneuver, snakebites, controlling of bleeding, etc.). ☐

8. Explanation of policies and procedures in health care delivery systems at Martin Army Hospital (i.e., medical record custodianship, appropriate use of Emergency Room, etc.). ☐

9. Other: _____ ☐

10. Other: _____ ☐

PART II

Section A - Patient Beneficiaries

Although it is also realized that each individual program or patient health education component that is undertaken, focuses on a respective segment of our patient beneficiaries, in general terms we solicit your opinion as to what specific segment of the patient population needs the most attention.

Instructions: Rank the following general portions of the population by inserting an "8" in the respective box for that segment which, in your opinion, needs attention immediately, down to "1" for that segment which is, in your opinion, least in need.

1. Active duty members in rank of E-1 to E-4 (and their dependents). ☐
2. Active duty members in rank of E-5 to E-9 (and their dependents). ☐
3. Active duty officers and warrant officers (and their dependents). ☐
4. Retired members and their dependents. ☐
5. Members of the Civil Service workforce employed at the Fort Benning installation. ☐
6. Soldiers of foreign nations (and their dependents) who are undergoing training at Fort Benning. ☐
7. Reserve and National Guard personnel. ☐
8. Dependents of deceased servicemembers. ☐

PART IISection B - Program Shortcomings

The following problem areas may or may not exist with our present patient health education program.

Instructions: Please place a check in the "YES" box if you feel the problem does exist to a significant degree. Conversely, place a check in the "NO" box if you feel that the problem does not significantly exist.

- | | <u>YES</u> | <u>NO</u> |
|---|--------------------------|--------------------------|
| 1. Poor execution of past/present programs. | ☐ | ☐ |
| 2. Lack of interdepartmental coordination. | ☐ | ☐ |
| 3. Lack of staff section, body or individual to oversee program implementation. | ☐ | ☐ |
| 4. Lack of adequate pre-implementation planning. | ☐ | ☐ |
| 5. Lack of ability to evaluate the effectiveness of programs. | ☐ | ☐ |
| 6. Lack of formally trained health educators. | ☐ | ☐ |
| 7. Lack of adequate personnel resources in general. | ☐ | ☐ |
| 8. Lack of adequate monetary and material resources. | ☐ | ☐ |
| 9. Command apathy. | ☐ | ☐ |
| 10. Staff apathy. | ☐ | ☐ |
| 11. Patient apathy. | ☐ | ☐ |

PART III

Please place a check in the appropriate box next to each response:

Rank (if military):

☐ E-1 to E-4 ☐ E-5 to E-9 ☐ O1 to O3 ☐ O4 to O6 ☐ Other

Rating/Classification (if civilian):

☐ GS-1 to GS-4 ☐ GS-5 to GS-10 ☐ GS-11 and Above ☐ WG-1 to WG-5 ☐ WG-6 and Above

☐ Other

Career Field:

☐ Physicians, Dentists, etc. ☐ Nurse, Physical Therapy, Occupational Therapy, etc. ☐ Administrative ☐ Other

APPENDIX C

PATIENT HEALTH EDUCATION OPINION SURVEY
QUESTIONNAIRE FOR PATIENTS

Patient Health Education Opinion Survey Questionnaire for Patients

Dear Patient:

Thank you for sparing a few minutes to complete this questionnaire. Its purpose is to evaluate the Patient Health Education Program of the Fort Benning Medical Department Activity as seen through your eyes. The opinion you render will be analyzed with all other completed questionnaires, and will be used in planning our Patient Health Education Programs of the future.

This questionnaire contains three short parts. Part I is designed to measure your awareness and use of presently established patient health education efforts. Part II is designed to gain your recommendations as to which direction the Health Education Program of the future should take. Part III is simply administrative data which will aid us in compiling our results. There is also a short section where you can add any additional comments.

PART I

Patient Health Education can take many forms. Generally the subject can be classified into categories which includes Medical-Administrative Subjects (such as Patient Education and Patient Information); Medical Subjects such as for the proper care for those with chronic diseases, treatment of minor illness, etc.); and Preventive Medicine Subjects (stressing the importance of immunizations, balanced diet, proper exercise, etc.). The listing included below is a sampling of some of the patient health education efforts presently available within the Fort Benning MEDDAC.

Instructions: Please place a check in the appropriate box next to each respective item. Two answers are desired for each response. For example, the first item is the "Patient Assistance Liaison" (PAL) Office. If you know of its existence, place a check in the box under the "known to me" column. If you have ever used this office, place a check in the box under the column labelled "have used." Other responses can be made to succeeding items in a similar manner.

<u>HEALTH EDUCATION RESOURCE</u>	<u>Known to me</u>	<u>Unknown to me</u>	<u>Have Used</u>	<u>Have Not Used</u>
1. Patient Assistance Liaison (PAL) Office.	☐	☐	☐	☐

<u>HEALTH EDUCATION RESOURCE</u>	<u>Known to me</u>	<u>Unknown to me</u>	<u>Have Used</u>	<u>Have Not Used</u>
2. Health nurse home visits following childbirth.	☐	☐	☐	☐
3. "Outpatient Bulletin" Newsletter.	☐	☐	☐	☐
4. "Patient Medical Advisor" booklet.	☐	☐	☐	☐
5. "Pediatric Medical Advisor" booklet.	☐	☐	☐	☐
6. Blood pressure screening at PX Mall.	☐	☐	☐	☐
7. Medical services briefings at club meetings, etc.	☐	☐	☐	☐

PART II

Which of the following methods of patient health education do you think is best?

Instructions: Of the ten below listed types of patient health education delivery methods, please rank them in order of those you feel are "most desired" (by inserting the number "10" next to the respective item), down to those you feel are "least desired" (by inserting the number "1"). Please do not leave any items blank.

10 = Most Desirable
1 = Least Desirable

1. Closed-circuit patient health educational television within the hospital and clinic facilities. ☐
2. Printed brochures and handouts available at hospital, clinics, and at selected locations on post. ☐
3. Guest speakers at unit formations and at meetings of groups, clubs, etc. ☐
4. Health visits made to homes. ☐
5. "Dial-A-Message" telephone services (where a patient can call a selected number for a certain health subject and receive that information in the privacy of their own home). ☐
6. Public radio and television spot announcements. ☐
7. "The Benning Bulletin" (weekly bulletin). ☐

8. Articles in the post newspaper (Bayonet) and civilian newspapers. ☐
9. Health educational material mailed to the home or unit. ☐
10. Orientation folders and briefings to new members of the military community. ☐

PART III

Please place a check in the appropriate box next to each response:

My age is: ☐ 14-25 Yrs ☐ 26-39 Yrs ☐ 40-60 Yrs ☐ 61 Yrs + Over

I am: ☐ On Active Duty in the Military. ☐ A Dependent of Active Duty Member ☐ A Retired Member ☐ A Dependent of Retired Member ☐ Other

I have used the hospital or clinic facilities at Fort Benning (including dental facilities) within the past year:

☐ 1-3 Times ☐ 4-6 Times ☐ 7-10 Times ☐ 11-20 Times ☐ 21 or More Times

My rank is (for Active Duty Military only):

☐ E-1 thru E-4 ☐ E-5 thru E-7 ☐ E-8 thru E-9 ☐ CWO-CW-4 ☐ O-1 thru O-3 ☐ O-4 thru O-5

☐ O-6 thru O-9

ADDITIONAL COMMENTS: _____

Please return the questionnaire to the surveyor. Your cooperation and responses are appreciated.

COMMANDER
FORT BENNING MEDICAL DEPARTMENT
ACTIVITY

APPENDIX D
AMBULATORY CARE WORKLOAD
BY PATIENT CATEGORY
JANUARY 1979 - DECEMBER 1979

TABLE 1 - Ambulatory Care Workload by Patient Category, Monthly/Daily Average, Fort Benning MEDDAC, January 1979 - December 1979

<u>STATUS CATEGORY</u>	<u>MONTHLY AVERAGE</u>	<u>DAILY AVERAGE</u>	<u>PERCENTAGE OF DISTRIBUTION</u>
Active Duty Military Personnel	25,694	857	48.2
Retired Members	5,024	167	9.4
Dependents of Active Duty Military Personnel	15,119	504	28.3
Dependents of Retired/ Deceased Members	6,874	229	12.9
Others	<u>618</u>	<u>21</u>	<u>1.2</u>
TOTAL:	53,329	1,778	100.0

Source: Headquarters, United States Army Medical Department Activity, "Medical Summary Reports," RCS-MED 302 (Fort Benning, Georgia: January through December 1979).

APPENDIX E

MEDDAC STAFFING LEVELS
BY GENERAL CATEGORY
AS OF 31 DECEMBER 1979

TABLE 2 - Staffing Levels by General Category, Fort Benning, MEDDAC,
31 December 1979

<u>CATEGORY OF STAFF</u>	<u>ASSIGNED PERSONNEL</u>	<u>PERCENTAGE</u>
Officer/WO (Total)	251	17.7
Officer	244	17.2
CWO	7	0.5
Enlisted (Total)	407	28.8
Civilian (Total)	757	53.5
Wage Grade	126	8.9
General Schedule	631	44.6
TOTAL MEDDAC:	<u>1,415</u>	<u>100.0</u>

APPENDIX F

A SAMPLING OF
METHODOLOGIES EMPLOYED
IN HOSPITAL-BASED PATIENT
HEALTH EDUCATION PROGRAMS

APPENDIX F

Typical Methodologies Employed in Hospital-Based Health Education Programs

Printed booklets, instruction sheets, flyers, news media announcements, etc.

Public speaking efforts, public radio and TV announcements/interviews, orientations, panel discussions, etc.

Patient questionnaires and surveys.

Phone-in educational tapes.

Home health instruction.

Health instruction by health providers, educators, and paraprofessionals in the inpatient and outpatient settings.

Closed circuit TV educational broadcasts, audiovisual instructions, etc.

Mailed reminder notices.

Computer assisted health education.

Screening booths for selected illnesses at shopping centers, public facilities, etc.

Conducting of health preservation/first aid training.

Tours and open house at Medical Treatment Facilities.

APPENDIX G

FREQUENTLY ADDRESSED SUBJECT
MATTER IN HEALTH EDUCATION

APPENDIX G

Frequently Addressed Subject Matter in Health Education

Medical-Administrative Oriented:

1. Facility services, hours of operation, key telephone numbers, procedures for facility use, et.
2. Regularly published bulletins reflecting changes in delivery procedures, administrative subjects, etc.
3. Patient complaints and assistance.
4. The role and duties of health care providers.

Medical Oriented:

1. Management of minor illnesses.
2. First aid and cardiopulmonary resuscitation.
3. Discharge planning.
4. Chronic disease management.
5. Coping with illness.
6. Stress management.
7. Medical research.
8. Home care and family adjustment.

Preventive Medicine Oriented:

1. Immunology.
2. Prevention of heat and cold injuries.
3. Safety and accident prevention.
4. Recognizing disease warning signs and symptoms.
5. Proper health maintenance and eating habits.

6. Sanitation and infection control.
7. Sports injury prevention.
8. Insect and rodent control.
9. Dental hygiene.
10. Poison prevention.
11. Epidemiology.
12. Occupational health.

APPENDIX H

ROLE AND FUNCTIONS OF THE
CONSUMER HEALTH AND EDUCATION COMMITTEE
FORT BENNING, GEORGIA

ROLE AND FUNCTIONS OF THE CONSUMER HEALTH AND EDUCATION COMMITTEE

PURPOSE: To provide a communication means for transmittal of information, suggestions, and expressed concerns of the Army community about health services; to improve consumer education and information services; to provide a means of conveying concern regarding health entitlements, benefits, and changes thereto; to provide plans and recommendations for implementation of new or projected services to meet the needs of the health consumer; to increase the effectiveness with which the Medical Treatment Facility and its supported population interact; to formulate objectives, policies, and guidance concerning the MEDDAC's Community Health Education Program.

FUNCTIONS:

- a. To familiarize the population with the Medical Treatment Facility organization, policies, schedules, and services.
- b. To assist individuals in learning to manage minor illnesses and injuries on a self-help basis.
- c. To encourage the maintenance of immunizations.
- d. To maintain an awareness of preventive measures for personal illnesses and injuries.
- e. To provide a community health education and information program that will enhance the effectiveness with which the MEDDAC and its supported community interact.
- f. To provide a medium for the exchange of ideas relating to the shared responsibility of the MEDDAC, and its supported community, in maintaining quality care.
- g. To provide an avenue for the evaluation of current health education and information programs to insure that the targeted public is being reached.
- h. To create awareness of problems unique to the MEDDAC which have impact on the supported population.

i. To review the comments and recommendations of the Human Relations Training Program and act on these as necessary.

j. To provide an avenue for discussion between the MEDDAC and its consumers on such topics as identifying problems, recommending solutions, and explaining changes in policy.

STANDING MEMBERSHIP: (With Vote)

Chairperson - MEDDAC Commander
 Deputy Chairperson - Director, Dental Services
 Recorder - Chief, Clinical Support Division (Secretarial support provided by CSD).
 Patient Affairs Officer
 Representative, Army Community Services
 Representative, Executive Officer, MEDDAC
 Representative, Preventive Medicine Activity
 Chief, Department of Primary Care and Community Medicine
 Hospital Inspector, Martin Army Hospital
 Administrative Resident, Martin Army Hospital (Ex Officio)
 Representative, Social Work Services
 Chief, Patient Administration Division
 Consumer Representatives - Active Duty Personnel:
 Representative, Assistant Commander, Fort Benning
 Post Command Sergeant Major
 1st AIT Brigade Command Sergeant Major
 197th Infantry Brigade Command Sergeant Major
 36th Engineer Group Command Sergeant Major
 The School Brigade Command Sergeant Major
 34th Medical Battalion Command Sergeant Major
 Directorate of Personnel and Community Activities
 Consumer Representatives - Dependents:
 Dependents of Active Duty, Retirees, and Dependents of Retirees, who are full-time Federal Government employees - the number and name to be provided by the Post Commander.

OTHER MEMBERSHIP: (Without Vote)

Representative, Active Duty Dependent Officers' Wives Club
 Representative, Retired Dependent Officers' Wives Club

Representative, Active Duty Dependent Noncommissioned Officers' Wives Club
 Representative, Retired Dependent Noncommissioned Officers' Wives Club
 Representative, Retired Officers Council
 Representative, Retired Noncommissioned Officers Council
 Representative, AUSA

MEETS: Quarterly or as necessary at the call of the Chairperson.

OFFICE OF RECORD FOR APPROVED MINUTES: Central Files, Headquarters, Martin Army Hospital.

FORMAL DISTRIBUTION OF APPROVED MINUTES: One copy of the approved minutes will be distributed to each Committee member; one copy provided to the Office of Record, and one copy to Health Services Command, ATTN: HSPA-A.

AUTHORITY:

- a. AR 40-2.
- b. Ambulatory Patient Care (APC) Program, Chapter 4, Section A, 1 October 1977.

REFERENCES:

- a. AR 40-2.
- b. APC Program, HSC, 1 October 1977.
- c. APC Models 6, 14, and 15.

SPECIAL INSTRUCTIONS:

- a. Responsibilities:
 - (1) Health Consumer and Community Health Education Committee. Recommend to the MEDDAC Commander ways to improve health care provided to the military community.
 - (2) MEDDAC.

(a) Evaluate consumer input.

(b) Take corrective action on comments/recommendations that are within the MEDDAC scope of authority.

(c) Develop procedures/means to provide response to all the consumers served by the MTF.

(3) Health Services Command.

(a) Review MEDDAC's Consumer Health and Education Committee reports.

(b) Take corrective action on comments/recommendations that are within HSC's scope of authority.

(c) Forward consumer comments/recommendations relevant to Department of the Army health policies through channels to HQDA (DASG-HCP), Washington, D.C. 20310.

(d) Provide responses to consumer comments/recommendations to the MEDDAC concerned.

(4) HQDA (Office of the Surgeon General).

(a) Review comments/recommendations received.

(b) Consider comments/recommendations in the decision-making process.

(c) Provide response to comments/recommendations to the medical company.

b. Tenure:

(1) Chairman - Duration of assignment.

(2) Deputy Chairman - Duration of assignment.

(3) Recorder - Duration of assignment.

(4) Army Community Services - Duration of assignment or employment.

- (5) Active Duty Personnel - One to two years.
- (6) Dependents of Active Duty Retirees) One to two years
 Dependents of Retired Full-Time) - contingent upon
 Federal Government Employees) employment.
- (7) Other MEDDAC Representatives - As deemed appropriate by the
 Chairman.

Source: United States Army Medical Department Activity, Fort
 Benning, Georgia, MEDDAC Regulation 15-1, MEDDAC Committees.
Subcommittees, Conferences, Boards and Councils, Fort Benning,
 Georgia, 1 July 1979.

APPENDIX I

Identified Health Education/Patient
Education Endeavors
MEDDAC, Fort Benning, Georgia

APPENDIX I

TABLE 3. Identified Health Education Endeavors, Fort Benning, MEDDAC

<u>SUBJECT ADDRESSED/ PROGRAM</u>	<u>RESPONSIBLE STAFF SECTION</u>	<u>METHOD OF EDUCATIONAL DELIVERY</u>	<u>TARGET POPULATION ADDRESSED</u>	<u>SITE UTILIZATION</u>
Back Care Classes	Physical Therapy	Verbal/Classroom Instruc- tion	Beneficiaries with back problems	PT Clinic; Wards, MAH
Behavior Weight Con- trol (20 Weeks)	Occupational Therapy; Diet Therapy	Classroom Instruction; Group Discussion; Printed Literature	Selected eligible bene- ficiaries with weight problems and no compli- cations	Clinical facili- ties, MAH
Birth Control Counsel- ing Program	Clinical Health Nurse	Classroom Instruction; Printed Literature	Active duty female per- sonnel	Selected Post facilities
Cardiac After Care (Rehabilitation) Group (5 Weeks)	Cardiology Ser- vice; Occupa- tional Therapy; Physical Therapy; Diet Therapy	Classroom Instruction; Individual Counseling; Demonstration; Printed Literature	Eligible beneficiaries admitted to MAH with Cardiac problems	Inpatient and Out- patient facili- ties, MAH
"Caring" Briefings	Patient Assis- tance Liaison	Verbal; Printed Literature	Staff members	Throughout MAH
CHAMPUS Benefits Briefings	Patient Admini- stration Division	Verbal/Classroom Instruc- tion; Printed Literature	All eligible benefi- ciaries	Various locations on or off Post (on request)
Chronic Disease Management	Department of Nursing	Classroom Instruction; Printed Literature	Staff members, MAH	Classroom facili- ties, MAH
Connective Tissue Disease Program	Occupational Therapy	Individual Counseling; Individualized Treatment Regimen.	Eligible beneficiaries with some form of arthritis	Occupational Therapy, MAH



TABLE 3. Identified Health Education Endeavors, Fort Benning, MEDDAC (CONT'D)

<u>SUBJECT ADDRESSED/ PROGRAM</u>	<u>RESPONSIBLE STAFF SECTION</u>	<u>METHOD OF EDUCATIONAL DELIVERY</u>	<u>TARGET POPULATION ADDRESSED</u>	<u>SITE UTILIZATION</u>
Death and Dying Seminar	Clinical Health Nurse and Hospital Chaplain	Seminar; Printed Literature; Audiovisual Aides	Selected staff members	Hospital
Diabetic Management Classes	Physical Therapy, Medical Specialty Clinic	Verbal/Classroom Instruction; Printed Literature	Diabetic beneficiaries and their families	Clinical facilities, MAH
Diabetic Counseling Sessions	Department of Medicine; Occupational Therapy	Classroom Discussion; Counseling	Eligible beneficiaries with diabetes	Meeting facilities, MAH
Diet Screening Walk-In Program	Food Service Division	Verbal Instruction; Printed Literature	Beneficiaries with nutritional problems	Diet Therapy Clinic, MAH
Discharge Classes for New Mothers	Labor and Delivery/Post Partum	Discussion; Printed Literature	All recently delivered mothers pending discharge	Post Partum Ward ⁷⁰
Expectant Parents Classes	OB Clinic	Classroom Instruction; Printed Literature; Group Discussion	All eligible parent beneficiaries	OB Clinic, MAH
First Aid and Cardiopulmonary Resuscitation (CPR Training)	Department of Nursing	Classroom Instruction; Printed Literature; Demonstration	Staff members, MAH	Classroom facilities, MAH

TABLE 3. Identified Health Education Endeavors, Fort Benning, MEDDAC (CONT'D)

<u>SUBJECT ADDRESSED/ PROGRAM</u>	<u>RESPONSIBLE STAFF SECTION</u>	<u>METHOD OF EDUCATIONAL DELIVERY</u>	<u>TARGET POPULATION ADDRESSED</u>	<u>SITE UTILIZATION</u>
Grief Reaction Seminar	Staff Chaplain	Seminar	Selected staff members	Facilities at MAH
Health Education Articles for Post Newspaper (Bayonet) and Other Post Publications	Clinical Health Nurse; Public Affairs Office; Other Staff Members	Written Narrative	All eligible patient beneficiaries	N/A
Hearing Conservation Briefings	Audiology	Verbal/Classroom Instruction; Printed Literature; Videotapes	All eligible beneficiaries	Audiology Clinic, MAH; Other Locations (on invitation)
Hypertension Screening and Counseling Program	Clinical Health Nurse	Demonstration and Individual Counseling	All eligible patient beneficiaries	Selected Post facilities and PX's
Infant Bathing and Care Classes	Labor and Delivery	Demonstration; Printed Literature	All recently delivered mothers	Post Partum Ward
Management of Minor Illnesses Classes	Department of Nursing	Classroom Instruction; Printed Literature	Staff members, Department of Nursing	Classroom facilities, MAH
Medical Advisory Printed Literature (See Appendix J)	Clinical Support Division	Printed Literature	All eligible patient beneficiaries	Literature available at MAH and selected facilities on Post
Medical Public Awareness Program (Addressing a wide variety of subjects including Toy & Safety, Immunizations, Fire Protection, Exercise Classes, etc.)	Community Health Nurse	Classroom, Demonstration; Printed Literature, Audio-visual Aids	All eligible patient beneficiaries	PX, Life Centers, other public areas

TABLE 3. Identified Health Education Endeavors, Fort Benning, MEDDAC (CONT'D)

<u>SUBJECT ADDRESSED/ PROGRAM</u>	<u>RESPONSIBLE STAFF SECTION</u>	<u>METHOD OF EDUCATIONAL DELIVERY</u>	<u>TARGET POPULATION ADDRESSED</u>	<u>SITE UTILIZATION</u>
Musculoskeletal Injury Prevention Classes	Physical Therapy	Verbal/Classroom Instruction; Demonstrations	Hospital Staff Members	Wards, MAH
Nutrition Education Program	Food Service Division	Verbal/Classroom Instruction; Printed Literature	Beneficiaries with nutritional problems	Diet Therapy Clinic Wards, MAH
Oral Hygiene Group Instruction	DENTAC	Public Speaking; Printed Literature	All eligible beneficiaries	On invitation before requesting groups (or or off Post)
Oral Hygiene Instruction	DENTAC	In-Clinic Instruction; Printed Literature and Handouts	All Active Duty Military Personnel and Dependents of Active Duty Military	All Fort Benning Dental Clinics
Parent Education Program (Learning Disabilities Group)	Occupational Therapy	Forum; Classroom Discussion; Printed Literature	Eligible parent beneficiaries who have children with learning disabilities	Clinical facilities, MAH; Learning Abilities Center, MAH
Personal Hygiene, Grooming and First Aid Classes	Community Health Nurse	Classroom Instruction; Printed Literature	On invitation to all eligible beneficiaries and groups	Selected Post facilities
Post Partum Dental Hygiene Classes	DENTAC	On-Ward Instruction; Printed Literature	Female patients who recently delivered infants at MAH	Post Partum Ward; OB Clinic
Post Schools Fluoride Self-Application/Dental Hygiene Program	DENTAC	In-Class Instruction; Printed Literature; Demonstration	Grade School Aged Dependents of Active Duty Military	Fort Benning Elementary Schools
Post Partum Health Education Program	Community Health Nurse	Discussion; Individual Counselling; Printed Literature	All recently delivered eligible beneficiaries	Inpatient facilities, MAH; home visits.

TABLE 3. Identified Health Education Endeavors, Fort Benning, MEDDAC (CONT'D)

<u>SUBJECT ADDRESSED/ PROGRAM</u>	<u>RESPONSIBLE STAFF SECTION</u>	<u>METHOD OF EDUCATIONAL DELIVERY</u>	<u>TARGET POPULATION ADDRESSED</u>	<u>SITE UTILIZATION</u>
Prenatal Physical Therapy Classes	Physical Therapy	Verbal/Classroom Instruc- tion; Printed Literature	Expectant beneficiaries and their spouses	Clinical facili- ties, MAH
Prenatal Orientation	OB Clinic; Diet Therapy; Dental Clinic	Classroom Instruction; Printed Literature, Group Discussion	Eligible female benefi- ciaries particularly those expecting for the first time	OB Clinic, MAH
Prevention of Heat and Cold Injuries	Department of Nursing	Classroom Instruction; Printed Literature	Staff members, Department of Nursing, MAH	Classroom facili- ties, MAH
Preventive Dentistry School Programs	DENTAC	In-Class Instruction; Printed Literature; Movies; Demonstrations	Grade school aged depen- dents of Active Duty military	Fort Benning Ele- mentary Schools
Preventive Medicine Orientation	Preventive Medicine Activity	Discussion; Printed Literature	All unit commanders upon their request	At unit locations
Proper Medication Administration and Precautions	Pharmacy	Verbal Instruction; Printed Package Inserts	All eligible beneficiaries	Pharmacy, MAH
Psychiatric Life Skills Group (and Stress Manage- ment)	Department of Psychiatry; Occupational Therapy	Individual and Group Counselling; Discussion	Selected Active Duty psychiatric inpatients	Ward facilities, MAH
Recognizing Disease Warning Signs and Symptoms	Department of Nursing	Classroom Instruction; Printed Literature	Staff members, Department of Nursing, MAH	Classroom facili- ties, MAH

TABLE 3. Identified Health Education Endeavors, Fort Benning. MEDDAC (CONT'D)

<u>SUBJECT ADDRESSED/ PROGRAM</u>	<u>RESPONSIBLE STAFF SECTION</u>	<u>METHOD OF EDUCATIONAL DELIVERY</u>	<u>TARGET POPULATION ADDRESSED</u>	<u>SITE UTILIZATION</u>
Safety and Accident Prevention	Department of Nursing	Classroom Instruction; Printed Literature	Staff members, Department of Nursing, MAH	Classroom facilities, MAH
Sports Injury Prevention Classes	Physical Therapy	Verbal/Classroom Instruction	Basically the Active Duty military population	Various locations at Ft Benning (on invitation)
Systematic Training for Effective Parenting (S.T.E.P.) Program (6-9 Weeks)	Occupational Therapy	Classroom Discussion; Printed Literature	Eligible beneficiaries who are parents of young children or identified as child abusers	Occupational Therapy, MAH
Tuberculosis and Skin Testing Program	Community Health Nurse	Demonstration and Individual Counseling	All eligible patient beneficiaries	Selected Post facilities
Veterinary Client Information System	Veterinary Activity	AMSCOM Projector	All eligible beneficiaries seeking Veterinary Services	Veterinary Clinic, Ft Benning, GA
Weight Control/Physical Fitness Education Program	Food Service Division	Verbal/Classroom Instruction; Printed Literature; Self-Assessment	Beneficiaries with weight control problems	Diet Therapy Clinic, MAH

TABLE 4. Identification of Health Education Endeavors by Target Population

<u>MAJOR SEGMENTS OF BENEFICIARY POPULATION</u>	<u>NUMBER OF PROGRAMS</u>
A. All Eligible Beneficiaries (without further delineation)	12
- Active Duty Military Population Only (Male and Female Members)	1
- Active Duty Military Female Population	1
- Active Duty Members and Their Dependents	1
- Unit Commanders and Cadre	1
- Hospital Staff Members	11
- Grade School Aged Dependents of Active Duty Members	2
B. Beneficiaries with Unique Characteristics or Medical Problems	
- Beneficiaries with Nutritional Problems	4
- Beneficiaries with Back Problems	1
- Beneficiaries Expecting Children	2
- Beneficiaries with Diabetic Conditions	2
- Beneficiaries with Young Children	1
- Beneficiaries with Arthritis	1
- Beneficiaries with Cardiac Problems	1
- Beneficiaries with Children with Learning Disabilities	1

TABLE 4. Identification of Health Education Endeavors by Target Population (Cont'd)

<u>MAJOR SEGMENTS OF BENEFICIARY POPULATION</u>	<u>NUMBER OF PROGRAMS</u>
- Active Duty Psychiatric Inpatients	1
- Female beneficiaries Recently Delivered	<u>4</u>
TOTAL PROGRAMS PRESENTLY IN EFFECT	= 47

APPENDIX J

LOCALLY DEVELOPED
PRINTED HEALTH EDUCATION
LITERATURE

APPENDIX J

Fort Benning Locally Developed Printed Health Education Literature

1. USAIC Pamphlet 40-7 (Jan 79) Family Practice Medical Advisor (Proponent: Clinical Support Division).
2. USAIC Pamphlet 40-4 (Oct 79) Adult Medical Advisor (Proponent: Clinical Support Division).
3. USAIC Pamphlet 40-4-1 (Jan 79) Pediatric Medical Advisor (Proponent: Clinical Support Division).
4. Booklet, "Patient Rights and Responsibilities," February 1977 (Proponent: Clinical Support Division).
5. Handout, "General Outpatient Clinic," June 1979. (Proponent: Clinical Support Division).
6. Handout, "Application of Heat and Cold," no date, (Proponent: Physical Therapy).
7. Handout, "Phone Numbers for Clinic Appointments," 30 July 1979 (Proponent: Clinical Support Division).
8. Handout, no title, subject relates to routine Radiological Procedures, no date (Proponent: Radiology).
9. Handout, "Family Practice Department, Fort Benning, Georgia 31905," no date (Proponent: Department of Family Practice).
10. Handout, "Outpatient News Bulletin," published monthly (Proponent: Clinical Support Division).
11. Letter, Headquarters, USAMEDDAC, Fort Benning, Subject: Aviation Medicine/Family Practice Program, no date, 3 Inclosures.
12. Letter, Headquarters, USAMEDDAC, Fort Benning, Subject: Aviation Medicine Service/Family Practice, dated 4 January 1979, with 1 Inclosure.
13. Booklet, "Caring/The Most Important Part of Patient Care," no date (Proponent: Clinical Support Division).
14. Booklet, "The Prevention of Hearing Loss," no date (Proponent: Audiology).

APPENDIX K
RESULTS OF PATIENT BENEFICIARY
QUESTIONNAIRE

TABLE 5. Data Recapitulation - Patient Survey Questionnaire

Part I - Patient Health Education Subjects

SUBJECT	FREQUENCY OF RESPONSES n = 60		Have Used	Have Not Used	PERCENTAGE OF RESPONSES		Have Used	Have Not Used
	Known To Me	Unknown To Me			Known To Me	Unknown To Me		
1. Patient Assistance Liaison (PAL) Office	25	35	10	50	41.7	58.3	16.7	83.3
2. CHN Home Visits Following Childbirth	13	47	2	58	21.7	78.3	3.3	96.7
3. Outpatient Bulletin Newsletter	30	30	15	45	50.0	50.0	25.0	75.0
4. Patient Medical Advisor Booklet	17	43	9	51	28.3	71.7	15.0	85.0
5. Pediatric Medical Advisor's Booklet	15	45	6	54	25.0	75.0	10.0	90.0
6. Blood Pressure Screening at PX	25	35	5	55	41.7	58.3	8.3	91.7
7. Medical Service Briefings at Club Meetings	11	49	2	58	18.3	81.7	3.3	96.7

TABLE 6. Data Recapitulation - Patient Survey Questionnaire
Part II - Desired Methods for Health Education Delivery

SUBJECT	$\bar{X}$	MEDIAN	MODE	s	$\sigma_{\bar{X}}$	$\bar{X} \pm 1.96 \sigma_{\bar{X}}$		
1. Closed Circuit TV	5.67	6	10	3.398	.438	4.82	$\leq \bar{X} \leq$	6.53
2. Printed Brochures and Hand-outs	5.98	6	10	2.764	.357	5.28	$\leq \bar{X} \leq$	6.80
3. Guest Speakers	4.68	4	3	2.600	.335	4.02	$\leq \bar{X} \leq$	5.34
4. Home Health Visits	5.37	5	9	2.888	.373	4.64	$\leq \bar{X} \leq$	6.10
5. "Dial-A-Message"	6.88	8	10	2.835	.366	6.16	$\leq \bar{X} \leq$	7.60
6. Radio and TV Spot Announcements	4.70	4	2,3	2.612	.337	4.04	$\leq \bar{X} \leq$	5.36
7. Weekly Bulletin	5.28	5	7	2.450	.316	4.66	$\leq \bar{X} \leq$	5.90
8. Bayonet	5.35	5	8	2.863	.369	4.63	$\leq \bar{X} \leq$	6.07
9. Material Mailed to Home	5.22	5	1	3.001	.387	4.46	$\leq \bar{X} \leq$	5.98
10. Orientation Folders and Briefings	6.13	7	8	2.819	.364	5.42	$\leq \bar{X} \leq$	6.84

TABLE 7. Data Recapitulation - Patient Survey Questionnaire

Part III - Administrative Data from Respondants

<u>SUBJECT</u>	<u>FREQUENCY OF RESPONSES</u> n = 60	<u>PERCENTAGE OF RESPONSES</u>
<u>Age:</u>		
14-25 Years	26	43.3
26-39 Years	18	30.0
40-60 Years	16	26.7
61 Years	0	0.0
<u>Status:</u>		
Active Duty	33	55.0
Dependent of Active Duty	6	10.0
Retired	5	8.3
Dependent of Retired	12	20.0
Other	4	6.7
<u>Use of Martin Army Hospital:</u>		
1-3 Times	36	60.0
4-6 Times	14	23.3
7-10 Times	4	6.7
11-20 Times	4	6.7
21 or More Times	2	3.3
<u>Rank:</u>		
E-1 to E-4	19	31.7
E-5 to E-7	13	21.7
E-8 to E-9	1	16.7
CWO to CW-4	0	0.0
O-1 to O-3	3	5.0
O-4 to O-5	0	0.0
O-6 to O-9	0	0.0

APPENDIX L
RESULTS OF STAFF QUESTIONNAIRE

TABLE 8. Data Recapitulation - Staff Survey Questionnaire

Part I, Section A - Patient Health Education Delivery Methods

METHOD	$\bar{x}$	MEDIAN	MODE	s	$\sigma_{\bar{x}}$	$\bar{x} \pm 1.96 \sqrt{\bar{x}}$		
1. Closed Circuit TV	6.15	7	10	3.82	.647	4.88	$\leq \bar{x} \leq$	7.42
2. Printed Brochures	7.47	8	9	2.36	.400	6.69	$\leq \bar{x} \leq$	8.25
3. Guest Speakers	4.85	5	8	2.54	.431	4.01	$\leq \bar{x} \leq$	5.69
4. Home Health Visits	5.21	5	2	4.81	.815	3.91	$\leq \bar{x} \leq$	6.52
5. "Dial-A-Message"	6.24	7	8	2.69	.380	5.50	$\leq \bar{x} \leq$	6.98
6. Radio and TV Announcements	4.47	5	1,6	2.39	.405	3.68	$\leq \bar{x} \leq$	5.26
7. Weekly Bulletin	4.82	4	2	2.67	.453	3.93	$\leq \bar{x} \leq$	5.71
8. Bayonet	5.53	7	7	2.45	.415	4.72	$\leq \bar{x} \leq$	6.34
9. Mailed Reminder Notices	4.12	4	2,6	2.01	.341	3.45	$\leq \bar{x} \leq$	4.79
10. Orientation Folders and Briefings	6.00	6	9	2.88	.488	5.04	$\leq \bar{x} \leq$	6.96

TABLE 9. Data Recapitulation - Staff Survey Questionnaire
Part I, Section B - Patient Health Education Subjects

METHOD	$\bar{x}$	MEDIAN	MODE	s	$\sigma_{\bar{x}}$	$\bar{x} \pm 1.96 \sigma_{\bar{x}}$		
1. Medical-Admin Information	6.15	6	8	1.95	.331	5.06	$\leq \bar{x} \leq$	6.36
2. Chronic Disease Management	4.94	5	7	2.09	.355	4.25	$\leq \bar{x} \leq$	5.64
3. Medical Advisors	5.44	5	6	2.13	.361	4.73	$\leq \bar{x} \leq$	6.15
4. Psychiatric Problems	3.88	4	5	2.04	.346	3.20	$\leq \bar{x} \leq$	4.56
5. Preventive Oriented Subjects	4.15	4	4	2.32	.393	3.38	$\leq \bar{x} \leq$	4.92
6. Public Health Subjects	3.56	3	2	2.22	.376	2.82	$\leq \bar{x} \leq$	4.30
7. Emergency Medical Service and First Aid	5.62	5	5,6	2.55	.432	4.77	$\leq \bar{x} \leq$	6.47
8. MTF Policies and Procedures	4.24	4	4	2.57	.436	3.39	$\leq \bar{x} \leq$	5.09

TABLE 10. Data Recapitulation - Staff Survey Questionnaire

Part II, Section A - Patient Beneficiaries

BENEFICIARY GROUP	$\bar{x}$	MEDIAN	MODE	s	$\sigma_{\bar{x}}$	$\bar{x} \pm 1.96 \sigma_{\bar{x}}$		
1. E-1 to E-4 (and their Dependents)	8.26	8	8	3.55	.602	7.08	$\leq \bar{x} \leq$	9.04
2. E-5 to E-9 (and their Dependents)	7.00	7	7	2.04	.346	6.32	$\leq \bar{x} \leq$	7.678
3. Officers and Warrant Officers (and their Dependents)	5.65	6	6	1.28	.217	5.23	$\leq \bar{x} \leq$	6.08
4. Retired Members and their Dependents	5.24	5	5	1.56	.265	4.72	$\leq \bar{x} \leq$	5.76
5. Civil Service Employees	2.68	3	2,4	1.37	.232	2.34	$\leq \bar{x} \leq$	3.24
6. Allied Military Members and their Dependents	2.15	2	1	1.21	.190	1.78	$\leq \bar{x} \leq$	2.52
7. Reserve and National Guard Personnel	2.91	3	2,3	1.19	.202	2.51	$\leq \bar{x} \leq$	3.31
8. Dependents of Deceased Service Members	3.24	4	4	1.88	.318	2.62	$\leq \bar{x} \leq$	3.86

TABLE 11. Data Recapitulation - Staff Survey Questionnaire

Part II, Section C - Program Shortcomings

<u>SHORTCOMING</u>	<u>FREQUENCY OF RESPONSES</u>		<u>PERCENTAGE OF RESPONSES</u>	
	<u>YES</u>	<u>NO</u>	<u>YES</u>	<u>NO</u>
1. Past poor execution	17	17	50.0	50.0
2. Lack of interdepartmental coordination	25	9	73.5	26.5
3. Lack of staff section, body or individual to oversee program	20	14	58.8	41.2
4. Lack of adequate pre-implementation planning	14	20	41.2	58.8
5. Lack of ability to evaluate the effectiveness of programs	14	20	41.2	58.8
6. Lack of formally trained health educators	16	18	47.1	52.9
7. Lack of adequate personnel resources in general	23	11	67.6	32.4
8. Lack of adequate monetary and materiel resources	21	13	61.8	38.2
9. Command apathy	15	19	44.1	55.9
10. Staff apathy	15	19	44.1	55.9
11. Patient apathy	19	15	55.9	44.1

TABLE 12. Data Recapitulation - Staff Survey Questionnaire

Part III - Administrative Information (Rank/Rating)

<u>RANK/RATING</u>	<u>FREQUENCY OF RESPONSES (n = 34)</u>	<u>PERCENTAGE OF RESPONSES</u>
Rank (If military):		
E-1 to E-4	4	11.8
E-5 to E-9	7	20.6
O-1 to O-3	4	11.8
O-4 to O-6	0	0.0
Warrant Officer	<u>1</u>	<u>2.9</u>
TOTAL:	16	47.1
Rating (If civilian):		
GS-1 to GS-4	6	17.6
GS-5 to GS-10	8	23.5
GS-11 and Above	2	5.9
WG-1 to WG-5	0	0.0
WG-6 and Above	2	5.9
Other	<u>0</u>	<u>0.0</u>
TOTAL:	18	52.9

TABLE 13. Data Recapitulation - Staff Survey Questionnaire

Part III - Administrative Information (Career Field/Job Setting)

<u>CAREER FIELD/ JOB SETTING</u>	<u>FREQUENCY OF RESPONSES</u>	<u>PERCENTAGE OF RESPONSES</u>
<u>Career Field</u>		
1. Physician, Dentist, etc	2	5.9
2. Nurse, Physical Therapist, Occupational Therapist, etc.	7	20.6
3. Administrative	7	20.6
4. Other	<u>18</u>	<u>52.9</u>
TOTAL:	34	100.0
<u>Job Setting</u>		
1. Direct Patient Care	16	47.0
2. Direct Support of Patient Care	7	20.6
3. Administrative	8	23.6
4. Other	<u>3</u>	<u>8.8</u>
TOTAL:	34	100.0

APPENDIX M

MANHOUR EXPENDITURE ESTIMATES
FOR EXISTING HEALTH EDUCATION
PROGRAMS

TABLE 14. Manhour Expenditure Estimates for Existing Health Education Programs (FY 1979)

<u>PROGRAM</u>	<u>ESTIMATED MANHOUR EXPENDITURE (FY 79)</u>
Back Care Classes	520
Behavior Weight Control	120
Birth Control Counseling Program	72
Cardiac After Care Group	200
"Caring" Briefings	25
CHAMPUS Benefits Briefings	30
Chronic Disease Management	260
Connective Tissue Disease Program	208
Death and Dying Seminars	32
Diabetic Management Classes	108
Diabetic Counseling Sessions	96
Diet Screening Walk-In Program	174
Discharge Classes for New Mothers	182
Expectant Parents Classes	144
First Aid and CPR Training	232
Grief Reaction Seminars	24
Health Education Articles	156
Hearing Conservation Briefings	72
Hypertension Screening and Counseling	96
Infant Bathing and Care Classes	245
Management of Minor Illness Classes	115
Medical Advisory Printed Literature	104
Medical Public Awareness Program	310
Musculoskeletal Injury Prevention Classes	50
Nutrition Education Program	116
Oral Hygiene Group Instruction	52
Oral Hygiene Instruction	72
Parent Education Program	76
Personal Hygiene Grooming and First Aid Classes	40
Post Partum Dental Hygiene Classes	15
Post Schools Flouride Self-Application/Dental Hygiene Program	105
Post Partum Health Education Program	78
Prenatal Physical Therapy Classes	26
Prenatal Orientation	70
Prevention of Heat and Cold Injuries	36
Preventive Dentistry School Programs	85
Preventive Medicine Orientation	20
Proper Medication, Administration and Precautions	10

TABLE 14. Manhour Expenditure Estimates for Existing Health Education Programs (FY 1979)

<u>PROGRAM</u>	<u>ESTIMATED MANHOUR EXPENDITURE (FY 79)</u>
Psychiatric Life Skills Group	15
Recognizing Disease Warning Signs and Symptoms	25
Safety and Accident Prevent	36
Sports Injury Prevention Classes	17
S.T.E.P. Program	36
Tuberculosis and Skin Testing Program	85
Veterinary Clinic Information System	56
Weight Control/Physical Fitness Program	27
TOTAL FY1979 ESTIMATED MANHOURS EXPENDED =	4,673

APPENDIX N
OPTIONS FOR CONSIDERATION

APPENDIX H

TABLE 15. Options for Consideration

GOAL/OBJECTIVE	PORTION OF TARGET POPU- LATION AD- DRESSED	OPTION A	OPTION B	OPTION C	ESTIMATED GENERAL RESOURCE REQUIREMENTS	ESTIMATED TIME FRAME REQUIREMENTS
<u>Goal 1:</u>						
Improve control, direction and management of overall Health Education Program	N/A	X	X	X		12-15 Months
Objective 1A - Establish CHEP Committee	N/A	X	X		Minimal (1 pt)	3 Months
Objective 2A - Vest Defined Authority in Appointed Staff Officer	N/A	X	X		Minimal (1 pt)	3 Months
Objective 3A - Define Specific Short and Long Term Goals	N/A	X	X	X	Minimal (1 pt)	6 Months
Objective 4A - Determine Costs in Manpower and Materiel Presently Being Expended with Existing Programs	N/A	X	X	X	Moderate (2 pts)	6 Months
Objective 5A - Conduct Survey of Resources Available from Other Agencies and Activities	N/A	X	X		Considerable (3 pts)	12 Months
Objective 6A - Develop Mechanism for Evaluating Program Components	N/A	X	X		Considerable (3 pts)	12-15 Months

TABLE 15. Options for Consideration

GOAL/OBJECTIVE	PORTION OF TARGET POPU- LATION AD- DRESSED	OPTION A	OPTION B	OPTION C	ESTIMATED GENERAL RESOURCE REQUIREMENTS	ESTIMATED TIME FRAME REQUIREMENTS
Objective 7A - Define and Implement Health Strategy Including Selling Program to Staff	N/A	X	X	X	Moderate (2 pts)	6 Months
Objective 8A - Determine Budgetary Limitations of Program	N/A	X	X	X	Moderate (2 pts)	6 Months
Goal 2: Select Program Components Commensurate with Determined Goals and Objectives and Appropriate Delivery Mechanisms		X	X	X		6 Months
Objective 1 - Establish "Concerned Consumer Care" Program	All Beneficiaries	X			Moderate (2 pts)	12 Months
Objective 2 - Form Speakers Bureau from within Organizational Staff	All Beneficiaries	X	X	X	Minimal (1 pt)	6 Months
Objective 3 - Refine Printed Literature Efforts	All Beneficiaries	X	X		Moderate (2 pts)	12 Months
Objective 4 - Establish Closed Circuit TV Health Education Program	Hospital Inpatients and Outpatients	X			Considerable (3 pts)	12 Months
Objective 5 - Establish Patient Education Center	Hospital Outpatients	X			Moderate (2 pts)	6-8 Months

TABLE 15. Options for Consideration

GOAL/OBJECTIVE	PORTION OF TARGET POPU- LATION AD- DRESSED	OPTION A	OPTION B	OPTION C	ESTIMATED GENERAL RESOURCE REQUIREMENTS	ESTIMATED TIME FRAME REQUIREMENTS
Objective 6 - Develop Special Program for Patients with Chronic Diseases	Beneficiaries with Chronic Diseases and Families	X	X		Moderate (2 pts)	6 Months
Objective 7 - Develop Special Program for Patients with Disabilities, Handicapping Conditions and Other Physical Impairments	Beneficiaries with these type conditions and their families	X	X		Moderate (2 pts)	6 Months
Objective 8 - Increase Home Health Visits	All Beneficiaries	X			Considerable (3 pts)	12-15 Months
Objective 9 - Instill "Dial-A-Message" Service	All Beneficiaries	X			Considerable (3 pts)	12 Months
Objective 10 - Increase Newspaper, Radio and TV Spot Announcements (Utilizing Fort Benning facilities)	All Beneficiaries	X	X		Moderate (2 pts)	6 Months
Objective 11 - Develop Special Program for Patients with Psychiatric Problems	Beneficiaries with psychiatric problems and their families	X	X		Moderate (2 pts)	6 Months
Objective 12 - Develop Special Program for Elderly	Retirees and their Dependents	X	X		Moderate (2 pts)	6 Months

TABLE 15. Options for Consideration

GOAL/OBJECTIVE	PORTION OF TARGET POPU- LATION AD- DRESSED	OPTION			ESTIMATED GENERAL RESOURCE REQUIREMENTS	ESTIMATED TIME FRAME REQUIREMENTS
		A	B	C		
Objective 13 - Strengthen Program to Acquaint Beneficiaries with Hospital Services, Policies, etc.	All Beneficiaries	X	X	X	Moderate (2 pts)	6 Months
Objective 14 - Establish Program in Computer Assisted Programs	All Beneficiaries	X			Considerable (3 pts)	12-15 Months
Objective 15 - Conduct Wider Range of Facility Tours	All Beneficiaries	X	X	X	Minimal (1 pt)	6 Months
Objective 16 - Establish Formal Program of Daytime/Evening Health Promotion Classes	All Beneficiaries	X	X		Moderate (2 pts)	6 Months
Objective 17 - Establish Program on Health Management Aimed Particularly at Lower Ranking Service Members	Active Duty Military Members	X	X		Moderate (2 pts)	6 Months
Objective 18 - Increased Participation in Community Affairs	All Beneficiaries	X	X	X	Minimal (1 pt)	6 Months
TOTAL COMPONENTS:		28	22	10		
RESOURCE REQUIREMENTS TOTAL POINTS:		58	36	12		
AVERAGE RESOURCE REQUIREMENTS IN POINTS:		1.85	1.64	1.2		
DESCRIPTIVE AVERAGE RESOURCE REQUIREMENTS:		Moderate	Minimal-Moderate	Minimal		

APPENDIX O

PROPOSAL FOR THE COMMUNITY HEALTH
EDUCATION AND HEALTH PROMOTION
COMMITTEE

APPENDIX O

Community Health Education and Health Promotion Committee

PURPOSE AND FUNCTIONS: To identify and assess the health education and health promotion needs of the patient beneficiaries. Using this information, serve as a working committee to develop a plan for program direction which includes immediate, intermediate, and long-range educational activities and educational methodologies. Identify and evaluate existing programs. Receive and evaluate proposals for new educational endeavors. Define specific objectives which may include, but not necessarily limited to, those noted in Ambulatory Patient Care Model #14 (Community Health Education Program), Health Services Command.

MEMBERSHIP:

Executive Officer (Chairperson)
Community Health Nurse
Chief, Clinical Support Division
Representative, Department of Nursing
Representative, Rehabilitation Services
Representative, American Red Cross
Representative, Department of Family Practice
Hospital Chaplain

MEETINGS: Monthly or more frequently as directed by the Chairperson.

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