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INSIDE

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Patient education like putty in the hands of outside regulators

Standards shape programs, teaching methods, materials

Following a mock survey in preparation for the real accreditation process conducted by the Joint Commission on Accreditation of Healthcare Organizations, administrators at York (PA) Health System hired a patient education coordinator one month prior to the process.

The goal of creating a new position was to improve compliance with the standards. When the mock surveyor asked who coordinated patient education or who was the central person responsible for it, there was no answer, explains **Donette Lasher**, MAT, who was hired as patient education coordinator at York in August 1998.

Other major changes at the health system included the formation of an interdisciplinary committee and the development of a record for documenting patient education.

"We relied on the mock surveyor to let us know what [the Joint Commission] was looking for, and the record was one of the recommendations she made because [the Joint Commission] is interested in how well we work together. The more we handed off to each other, the happier they were," says Lasher.

An interdisciplinary teaching record not only provides evidence of education; it provides evidence of interdisciplinary teaching, she says. **(For information on where to find a mock surveyor, see editor's note, p. 16.)**

Although most health care facilities don't undergo such a dramatic transformation before a Joint Commission survey, the standards of the Oakbrook Terrace, IL-based accreditation agency do shape and mold patient education throughout the health system.

While patient education was being done at Shands Hospital at the University of Florida in Gainesville, the Joint Commission survey prompted staff to create a team to go over the standards and look for areas for improvement, says **Kathy Conner**, ARNP, MN, coordinated

care manager in the department of nursing and patient services at Shands.

The team saw the need to make patient education more interdisciplinary and collaborative. Therefore, they created an interdisciplinary tool for documentation so staff could easily see which disciplines had taught and built on the education.

Following the survey, the team focused on CQI efforts for education and came up with five recommendations that were approved. They include the creation of a multidisciplinary team to oversee patient and family education and developing a computerized index of patient education materials. **(For information on preparing staff for a JCAHO survey, see article, p. 15.)**

Program design shaped by standards

Standards for other regulatory agencies don't have such a hospitalwide impact. Most affect how patients are educated within individual programs. For example, The Commission on Accreditation of Rehabilitation Facilities (CARF) in Tucson, AZ, creates standards for individual rehab programs.

"Whenever you get CARF-accredited, it is not an organization that gets accredited; it is specific programs within that organization, and there are different specialty accreditations," says **Terrie Black**, MBA, BSN, CRRN, RNC, a CARF surveyor and rehabilitation consultant at Hospital for Special Care in New Britain, CT.

There are standards for brain injury programs, spinal cord injury programs, outpatient rehab programs, and comprehensive integrated inpatient programs that include stroke patients, she explains.

CARF standards are more specific for some programs than for others. A spinal cord injury program must cover a wide range of education such as pulmonary care, sexual counseling, skin care, and substance abuse. However, the standards emphasize that the education must meet an individual's needs, so it is not limited to the suggested topics.

"The program we have for spinal cord patients, Independent Living Skills, is driven by the CARF standards," says **Susan Wise**, BSN, RNC, DRRN, a rehabilitation educator at the University of Utah Hospitals and Clinics in Salt Lake City. However, many educational sessions are given in addition to the required curriculum. For example, patients are taken out to eat at a restaurant of their choice one day so they can get used to being in public.

To have a diabetes program recognized by the Alexandria, VA-based American Diabetes Association (ADA), stringent patient education standards must be met. There are 15 content areas that basic diabetes education must cover, and the teaching within these areas must be based on an assessment of patient needs, says **Betty Nalli**, ARNP, MSN, coordinated care manager in the department of nursing and patient services at Shands.

The ADA standards not only govern the topics taught, but the materials distributed as well. All patient education materials written in-house must be submitted for approval, says **Amparo Gonzalez**, RN, BSN, CDE, director of the Specialty Center for Diabetes Care at Saint Joseph's Hospital of Atlanta. One of the most challenging aspects of the standards is the data collection required to prove the education is enhancing the patient's ability to self-manage the disease.

Systems must adhere to standards

A fourth agency, the National Committee on Quality Assurance (NCQA) in Washington, DC, sets standards for managed care plans. Health systems that wish to contract with a managed care company to educate its members must adhere to the standards by which these companies are accredited.

"You have to use recognized guidelines. We go through a lengthy research process of educational designs. In that way we can take bits and pieces, but they have to be based strongly on a recognized entity and you have to quote that entity within your model," says **Stacey Bateman**, RN, BSN, director of program development at Flagship Healthcare in Miami Lakes, FL. For example, the ADA guidelines were used to design Flagship's diabetes education program.

Also, outcomes are crucial. There must be some sort of proof that the education is effective, she says. **(To learn how to tailor a patient education program to NCQA standards, see article on p. 17.)**

Get a copy of HEDIS 3.0 (Health Plan Employer Data and Information Set), advises **Nancy Walch**, BSN, MPH, CDE, CHES, coordinator of the health education and wellness department at Queen's Medical Center in Honolulu. HEDIS is a set of standardized performance measures set by NCQA to measure the performance of managed health care plans. Programs must

Bring lofty standards down to staff level

Teach how to talk with surveyors on compliance

The biggest challenge to complying with the standards of the Oakbrook Terrace, IL-based Joint Commission on Accreditation of Healthcare Organizations is education of staff, says **Kathy Ordelt**, RN, CRRN, CPN, patient and family education coordinator at Egleston-Scottish Rite Children's Health Care System in Atlanta. Staff need to understand how the hospital globally applies the standards and how their own department complies with Joint Commission, she explains.

To educate staff and make sure all departments were in compliance with the Joint Commission's standards for patient education, the health care system began an education campaign about 18 months before the survey.

Following is a list of the educational methods employed:

• Explain standards in a variety of print methods.

Each month, an in-house nursing publication featured a Joint Commission patient education standard in question form, then provided the answer. For example, employees might be asked: "How do we educate patients about medications and potential food and drug interactions?" Ordelt would provide the answer in bullets following the question.

The information also was sent to managers on a flyer and as an e-mail message. "I made sure all the managers knew it was a piece of information the Joint Commission was concerned about," says Ordelt.

The 750 pediatricians associated with the health care facility were sent the flyers on patient education standards as well.

• Make learning fun by playing games.

A core team was assembled with leaders for each chapter of the standards. Ordelt was selected for patient education. This team created games to help employees remember standards and went to each department to play the games with staff in those areas.

The games also were played with different physician groups where patient education questions were included. One of the favorite games was "Joint Commission Feud," where the employees would divide into teams and compete to answer questions about standards appropriate to their area.

If an area did not do well with patient education questions, Ordelt would return with the game and focus on patient education topics.

Reward staff with candy, yogurt

Another game was similar to the TV game show *Jeopardy!*. A large nylon board with pockets had categories across the top and answers to questions in each pocket. As the answers were pulled from the pockets, competing teams would have to give the question. Candy or yogurt coupons were handed out as prizes whenever games were played.

"We had a sign-up sheet so the departments could borrow all our games from the education department and take them to their staff meetings and inservices," says Ordelt.

• Verbally test employees on standards.

Ordelt would visit different units and stop employees as a surveyor might to ask questions about patient education. For example, she might ask an employee to explain how he or she personally meets the standard for education on food and drug interaction with the patients on the unit.

• Thank staff for their efforts.

When the survey is completed, send out thank-you notes immediately, advises Ordelt. Don't wait until the results of the survey are known. Also, celebrate good results and the effort of staff to achieve them. "After we found we got our third accreditation with commendation, we had a very large dessert party and invited all staff to come," says Ordelt. ■

help managed care meet these performance measures, she says.

Do all these standards fit together? "We see them complementing each other. The ADA standards reinforce where we see the Joint Commission going," says **Sharon Valley**, MS, CDE, education coordinator for the diabetes center at Shands Hospital. For example, the Joint Commission emphasizes an interdisciplinary approach for patient education, and ADA-recognized diabetes

programs incorporate nurses, dietitians, physicians, and specialists in adult education.

The Joint Commission also looks for education over the continuum of care. Diabetes teaching is a perfect example because it often begins in the hospital and is completed in an outpatient setting, and follow-up continues to make sure that the outcomes were achieved.

Inpatient nurses and certified diabetes educators from the outpatient area at Shands worked together to create an education pathway that provides guidance on what to teach in an acute setting. "In the inpatient setting, we try to focus on the essential education, and then when the patient is referred to the diabetes center, the educators can do the follow-up with more in-depth education," says Valley.

The health system also created a documentation form to record inpatient education. A copy of the form is either sent or faxed to the diabetes center when the patient is discharged, says Valley.

Surveyors find common ground

Some accreditation agencies are beginning to work together. The Joint Commission and CARF now will arrange to do surveys of a health care facility at the same time. "There is a lot of collaboration going on between the two accrediting agencies that has not always existed in the past," says Black.

While it takes time to make sure educational programs are in compliance with standards from outside regulatory agencies, most educators agree that becoming accredited is well worth the effort. For diabetes programs, having your program recognized by the ADA helps ensure reimbursement for patient education.

"Any time I talk to a managed care company or case manager for a third-party payer, the first thing they ask is are you recognized. No one wants to talk to you if you are not," says Gonzalez.

The accreditation process, which ensures that standards are being met, is a catalyst for good patient education, says Lasher. "Surveys and standards are a benefit to us because every three years, on a regular cycle, they remind us of what good patient care is. They help keep us accountable and give us the priority to do it," she explains.

Following standards by a reputable agency ensures that you are implementing best-practice principles based on the latest research, says Valley. "If one wants to be associated with the cutting-edge clinical standards in a given specialty area, then one allies with that organizing body," Gonzalez says.

[Editor's note: The mock surveyor used by York Health System came from Quality Systems Group Consultants, 25 South Arizona Place, Suite 570, Chandler, AZ 85225. Telephone: (602) 821-9116.] ■

SOURCES

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Cardiac education tailored for managed care

Enhance education by teaching at home

The best setting for patient education is not within the walls of a medical facility but at home, contends **Stacey Bateman**, RN, BSN, director of program development for Flagship Healthcare in Miami Lakes, FL.

"We don't treat our diseased population from behind ivory doors. We send our home care nurses out into the community," she explains.

At Flagship, educational programs to impact a particular patient group are designed to be taught within the home, not the classroom. This form of teaching gives the educator the opportunity to see if patients are applying their knowledge.

For example, the educator can see where patients keep their medications and how they take them. Also, multiple educational sessions tailored to a patient's needs have more of an impact on lifestyles, says Bateman.

The educational programs target major health problems in South Florida to attract managed care contracts. Total Heart Wellness is the health care company's latest program. "We saw that a great portion of the cardiac population were poorly educated on the disease, and as a result, they were going back to the hospital and physician's office and missing work. Their whole family dynamics were interrupted because no one ever really taught them how to manage cardiac disease. They just treated them for whatever problem they were having at the time," she says.

Each HMO that contracts with Flagship to manage its cardiac population determines which patients participate in the program and which do not. Once the patient enters the program, a Flagship cardiac nurse completes an evaluation in conjunction with a conference with the patient's physician. This determines the number of educational visits each patient will receive.

The number of visits is usually based on the stage of the disease, with stage one being minor symptoms and stage four being symptoms so severe that the patient cannot get out of a chair without shortness of breath.

The staging is based on the New York Classification Staging Process, a nationally recognized guideline for staging cardiac disease. When targeting managed care companies, it is important to use national guidelines to obtain contracts, explains Bateman. **(For information on accreditation standards affecting education programs for HMOs, see article on p. 13.)**

During the first visit, the cardiac nurse sets up an educational goal with the patient that is adjusted at every visit. For example, a patient may need to learn how to follow a low-sodium diet. The goals are taken from a critical pathway, and there is a pathway for every cardiac condition, such as congestive heart failure. "The cardiac nurse uses the pathway to set a goal and key plan of care," says Bateman.

Also to aid education, the cardiac nurse follows an educational calendar listing the topics that need to be covered in a certain number of visits, according to the patient's learning needs. For example, visit two might cover diet, exercise, and cardiac dietetics. Material from the past visit is reviewed each time, and one new topic is added to build upon the education.

While the cardiac nurse does the basic teaching, other disciplines are called in as needed. These disciplines might include social workers, dietitians, cardiac rehabilitation therapists, and respiratory therapists.

Patient works with case manager

During the education process, patients can call their case manager with questions or call a 24-hour hotline. These services help patients determine when they should visit the emergency department or see their physician, and when the symptom can be handled at home.

"The telephonic network is key, because the object of our program is not only to educate people about their disease, but also to keep them from making unnecessary visits to the ER and physician," she says. When patients have a medical problem, such as retaining fluid, the patient is treated, and then the cardiac nurse helps them determine what led to the problem in an effort to change behaviors that cause such episodes.

SOURCES

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Although Total Heart Wellness has only been in place since September 1998, Flagship is tracking outcomes to prove to HMOs that it is effective. Having the numbers to show that the program kept a stage two cardiac patient out of the emergency department and taught them how to properly take medications in 20.1 visits vs. the competition's 45 visits is very important, says Bateman. "You want to be able to manage that patient's dollar more effectively," she explains. ■

Reader Questions

Give patients skills for responsible self-care

Patients must understand the role they play

Question: The Joint Commission requires that hospitals "make clear to patients and families what their responsibilities are regarding the patient's ongoing health care needs, and gives them the knowledge and skills they need to carry out their responsibilities." What do you teach patients about their responsibilities as far as their ongoing health care needs? What steps do you take to teach the skills they need to carry out these responsibilities?

Answer: Upon hospital admission, each patient receives a handbook consisting of information that is mandated by law, says **Megan Finch**, RNC, MS, patient education coordinator at Union Hospital in Terre Haute, IN. The Patient Handbook contains legal materials only, such as advance directives and the patient's rights and responsibilities. Information on hospital operations, such as cafeteria hours or parking, is kept in a separate guest service book. "We keep all the legally important materials that patients need access to in a separate piece," says Finch.

In addition to handing patients and family members the information in writing, a nurse reviews the materials with them, explaining that it is their responsibility to provide accurate information, participate in teaching sessions, and let health care workers know when they don't understand something, says Finch.

In the outpatient areas, patient rights and responsibilities are available in handouts in the waiting areas, says Finch. The information also is posted.

At Memorial Hospital of Sheridan (WY) County, patients will find a list of global rights and responsibilities in a folder next to their beds. The responsibilities they have for their ongoing health care needs specific to their diagnosis are given to them in writing.

Also, a letter is included explaining that the patient and his or her family are the most important members of the care team. **(See example of letter and instructions, inserted in this issue.)**

It is important to solicit patients' aid in their own care, rather than simply telling them it is their responsibility to follow instructions that can be adversarial, says **Janet Swift**, RN, BSN, patient education coordinator at Sheridan. "We tell them how to get the best out of their treatment, the best out of their stay," she explains.

Provide the proper tools

It's important to make sure patients have the knowledge and skills to carry out their responsibilities and set goals with the patient and or family, depending on who is going to be providing care at home, says **Jean Wadnik**, MA, RNC, director of staff development and health education at Warren Hospital in Phillipsburg, NJ. "What we try to do is give them the tools to carry out their responsibilities," she says.

A teaching record prompts staff to cover all areas that must be addressed, and written materials reinforce teaching. For example, for each medication patients are taking, they receive a fact sheet and a small card on which to track the medications. They also receive information sheets on their diagnosis and a diagnosis-specific community resource sheet that lists agencies they can contact for additional information or to meet ongoing needs such as financial aid for equipment and supplies.

"In some cases, such as diabetes, we do outpatient follow-up because we can't complete the teaching in the short time they are in the hospital," says Wadnik.

An interdisciplinary teaching checklist also is used to prompt education at St. Francis Hospital and Health Center in Blue Island, IL. Yet rather than relying solely on each discipline's assessment of learning needs, the patient is brought

into the teaching process upon admission when asked to identify learning needs on a questionnaire, says **Allison Reid**, MS, RNC, an educator at St. Francis.

Patients are asked whether they need information related to their current illness, treatment plan, medication, medical equipment, nutrition, diet, rehabilitation, community resources, personal hygiene, grooming, or other information. They also are asked how they best learn, such as reading, by demonstration, verbally, by practice, or visually by watching a video. "Our policy states that education includes instruction of specific knowledge or skills needed to meet the patient's ongoing health care needs," says Reid.

At Union Hospital, preparation for discharge is a part of the daily teaching strategy so patients will be capable of self-care when they go home. Patients are taught something new each day so they will be able to take responsibility for their care upon discharge.

Each patient should be re-evaluated on discharge by asking him or her to either perform a task or verbally explain a concept such as how to take their medication, advises Finch. "If patients can't demonstrate a skill, it is our responsibility to point out that we think they need some additional follow-up by a home care agency, visiting nurse association, or other community resource and offer to set it up," says Finch. ■

SOURCES

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Tailor resource centers to population

Topics taught, teaching methods depend on mission

The first step in creating a community and patient resource or learning center is to determine your goal or mission, says **Carol Maller**, MS, RN, CHES, patient education coordinator at Veterans Affairs (VA) Medical Center in Albuquerque, NM.

"Our mission focuses more on prevention and self-care than it does on diseases. We feel that if someone has a particular disease, the information about that individual's situation needs to come from his or her provider, who knows the extent and complexity of the disease," says Maller.

Therefore, the Fountain of Healthy Living Learning Center at the VA Medical Center is designed to support people in lifestyle changes such as weight loss and exercise. Also, staff coach patients on how to manage their visit with their physician, helping them determine what kinds of questions to ask to get the information they need about treatment or their illness. While general information is given to patients, specific questions are directed to their physician.

Almost all need help

The learning center is tailored to the needs of the medical center's patient population. Almost all the patients who walk through the door need help with prevention and lifestyle change, says Maller.

Determining the purpose of the learning center up front is vital, agrees **Zeena Kies Engelke**, RN, MS, senior clinical nurse specialist in patient and family education at University of Wisconsin Hospital and Clinics in Madison. "Our learning center is an extension of clinical teaching. It is not a stand-alone resource library, but an integral part of the teaching process. We draw on defined skills [to achieve specific goals] or video technologies to support the clinical teaching rather than simply offering books, pamphlets, videos, and computer access," she explains.

Physicians, nurses, and other disciplines send patients to the learning center for specific teaching. The center also has open hours where anyone interested in obtaining information can walk through the door.

In pursuit of a paperless resource center

Information at your fingertips, on-line

Using computers with Internet access helps to eliminate paper clutter in a resource center, says **Carol Maller**, MS, RN, CHES, patient education coordinator for Veterans Affairs (VA) Medical Center in Albuquerque, NM.

"I feel we should be going paperless in our center instead of having stacks of pamphlets that get outdated and take resources to track. By using computers and going automated, you eliminate some of the manpower that is required with paper collection," she explains.

The computer at the VA is located behind the reception desk in the resource center, and only staff are permitted to retrieve information from a Web site. "Information is from approved sites that I oversee. They are mostly government sites that are not copyrighted," says Maller.

Although visitors are allowed to use the computers at the learning center at the University of Wisconsin Hospital and Clinics in Madison, they are guided by staff.

"We act as a filter, not to control what information they get, but to help them gain a little better sense of the information that is within their reach and help them to find information quickly," explains **Zeena Kies Engelke**, RN, MS, senior clinical nurse specialist for patient and family education at the health care facility.

At the Senior Resource Center located at J. Paul Sticht Center on Aging and Rehabilitation at Wake Forest University Baptist Medical Center in Winston-Salem, NC, the Web sites with information pertinent to visitors are bookmarked. This process makes it easier for people to find information, says **Patricia Suggs**, MDiv, MEd, PhD, coordinator for the center.

One of Maller's favorite Web sites is Healthfinder. Following are the Internet addresses for this site and a few others that provide access to consumer health information:

- **Centers for Disease Control & Prevention**
  http://www.cdc.gov

  Information on health topics from A to Z. These topics include ulcers, shingles, fetal alcohol syndrome, cold sores, and brain injury. Statistics and publications also are available.
- **Healthfinder**
  http://www.healthfinder.gov/

  A consumer health information Web site sponsored by the United States government. Resources, links to organizations, libraries, online journals, and databases. Site has health information for such patient groups as infants, children, teens, adults, and seniors.
- **Healthtouch**
  http://www.healthtouch.com

  This site has drug information, a pharmacy resource directory, and health information.
- **KidsHealth at the AMA**
  http://www.ama-assn.org/kidshealth

  Topics covered include childhood nutrition, safety and accident prevention, childhood infections, emergencies, and first aid.
- **Wellness Web, The Patient's Network**
  http://www.wellweb.com/

  Sections on conventional medicine, alternative medicine, and nutrition and fitness. The conventional medicine section includes a master index of diseases and conditions; a cancer, cholesterol, and heart center; and information on diagnostic tests. Contents for alternative medicine include an index of diseases, conditions, and treatments; cancer prevention/treatments; herbs and supplements; and therapeutic systems and approaches. ■

The location of a resource center often is determined by its purpose. Because the learning center at the University of Wisconsin hospital focuses on clinical teaching, it is located on a nursing unit, so it is convenient for very sick patients. The medical center is currently creating learning centers for two large clinics that are being built. The learning centers will be tailored to the services provided by those clinics.

"If one clinic has more pediatric surgeries, we'll do more pediatric surgical teaching. Our offerings will depend on the services that surround us," says Engelke.

Also, materials selected for a collection must be tailored to customer need, says **Arlen Gray**, MA, coordinator of the Family Library at Egleston Children's Hospital at Emory University in Atlanta. At Egleston, areas of high interest include cardiology, hematology-oncology, neonatal services, pediatric organ transplantation, and

acquired brain injuries. **(To learn more about Web sites as information sources, see article, p. 20.)**

To be of benefit to all customers, offer the material in a variety of formats, such as print, video, electronic, and models, advises Gray. Make these materials as culturally inclusive as possible, selecting pieces that reflect the cultural norms and languages of your customer groups.

Before selecting materials for the Senior Resource Center at J. Paul Sticht Center on Aging and Rehabilitation at Wake Forest University Baptist Medical Center in Winston-Salem, NC, staff surveyed all geriatric specialists and faculty. They were asked what sort of materials and topics they would want stocked at a resource center for their patients, says **Patricia Suggs**, MDiv, MEd, PhD, resource center coordinator.

All materials at the Senior Resource Center focus on issues of aging. There is even a section for brochures and fact sheets from local assisted living facilities and retirement communities. Also, learning methods are senior-friendly. For example, the center has a collection of audiotapes for those who are visually impaired.

The resource center at Rapides Regional Medical Center in Alexandria, LA, is located near an OB/GYN clinic and therefore focuses on women's issues. Physicians and other health care workers, such as childbirth educators, refer patients to the center for additional information.

To determine what new materials to stock, staff look to educators, current medical practice, and consumer information. "If you are reading magazines, listening to the radio and the TV, you'll know what is popular. Natural childbirth is very big again, and there are many new techniques," says **Mamie Gandy**, assistant to the manager of the resource center at Rapides medical center.

The Rapides resource center allows customers to check out materials and bring them back when they come for their next physician appointment. Other centers provide written materials that are distributed free of charge.

Staff at the Senior Resource Center issue cards with ID numbers to each person who receives material. This ID number is used to track via computer the pamphlets and information customers are taking (all the information is free). "The database will tell us when we need to reorder materials. Also, we can run reports on who is using the center, what region of the county they are from, their sex, and their age," says Gandy. ■

SOURCES

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Jump-start breast cancer early detection

Mobility brings awareness to doorstep

"When we started our mobile mammography program in 1988, it was almost like someone landing from another planet," says **Vera Garofalo**, MT, director of mammography services at The Ohio State University Medical Center, Arthur James Cancer Hospital and Research Institute in Columbus.

Women were not aware of the benefits of early detection of breast cancer. Also, there were not as many mammography sites as there are currently, mammograms were not covered by insurance companies, and they were expensive, she explains.

Early cancer detection saves huge costs

Keep mammogram outreach well-organized

Although it is difficult to determine the exact financial impact of mobile mammography units, there is a tremendous difference in the cost of treating early-stage breast cancer vs. late-stage cancer.

"We can treat early-stage breast cancer for $6,000 to $8,000 maximum, and late-stage breast cancer for $150,000 to $200,000, so mammograms save companies money," says **Vera Garofalo**, MT, director of mammography services at The Ohio State University Medical Center, Arthur James Cancer Hospital and Research Institute in Columbus. Also, women miss very little work with a mobile unit, because they can be in and out of the van in 10 minutes.

While beneficial, mobile sites must be well-organized to work as an effective outreach tool. In particular, scheduling must be well-planned. "Initially, we had the sites schedule the mammograms, but we found that by the time the van would show up we had either too many patients or none. Therefore, we increased our clerical staff, and with the exception of a handful of senior centers, everyone calls directly through us," says **Kate McKenzie**, RN, program manager for Mammography of Delaware in Wilmington.

Businesses and organizations that schedule a time for the mobile unit to come to a site are sent a kit that has all the information they will need to promote the program. Included is a sample letter to be used as a blueprint to inform women about the screening and how to sign up. Also, everyone who has had a mammogram through the mobile unit is in the computer system and automatically receives a card each year to remind them to get their annual mammogram.

"We have to have a minimum of 25 appointments to come to a site. Therefore, we use our appointment line to keep track," says **Karen Spears**, LVN, mobile screening coordinator for the University of Texas MD Anderson Cancer Center in Houston. Companies usually e-mail a notice to all employees with the date of the screening and the telephone number of the appointment line.

A good tracking system of previous mammograms is needed as well, because one of the benefits of having annual mammograms is comparing results from year to year, says Garofalo. "A downside to mammography, and it has nothing to do with mobile, is that women choose to go to different locations," she says. They often have their mammograms at varying locations because their insurance coverage changes or they switch physicians.

Search for the missing film

Therefore, if a woman's past films need to be viewed, staff go on a search mission. They call the patient's physician and other mammogram sites to find the film. If the film cannot be found, the woman is asked to come in to the medical center's comprehensive breast center for additional X-rays with varying views. "We can still make a complete assessment if we can't get the previous films to compare," says Garofalo. When there are problems, results are immediately faxed to a woman's physician and the radiologist calls him or her.

It is often easiest to work with companies if rules are not set in stone, says McKenzie. For example, one company asked that only one employee from each department be at the van at the same time. Therefore, when employees from that company called to schedule an appointment, the clerks were instructed to ask what department they worked in first. "We customize our process for each site," says McKenzie. ■

The mobile unit outreach helped women understand the importance of being screened for breast cancer, and it helped them get into the habit of having regular mammograms.

"When we began screening women with the mobile unit, about 20% had been having mammograms, and 80% were having mammograms for the first time. Now it is completely reversed, with 20% having mammograms for the first time," says Garofalo.

The mobile mammography units at Ohio State travel to corporate sites, organizational sites such as the YMCA, and rural areas acting in partnership with the local health departments.

There was a 12% decrease in the state of Delaware's breast cancer mortality rate from 1993 to 1997, which coincides with the operation of Mammography of Delaware, a mobile mammography screening unit and education campaign. "Directly it is not correlated to us, but indirectly it is because of the outreach initiative we do," says **Kate McKenzie**, RN, program manager for Mammography of Delaware in Wilmington, a partnership between the state of Delaware and Christiana Care Health Services.

The mobile mammography unit works with employers and organizations. The program currently is targeting seniors and the underserved population. One effort partners with Planned Parenthood of Delaware, which provides breast exams and pap smears, while Mammography of Delaware provides the mammograms.

When mobile mammography units travel to a site, all women benefit — whether or not they are screened for breast cancer at that time, says McKenzie. First there is the visual reminder of the van, which is purple and white with a picture of a woman with arms crossed over her chest. Also, corporate managers can select from various educational programs for employees.

For work sites where women aren't given time off to attend an educational session, Mammography of Delaware sets up a display booth in the break room. At the booth, women can pick up brochures on breast health and talk to someone who can discuss breast cancer and the benefit of having annual mammograms and doing monthly breast self-exams.

Companies also have the option of selecting an educational program such as Breast Health 101, which explains the basics of a breast self-exam, or Breast Health 202, which includes information on the diagnosis and treatment of breast cancer. "Sometimes companies will allow us to attend their safety meeting or staff meeting to present the information," says McKenzie.

Education has changed during the 11 years the mobile unit from Ohio State has been traveling to corporations, senior centers, and community sites because attendance at educational sessions began to decline after a few years.

"The big push in the beginning was education on early detection and how to do a breast self-exam. We would do extensive presentations on breast health and then sign women up for mammograms," says Garofalo. Now X-ray technicians pass out shower cards on breast self-exams and briefly go over the information. At some sites, educational sessions are offered every other year.

Teaching often is most successful if tailored to the needs of the group, says McKenzie. At senior

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- Use NCI patient education guidelines to shape programs
- Teaching methods boost medication compliance
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- Outreach strategies curb domestic violence

SOURCES

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centers and sometimes at churches, people are invited to play breast health bingo. Words like "mammography" replace the letters and numbers on a bingo card.

While people search their bingo card for the word, the nurse conducting the game explains the meaning of the word. Also, the nurse gives a short talk before the game and a brief review of the material once the game has been played several times.

Many times, an organization will provide education on breast health rather than having staff from the mobile van do it, says **Karen Spears**, LVN, mobile screening coordinator at University of Texas MD Anderson Cancer Center in Houston. Some corporations have a medical department that oversees the education portion.

Other organizations provide a nurse to give breast exams and teach the technique at the time of the mammograms. However, no matter what education is provided, women also see a video on breast self-exams while waiting in the reception area on the coach for their mammogram.

Mobile mammography removes the excuses that many women have for not getting a mammogram. "Women tell us that if we didn't come to their work site, they might not have a mammogram or they wouldn't be as consistent in getting it done," says Garofalo. Yet consistency is what makes a mammogram beneficial. "Having your annual mammogram every 10 years is not at all beneficial," she says. **(For information on scheduling and tracking, see article on p. 22.)** ■

Book to improve cultural communication

An Introduction to Spanish for Health Care Workers is a book designed to help health care workers who speak no Spanish communicate with patients who speak only Spanish. It focuses on vocabulary and grammar, including colloquial terms and slang. The authors also provide cultural notes on Hispanic values and customs.

The book costs $20 plus $3.50 handling. Contact: Yale University Press, Special Projects Dept., P.O. Box 209040, New Haven, CT 06520-9040. Phone: (800) 987-7323. Fax: (800) 777-9253. Web: www.yale.edu/yup/books/chaseF98.html. ■