



MassHealth

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Antibiotic Resource Toolkit for Clinicians

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Section One: Introduction

Over the past two decades, the use of antibiotics to treat pediatric upper respiratory infections (URIs) has increased tremendously.¹ While there has been a modest increase in the rate of ear infections among children, the Centers for Disease Control and Prevention (CDC) estimate that up to 50% of antibiotic use is inappropriate.² The primary reason for inappropriate use is the use of antibiotics to treat viral infections, despite the fact that antibiotics are known to be ineffective in treating viral illness.

Inappropriate antibiotic use has led to widespread concern within the medical and public health communities but because of a marked increase in the number of bacteria that are resistant to antibiotic treatment. Of particular concern to those caring for sick children is the increasing resistance among streptococcus pneumonia, as this organism is the most common cause of meningitis, sinusitis, acute otitis media (AOM) and pneumonia in children. As a result, children are at increasing risk for bacterial infections that do not respond to treatment. In essence, if antibiotics are overused on infections that do not require them, antibiotics will not be available to us when they are needed.

So, what can your office do to help?

Reducing prior exposure to antibiotics is the one risk factor for antibiotic resistance with which your office can help. Using strict clinical criteria to diagnose and treat bacterial infection to guide patient treatment, and working to educate office staff and parents/caregivers about the appropriate use of antibiotics are two strategies you and your office team can use in this effort.

Antibiotic Toolkit

This Toolkit provides you with information, resources and office system tools that you can use to help your practice join the effort to improve the judicious use of antibiotics. It was designed to accompany the document “Judicious Antibiotic Use: An Approach to Upper Respiratory Illness in Children” (Recommendations) and educational materials created by the Office of Clinical Affairs of the Massachusetts Division of Medical Assistance (DMA or MassHealth), REACH-MASS, and the Antibiotic Recommendation Workgroup.

This Toolkit is not designed to be read from cover to cover. Instead, it is designed to give you, your clinical staff, and office support staff resources and tips for planning and implementing projects that may improve judicious antibiotic use in your practice. Throughout the text you will find highlighted sections labeled:

Key Clinical Issues

Quick Reference: Reassuring Parents/Caregivers

Quick Reference: Implementing the Recommendations

Quick Reference: Educating Parents/Caregivers.

¹ McCaig L, Hughes J. (1995). Trends in antimicrobial drug prescribing among office-based physicians in the United States, JAMA 273:214-219.

² Centers for Disease Control and Prevention, Division of Bacterial and Mycotic Diseases. (April 1999). Antibiotic Resistance Homepage, www/cdc/gpv/ncidod/dbmd/antibioticresistance/default.htm

These sections are designed to help you quickly find information or resources in the text that you can immediately use. DMA is aware that many different people in a primary care practice have responsibility for ensuring that the best care is given to your patients—from physicians to the triage and office staff. Teamwork is essential to great care. Different materials in the Toolkit may have relevance to different members of your pediatric care team. It is your choice to decide what information gets delivered to whom. You know best how to make the care better in your practice. If there are things here that you already know or have expertise with. If so, skip these sections!

DMA worked with a team of practicing pediatricians and family practitioners to compile this Toolkit. In addition, information from focus groups with physicians and MassHealth members helped shape the content areas and office support tools created for this Toolkit. It is up to you and your practice to review this resource and pull out the materials and tools that you think will advance your efforts to promote judicious antibiotic use.

If you have any questions about how to use this Toolkit or DMA's efforts to promote the judicious use of antibiotics, please call the Office of Clinical Affairs at 617-210-5694. Good luck!

Section Two: Implementing the Recommendations in Your Practice

Several research studies have shown that parental pressure or parental expectations have led physicians to knowingly prescribe antibiotics against their better clinical judgement.³ Yet, other studies have shown that physician's perceptions of what the parent/caregiver want does not always match what the parent/caregiver expects.⁴ Still other studies suggest that communication, not the antibiotic prescription, determines parent/caregivers satisfaction with the visit and care given to their child.⁵

So what does this all mean? DMA thinks that it emphasizes the need to:

- Strictly adhere to your best clinical judgement and the Recommendations;
- Listen carefully to the parent/caregiver concerns, and create an environment where concerns are addressed and reassurance is offered;
- Work with your whole office in your efforts to improve judicious antibiotic use;
- Educate parents/caregivers about diagnosis and treatment of URIs.

It also points to the importance of good relationships between the health care providers and the patient and parent/caregiver. As you know, trust in a provider's judgement is centered on the relationship they have with the patient and parent/caregiver.

This section of the Toolkit provides information you and your office might find useful for implementing the Recommendations for Judicious Use of Antibiotics. It reviews key sections of the Recommendations and includes strategies for addressing each of the four points above. These are some ideas for actions you can undertake in your practice to minimize the unnecessary use of antibiotics. This Toolkit will elaborate on each of these points:

- A. Prescribe oral antibiotics only following an examination;
- B. Making the diagnosis: viral vs. bacterial;
- C. Symptom management strategies;
- D. Non-Western ways of managing systems;
- E. Start treatment with amoxicillin (unless allergic) for bacterial otitis media and sinusitis;
- F. Recommend immunization with Prevnar;
- G. Verify in writing that a child can return to day care without antibiotics;
- H. Antibiotic prophylaxis;
- I. Understanding the side effects of antibiotics.

³ Bauchner H, Pelton S, Klein J. (1999) Parents, physicians and antibiotic use. *Pediatrics* 103(2):395-401.

⁴ Mangione-Smith R., McGlynn EA., Elliott MN., Krogstad P., Brook RH. The relationship between perceived parental expectations and pediatrician antimicrobial prescribing behavior. *Pediatrics* 103(4 pt 1):711-8.

⁵ Brody DS, Miller SM, Lerman CE, Smith DG, Lazaro CG, Blum MJ. (1989). The relationship between patients' satisfaction with their physicians and perceptions about interventions they desired and received. *Medical Care* 27:1027-35.

2A.

Prescribe oral antibiotics only following an examination

DMA knows that parents/caregivers often request that you prescribe antibiotics without your seeing the child in the office. Antibiotic treatment may also be sought from on-call/after hour physicians, or in the local urgent care center or emergency room. Focus groups with MassHealth members revealed the following concerns of MassHealth parents that may drive their requests for antibiotics:⁶

- Concern about the level of discomfort their child is experiencing and the long term side effects of not treating specific illnesses (e.g. loss of hearing due to ear infections);
- Belief that antibiotics will help to alleviate the child’s fever and pain;
- Knowledge of their child and familiarity with pain and behavior from previous bacterial illness;
- Concern about getting time off from work or finding transportation to and from your office;
- Pressure from daycare providers to demonstrate a treatment intervention before returning a child to daycare (expanded upon in Section 2G);
- Cultural experience with getting antibiotics over-the-counter (e.g. patients from the Dominican Republic).

The focus groups also showed that parents are most likely to call the physician for treatment when their children are experiencing ear pain or fever. In addition, parents of children with MassHealth insurance also revealed that they may use the emergency room for care when they feel their doctor has not given their child a “thorough” examination to determine the cause of illness.

QUICK REFERENCE: Key Clinical Issue

Because a clinical evaluation and possible laboratory test will be necessary to determine if the infection is bacterial in nature, the Recommendations state that antibiotics be prescribed only after a clinical examination.

Given this element of the Recommendation, how might you encourage parents/caregivers to come to the office for an exam when they call to request antibiotic treatment? And, how can you ensure that your on-call and emergency room colleagues are supporting your efforts to discourage antibiotic prescribing without an office visit? Reassuring the parent’s/caregiver’s fears, providing sound and easy-to-understand clinical information, and offering symptom management strategies are all things that can be done over the phone to immediately address the parent/caregivers concern for the child, while also providing good clinical care.

⁶ Focus groups with MassHealth members were held in Worcester on September 6th and October 3rd. For a copy of a summary of these focus groups, prepared by the MassHealth Access Program at UMass Medical School, contact the Office of Clinical Affairs at the Division of Medical Assistance, 617-210-5694.

Reassuring parents/caregivers over the telephone

As you know, reassuring parents/caregivers that you understand their concerns, and trust their judgement regarding their child's pain or discomfort is a first step in working with them to improve care and demand for antibiotic prescriptions. There are a couple of things you might want your entire staff to say to parents who request antibiotics over the phone in order to convince them to bring the child in for a visit.

- ❑ Reassure parents that you will listen to their concerns and help them make their child more comfortable using symptom management interventions.
- ❑ Reinforce that it is a safer course of action for their child to be examined before antibiotics are prescribed.
- ❑ Offer to examine the child in your office or to make arrangements for them to be seen by another physician, if indicated.

This type of reassurance can be offered by you, your triage staff, office staff who answer the phones, or by your on-call colleagues or after-hours service. A sample transcript in Section 4D may help your office triage staff address this issue more uniformly.

QUICK REFERENCE:

Reassuring Parents/Caregivers on Transportation or Work Issues:

If a parent/caregiver makes a request for a prescription by phone, it is important to understand why they do not want to bring the child in to your office. Without knowing this it will be hard to address their concerns and expectations appropriately. Parent/caregivers may be embarrassed to mention that work, transportation, or daycare concerns are paramount, so this question may need to be asked of them directly. Consider asking them something like:

"I want to make sure your child gets the best care. I trust your judgement and really want to see her/him in the office so I can give her/him the best medicine or other care. Are there work or transportation issues that make it difficult for you to come into the office? Maybe we can work together to make it easier for you."

Be prepared to offer assistance such as cab vouchers to deal with these types of concerns.

QUICK REFERENCE:
Reassuring Parents/Caregivers about Ear Pain:

Parents/caregivers are very concerned about ear pain and the implications of not treating ear infections. Fear of a child losing her/his hearing, or experiencing the discomfort of a burst eardrum are among the reasons parents of children with MassHealth insurance expressed this concern. If the parent/caregiver wants an antibiotic because s/he suspects the child has an ear infection, one way to reassure the parent/caregiver is to say something like:

“Sounds like your child’s ears are hurting a lot and I hear that you are very concerned. But, an ear infection can only be diagnosed by looking inside the ear with a special instrument. I’d like to confirm your suspicions about an ear infection by examining her/him in the office. There are some things you can do to help with the pain at home until the appointment. These are...(refer to Section 2C for specific symptom management ideas).”

QUICK REFERENCE:
Reassuring Parents/Caregivers about Antibiotic Resistance:

A phone request by the parent/caregiver provides an opportunity to discuss the detrimental aspects of inappropriate antibiotic use. When parent/caregivers understand that they could actually be harming their child by increasing antibiotic resistance, they may be more willing to either “wait and watch” or to bring the child in for a clinical examination.

QUICK REFERENCE:
Reassuring Parents/Caregivers with On-call physicians and After-hours Services:

It is important to have agreement with all covering/on-call physicians on the handling of phone requests for antibiotics. Because these physicians may not have ever treated the child in the office, it may be even more difficult to get an accurate accounting of a child’s illness from a phone conversation with the parent/caregiver. One suggestion is to have all physicians in your coverage pool give a consistent response to parents making these requests. Possible dialogue for covering physicians to consider:

“Mr./Ms. ____, Dr. ____ and I have an agreement that all children must be evaluated by him/her before antibiotics are prescribed. Your doctor requires this because antibiotics are needed only for bacterial infections and we need to examine your child to determine whether a bacterial infection is likely. Dr. ____ and I believe that this is safest course of action so that we do not expose your child unnecessarily to medications that s/he does not need. Do you want to bring (child’s name) to (the office) to be seen (today or tomorrow)? In the meantime, there are some things you can do to help with the pain at home until the appointment. These are...(refer to Section 2C for specific symptom management ideas).”

QUICK REFERENCE: Implementing the Recommendations

Is your office set up to ensure antibiotics are appropriately prescribed only after an office visit? Consider these questions to determine what your office may need in this area:

- Do we have a written policy as protocol regarding no antibiotic prescriptions by phone? Are there any legitimate exceptions? If yes, what are they?
- Who needs to know about our policy or clinical standards regarding no antibiotic prescriptions over the phone? Who will communicate with these people?
- Do we have agreement among all covering staff for the handling of after-hour requests for antibiotics?
- Can after-hour visits be scheduled when a parent's/caregiver's work schedule restrictions are an obstacle? If not, what is the best way for the child to be evaluated after normal business hours?
- Are the charts readily available for the triage nurses to use during phone consultations with parents/caregivers?
- What parent/caregiver education can be achieved during this phone conversation? How will this be documented?
- What resources are available to assist with transportation problems?

2B.

Making the diagnosis: viral versus bacterial.

Medicine has always been a combination of art and science. Often the clinical signs of infections are subtle. For some providers, there can be a well-meaning tendency to treat for bacterial infection “just in case.” Appropriate diagnosis is the key to appropriate use of antibiotics for the management of the complications of URIs. Always, you should remember that 95% of all respiratory infections are viral, and there are findings in the history, the physical exam and the laboratory evaluation of the child which will permit the diagnosis of “viral syndrome” to mean something more than “the doctor couldn’t figure it out.”⁷ Some areas where misdiagnosis is common include otitis media, sinusitis, and bronchitis. Illustrated below are some guidelines to assist you and your office in making a definitive diagnosis of bacterial infection.

⁷Denny. (1984). Pediatrics in Review.

Step 1: Is it upper or lower tract infection?

This distinction is usually made on physical exam. Did you hear anything in the lungs? The art of medicine comes into play when interpreting sounds in the lungs. However, some rules of thumb include:

- If you heard wheezing, then you may be dealing with bronchiolitis or pneumonia.
- If you heard stridor, then it may well be croup.
- Rales or crackles most often represent pneumonia.

Even with the diagnosis of a lower respiratory tract infection, keep in mind that you are probably dealing with a virus. Surveillance studies have shown that, in children under 5 years of age, bronchiolitis and croup are almost always viral and 95% of pneumonias in that age group are also viral. Bacterial pneumonias are usually lobar; you may wish to get a chest x-ray to confirm that diagnosis. In older children, 15-30% of pneumonias are mycoplasmal, and do require antibiotics.

Step 2: What kind of upper respiratory infection is it?

URIs can be classified based on the history and physical examination as complicated or uncomplicated. Most URIs start in the nasopharynx. If the infection is just in the nose and throat, it is either viral or related to group A beta-hemolytic streptococcus (strep). So look at the patient! Is there nasal congestion? Is the throat erythematous? How big are the tonsils? Do they have pus? Are the lymph nodes tender and swollen? What about palatal pettichiae? Back in the 1950s, Breese and his colleagues in Rochester established a clinical scoring system for the diagnosis of strep throat, which relied on the following criteria:

- Fever
- Red throat
- Palatal pettichiae.
- Tender lymph nodes
- Large and pussy tonsils

If you had all criteria, then there was an 80% chance that your culture would be positive. In our current environment of antibiotic overuse, 80% is not good enough. Except under special circumstances, no child should be treated with antibiotics for strep throat without benefit of a throat culture to confirm the diagnosis. When treating strep, remember old-fashioned penicillin still works as well as any of the newer antibiotics. Anything that we can do to “keep it simple” will keep the rate of antibiotic resistance lower.

Physical Examination: What is and is not AOM?

Otitis media is a frequent complication of URI. “Is it his/her ears doctor?” is probably the most persistent and frequent question that you probably answer each day. Studies have shown that physicians are inconsistent in the criteria they use for this diagnosis. Researchers at the University of Pittsburgh have established the best criteria for the diagnosis of otitis media. Remember, redness alone is not enough to diagnose AOM. They recommend four criteria for the diagnosis of otitis media:

- ❑ Color: Is the eardrum red, whitish, yellow or pearly grey? It is important to examine the center of the eardrum, not just the periphery, to make that judgement.
- ❑ Thickness: Is the eardrum opaque or translucent? Usually, the drum is paper thin, and you can see the bones through it. It becomes opaque as the white cells infiltrate the drum in response to infection.
- ❑ Position: Is the drum bulging or retracted? Retraction indicates negative pressure, and suggests that the Eustachian tube is blocked. Bulging can be a sign of pus accumulation.
- ❑ Mobility: Does the eardrum move with insufflation? As a clinician, it is important to use pneumatic otoscopy in assessing otitis media. A red ear that moves well is probably not infected with bacteria.

Studies that have looked at the clinical correlates of tympanocentesis suggest that if two or more of these physical findings are at least moderately abnormal, the child has AOM or an ear infection. The Recommendations state that effusion AND inflammation are two clear signs that a child has AOM. The problem is that these are all somewhat subjective, and require practice. Force yourself to think about the criteria on every patient, and practice pneumatic otoscopy at any chance.

KEY CLINICAL ISSUE *diagnosing Sinusitis*

What does it look like? What does it get confused with?

Sinusitis is another frequent complication of URI and unfortunately has criteria even vaguer than those for otitis media. In her remarkable study in the early 1980s, Ellen Wald and her colleagues in Pittsburgh studied about a hundred children in the emergency room with sinus aspiration, a painful study that is unlikely to be replicated. She showed that bacterial sinus infection is correlated with two sets of clinical conditions:

- Purulent nasal discharge with temperature greater than 102 degrees F
- AND
- Persistent cough lasting more than two weeks.

A viral URI can last for up to ten days, and nasal discharge will evolve from clear to white, to yellow, to green. The Recommendations state that the hallmark of sinusitis is persistent symptoms **WITHOUT** improvement for 10 to 14 days.

There really is no objective test to confirm the diagnosis, and providers are forced to use their clinical judgement to refine the diagnosis. Keep in mind that asthma and allergies can also give persistent cough, and need to be considered in making a diagnosis of clinical sinusitis. Sinus films are only marginally helpful in this case- they are hard to read in children, who really only have ethmoid and paranasal sinuses until they are six years of age.

KEY CLINICAL ISSUE *in diagnosing Bronchitis*

What is it? What does it look like? Why don't children get it? What do providers see that they confuse with bronchitis?

The Recommendations assert that a diagnosis of bronchitis cannot be made in children. According to Harrison's Textbook of Internal Medicine, acute bronchitis is defined as "cough productive of purulent sputum", and, as you know, children are seldom able to product sputum for inspection. Some doctors feel that they can distinguish bronchitis from a URI based on the sound of the cough; others use the "coarseness" of the breath sounds as the distinguishing characteristic. However, you define it, surveillance cultures of children identified with bronchitis have shown the same overwhelming preponderance of viral etiologies. In children, bronchitis, if it truly exists, is a viral disease and does not require antibiotics.

QUICK REFERENCE:
Reassuring Parents/Caregivers

It is important, when making the distinction between bacterial and viral illness, to acknowledge the concerns of the parent/caregiver. When reassuring parents/caregivers, you might want to consider including statements about:

- The length of time they should expect their child to be sick with a virus;
- Your agreement that the child was sick enough to see the doctor;
- Confirmation that you know it is “just a virus.”

If you are open, supportive, and willing to follow them with the illness, usually they will follow your recommendations.

QUICK REFERENCE:
Educating Parents/Caregivers

There is no perfect way to explain to parents/caregivers the difference between a bacterial and viral infection. Generally, start with a careful physical examination and interject comments as you examine the patient such as “throat is not red, ears look clear, lungs sound clear.” Then you might consider a conversation that goes something like this:

- Doc: Trixie, you can jump down now. (Child jumps down.) She's still got some energy in her.*
- Mrs. T.: Well, she hasn't had any energy at home. Figures that she would get here and make a liar out of me.*
- Doc: Not at all Mrs. T. This is very consistent with a viral infection. They do this: miserable high fevers one minute, acting fine the next. I examined her carefully, and she has no signs of a bacterial infection. No pus on the throat, no crackles in the lungs...It has got to be a virus.*
- Mrs. T.: So I just wasted my time, bringing her here?*
- Doc: Mrs. T., no chance to see your charming daughter is a waste of time! Besides, there is not much you can do at home to diagnose a virus. So we have to examine her, and then give the good and bad news.*
- Mrs. T.: Huh?*
- Doc: Well, the good news is that your daughter is wonderful, and has a nasty virus. It will get better (the good news), but not for a couple of days (bad news). Antibiotics won't make the fever pass any faster.*
- Mrs. T.: Can you give me an antibiotic so she can go to day care?*
- Doc: Won't help, I'm afraid. She'll still have the fever, and she really needs one-on-one care when she is sick. Keep giving her the fluids and the acetaminophen, and make her rest. If she's still got the fever in 2 days or she looks worse to you than she does today, bring her back in to be re-examined. Sometimes these things develop into pneumonias or other kinds of infections. But an illness can be quite severe, even when it is “just a virus.”*

2C. Symptom management strategies

Generally, when a parent/caregiver brings their child in for a sick visit, their primary concern is making their child feel more comfortable. Chances are the parent/caregiver has already tried to manage the child's symptoms but has gotten less than optimal results.

When dealing with URIs, whether viral or bacterial, the symptoms causing the greatest concern to parents/caregiver usually include:

- Pain, particularly ear pain;
- High (over 100 degree Fahrenheit) and persistent fever;
- Congestion (nasal or chest) and airway clearance;
- Nasal discharge (color, amount, duration);
- Lack of nutritional intake;
- Lack of sleep.

Additional parental concerns include:

- Does taking a watch and wait approach threaten my child's safety?
- When and where do I get help if my child's condition worsens?

You have seen many hundreds of parents/caregivers in your office with concerns about their child's URI. You know that they are not always rational when they are worried or stressed. The first steps in offering symptom management strategies is to offer reassurance and find out what the parent/caregiver is already doing to help comfort the child and alleviate symptoms. After reassurance is offered, you can more easily have a conversation with the parent/caregiver about additional symptom management strategies.

QUICK REFERENCE: Reassuring Parents/Caregivers

If parents/caregivers get help managing symptoms they are more likely to accept non-pharmacologic treatment.⁸ It is also known that if they feel they have been listened to. Then they are more likely to be satisfied with the visit, regardless of whether a prescription was given.⁹ So in the case of all URIs, but especially those of viral origin, it is important to:

- Understand what symptoms the child is experiencing and express empathy for their discomfort;
- Ask what symptoms are causing the parent/caregiver the greatest concern;
- Determine what interventions the parent/caregiver has already put in place;
- Offer reassurance for appropriate interventions already taken.

In developing a plan for continued symptom relief, it is important to offer concrete interventions that the parents/caregivers can safely implement and will address any fears the parents/caregivers might have regarding serious injury to their child. Here are some symptom management interventions and parent/caregiver reassurances your office could offer.

PAIN Management

- Take acetaminophen or ibuprofen as directed by your office.
- Raise child's head on a pillow to help with ear pain.
- Feed child ice chips, ice cream, popsicles for throat pain, and avoid acidic fluids like orange juice.
- Have the child gargle with warm salt water for throat pain.

PAIN Reassurance

"When their child hurts, every parent wants to make the pain go away. Antibiotics only do that in certain illnesses, and your child doesn't seem to have one of those. So, we are going to let her body take care of the infection, and we'll work together on managing the pain."

⁸ Schwartz B, Dowell S., (1997). CDC program activities and progress to date. *The Cause* 1:1-2.

⁹ Brody DS, Miller SM, Lerman CE, Smith DG, Lazaro CG, Blum MJ. The relationship between patients' satisfaction with their physicians and perceptions about interventions they desired and received. *Medical Care* 27:1027-35.

FEVER Management

- Take acetaminophen or ibuprofen as directed by your office.
- Promote fluids (apple juice, water and other caffeine-free drinks) to keep the child hydrated. Soda is not good for fighting fever.
- Bathe the child in lukewarm water to make him/her more comfortable.

FEVER Reassurance

“A fever is one of the signs that your child’s body is really fighting off this infection. Fevers are not dangerous unless they get higher than 104 degrees. Children’s Tylenol will help them feel better.”

If the parent expresses concern about seizures:

“Seizures due to high fevers really only happen in children who have already had them. Has your child ever had one? And, seizures usually happen when the fever goes up really quickly. Once the fever is up, the chance of seizures goes way down. And, if your child were to have a seizure, the chance of brain damage is very unlikely, unless s/he had a really long seizure (more than a half-hour) to do that.”

CONGESTION Management

- Breathe steam from a bathroom shower or cool mist vaporizer.
- Keep your child away from cigarette smoke.
- Use cold or cough medicine as directed by your office.
- Use salt-water nose drops for nasal congestion.
- If you are concerned that your child is choking on secretions, you should apply four firm blows to the back in order to dislodge the phlegm, just like in CPR.
- If your child has any blueness around the lips with the choking, s/he should be seen immediately, either at your doctor’s office or in the emergency room.

CONGESTION Reassurance

- *“Coughing is a natural defense mechanism and is the body’s best way to keep the lungs clear.”*
- *“Most coughs are related to a viral infection, which does not need antibiotics to heal.”*
- *“Neither antibiotics nor cough medicine will cure coughs or prevent a simple infection from progressing to pneumonia.”*
- *“Even when coughing, children are usually able to breathe well enough that they will not choke on their phlegm.”*

RUNNY NOSE Management

- Drink plenty of fluids to keep the mucous thin; apple juice and water are good.
- With infants and young children, suction mucous from the nose with a bulb syringe.
- Have older children blow their noses to clear them.
- Put petroleum jelly/Vaseline on irritated lips and nostrils to keep them moist so they do not crack.

RUNNY NOSE Reassurance

- *“It is normal for nose mucous to get thick and change color during a viral cold.”*
 - *“Yellow or green mucous does not necessarily mean your child has a bacterial infection.”*
 - *“Runny noses can last up to 14 days. This is normal.”*
 - *“Your child can still breathe, even with a thick runny nose, because s/he will breathe through the mouth if his/her nose is stuffy.”*
-

LACK of SLEEP Management

- Place child in quiet surroundings to promote relaxation.
- Limit activities to encourage rest.
- Utilize pain management interventions to promote rest.

LACK of SLEEP Reassurance

- *“Even though sleep is disrupted, your child will still have the strength to overcome her/his illness.”*
 - *“Even if your child is not sleeping, periods of rest and quiet activity throughout the day will be of benefit to her/him.”*
 - *“I know it is hard for you to get a good night’s sleep when your child is sleeping poorly.”*
-

LACK of NUTRITIONAL INTAKE Management

- Offer small amounts of fluids, every hour while awake, and watch the frequency of urine output.
- Offer food the child likes in small quantities, and do not worry if s/he refuses them.

LACK of NUTRITIONAL INTAKE Reassurance

- *“It is common for appetite to drop considerably when your child is not feeling well.”*
- *“Your child’s appetite will return to normal once the illness has run its course.”*
- *“Your child’s health will not be threatened by lack of food for at least a week.”*
- *“If your child has not urinated for more than 10-12 hours, s/he should be seen in my office or the emergency room.”*

QUICK REFERENCE: Implementing the Recommendations

There are several ways you can implement interventions to help your office improve their efforts to educate parents/caregivers about symptom management. Some ideas include:

- ❑ Offer the DMA educational materials on the symptom management interventions for the particular URI that the child is experiencing. DMA has also created a symptom management “prescription” for both viral and bacterial infections that you “prescribe” for parents/caregivers to help manage their child’s upper respiratory infection.
- ❑ Develop a symptom management flowsheet to document what symptoms are present, what comfort measures are in place and what additional measures have been recommended.
- ❑ Create a “when to call the doctor” form that you will tailor for each child that will outline when a child’s symptoms require additional physician attention. This could be separate form with one copy given to the parent/caregiver and the other to go on the medical record or it could be incorporated into the symptom management educational materials.
- ❑ Flag the chart for the next visit or call to review how the patient fared without antibiotics and reinforce the value of non-antibiotic interventions?
- ❑ Decide what symptom management interventions may require hands-on teaching to accompany written educational materials e.g. ear drops, nasal aspiration, nose drops? Which office staff members will handle these hands-on demonstrations?

2D.

Non-Western symptom management

Many cultural and religious groups have different experiences with and opinions about treatment of illness with medicine, including antibiotics. For example, many prefer prayer or faith healing, or alteration of the diet to cure illness. To them, this illness may be caused by an imbalance in the body and through restoration of this balance the illness will be cured. In fact, very few cultures or religions actually prohibit the use of medicine; Christian Science is most widely known. Providers who believe that an antibiotic is indicated for a patient's bacterial illness may encounter non-adherence for various cultural and religious reasons. Adherence (or lack thereof) may be related to:

- Preference to let faith or prayer direct recovery
- Different eating habits
- Time orientation
- Belief that an antibiotic carries properties (“hot” or “cold”) that, in their culture, would not be used for the specific infection or
- Preference for the way the medicine is given (PO, IM, IV).

According to Kleinman, Eisenberg and Good, understanding the patient's cultural background assists in the development of an individualized, comprehensive plan of care.¹⁰ Asking certain questions may help you establish a relationship and exchange important information with the parents/caregivers. The Explanatory Model of Illness posits that a patient (or the patient's parent/caregiver) interprets and defines symptoms. Using this dialogue, you can help the parent/caregiver understand and communicate her or his feelings about their child's illness.

QUICK REFERENCE: Reassuring Parents/Caregivers

The Explanatory Model of Illness calls for the following questions to be asked of the patient or parent/caregiver of the patient:

- What do you know about your child's illness?
- What do you think has caused this illness?
- How has it affected your daily life? Your child's life?
- Have you made any changes to your child's diet/food because of this illness? What changes?
- Do you believe you have control over your health?
- Do you believe that staying healthy has to do with a higher power, good luck, fortune or fate?
- Do you see a healer, eat special foods or use herbs or home remedies to manage this type of illness? If yes, what are they? What do they do?
- Do you give your child medicine or pills for this illness? If yes, what are they? What do they do?
- What worries you most about this illness and its treatment?
- What would you like to have happen today at the clinic to help your child?

¹⁰ Kleinman, A., Eisenberg, L., Good, B. (1978). “Culture, illness and care: clinical lessons from anthropological and cross-cultural research.” *Annals of Internal Medicine*; 88(2): 251-258.

Anecdotal information about the use of the Explanatory Model of Illness shows that it helps break down cultural assumptions between physicians and patients, and promotes a clear understanding of the language and issues to address when treating a patient's illness. This type of dialogue further supports the development of trust and open communication between the physician and the patient, which, as you know, goes on to support greater treatment adherence and patient satisfaction.

There are also a variety of clinical issues that you and your practice may want to be aware of when prescribing antibiotics, or other forms of symptom management for your ethnically diverse patients. These are highlighted in Table One below.¹¹

Table One: Clinical and cultural issues related to judicious use of antibiotics

Cultural Group	Key Cultural Issue	Key Clinical Issue
<p>General</p>	<p>Many cultural and religious groups prefer prayer and faith healing to medicine.</p> <p>Different cultures have different dietary trends; main meal times vary.</p> <p>Many recent immigrants from Developing countries are present-time oriented. In the context of illness, they may not be familiar with preventive care.</p>	<p>Discuss with the patient his/her feelings about taking medicine, and the importance of medicine, if indicated, in combination with prayer.</p> <p>Ampicillin, Lorabid, Tetracycline, Cipro without food, Cephalosporins, Penicillins with food. Many antibiotics should not be combined with antacids. Tetracycline should not be taken with milk.</p> <p>This means that it is more important to be “in the moment” rather than concern oneself with the future. In the United States, where preventive care is ubiquitous, most people are future oriented. They may stop the medicine when they start to feel better. Providers should inform ALL patients regarding the necessity to take the entire prescription until it is done. Examples of the effect of culture and religion on antibiotic use follow.</p> <p>Use of some antibiotics may result in a false positive Coomb’s test.</p>

Sources include:

¹¹Rundle, Robinson, Carvalho, (1999). Honoring Patient Preferences: a Guide to Complying with Multicultural Patient Requirements. San Francisco, Jossey Bass.
 Spector, R. E. (1996). Cultural Diversity in Health and Illness (4th Ed). Norwalk, CT, Appleton & Lange. Pp191 – 305.
 Nursing 2000 Drug Handbook. Springhouse PA, Springhouse Pub. Pp. 63-155 www.NDHNOW.com.

Table One: continued

Cultural Group	Key Cultural Issue	Key Clinical Issue
Latino	<p>Many Latinos rely on traditional medicines made from herbs or oils.</p>	<p>The combination of Cipro and Yerba Maté has been known to be toxic.</p>
African American	<p>Many Puerto Ricans and other Latinos believe in the hot/cold theory of illness (“cold” foods treat “hot” illness) which, in theory, balance each other to maintain health.</p> <p>Diabetes is more common in the African American population.</p>	<p>Penicillin, a “hot” medicine, would not be used for “hot” illness (ulcers, rashes) but would be accepted for a “cold” illness, such as a cold.</p> <p>Cipro can increase the effects of oral hypoglycemics.</p>
Caucasian	<p>Many Caucasian North Americans’ thinking is future-oriented. In the context of illness, they worry about how being sick will infringe on tomorrow’s plans.</p>	<p>Many may want to take an antibiotic to stop the illness before it starts.</p>
Asian East Indian	<p>Many practice the hot/cold theory of illness.</p>	<p>Many Chinese and Southeast Asians believe that an antibiotic is not indicated according to the hot/cold theory, rather that a “hot” food or medicine would eradicate a “cold” illness.</p>
Russian	<p>The focus of medicine in Russia is on revealing the cause of the illness.</p> <p>Doctors in Russia are judged by their ability to find the cause and treat the illness. A doctor who does not have an immediate solution to a problem may not be as well respected.</p>	<p>Providers might discuss etiology of illness and reason for antibiotics.</p>
Muslim (African or Arab)	<p>Muslims will fast during the daylight hours of Ramadan, which begins either in December or January, depending on the Western calendar, and lasts for one month.</p> <p>Many immigrants from rural parts of East Africa may assume that a visit to the doctor means that they will receive antibiotics, even when not indicated and will appear disappointed when they are not described.</p>	<p>Religious preferences may prohibit small, frequent meals throughout the day. Providers should consider antibiotics that are to be taken without food, or that can be taken with their one evening meal.</p> <p>Important to explain the reasons for cultures, why antibiotics are not indicated for viral infections, why they may cause more harm than good.</p>

2E. Start treatment with amoxicillin (unless allergic) for bacterial otitis media and sinusitis

After diagnosing a child's illness as bacterial, remember to next talk with the parent/caregiver about the choice of antibiotic treatment for the specific condition the child, and offers an opportunity to discuss the role that antibiotic choice can play in reducing bacterial resistance.

KEY CLINICAL ISSUE

The Recommendations call for the use of amoxicillin as the first line treatment for sinusitis and AOM caused by a bacterial agent. Erythromycin is the first choice for treatment of sinusitis if the patient is allergic to amoxicillin. A penicillin is recommended for streptococcal pharyngitis.

QUICK REFERENCE: Implementing the Recommendations

Is your office set up to ensure that amoxicillin is the first line of antibiotic treatment with bacterial otitis media and sinusitis? Penicillin for strep pharyngitis? Consider these questions to determine what your office might need in this area:

- How do we decide when an antibiotic didn't work? How many days into therapy is too long?
- If compliance is an issue, how can we promote better compliance with Amoxicillin?
- How do we define antibiotic allergy?
- What are our second and third line antibiotics for otitis media? For sinusitis? Pharyngitis?

Amoxicillin has many benefits. It has a long history in treating bacterial AOM. A recent study sponsored by the Agency for Healthcare Research and Quality (AHRQ) also revealed that children with AOM treated with amoxicillin did not fare any differently from those treated with antibiotics, such as Cefaclor, Cefixime, Azithromycin or Clarithromycin.¹² Using amoxicillin and penicillin as outlined in the Recommendations is also beneficial because these tend to be narrow spectrum antibiotics. Use of narrow spectrum drugs makes the window of antibiotic resistance narrower as fewer bacterial agents are likely to be affected by them. Using amoxicillin and penicillin as outlined in the Recommendations is also beneficial because these tend to be narrow spectrum antibiotics.

¹²AHRQ. (August 2000). "Management of Acute Otitis Media" Evidence Report/Technology Assessment, 15: 1-5. on-line at www.ahrq.gov/clinic/otitisum.htm).

Parents/caregivers may not want amoxicillin/erythromycin or penicillin treatment for their children. Misconceptions about the role antibiotics play in treating illness, or previous experience with and exposure to other antibiotics may shape their desire for other medicines. Reassuring parents/caregivers that their child will receive the best care for their illness, and educating them about the role of antibiotics in treating bacterial illness may help to alleviate their concerns.

QUICK REFERENCE:
Educating Parents/Caregivers

How many times have you heard a parent/caregiver say this “But doctor, s/he had that medicine the last time and it didn’t work for her.” Parents/caregivers might need help understanding that amoxicillin and penicillin work great at killing the bacteria that cause illness, and when a medicine doesn’t work it is probably because it was being used for the wrong reason or was being used incorrectly. Key points to make might include:

- ❑ “Antibiotic medicine is used to kill the germs that are making your child ill. Amoxicillin works the best at killing the germs that make (child’s name) feel so uncomfortable right now.”
- ❑ “Antibiotics cannot make (child’s name) ear pain and fever feel better immediately. It is only after the antibiotic kills the germs that her symptoms will go away this time. This will take 10 days to complete. So it is important to take the medicine as prescribed, for the full length of time, so all the germs are killed.”
- ❑ “I know you are working hard to help (child’s name) feel better when s/he is sick. Until the germs are killed, there are other things you can continue to do to help her feel better. These are...(refer to Section 2C for specific symptom management ideas).”

2F. Recommend Prevnar immunizations

According to the American Academy of Pediatrics (AAP), pneumococcal infections are the most common bacterial infections in children in the United States, with incidence peaking at about two years of age.¹³ Clinical research has shown that rates of infection from pneumonia, meningitis and AOM can be reduced through the use of pneumococcal conjugate vaccine (Prevnar or PCV7). The AAP recommends that these vaccines be given concurrently with other scheduled vaccines at 2, 4, 6, 12 and 15 months of age and at other intervals as noted in Table 2, below.¹⁴

KEY CLINICAL ISSUES:

The Recommendations also call for the administration of Prevnar in accordance with the AAP schedule. As you know, preventing bacterial infections is one of the best ways to reduce unnecessary antibiotic use. Prevnar is now available for free from the Massachusetts Department of Public Health.

TABLE 2:
Recommended Schedule of Doses for PCV7, Including Primary Series and Catch-Up Immunizations, in Previously Unvaccinated Children*

Age at First Dose	Primary Series	Booster Dose†
2-6 mo	3 doses, 6-8 wk apart	1 dose at 12-15 mo of age
7-11 mo	2 doses, 6-8 wk apart	1 dose at 12-15 mo of age
12-23 mo	2 doses, 6-8 wk apart	
>24 mo	1 dose	

*Recommendations for high-risk groups are given in Table 4.

†Booster doses to be given at least 6 to 8 weeks after the final dose of the primary series.

AAP guidelines suggest that moderate to high-risk children from 24–59 months of age may also benefit from immunization with the Prevnar (PCV7) or the polysaccharide (23PS) version of the vaccine. Children considered by the AAP to be at moderate and high risk are included in Table 3 below.¹⁵

¹³ American Academy of Pediatrics. (August 2000). Policy statement; Recommendations for the prevention of pneumococcal infections including the use of pneumococcal conjugate vaccine (Prevnar), pneumococcal polysaccharide vaccine and antibiotic prophylaxis (RE960). *Pediatrics*, 106(2): 362-66.

¹⁴ Overturf G, Committee on Infectious Diseases. (2000). American Academy of Pediatrics Technical Report: Prevention of pneumococcal infections, including the use of pneumococcal conjugate and polysaccharide vaccines and antibiotic prophylaxis (RE99660). *Pediatrics*, 106, 367-76

¹⁵ Ibid.

**TABLE 3:
Children at High Risk of Invasive Pneumococcal Infection**

High risk (attack rate of invasive pneumococcal disease >150/100 000 cases/y)

1. SCD, congenital or acquired asplenia, or splenic dysfunction
2. Infection with HIV

Presumed high risk (attack rate not calculated)

1. Congenital immune deficiency: some B- (humoral) or T-lymphocyte deficiencies, complement deficiencies (particularly C1, C2, C3, and C4 deficiencies), or phagocytic disorders (excluding chronic granulomatous disease)
2. Chronic cardiac disease (particularly cyanotic congenital heart disease and cardiac failure)
3. Chronic pulmonary disease (including asthma treated with high-dose oral corticosteroid therapy)
4. Cerebrospinal fluid leaks
5. Chronic renal insufficiency, including nephrotic syndrome
6. Diseases associated with immunosuppressive therapy or radiation therapy (including malignant neoplasms, leukemias, lymphomas, and Hodgkin's disease) and solid organ transplantation.¹⁶
7. Diabetes mellitus

Moderate risk (attack rate of invasive pneumococcal disease >20 cases/100 000/y)

1. All children 24-35 mo old
2. Children 36-59 mo old attending out-of-home care
3. Children 36-59 mo old who are of Native American (American Indian and Alaska Native) or African American descent

The AAP recommendations for immunizing moderate and high-risk children are outlined in Table 4 below.¹⁷

¹⁶Guidelines for the use of pneumococcal vaccines for children who have received bone marrow transplants are currently undergoing revision (Centers for Disease Control and Prevention, personal communication, 2000).

¹⁷Overturf G, Committee on Infectious Diseases. (2000). American Academy of Pediatrics Technical Report: Prevention of pneumococcal infections, including the use of pneumococcal conjugate and polysaccharide vaccines and antibiotic prophylaxis (RE99660). *Pediatrics*, 106(2).

QUICK REFERENCE:
Educating Parents/Caregivers

Unfortunately, a lot of misinformation is disseminated regarding the need for and value of immunizations. Horror stories abound on the internet and elsewhere which tend to exaggerate the instances of serious side effects. Too often the data that supports the benefits of these immunizations is not readily available to parents/caregivers; as a result they may be leery as to whether yet another immunization is indicated for their child. Your office can help allay these fears by communicating the following:

- *“Our office is following the recommendations of the American Academy of Pediatrics in recommending this immunization for your child.”*
- *“This immunization has been widely tested and has been found to be especially beneficial to young children, as well as moderate to high-risk children in reducing the rates of pneumonia, ear infections and meningitis.”*
- *“We recommend that your child receive this immunization because meningitis can be a serious threat to young children. I want your child to be protected against it.”*
- *“It is safe. Clinical trials have shown fever and soreness of the arm to be the major side effects of the vaccine, both of which are temporary.”*

QUICK REFERENCE:
Implementing the Recommendations

Is your office set up to provide immunizations are given according to the Recommendations? Consider these questions to determine what your office may need in this area.

- How can we address this DMA Recommendation? What are potential obstacles to implementation?
- What modifications to our immunization recording system are needed to accommodate this addition?
- What parent/caregiver education is implicated? How can this be incorporated into our antibiotic education program?
- How will we identify and discuss this option with the parent/caregivers of our moderate to high risk children, aged 2-5.
- Do we have the necessary forms to request our supply of the vaccine from DPH? What is our timeframe for obtaining and distributing the vaccine? Who will be responsible for maintaining our supply of the vaccine?

**QUICK REFERENCE:
Implementing the Recommendations**

The Prevnar vaccine can be obtained for FREE from the Department of Public Health. Contact your Regional Immunization Program to discuss how to obtain the vaccine. Massachusetts Immunization Program phone numbers are:

Central Region	Pat Reynolds-Caouette, RN	508-792-7880
Metro Boston Region	Peg O’Toole, RN	617-984-6860
	Boston Public Health Commission	617-534-5609
Northeast Region	Jane Sittnick, RN	978-851-7261
Southeast Region	Sonia Kobrin, RN	508-947-1231
Western Region	Helen Taugher, RN	413-545-6600

If you are not sure what region you are in, contact the Massachusetts Immunization Program at 1-888-658-2850 or go to the DPH website at www.state.ma.us/dph/cdc/imuregof.htm.

2G.

Verify in writing that a child can return to day care without antibiotics

As you know, research shows us that a child's presence in day care increases the likelihood for developing URIs.¹⁸ Furthermore repeated use of antibiotics, even when necessary, increases the likelihood of developing a bacterial-resistant URI. Therefore, the judicious use of antibiotics is especially indicated for these children. DMA understands that day care staff, like most parents, may have a limited understanding of the appropriateness of antibiotic use. Sometimes, they may even have policies requiring that a child be placed on an antibiotic regime before they can return to day care believing that this will provide some type of protection for the remaining children.

As you know, this pressure from the day care providers can put parents in a very difficult position as they may have little, if any, sick time or vacation time available from their own employer for caring for their child at home. In addition, they may have limited transportation assistance for getting their child to the office for an evaluation. These may be some of the same parents/caregivers who call requesting a prescription by phone or who frantically try to persuade their physician to give them a prescription during the sick visit even when the clinical evidence suggests that it is unnecessary.

Nevertheless, the Recommendations call for you or your office to verify, in writing, that a child has been seen in your office and is being treated according to the best clinical knowledge. A standardized handout, tailored by DMA with permission from materials created and tested by a CDC grantee, is included for you to use in your communication with day care providers.

¹⁸ Bauchner H. (1997). "Parents' impact on antibiotic use" APUA Newsletter;15(1): 1-3.

QUICK REFERENCE:
Reassuring Parents/Caregivers

If a parent/caregiver insists on getting an antibiotic prescription, even when you have decided they are not clinically indicated, ask them directly if they want an antibiotic because of a day care or school policy. If yes, try building an alliance with the parent/caregiver to reassure them that you can work together to try to give the child the best care and meet day care requirement. You might say something like:

“What is (child’s name)’s day care teacher/school name? You and I both know that the best care for (child’s name)’s illness is to do (list the treatments/symptom management previously discussed). Let’s work together to help (day care teacher/school name) understand the care we are giving to (child’s name).”

Fill out the “DMA Day Care Excuse” form and give it to the parent/caregiver. Remember to sign it and leave a phone number for your office.

“This form is an note from me for (day care teacher/school). Please give it to her/him when you drop (child’s name) off the next time. Please tell them to call me with any questions and I will advocate for you.”

Give the parent/caregiver an additional set of educational materials to give to the day care provider or school health official.

QUICK REFERENCE:
Implementing the Recommendations

Is your office set up to work with parents/caregivers to ensure their children can return to daycare without unnecessary antibiotics? Consider these questions to determine what your office may need in this are:

- Do we document our patients’ day care status or school name? Do we have contact information (name, phone number, fax number, address) for their daycare providers or school?
- Do we have copies of the “DMA Day Care Excuse” form in our exam rooms? Extra copies of the DMA antibiotic educational materials?

2H. Antibiotic prophylaxis

The Recommendations suggest that antibiotic prophylaxis should be used infrequently as it contributes to antibiotic resistance. The latest clinical research shows that the few children who are treated prophylactically are generally children with chronic or recurrent otitis media for whom antibiotic prophylaxis is an alternative to tympanostomy surgery. Yet constant trips to the pediatrician's office, with the associated potential employer and/or transportation implications, are real concerns for parents/caregivers. If a child has frequent bacterial infections and yet their risk for developing drug resistant infections increases with each treatment, what is the best treatment approach to meet the needs of the child and parent/caregiver?

KEY CLINICAL ISSUE

The Recommendations call for the minimization of use of antibiotic prophylaxis. However, decision regarding the use of prophylactic treatment is a clinical issue for you and your office to consider. When deciding to use antibiotic prophylaxis, you may want to consider the following questions:

- What risk factors exist for recurring infections with the child?
- Have past pain management interventions been effective?
- Is this parent/caregiver a good candidate for an observation program?

QUICK REFERENCE: Implementing the Recommendations

Is your office set up to ensure that antibiotic prophylaxis is used infrequently as a treatment intervention? Consider these questions to determine what your office may need in this area.

- What are our criteria for offering prophylactic antibiotic treatment? Are these criteria in writing?
- Are all office clinicians in agreement with the criteria?
- How will we handle children that do not meet criteria but for whom prophylactic treatment has been requested by the parent/caregivers?

21. Understanding the side effects of antibiotics

Parent/caregivers usually think of antibiotics as an ally—a drug that helps their child overcome “bad germs” associated with infections. There are even places in the world where antibiotics can be obtained over-the-counter, like aspirin or cough medicine. These perceptions and experiences might make it difficult for parents/caregivers to understand concepts of judicious antibiotic use and antibiotic resistance. Antibiotic treatment can have both short-term and long-term effects, with the long-term effect being, of course, bacterial resistance. Understanding these side effects might help parents/caregivers understand the importance of judicious antibiotic use, and help them better adhere to your treatment decisions.

QUICK REFERENCE: Educating Parents/Caregivers

Some key concepts for you to convey to help reassure the parent/caregiver that symptom management is the best course of action include:

- All medications have side effects.
- The most common and immediate side effects of antibiotics are nausea, stomach pain, rash, and diarrhea, all of which cause your child discomfort.
- While common side effects can usually be treated safely at home and disappear completely once the antibiotic sequence is completed, your child should not be subjected to them unless your doctor decides that antibiotics are necessary for your child’s treatment.
- Occasionally a child can have a severe, allergic reaction to an antibiotic that could be life threatening.

The best way to prevent the most serious side effects of antibiotic use is to encourage parent/caregivers to:

- Use antibiotics only when you or another doctor prescribes them for verified bacterial infections.
- Use antibiotics for as long as you or another doctor prescribes them even if your child starts to feel better.
- Discuss other non-antibiotic options such as pain management and observational support as an alternative to antibiotic treatment.

Section Three: Educating parents/caregivers

Central to the Recommendations is the need to educate parents/caregivers about antibiotics and upper respiratory infections. To assist you and your office with doing this, DMA has created a set of educational materials to use with the parents/caregivers of your patients. This section of the Toolkit offers information about these educational materials and ideas for approaching the education of parents/caregivers about antibiotic resistance, and diagnosis and treatment of URIs. It includes an overview of the type of information you may wish to include in your education program, suggestions on how to implement a program within the office setting, and discusses some operational challenges that can get in the way of a successful office based program.

Here's what you'll find:

- A. Getting started: thoughts on developing an antibiotic educational program
- B. Program content
 - Frequency and natural history of viral upper respiratory infections (URIs)
 - Difference between viral and bacterial infections
 - Appropriate antibiotic use at 4 and 12-month well child visits as recommended by the American Academy of Pediatrics (AAP) Guidelines for Health Supervision
 - "Some questions to ask when your doctor recommends antibiotic treatment" – a checklist for parents/caregivers
- C. Creating an office environment that promotes the judicious use of antibiotics
- D. Addressing demanding parent/caregivers
- E. Addressing parents/caregivers with limited English speaking (LES) ability

3A.

Getting started: thoughts on implementing an antibiotic education program

In general, when developing and/or implementing an educational program for your office you may wish to consider the following factors:

- What information needs to be communicated?
- When are the best teachable moments?
- How can the educational exchange be reinforced?

What information needs to be communicated?

DMA worked collaboratively with REACH-MASS to develop a series of fact sheets for your office to use when educating parents/caregivers about antibiotics or URIs.¹⁹ These are:

- Kids and antibiotics;
- Kids and sore throat;
- Kids and ear infections;
- Kids and fluid in the middle ear;
- Kids and colds.

Health education is considered to be a separate health field, so DMA does not expect you and your office to become experts in health education! There are, however, a couple of tidbits that you may want a refresher on, to help you and your office gear up to implement an education program that supports the judicious use of antibiotics.

DMA often talks about the need to share health information with MassHealth members “eight times, eight ways.” As you know from your practice, or perhaps your experience as a parent, reinforcement is one of the key tenets behind effective health education. Sharing the same message about antibiotic use or treatment for URIs in several different ways can help reinforce the information with the parents/caregivers of your patients. Consider this scenario:

A foster parent brings her 4-year old charge, James, to your office because he has had a runny nose for about a week. When she checks-in, stating her reason for the visit as a cold, she receives the DMA brochure “Kids and Colds.” After a short wait, a nurse ushers James and his foster mom into the exam room where his vitals are taken and presenting problems recorded. The nurse directs the foster parent’s attention to the “Kids and Colds” poster hanging on the wall. She encourages the foster parent to ask her or her physician about the material. After another short wait, the physician comes in and gives James a thorough exam. He talks to James and his mom about the difference between viral and bacterial illness, and explains that James’ runny nose is the result of a viral cold. The doctor reviews symptom management strategies with the foster mother and writes out a “Prescription for Treatment of Viral Illness” using the DMA prescription pad.

¹⁹ DMA conducted focus groups with MassHealth members to ensure that the concepts in these materials are easy for your patients to understand. DMA also had a health literacy reviewer make sure that the materials are easy to read. Finally, individuals trained in the skill of medical translation converted the information to Spanish language, and double-checked to make sure the spirit and intent of the materials was not lost in the translation process.

During this visit to the doctor, James' foster mother received four separate educational messages related to the effort to improve judicious use of antibiotics. These were:

- Kids and Colds brochure at check-in;
- Kids and Colds poster during vitals check;
- One-on-one discussion with the physician;
- Prescription for viral treatment.

How many times do parents/caregivers receive intentional, educational messages in your office?

QUICK REFERENCE:

Implementing the Recommendations

In order to effectively create an office environment that can reinforce educational messages like it was done in the scenario above, there are several questions you and your staff can ask:

- During what sick or routine visits should our clinical and/or office staff address the subject of appropriate antibiotic use?
- During a typical patient visit, at what points do clinical and office staff members have contact with the parent/caregiver?
- What are the opportunities for disseminating educational materials to the parent/caregiver at each of these points of interaction?
- What are the opportunities for discussing key concepts with the parent/caregiver at each of these points of interaction?
- Are there opportunities to discuss key educational concepts before or after a patient visit such as during appointment setting, phone triage or scheduled group programs?
- What materials can be given to or reviewed with the parent/caregiver before, during, or after the visit?

3B. Program content

The Office of Clinical Affairs at DMA and the REACH-MASS project of the Department of Ambulatory Care and Prevention at Harvard Medical School²⁰ created five fact sheets for you to use with the parents/caregivers of your patients. These are:

- Kids and antibiotics;
- Kids and sore throat;
- Kids and ear infections;
- Kids and fluid in the middle ear;
- Kids and colds.

These fact sheets address many of the issues detailed below. You and your clinical and office staff may want to consider how to expand upon these points when talking one-on-one with parents/caregiver.

Frequency and natural history of viral URIs

Research shows us that there are big gaps between what parent/caregivers understand about appropriate treatment and what available evidence suggests regarding treatment effectiveness. Your educational program might include the following points:

- Viral upper respiratory infections (URIs) occur often in young children 8 to 10 times each year. Children in daycare settings can have more URIs because of their contact with other children.
- The most common URIs include
 - Colds
 - Coughs
 - Ear infections
 - Sinus infections
 - Sore throat (pharyngitis)
- ALL colds, and most coughs and sore throats are caused by viruses.
- Children with a runny nose, sore throat, cough, hoarseness, are likely to suffer from a viral infection, NOT a bacterial infection.
- Viral infections are still uncomfortable and their child may experience any of the following symptoms with a viral URI:
 - Persistent fever
 - Cough
 - Runny nose
 - Yellow or green mucous from their nose
 - Fatigue
 - Irritability.

²⁰ McKee M, Mills, Mainous A. (1999). Antibiotic use for the treatment of upper respiratory infections in a diverse community. *The Journal of Family Practice*; 48:993-996.

- ❑ If their child has a viral infection, they will usually recover in about 10-14 days with the help of non-prescription medications and other comfort measures like plenty of drinks (for example juice or water) and rest. However, nasal discharge may continue for a longer period even when the other symptoms have disappeared.
- ❑ Antibiotics will not help viral URIs at all, and the unnecessary use of antibiotics can harm their child by making them and those around them more likely to get a bacterial infection that is resistant to antibiotics.

QUICK REFERENCE:
Reassuring Parents/Caregivers

Parents/caregivers need to be reassured that their concerns about their child's well being are being heard and addressed. As part of your educational efforts, make sure your office provides reassurance by emphasizing the following:

- ❑ Frequent upper respiratory infections are not uncommon and most are self-resolving
- ❑ Their child can be made to feel more comfortable during the course of their illness with a variety of supportive symptom management interventions.(see section 2D)
- ❑ Your office will help them identify strategies to help manage their child's illness and will work with them to monitor their child's progress.

QUICK REFERENCE:
Reassuring Parents/Caregivers

After diagnosis, the most important role of the practitioner is communicating the findings to the parents in a way that reflects their health beliefs and experiences. Here are a few scenarios that may be helpful:

Xander, a three-year old boy, was sent home from daycare with a cough and a temperature of 100.2 (ax). He is otherwise acting fine, but his mother is anxious that he be started on an antibiotic, so that he will be able to return to daycare in the morning. You have just finished examining Xander, and you have found only a pleasant boy with a cold.

Doctor: Xander, that was great. You even held still while I looked at your ears. He is really growing up, Mrs. P.

Mrs. P: Yes, he is. I don't know where the time goes. So Doctor, what is wrong with him?

Doctor: Well, as best I can tell, he has a cold. Even though he has a temperature, he looks great. Ears are fine, throat looks good and his lungs are clear.

Mrs. P: What about his fever? I keep worrying that he's going to go into a convulsion.

Doctor: Really? Why are you worried about that?

Mrs. P: My sister's boy used to get fevers and have seizures all of the time.

Doctor: I see. So you are worried that it might run in the family?

Mrs. P: Yes, I am. How do you know that Xander is going to be all right?

Doctor: He does have a few things in his favor. First, he hasn't done it before. Most kids with febrile seizures do it before his age. Second, he hasn't done it yet. Usually, if you are going to have a seizure, it happens when your temperature is going up. Finally, he looks great, even with a cold. I'm really not too worried about a seizure.

Mrs. P: So there is nothing wrong with him?

Doctor: Well, I didn't say that. He has a cold, and likely will be sick for a week or so. The fever will last another day or so, and then the congestion will go on for another week. Feels like it goes on forever.

Mrs. P: Don't I know it! So, there's nothing to be done?

Doctor: I didn't say that. Fluids, fever control, humidity from a vaporizer or humidifier may help. I'm not a big fan of cold medications, but you may want to try some of the over-the-counter things. Mostly, he needs rest, and unfortunately, that is best done at home.

Difference between viral and bacterial infections

Research tells us that most parents do not know the difference between a bacterial and viral infection.²¹ As you implement an educational program in your office it is important to convey to parents/caregivers that they are not alone in not knowing the difference and that you will work with them to decide when antibiotics will be helpful to their children. You might want to include the following points in your education efforts:

- There are two types of infections, those caused by bacteria and those caused by viruses
- The word infection does not mean that an antibiotic will help.
- An antibiotic will help only if it is a bacterial infection.
- Some ways that bacterial infections are different from viral infections:
 - If untreated, the infection will last beyond 14 days.
 - Bacteria from a throat or nose culture/swab can be seen under a microscope; viruses cannot be seen under a microscope.
 - In the case of ear infection, the doctor will look into the ear with a special instrument for signs of fluid, swelling, and color changes in the ear that suggest infection, most of which are viral.
- Since viruses cause most URIs, antibiotics are usually not needed for sore throats or coughs and are never needed for colds.
- Antibiotics should be used for throat infections that test positive for strep throat, and for ear and sinus infections where there the doctor has strong evidence that the infection is caused by a bacteria rather than a virus.
- Parents/caregivers should talk with their pediatrician to help determine:
 - Whether their child has a viral or bacterial infection;
 - Whether antibiotics are needed.

²¹ Collett C, Pappas D, Evans B, Hayden G. (1999). Parental knowledge about common respiratory infections and antibiotic therapy in children. *Southern Medical Journal*; 92(10):971-976.

QUICK REFERENCE:
Reassuring Parents/Caregivers

MassHealth parents/caregivers may feel they are not getting good treatment from you and your office if they do not get an antibiotic prescription, regardless of the cause of their child's illness. Educating the parent/caregiver about the difference between viral and bacterial illnesses should include reassurance that the treatment they receive for viral illness is the best care for their child. Other points to include might be:

- ❑ Parent/caregiver knows their child best and their role in managing pain and discomfort is very important.
- ❑ Antibiotics are good only for killing the germs that cause the illness, NOT for treating pain and discomfort. Unfortunately, antibiotics cannot kill viruses, so they are no good for the child's illness.
- ❑ If their child takes an antibiotic for a virus/germ, then the medicine could actually invite bad bacteria in. You do not want to invite more bacteria in.

Discuss the judicious use of antibiotics at 4 and 12-month well child visits as recommended by the American Academy of Pediatrics (AAP) Guidelines for Health Supervision

Some research has determined that as many as 18% of parents have given an antibiotic to their child before consulting a physician, and that often the source of the antibiotic is outside of a controlled pharmacy system (for example, a neighbor or family member from another country).²² For these and other reasons, you and your office might want to consider having an established process and timeline for discussing both appropriate antibiotic use as well as the harmful effects of unnecessary antibiotic use with all parents/caregivers.

The AAP recommends that pediatric offices adopt a practice of discussing the appropriate use of antibiotics during a child's scheduled 4-month and 12-month well child visits. One possible benefit of including an educational component in these well visits is that the parent/caregiver may be more receptive to information when they are not attending to an acutely ill child. This is because the parent/caregiver is less stressed and her/his concern is less focused on the immediate concern of making the child feel better.

²² Bauchner H. (1997). Parents' impact on antibiotic use. *APUA Newsletter*;15(1): 1-3.

QUICK REFERENCE:
Reassuring Parents/Caregivers

Parent/caregivers need assurance that their child is not being “cheated” out of necessary treatment if they are not prescribed an antibiotic. During your well-child visit discussions with parents/caregivers, it might be helpful to encourage parent/caregivers to take a more active role in their discussion with you when they bring their child in for a URI. By encouraging them to ask questions about their child’s diagnosis and treatment, they may be more open to what you are trying to teach them. In order to help parents/caregivers better understand the treatment decisions of your office, consider creating a handout of questions for them to ask when you recommend antibiotic treatment for their child. Questions might include:²⁴

- Why are antibiotics necessary for my child?
- If a strep throat infection is suspected, did the office perform a strep test and get a positive result?
- What is the name of the antibiotic?
- How and when should it be taken and for how long?
- Would a reduced period of antibiotics be possible?
- Does this medication cause side effects? What are they and how can I prevent them in my child?
- Are there food drinks or activities that my child should avoid while taking this medication?
- Can my child take this medication while s/he is taking other medications?
- Are there other treatment options that we could consider?
- Could we try an observation program combined with pain and fever management?
- What would be the signs that my child’s condition is worsening?

A sample handout to give to parents to encourage them to ask these questions is included in Section 4B.

²⁴ Adapted from the Centers for Disease Control and Prevention.

QUICK REFERENCE:
Implementing the Recommendations

Is your office set up to ensure implementation of this AAP recommendation? Consider these questions to determine what your office may need in this area.

- What percentage of our parents/caregivers come in for their scheduled well-child visits?
- What key points will we discuss with parents/caregivers?
- Is this information in written form so that all staff teach the same material? If not, how will we ensure a consistent message is conveyed through parent/caregiver education?
- Will we discuss the same material at each or discuss selected subjects at each visit?
- Do we want to send a pre or post-test to the parent/caregiver before or after the visit to test whether the parent/caregiver understood the materials?
- What written educational materials will be given to the parent/caregiver to take home?
- Which members of our office/care team will be responsible for this education? Who will make sure they have the support they need to do this?
- How will the actual (vs. intended) educational intervention be tracked and reported? For example, will we require a note be put in the medical record? Who will check to make sure this tracking is taking place?
- Is there a place on our existing patient medical record for recording this effort?

To facilitate and help track one-on-one education provided to your patients, a sample flow sheet for tracking parent/caregiver education is provided in Section 4A of this Toolkit.

3C.

Create an office environment that promotes the judicious use of antibiotics

There are many ways to help parents/caregivers understand the appropriate use of antibiotics. The strategies that work best for your office will depend on many factors such as the number of patients you serve, physical space constraints, staffing levels and office hours. Some keys to success are to involve your office staff in developing your program, repeat the message often, and use many different teaching methods so that parent/caregiver learning is supported to the fullest.

The first and easiest intervention to implement is to provide and/or display educational materials about the judicious use of antibiotics and the management of URIs in your waiting room and in exam rooms. This is a passive information distribution approach. DMA and REACH-MASS developed many materials that are available for your use. In addition, there are many other materials available through other insurers, pharmaceutical companies and state and national advocacy groups.

If you are going to use additional printed or video-based educational materials to reinforce the DMA materials, start by reviewing those materials currently available in your office. Parent/caregiver education literature designed to address antibiotic use and upper respiratory care might include:

- Answers to common questions about antibiotics and antibiotic resistance;
- An explanation of clinical terms;
- A review of AOM risk factors;
- A summary of symptom management interventions;
- Coloring books for kids that address the appropriate use of antibiotics and other related topics;
- A list of questions that the parent/caregiver should ask before they accept antibiotic treatment for their child;
- Materials to give to the schools and daycare center that specify why antibiotic treatment for this specific visit is not warranted;
- An in-office video covering the appropriate use of antibiotics and other related topics.

It is important that the complementary materials reinforce the same messages. If there are any contradictions, your educational efforts may be derailed. Therefore, consider strongly whether you want to use materials to complement the DMA fact sheets provided to you.

Other potential ways to communicate information include interactive discussions of the subject matter between the parent/caregiver and a member of the office staff during teachable moments. Ways to do this might include:

- Adopting the AAP guidelines for discussions during the 4 month and 12 month well visits;
- A monthly or bi-monthly program offered after hours at the office. For example, this could be an orientation session for parents new to the practice or suggested participation for a “difficult to manage” parent/caregiver;
- Offer a pre-test or questionnaire for the parent/caregiver to complete while in the waiting room. Results will be reviewed during the patient visit and key concepts reinforced.

It will be helpful to look for as many opportunities as possible to reinforce and/or reward positive behavior. There may be some simple reward systems worth considering for parents/caregivers. For example, your office may want to offer a gift certificate to a local drug store to parents/caregivers who attend a scheduled educational program sponsored by your office. Other rewards could include:

- A special sticker (or other trinket) reward for the child or their parents/caregivers;
- Have the child’s name and/or photo added to an office wall display of families committed to appropriate antibiotic use.

QUICK REFERENCE: Implementing the Recommendations

Is your office set up to create an environment that supports parent/caregiver education and the judicious use of antibiotics? Consider these questions to determine what your office may need in this area.

- Who needs to be involved in creating a supportive office environment?
Who is responsible for communicating this across the practice?
- Can we implement both passive and interactive methods of education?
What methods will we use?
- Will we use additional educational materials to complement the DMA materials? If yes, who will be responsible for reviewing them to ensure the messages are reinforced and not contradictory?
- Will we reward parents/caregivers for compliance or appropriate antibiotic use? If yes, how will we do this?
- Is it possible for the greeter/receptionist to offer materials such as information pamphlets and a pre-tests to the parent/caregivers upon arrival?
- Does teaching the parent/caregiver during phone triage take less practice time than combined time spent by the scheduler, receptionist, medical assistant, and nurse during a sick visit?
- How will we measure our success in reducing inappropriate antibiotic use?
 - What will the target benchmark be for prescribing patterns within the practice pediatricians?
 - Does our office information system have the ability to look at number and types of prescriptions as well as those tied to a sick visit?

3D. Addressing “demanding” parent/caregivers

Most pediatricians and their staff can recall having at least one particularly problematic parent/caregiver who badgered staff until an antibiotic prescription was given, even when clinical evidence suggested it was not necessary. Simply stated, it was easier and more efficient for the doctor to write the prescription than to take the time to educate the parent/caregiver. If you have ever given an antibiotic prescription against your best clinical judgement, you know that it does not feel good and it may be detrimental to future efforts to ensure that parents/caregivers adhere to your clinical recommendations. What might you or your office do to avoid giving in to demanding parents/caregivers against your clinical judgement? No one has a magic formula for dealing with this problem, but some suggestions include:

- ❑ Give the parent/caregiver the DMA patient education materials and instruct them that you will return to continue your discussion once they have had a chance to read the materials;
- ❑ Contact your after-hours service, on-call colleagues and/or local emergency room to inform them of the parent/caregiver demand, and ask them to reinforce your refusal to prescribe an unnecessary antibiotic;
- ❑ Make a notation on the patient record to review key antibiotic usage concepts at the next patient visit;
- ❑ Request that the parent/caregiver attend a scheduled educational meeting with a designated office staff educator-this could be a one on one or group session.

QUICK REFERENCE: **Reassuring Parents/Caregivers**

Asking the parent/caregiver directly about the influence on their demand for antibiotics may help them open up to you and discuss topics they did not feel were appropriate to share with you or your staff. Consider the following dialogue: “We’ve talked about giving (child’s name) the best care for her illness. (Review diagnosis and treatment recommendations.) Can you help me understand why you still want an antibiotic?” Specific probing questions might include:

- “Did you get an antibiotic the last time (child’s name) felt this way? Or maybe your neighbor/friend/sister’s child received an antibiotic when they felt this way?”
- (If parent/caregiver is a member of an ethnic minority) “Were you able to get an antibiotic from the pharmacy or corner store in your country?”
- “Do you feel like it would be better for (child’s name) health if I gave him/her an antibiotic?”
- “Do you want an antibiotic so (child’s name) will get better faster so you don’t have to take time off from work (or school)?”

Acknowledge the parent’s/caregiver’s concern and reinforce why antibiotic treatment is not needed, and may even be bad for their child.

You may also want to get a verbal agreement from the parent/caregiver to NOT call the office after-hours or to visit the emergency room/urgent care center to get an antibiotic. Use this strategy only if you know the parent/caregiver has tried this before.

QUICK REFERENCE:
Implementing the Recommendations

Is your office set up to deal effectively with parent/caregivers who demand antibiotics? Consider these questions to determine what your office may need in this area.

- Does our practice have an agreed upon plan for dealing with demanding parent/caregivers? If no, then who within the office should be involved in its development?
- Is the plan in writing?
- Does the plan currently include an educational component? At what point in the interaction does the education occur? Is the parent caregiver receptive to learning in that moment?
- Do the phone triage staff advise parent/caregivers that an antibiotic may be needed when they decide that a sick office visit is indicated? (This sets up an expectation for an intervention that may not be clinically appropriate.)
- Do the physicians feel that they generally back up nursing staff when parent/caregivers refuse to accept the nursing staff's non-treatment recommendation?
- Do the nurses feel that the physicians generally back them up when parent/caregivers refuse to accept the nursing staff's non-treatment recommendation?
- Do our covering physicians support our policy of not prescribing antibiotics without seeing patients? If not, how do we notify covering physicians of a potential request for unnecessary antibiotic treatment?

3E.

Addressing parents/caregivers with limited English-speaking ability

When parents/caregivers have limited English speaking ability (LES) or come from another culture, a level of complexity is added to the management of care for the child. Because a third party is likely to be involved in translating, additional time needs to be allocated to the visit for such things as:

- Understanding the parents/caregivers concerns that warranted the visit;
- Communicating key educational concepts;
- Offering reassurance that, despite the language or cultural barriers, their child will get appropriate treatment;
- Locating or developing materials that will support the educational aspect of the encounter;
- Reinforcing the parent's/caregiver's understanding of medication administration and other aspects of treatment and symptom management.

Focus groups with MassHealth members, as well as other research, shows that language barriers can pose a significant problem for practice trying to improve the judicious use of antibiotics. Your education and improvement efforts will be wasted if a parent/caregiver cannot read a printed fact sheet, or does not understand the verbal instructions given to her for giving her child medicine, or cannot read a prescription bottle. Consider the following:

A doctor tells a parent, whose primary language is Spanish, to make sure her child takes the entire amoxicillin prescription for his bacterial ear infection. The parent gives the child the entire bottle of medicine the next day. The parent then complains to her neighbor that the doctor gave her bad care because the child never got better.

KEY CLINICAL ISSUE

To avoid scenarios like the one printed above, you might want to consider:

- Asking the parent/caregiver to repeat the instruction back to you, and repeat how they will follow them.
- Having a nurse or medical assistant “train” the parent/caregiver to give medication through hands-on demonstrations and an orientation to the prescription bottle.
- Making arrangements with your patients’ pharmacy to use picture instructions on prescription labels.
- Explaining medication and other treatment instructions in more concrete terms. For example:

“On Tuesday, give the child one tablespoon of medicine when he wakes up (show a tablespoon). On Tuesday, give the child one-tablespoon of medicine when he goes to bed. On Wednesday....”

Other issues to be reminded of when working with parents/caregivers with Limited English-Speaking ability:

- Allow family members to choose their own seating for comfortable personal space and eye contact;
- Speak directly to the child or parent/caregiver as appropriate, even if another person is serving as the interpreter;
- Avoid body language that may be offensive or misunderstood, such as sitting too close or looking directly into someone's eyes;
- Use open-ended questions or questions phrased in several ways to obtain information;
- Avoid slang, technical jargon, and complex sentences;
- Use a speech rate and style that promotes understanding and demonstrated respect for the client.

QUICK REFERENCE:

Implementing the Recommendations

Many times, children, who many even be the patients, are called upon to translate medical encounters for their parent/caregivers. This places an undue stress and responsibility on the child or other family member involved in the clinical encounter. Is your office set up to serve the needs of parents/caregivers with Limited English speaking ability? Consider these questions to determine where your office may need improvement to serve LES parents and patients.

- Do we know what parents/caregivers are LES because of low literacy or because English is not their primary language? How can we learn this? Where will it be recorded?
- Can the medical record be flagged to note that the parent/caregiver has LES?
- Who will be the primary contact for the office regarding the child's treatment? How will we talk to them if they do not speak English as a primary language?
- Who will be responsible for ensuring the parent/caregiver understands the medication administration regiment and other aspects of treatment for their child? When will this happen?
- How can we make medication instructions easier to read or understand?
- What resources exist among the office practice that can assist with interpretation during the scheduled visit? For what languages?
- What educational materials are available in the parent/caregivers native language?

Section Four: Office Implementation Tools

This section of the Toolkit offers several tools that you can use or modify to help implement your antibiotic improvement and educational program. You may already be using some tools like these in your office. If you already have similar systems in place, then skip this section, unless you feel that there is a need to improve or expand your existing office systems.

Here's what you'll find

- A. Flow sheet to track education of parents/caregiver regarding antibiotic use and URIs
- B. Parent handout on questions to ask when your doctor recommends antibiotic treatment
- C. Sample Receptionist Transcript
- D. Sample Transcript for Handling Phone Requests for Antibiotic Treatment

4A.

Flow sheet to track education of parents/caregiver regarding antibiotic use and upper respiratory infections

Use this form to document when you have discussed various aspects of the antibiotic educational program with the parent/caregiver. You could use it as a stand-alone document or integrate it with other educational and/or immunization flow sheets. .

Document the type of encounter using the key below:

4m –4 month well-visit

12m –12 month well visit

SV – sick visit

PS – phone session

Date of educational intervention

Type of visit encounter					
Educational element					
Administer pre-test					
Discuss pre-test results					
Explain viral URIs					
<input type="checkbox"/> 5 most common types					
<input type="checkbox"/> symptoms					
<input type="checkbox"/> treatment					
Discuss antibiotic resistance					
Discuss differences between viral and bacterial					
<input type="checkbox"/> Most common bacterial infections					
<input type="checkbox"/> How diagnosis is made					
<input type="checkbox"/> Use of antibiotics					
Discuss Prevnar /23PS vaccinations					
Symptom management for presenting problem (will vary by patient problem)					
<input type="checkbox"/> Pain					
<input type="checkbox"/> Fever					
<input type="checkbox"/> Cough					
<input type="checkbox"/> Runny nose					
<input type="checkbox"/> Loss of sleep					
<input type="checkbox"/> Loss of appetite					
<input type="checkbox"/> Other (describe)					
Discuss office policy on phone-in antibiotic prescriptions					
Handouts given – (Describe materials)					
Observed video					

4B.

Sample Parent Handout

Questions To Ask When Your Doctor Recommends Antibiotic Treatment ²⁵

- Why does my child need an antibiotic? _____

- If a strep throat infection is suspected, did the office perform a strep test and get a positive result?

- What is the name of the antibiotic my child will be taking?

- How and when should it be taken and for how long?

- Does this medication cause side effects? _____
What are they and how can I prevent them in my child?

- Are there food, drinks or activities that my child should avoid while taking this medication?

- Can my child take this medication while s/he is taking other medications?

- What would be signs that my child's condition is worsening?

Your Doctor's Name: _____

Your Doctor's Phone Number: _____

Office Hours: _____

***Call during Office Hours to talk with a nurse or your doctor.
If you call after these hours, you will need to talk with a person who answers phones
for the doctor or someone who helps answer questions for your doctor.***

²⁵ Adapted from CDC materials.

4C. Sample Receptionist Transcript

In order to use this transcript effectively your receptionist should:

- Know both the child and parent/caregiver name
- Know that the reason for the sick visit is a URI
- Know the names of the main types of URIs
- Know which educational materials to offer to the parent/caregiver

At the point of check-in the receptionist says:

“Mr./Ms (parent/caregiver), I understand that (child’s name) is to be seen here today for an upper respiratory infection. Our office is participating in a special parent education effort on the use of antibiotics for the treatment of upper respiratory infections. Have you received any of our office literature on the treatment of upper respiratory infections?”

If parent/caregiver says “No” they have not received materials, the receptionist then asks, “May I give you these materials now?”

- If the parent/caregiver says “Yes” the receptionist says,** “We hope you find these materials helpful. (Give out pamphlets, caregiver questionnaire, other materials as determined by each office) I am giving you a (describe-a pamphlet and a caregiver questionnaire for example). We would like for you to read the material and complete the parent/caregiver questionnaire either today while you wait or at a time when it is more convenient for you. Either today or on a future visit if you discuss your questionnaire responses with the nurse/doctor then your child can become a member of our Prudent Antibiotic Users Club and have their photo added to the display in our waiting room.”
- If the parent/caregiver says “No” the receptionist says,** “OK well thanks anyway” and alerts the nurse or doctor seeing the patient that this educational overture was declined. The clinician can decide what level of education to incorporate into the visit.

If the parent/caregiver says “Yes” they have received the office materials, the receptionist asks “Have you completed the parent/caregiver questionnaire and discussed it with your nurse or doctor?”

- If parent/caregiver says “No” they have not completed the questionnaire the receptionist asks,** “May I give you another copy?”
- If the parent/caregiver says, “Yes” then the receptionist says,** “Great, we really appreciate your participation. You can complete this either today while you wait or at a time that is more convenient for you. Either today or on a future visit if you discuss your questionnaire responses with the nurse/doctor then your child can become a member of our Prudent Antibiotic Users Club and have their photo added to the display in our waiting room.”
- If the parent/caregiver says “No” then the receptionist says,** “OK well thanks anyway” and alerts the nurse or doctor seeing the patient that parent/caregiver questionnaire was declined. The clinician can decide what level of education to incorporate into the visit.
- If the parent/caregiver says “Yes” they have completed the parent/caregiver questionnaire but have not yet reviewed it with their nurse/doctor then the receptionist says** “Great, we really appreciate that you read the literature and completed the questionnaire. Either today if you have it with you, or on a future visit if that is more convenient, if you discuss your questionnaire responses with the nurse/doctor then your child can become a member of our Prudent Antibiotic Users Club and have their photo added to the display in our waiting room.”
- If the parent/caregiver says “Yes”, they have completed the questionnaire and discussed it with their nurse/doctor then the receptionist says** “Great, we really appreciate your participation. We look forward to having a photo of (child’s name) to add to our Judicious Antibiotic Users Club display.

4D.

Sample Transcript for Handling Phone Requests for Antibiotic Treatment

If the person in your office who initially receives this phone request is not the staff person responsible for triage, then the parent/caregiver call should be forwarded to the designated office triage person.

The person initially answering the call says to the parent/caregiver:

“You will need to speak with our (office nurse or whoever is doing triage) to discuss this. Let me forward your call to (name of triage person).”

The triage person first says:

“I understand that you are asking for an antibiotic prescription for (child’s name.) First, let me make sure I understand all of (child’s name) symptoms and then we can discuss the best course of action.” (Triage person listens carefully to parent/caregiver and completes a URI symptom checklist based on the information that the parent/caregiver relays.)

When the parent/caregiver is finished speaking, triage person says:

“I want to make sure I understand all of the symptoms that (child’s name) is experiencing. Let me repeat what I have heard from you and let me ask you about some other symptoms as well.” (Ask about other URI symptoms on checklist that were not mentioned by parent/caregiver to help you determine bacterial vs. viral likelihood.)

If triage person thinks that the child’s symptoms point to a bacterial URI then triage person says:

“Mr./Ms. ____ our office policy is to have children evaluated by a doctor here in the office before antibiotics are prescribed. We require this because physical examination and certain tests that can only be done in the office can best confirm a bacterial infection. We believe that this policy provides the greatest protection for your child. Do you want to have (child’s name) evaluated by a doctor in the office today? “

- If parent/caregiver says, “Yes” then triage person schedules a sick appointment.
- If parent/caregiver says “No” then, triage person says “I am sorry but I can not make any exceptions. Do you want to speak with your physician about this?”
- If parent/caregiver says, “Yes” then triage person says “I will let Dr. _ know that you would like to speak with him and ask him/her to call you today.”
- If parent/caregiver says “No” then triage person says, “call us if (child’s name) seems to get worse or if you change your mind about bringing him/her in to be evaluated.

If triage person thinks the symptoms point to a viral URI, the triage person says:

“Mr./Ms., based on what you have told me it sounds like (child’s name) has a (type of URI) which is probably due to a virus. I say this because (explain what symptoms would exist if it were a bacterial infection). Antibiotics are not helpful in treating viral illnesses and in fact could actually harm your child by making him/her more susceptible to bacterial illnesses in the future. Let’s talk about what you can do to make your child more comfortable.” (Review symptom management flow sheet with parent/caregiver and record educational exchange in child’s medical record. Review when to call the doctor.)

If parent/caregiver is adamant that they want antibiotics anyway then triage person says:

“ I want to reassure you that we want your child to get the best treatment for their illness. Help me understand why you think an antibiotic will help with your child’s recovery?” (Based on the information offered by the parent/caregiver, provide additional education and advice on symptom management. If the parent, still is not satisfied with the treatment recommendation, again reiterate the office policy and request that the parent/caregiver bring the child to the office for further evaluation.)

Section Five: Evaluation

DMA will be evaluating this pilot initiative for the purpose of determining the impact of the Judicious Use of Antibiotics Initiative on antibiotic prescribing at your primary care site, as well as the other sites participating in the project. In addition, the evaluation will gather qualitative information about the usefulness of the educational materials, as well as the applicability of the materials for use statewide.

The evaluation will involve nine sites: three sites not participating in the education initiative but who will be asked to participate in a trending study only; and three sites that will not be aware that a trending study is underway. None of the participating sites will be involved in any other educational initiatives sponsored by DMA or its research partners.

For those participating sites, pre- and post-studies will be done on all identified indicator. That is, studies will be done on participating sites, such that February, March and April 2000 performance data will be used as baseline. Following the educational initiative, that is February, March and April 2001, performance data will be compared to the baseline data to determine whether performance changed over time. Additionally, each site will be compared to each of the eight other sites on all performance indicators; and, a follow-up study will be conducted using February, March and April 2002 data to determine whether the gains, if any, were held.

By involving six alternative sites, three that know of the study and three that do not know of the study, the evaluation will determine the degree of impact the educational intervention had on antibiotic prescribing, in relation to the degree of impact resulting from other environmental forces.

The qualitative aspect of the study will involve interviews and/or focus groups with participating physicians. In addition, a brief, self-addressed feedback questionnaire will be distributed to members following their office visits. This questionnaire will ask patients to comment on aspects of the office visits and educational materials, as related to the antibiotic project.

Section Six: Facilitating Improvement Teams

This section of the Toolkit provides you with tools and resources for organizing your own project team to focus on promoting the judicious use of antibiotics. The agendas are designed to assist you to focus on the major topics contained within this Toolkit and to assist you in putting the Recommendations, educational materials and Toolkit information to use within your practice. The tips for meeting facilitation and quality improvement information are intended to be a refresher only, or to share with colleagues and office support staff who may need this information.

DMA wants to make implementation of the recommendations and educational materials as simple as possible for you by providing easy to use information. Which materials you use or how you use them is entirely up to your office to decide.

Here's what you'll find:

- A. Agendas and planning activities for improvement team meetings
- B. Refresher: Facilitation skills
- C. Refresher: Continuous quality improvement process: Plan-Do-Check-Act

6A. Improvement Team meeting agendas

Your primary care practice has agreed to work with the Division of Medical Assistance and its agent, the MassHealth Access Program at the Office of Community Programs at the University of Massachusetts Medical School, to implement the Recommendations for Judicious Use of Antibiotics using a continuous quality improvement approach. The basic steps of this initiative are as follows:

- Conduct baseline chart review of current use of antibiotics in MassHealth PCC Plan members as outlined in the Recommendations;
- Receive training on the Recommendations and their relevance to your current performance related to the judicious use of antibiotics;
- Work with the MassHealth Access Program to plan a clinical and educational intervention designed to improve at least one area of care related to the judicious use of antibiotics;
- implement intervention(s) and track improvement through additional chart reviews.

Several agendas have been developed to help you facilitate this simple process with your primary care team. The MassHealth Access Program and its agents will work with you to modify them for use by you and your antibiotic improvement team regularly through the duration of this initiative. The MassHealth Access Program can be reached by telephone at **508-856-3188**.

Suggested agenda for:

Meeting One-Introduction to the Recommendations for Judicious Use of Antibiotics

Time	Topic	Facilitator
10 minutes	Welcome and introduce project team	
5 minutes	Distribute handouts <ul style="list-style-type: none"> • Recommendations • DMA Educational Materials • Presenter handouts • Chart review report 	
5 minutes	Welcome and introduce presenter(s)	
60 minutes	Training Program	
30 minutes	Questions and Discussion	
5 minutes	Next Steps	
5 minutes	Confirm date, time, location of next meeting	

Suggested agenda for:

Meeting Two-Choosing an Improvement Area and Intervention

Time	Topic	Facilitator
5 minutes	Welcome and introduce project team	
10 minutes	Review outcomes of Meeting One	
30 minutes	Antibiotic Toolkit orientation: Improvement areas and resources <ul style="list-style-type: none"> • Prescribe oral antibiotics only following an examination • Making correct diagnoses • Symptom management strategies/education • Non-western ways of managing symptoms • Amoxicillin as first line treatment for most URIs • Prevnar immunization • Addressing day care and school health concerns • Reduce antibiotic prophylaxis • Understanding the side effects of antibiotics • Parent/caregiver education 	
15 minutes	Select improvement area(s) to be addressed in the project as outlined in the Toolkit	
45 minutes	Use the Toolkit to discuss specific clinical and educational intervention(s) to be undertaken by the project	
15 minutes	Next Steps <ul style="list-style-type: none"> • Follow-up assignments • Intervention timeline • Resources needed 	
5 minutes	Confirm date, time, location of next meeting	

Suggested agenda for:

Meeting Three-Planning Improvement Intervention(s)

Time	Topic	Facilitator
5 minutes	Welcome and introduce project team	
10 minutes	Review outcomes of Meeting Two	
30 minutes	Update on intervention development	
	<ul style="list-style-type: none"> •Timeline for intervention implementation •Detail clinical intervention •Detail parent/caregiver educational content to be delivered-what, who and how •Resources obtained/created and resources needed •Technical assistance needed from expert panel members 	
15 minutes	Communication	
	<ul style="list-style-type: none"> •To whom does the intervention(s) need to be communicated to ensure success? •Who will take responsibility for doing this? • When will it be done? 	
30 minutes	Measuring improvement	
	<ul style="list-style-type: none"> •How will we know we have made improvement(s) in our intervention area(s)? •What information will be useful to physicians? •To other team members? •Who will be responsible for collecting and reporting on data? 	
20 minutes	Intervention implementation	
5 minutes	Mid-course chart review and team training	
5 minutes	Confirm date, time, location of next meeting	

6B.

Refresher: Meeting facilitation skills

Contributed by Marya Axner

Edited by Bill Berkowitz



What are facilitation skills?

One of the most important sets of skills for leaders and members are facilitation skills. These are the “process” skills we use to guide and direct key parts of our organizing work with groups of people such as meetings, planning sessions, and training of our members and leaders.

Whether it’s a meeting (big or small) or a training session, someone has to shape and guide the process of working together so that you meet your goals and accomplish what you’ve set out to do. While a group of people might set the agenda and figure out the goals, one person needs to concentrate on how you are going to move through your agenda and meet those goals effectively. This is the person we call the “facilitator.”

So, how is facilitating different than chairing a meeting?

Well, it is and it isn’t. Facilitation has three basic principles:

- A facilitator is a guide to help people move through a process together, not the seat of wisdom and knowledge. That means a facilitator isn’t there to give opinions, but to draw out opinions and ideas of the group members.
- Facilitation focuses on HOW people participate in the process of learning or planning, not just on WHAT gets achieved.
- A facilitator is neutral and never takes sides.

The best meeting chairs see themselves as facilitators. While they have to get through an agenda and make sure that important issues are discussed, decisions made, and actions taken, good chairs don’t feel that they have all of the answers or should talk all the time. The most important thing is what the participants in the meeting have to say. So, focus on how the meeting is structured and run to make sure that everyone can participate. This includes things like:

- Making sure everyone feels comfortable participating
- Developing a structure that allows for everyone’s ideas to be heard
- Making members feel good about their contribution to the meeting
- Making sure the group feels that the ideas and decisions are theirs, not just the leader’s. Supporting everyone’s ideas and not criticizing anyone for what they’ve said.

Why do you need facilitation skills?

If you want to do good planning, keep members involved, and create real leadership opportunities in your organization and skills in your members, you need facilitator skills. The more you know about how to shape and run a good learning and planning process, the more your members will feel empowered about their own ideas and participation, stay invested in your organization, take on responsibility and ownership, and the better your meetings will be.

Facilitating a meeting or planning session: What's it all about?

The three basic parts of facilitation are:

- The process of the meeting
- skills and tips for guiding the process
- Dealing with disrupters: preventions and interventions

The meeting process

As we've already said, the facilitator is responsible for providing a "safe" climate and working atmosphere for the meeting. But you're probably wondering, "What do I actually do DURING the meeting to guide the process along?" Here are the basic steps that can be your facilitator's guide:

1. Start the meeting on time

Few of us start our meetings on time. The result? Those who come on time feel cheated that they rushed to get there! Start no more than five minutes late, ten at the maximum and thank everyone who came on time. When latecomers straggle in, don't stop your process to acknowledge them. Wait until after a break or another appropriate time to have them introduce themselves.

2. Welcome everyone

Make a point to welcome everyone who comes. Don't complain about the size of a group if the turnout is small! Nothing will turn the folks off who DID come out faster. Thank all of those who are there for coming and analyze the turnout attendance later. Go with who you have.

3. Make introductions, especially if new participants are present

There are lots of ways for people to introduce themselves to each other that are better than just going around the room. The kinds of introductions you do should depend on what kind of meeting you are having, the number of people, the overall goals of the meeting, and what kind of information it would be useful to know. Some key questions you can ask members to include in their introductions are:

- How did you first get involved with our organization? (if most people are already involved, but the participants don't know each other well)
- What do you want to know about our organization? (if the meeting is set to introduce your organization to another organization)
- What makes you most angry about this problem? (if the meeting is called to focus on a particular problem)

Sometimes, we combine introductions with something called an “ice breaker.” Ice breakers can:

- Break down feelings of unfamiliarity and shyness
- Help people shift roles – from their “work” selves to their “more human” selves
- Build a sense of being part of a team
- Create networking opportunities
- Help share participants’ skills and experiences

Some ways to do introductions and icebreakers are:

- In pairs, have people turn to the person next to them and share their name, organization and three other facts about themselves that others might not know. Then, have each pair introduce EACH OTHER to the group. This helps to get strangers acquainted and for people to feel safe – they already know at least one other person, and didn’t have to share information directly in front of a big group at the beginning of the meeting.
- Form small groups and have each of them work on a puzzle. Have them introduce themselves to their group before they get to work. This helps to build a sense of team work.
- In a large group, have everyone write down two true statements about themselves and one false one. Then, every person reads their statements and the whole group has to guess which one is false. This helps folks get acquainted and relaxed.
- Give each participant a survey and have the participants interview each other to find the answers. Make the questions about skills, experience, opinions on the issue you’ll be working on, etc. When everyone is finished, have folks share the answers they got.

When doing introductions and icebreakers, it’s important to remember:

- Every participant needs to take part in the activity. The only exception may be latecomers who arrive after the introductions are completed. At the first possible moment, ask the latecomers to say their name and any other information you feel they need to share in order for everyone to feel comfortable and equal.
- Be sensitive to the culture, age, gender and literacy levels of participants and any other factors when deciding how to do introductions. For example, an activity that requires physical contact or reading a lengthy instruction sheet may be inappropriate for your group. Also, keep in mind what you want to accomplish with the activity. Don’t make a decision to do something only because it seems like fun.
- It is important to make everyone feel welcome and listened to at the beginning of the meeting. Otherwise, participants may feel uncomfortable and unappreciated and won’t participate well later on. Also, if you don’t get some basic information about who is there, you may miss some golden opportunities. For example, the editor of the regional newspaper may be in the room; but if you don’t know, you’ll miss the opportunity for a potential interview or special coverage.

- And don't forget to introduce yourself. You want to make sure that you establish some credibility to be facilitating the meeting and that folks know a bit about you. Credibility doesn't mean you have a college degree or 15 years of facilitation experience. It just means that you share some of your background so folks know why you are doing the facilitation and what has led you to be speaking up.

4. Review the agenda, objectives and ground rules for the meeting

Go over what's going to happen in the meeting. Check with the group to make sure they agree with and like the agenda. You never know if someone will want to comment and suggest something a little different. This builds a sense of ownership of the meeting and lets people know early on that you're there to facilitate THEIR process and THEIR meeting, not your own agenda. The same is true for the outcomes of the meeting. You'll want to go over these with folks as well to get their input and check that these are the desired outcomes they're looking for. This is also where the ground rules that we covered earlier come in.

5. Encourage participation

This is one of your main jobs as a facilitator. It's up to you to get those who need to listen to listen and those who ought to speak. Encourage people to share their experiences and ideas and urge those with relevant background information share it at appropriate times.

6. Stick to the agenda

Groups have a tendency to wander far from the original agenda, sometimes without knowing it. When you hear the discussion wandering off, bring it to the group's attention. You can say "That's an interesting issue, but perhaps we should get back to the original discussion."

7. Avoid detailed decision-making

Sometimes, it's easier for groups to discuss the color of napkins than the real issues they are facing. Help the group not to get immersed in details. Suggest instead, "Perhaps the committee could resolve the matter." Do you really want to be involved in that level of detail?

8. Seek commitments

Getting commitments for future involvement is often a meeting goal. You want leaders to commit to certain tasks, people to volunteer to help on a campaign, or organizations to support your group. Make sure adequate time is allocated for seeking commitment. For small meetings, write people's names down on newsprint next to the tasks they agreed to undertake.

One important rule of thumb is that no one should leave a meeting without something to do. Don't ever close a meeting by saying "We'll get back to you to confirm how you might like to get involved." Seize the moment! Sign them up!

9. Bring closure to each item

Many groups will discuss things ten times longer than they need to unless a facilitator helps them to recognize they're basically in agreement. Summarize a consensus position, or ask someone in the group to summarize the points of agreement, and then move forward. If one or two people disagree, state the situation as clearly as you can: "Tom and Levonia seem to have other feelings on this matter, but everyone else seems to go in this direction. Perhaps we can decide to go in the direction that most of the group wants, and maybe Tom and Levonia can get back to us on other ways to accommodate their concerns." You may even suggest taking a break so Tom and Levonia can caucus to come up with some options.

Some groups feel strongly about reaching consensus on issues before moving ahead. If your group is one of them, be sure to read a good manual or book on consensus decision making. Many groups, however, find that voting is a fine way to make decisions. A good rule of thumb is that a vote must pass by a two-thirds majority for it to be a valid decision. For most groups to work well, they should seek consensus where possible, but take votes when needed in order to move the process forward.

10. Respect everyone's rights

The facilitator protects the shy and quiet folks in a meeting and encourages them to speak out. There is also the important job of keeping domineering people from monopolizing the meeting or ridiculing the ideas of others.

Sometimes, people dominate a discussion because they are really passionate about an issue and have lots of things to say. One way to channel their interest is to suggest that they consider serving on a committee or task force on that issue. Other people, however, talk to hear themselves talk. If someone like that shows up at your meeting, look further ahead in this chapter for some tips on dealing with "disrupters."

11. Be flexible

Sometimes issues will arise in the meeting that are so important, they will take much more time than you thought. Sometimes, nobody will have thought of them at all. You may run over time or have to alter your agenda to discuss them. Be sure to check with group about whether this is O.K. before going ahead with the revised agenda. If necessary, ask for a five-minute break to confer with key leaders or participants on how to handle the issue and how to restructure the agenda. Be prepared to recommend an alternate agenda, dropping some items if necessary.

12. Summarize the meeting results and needed follow-ups

Before ending the meeting, summarize the key decisions that were made and what else happened. Be sure also to summarize the follow-up actions that were agreed to and need to take place. Remind folks how much good work was done and how effective the meeting hopefully was. Refer back to the objectives or outcomes to show how much you accomplished.

13. Thank the participants

Take a minute to thank people who prepared things for the meeting, set up the room, brought refreshments, or did any work towards making the meeting happen. Thank all of the participants for their input and energy and for making the meeting a success.

14. Close the meeting

People appreciate nothing more than a meeting that ends on time! It's usually a good idea to have some "closure" in a meeting, especially if it was long, if there were any sticky situations that caused tension, or if folks worked especially hard to come to decisions or make plans. A nice way to close a meeting is to go around the room and have people say one word that describes how they are feeling now that all of this work has been done. You'll usually get answers from "exhausted" to "energized!" If it's been a good meeting, even the "exhausted" ones will stick around before leaving.

Facilitator skills and tips

Here are a few more points to remember that will help to maximize your role as a facilitator:

1. Don't memorize a script

Even with a well-prepared agenda and key points you must make, you need to be flexible and natural. If people sense that you are reading memorized lines, they will feel like they are being talked down to, and won't respond freely.

2. Watch the group's body language

Are people shifting in their seats? Are they bored? Tired? Looking confused? If folks seem restless or in a haze, you may need to take a break, or speed up or slow down the pace of the meeting. And if you see confused looks on too many faces, you may need to stop and check in with the group, to make sure that everyone knows where you are in the agenda and that the group is with you.

3. Always check back with the group

Be careful about deciding where the meeting should go. Check back after each major part of the process to see if there are questions and that everyone understands and agrees with decisions that were made.

4. Summarize and pause

When you finish a point or a part of the meeting process, sum up what was done and decided, and pause for questions and comments before moving on. Learn to "feel out" how long to pause -- too short, and people don't really have time to ask questions; too long, and folks will start to get uncomfortable from the silence.

5. *Be aware of your own behavior*

Take a break to calm down if you feel nervous or are losing control. Watch that you're not repeating yourself, saying "ah" between each word, or speaking too fast. Watch your voice and physical manner. (Are you standing too close to folks so they feel intimidated, making eye contact so people feel engaged?) How you act makes an impact on how participants feel.

6. *Occupy your hands*

Hold onto a marker, chalk, or the back of a chair. Don't play with the change in your pocket!

7. *Watch your speech*

Be careful you are not offending or alienating anyone in the group. Use swear words at your own risk!

8. *Use body language of our own*

Using body language to control the dynamics in the room can be a great tool. Moving up close to a shy, quiet participant and asking them to speak may make them feel more willing, because they can look at you instead of the big group and feel less intimidated. Also, walking around engages people in the process. Don't just stand in front of the room for the entire meeting.

9. *Don't talk to the newsprint, blackboard or walls – they can't talk back!*

Always wait until you have stopped writing and are facing the group to talk.

Dealing with disrupters: Preventions and interventions

Along with these tips on facilitation, there are some things you can do both to prevent disruption before it occurs to stop it when it's happening in the meeting. The most common kinds of disrupters are people who try to dominate, keep going off the agenda, have side conversations with the person sitting next to them, or folks who think they are right and ridicule and attack other's ideas.

Try using these "Preventions" when you set up your meeting to try to rule out disruption:

1. *Get agreement on the agenda, ground rules and outcomes*

In other words, agree on the process. These process agreements create a sense of shared accountability and ownership of the meeting, joint responsibility for how the meeting is run, and group investment in whether the outcomes and goals are achieved.

2. Listen carefully

Don't just pretend to listen to what someone in the meeting is saying. People can tell. Listen closely to understand a point someone is making. And check back if you are summarizing, always asking the person if you understood their idea correctly.

3. Show respect for experience

We can't say it enough. Encourage folks to share strategies, stories from the field, and lessons they've learned. Value the experience and wisdom in the room.

4. Find out the group's expectations

Make sure that you uncover at the start what participants think they are meeting for. When you find out, be clear about what will and won't be covered in this meeting. Make plans for how to cover issues that won't be dealt with: Write them down on newsprint and agree to deal with them at the end of the meeting, or have the group agree on a follow-up meeting to cover unfinished issues.

There are lots of ways to find out what the group's expectations of the meeting are: Try asking everyone to finish this sentence: "I want to leave here today knowing...." You don't want people sitting through the meeting feeling angry that they're in the wrong place and no one bothered to ask them what they wanted to achieve here. These folks may act out their frustration during the meeting and become your biggest disrupters.

5. Stay in your facilitator role

You cannot be an effective facilitator and a participant at the same time. When you cross the line, you risk alienating participants, causing resentment, and losing control of the meeting. Offer strategies, resources, and ideas for the group to work with, but NOT opinions.

6. Don't be defensive

If you are attacked or criticized, take a "mental step" backwards before responding. Once you become defensive, you risk losing the group's respect and trust, and might cause folks to feel they can't be honest with you.

7. "Buy-in" power players

These folks can turn your meeting into a nightmare if they don't feel that their influence and role are acknowledged and respected. If possible, give them acknowledgment up front at the start of the meeting. Try giving them roles to play during the meeting such as a "sounding board" for you at breaks, to check in with about how the meeting is going.

Try using these “Interventions” when disruption is happening during the meeting:

1. Have the group decide

If someone is dominating the meeting, refuses to stick to the agenda, keeps bringing up the same point again and again, or challenges how you are handling the meeting:

First try to remind them about the agreed-on agenda. If that doesn't work, throw it back to the group and ask them how they feel about that person's participation. Let the group support you.

2. Use the agenda and ground rules

If someone keeps going off the agenda, has side conversations through the whole meeting, verbally attacks others:

Go back to that agenda and those ground rules and remind folks of the agreements made at the beginning of the meeting.

3. Be honest: Say what's going on

If someone is trying to intimidate you, if you feel upset or undermined, if you need to pull the group behind you:

It is better to say what's going on than try to cover it up. Everyone will be aware of the dynamic in the room. The group will get behind you if you are honest and up-front about the situation.

4. Use humor

If there is a lot of tension in the room, if you have people at the meeting who didn't want to be there, if folks are scared/shy about participating, if you are an outsider:

Try a humorous comment or a joke. If it's self-deprecating, so much the better. Humor almost always lightens the mood. It's one of the best tension-relievers we have.

5. Accept or legitimize the point or deal:

If there is someone who keeps expressing doubts about the group's ability to accomplish anything, is bitter and puts down others' suggestions, keeps bringing up the same point over and over, seems to have power issues:

Try one or more of these approaches: Show that you understand their issue by making it clear that you hear how important it is to them. Legitimize the issue by saying, “It's a very important point and one I'm sure we all feel is critical.” Make a bargain to deal with their issue for a short period of time (“O.K., let's deal with your issue for 5 minutes and then we ought to move on.”) If that doesn't work, agree to defer the issue to the end of the meeting, or set up a committee to explore it further.

6. Use body language

If side conversations keep occurring, if quiet people need to participate, if attention needs to be re-focused:

Use body language. Move closer to conversers, or to the quiet ones. Make eye contact with them to get their attention and convey your intent.

7. Take a break

If less confrontational tactics haven't worked, someone keeps verbally attacking others, shuffling papers, cutting others off:

In case you've tried all of the above suggestions and nothing has worked, it's time to take a break, invite the disruptive person outside the room and politely but firmly state your feelings about how disruptive their behavior is to the group. Make it clear that the disruption needs to end. But also try to find out what's going on, and see if there are other ways to address that person's concerns.

8. Confront in the room

If all else has failed, if you're sure it won't create backlash, if the group will support you, and if you've tried everything else:

Confront the disruptive person politely but very firmly in the room. Tell the person very explicitly that the disruption needs to stop now. Use body language to encourage other group members to support you. This is absolutely the last resort when action must be taken and no alternatives remain!

We encourage the reproduction of this material, but ask that you credit the:



Resources

- Auvine, B., Dinsmore, B., Extrom, M., Poole, S., Shanklin, M. (1978). A manual for group facilitators. Madison, WI: The Center for Conflict Resolution.
- Bobo, K., Kendall, J., Max, S., (1991). A manual for activists in the 1990s. Cabin John, MD: Seven Locks Press.
- Nelson-Jones, R. (1992). Group leadership: A training approach. Pacific Grove, CA: Brooks/Cole.
- Schwarz, R.M. (1994). The skilled facilitator: Practical wisdom for developing effective groups. San Francisco, CA: Jossey-Bass.

6C.

The Continuous Quality Improvement Process – Plan, Do, Check, Act

1. PLAN the change

- ❖ Precisely what change is to be made?
- ❖ How do you know the planned change is appropriate? Have other alternatives been explored? If no other alternatives have been explored, you may first want to work through the strategy.
- ❖ What sequence of major steps is needed for this change? What are the major sub-steps of each step? Map out the new process on a flowchart.
- ❖ Who will be directly involved in carrying out each step and substep? Who will need to be consulted?
- ❖ Whom will the change affect? Who will need to change the way they do their jobs? How will they need to change the way they do their jobs? How will they be trained? How will you get qualified trainers? How will the effects of the training be checked?

Do not surprise people with change. Get information to everybody before they hear rumors. Seek input from people who will be affected by the change. Explain the change and explain how it will affect them and how they will be kept informed. Ask then what they need to know to be comfortable with the change. Incorporate suggestions from them into the plan, if reasonable.

- ❖ What will you do about unexpected problems? Who will have the authority to take action?
- ❖ Taking all these factors into account, what can be done to increase the likelihood of success?
- ❖ How will you monitor and check the progress of the change? The effectiveness of the change? How will you measure the benefits of the change? What are the key points to monitor to determine if the change is proceeding as expected?
- ❖ How will you collect, review, and act on this information?

2. DO the change

- ❖ It is often best to carry out a small-scale study of the change before making it widespread. Train those whose jobs will change. Personally supervise execution of the change.

3. CHECK the change

- ❖ Monitor the progress and effectiveness of the change according to your plan. Gather data from key points. Check for side effects and backsliding.

4. Refine and standardize the change

- ❖ What did the information you collected tell you about the effectiveness of the change?
- ❖ What can be done to error proof the process?
- ❖ How can the change be refined? Do another Plan-Do-Check-Act cycle if refinements are substantial. Standardize the new procedures. Transfer responsibility for ongoing monitoring and improvement to everyday operators and supervisors.
- ❖ What do you need to complete the documentation of the change?
- ❖ What lessons learned here about the new procedure and implementing change apply elsewhere? How can these lessons be communicated?

5. ACT on the change

- ❖ When you have refined your change, it is then time to put it into action at your practice.

Congratulations and Good Luck!

Adapted from: *The Team Handbook* by Peter R. Scholtes.