

Patient Education ManagementTM

For Nurse Managers, Education Directors, Case Managers, Discharge Planners



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Partnering for patient-centered education: Consider the possibilities!

Start small, but aim big to include a patient perspective in all aspects

As health care organizations embrace the concept of patient- and family-centered care, patient education managers must start looking at ways to partner with patients and families in the planning, delivery, and evaluation of education.

There are two actions you can take, says **Karen I. Wayman**, PhD, director of family-centered care at Lucile Packard Children's Hospital at Stanford in Palo Alto, CA. One is to determine how to incorporate the philosophy of patient- and family-centered care into education. The other is to determine how to participate in the family-centered care initiative within the hospital.

Usually, health care institutions that are beginning to embrace patient- and family-centered care form an advisory council, and that is a good place for a patient education manager to begin, says Wayman.

EXECUTIVE SUMMARY

Patient- and family-centered care is a popular concept that more and more institutions are adopting. Basically, it is an approach to the planning, delivery, and evaluation of health care that is grounded in mutually beneficial partnerships among health care patients, families, and providers.

What does patient education look like when an institution adopts these principles? In the March 2009 issue of *Patient Education Management*, we look at ways to partner with patients in all aspects of the process of patient education.

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Bring patient education initiatives to the advisory council, she advises. For example, the council might review a written piece for family-friendly language, or the council could be used to help develop an idea for a project. A patient or family-member could be placed on the committee working on the project, as well. It depends on how comfortable staff members are about sharing their thought processes with consumers. Sometimes, the partnership must begin with small steps.

The way this partnership develops depends on the institution at which you work. However, there are many ways to make patient education a partnership that reflects the family-centered care

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philosophy.

At Seattle (WA) Children's Hospital, guidelines for developing health education and policies pertaining to working with patients incorporate the institution's commitment to family-centered care, says **Christoph Hanssmann**, MPH, CHES, a health educator. For example, education guidelines discuss the use of a question-and-answer format and the use of the pronoun "you" when writing materials so the reader is engaged. As part of their standard, they always state that parents know their child best and as such are an important part of the care team.

Projects often are taken before the Family Advisory Council; however, getting feedback from this long-standing council is just one way that families are involved at Seattle Children's. More than 150 family consultants serve in many roles and regularly participate in quality improvement workshops as team members alongside staff, give feedback in focus groups, and formally review health education materials, says **Devora Chavez**, MA, MPH, CHES, a family-centered care coordinator at Seattle Children's.

Early on, the health care facility realized a diverse group of people would be needed for input; therefore, a family consultant program was developed in addition to the Family Advisory Council.

Many methods can be used to shape a patient-and family-centered care educational program or teaching sheet, says **Megan Woltring**, MS, a health educator at Seattle Children's Hospital.

In recognition that no one parent can represent the whole family experience, the hospital tries to use many methods for gathering diverse family input. One strategy is to interview families who are in the hospital about their experience. Also, there is a group of regular family reviewers who evaluate educational materials. One dimension rated is how well the educational piece "includes me as part of my child's care team."

While it's important to have people who understand the partnership role involved, such as those who serve as family consultants, input from all types of families that use the hospital services should be included in the planning, development, and evaluation process, says **Carol Parry**, MA, a family-centered care coordinator at Seattle Children's Hospital.

Evaluate the project, committee, program, or written piece and select a couple of parents who might have an ongoing involvement, and then solicit input from others — such as someone who

has just come for a clinic appointment and never participated to — provide a fresh perspective, advises Parry.

"We try to keep in mind there is the convenient sample of people who have time to participate in long, ongoing work, and then there are people who come in through the ED for the first time — or those living across the state who have language barriers. We always try to keep all those people in mind when we are looking to involve families," adds Chavez.

Wayman says that at Lucile Packard Children's Hospital, it is understood that one parent on a committee does not speak for all parents. Therefore, committee members may request a focus group when they think more consumer input is needed.

How far should you go?

Bring patients and families into every aspect of program development, advises **Cezanne Garcia**, MPH, senior program and resource specialist for the Institute of Family Centered Care in Bethesda, MD. If forming a focus group, use those patients who sit at the table of an advisory board or patient education committee to help design the questions — and also to look at the data collected. It's often very difficult for health care providers to separate what they think patients need to know from what they are authentically saying they need to know, explains Garcia.

Another partnership to consider is in the actual education, says Garcia. In addition to having patients and family members help design and evaluate a program, have them help with the teaching. For example, in a community outreach forum on spinal cord injuries or chronic illness, a patient or caregiver could address the issue of hiring a caregiver.

At Lucile Packard Children's Hospital, some of the parent advisors partner with the health care providers to provide family-related discharge teaching, says Wayman.

For example, the health care provider will provide the information about medications the patient would need to take at home, and the family member would discuss such issues as what help might be needed or how to ask questions once discharged.

The organizational structure for family-centered care at Lucile Packard Children's Hospital has a three-tiered approach to parent involvement. First, parents are selected for the family

advisory council. After working on the advisory council for a while, parents can be considered for work in a service line. For example, a parent of a child with a heart problem might be assigned to cardiology to help develop family-centered care programs within this service line.

A few parents move on to the third level, where they help lead programs, oversee the family advisory councils, take part in the parent mentor programs, and help publish materials. One of the lead parents at LPCH is co-chair of the Patient Education Committee and brings the family perspective when reviewing patient education materials.

"They all begin as part of the advisory council. We decide together whether it makes sense to progress, given what is going on with their child or with their skill set and interests. Not everyone is chosen. It is a paid position, and we have the recruitment process, screening process, and then the training. We treat them as employees," explains Wayman.

Involving patients and families in the continuous performance improvement process not only improves patient education but can make it more patient-and family-centered.

Recently, a parent was recruited at Seattle Children's Hospital to be part of a review of a serious event that looked at the process of teaching, says Parry. "The parent reported that she felt everyone around the table was equal and her participation was valued," she adds.

The philosophy of partnership is highly beneficial to patient education. It results in better teaching materials, says Wayman. With patient and family involvement in the development process, not only is the language clearer, but also the tasks the patient is to perform are more understandable, as well.

Ultimately, partnerships in patient education mean better outcomes for everyone, says Parry. "There will be better patient safety, because the information and education is something the parents understand and use. The quality of the child's care will be better, and it will be more cost-effective, because we won't produce materials and resources that are not helpful," she explains.

Woltring adds, "When we have that partnership, we recognize that families are a key part of the health care team. Then they are more likely to feel empowered to ask questions, to advocate for their child, and to feel engaged in the patient teaching." ■

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the Health Information Resource Center, Patient and Family Education Services. The Education Development Committee is one subcommittee, and the Resource Center Work Group is the second.

Eight patient advisors sit on the main committee, which consists of 38 members. This committee has a variety of goals that include developing and implementing long-range plans for the delivery of patient and family education, and selecting and implementing initiatives for a three-year plan determined by a house-wide assessment.

The Education Development Committee works on staff education projects, such as cultural training and online access to educational materials. It also oversees the development of patient education materials. According to Dotson, patient advisors don't often choose to become part of this subcommittee. Therefore, they are brought in for special projects such as developing tip sheets for physicians on a variety of cultures.

However, the Resource Center Work Group is a popular choice among patient advisors, and they make up half this committee, with staff members filling the remaining seats.

This work group was in place before the resource center opened, helping with the blueprints, design elements, and operational ideas, such as how to label the library books and make the computers accessible to all patients. It continues to help in the operational decision-making process.

"The purpose of the committee is to help sustain and grow a successful health information resource center at the University of Washington Medical Center," says Dotson.

The resource center was designed to help patients and families find health information and provide services, such as copy machines and e-mail access, to family members who need to remain close to a loved one who is hospitalized. Patient advisors help to make sure the medical

Consider patients' family members for committees

Input from consumers key

To form a partnership with patients and family members, consider including them as members of councils and committees pertaining to patient education.

Health care institutions that have patient and family education committees in place have long realized the importance of making them interdisciplinary, including not only nurses and physicians, but also nutritionists, physical therapists, and others involved in education. Now, patients and family members are being added to these committees.

This makes sense, says **Cezanne Garcia**, MPH, senior program and resource specialist for the Institute of Family Centered Care in Bethesda, MD. The focus of the committee is patient and family education; therefore, this group should be represented on the committee, she explains.

This practice is followed at the University of Washington Medical Center in Seattle. People who volunteer as patient advisors have a chance to work on the main patient and family education committee or be a part of one of two subcommittees, states **Andrea Dotson**, a health educator at

EXECUTIVE SUMMARY

Creating a patient- and family-centered care institution requires input from consumers. Therefore, it often makes sense to give them an equal voice on a committee. Patient education can benefit by including patients and families on key councils and committees.

center meets the needs of all visitors.

Tap into interests

The committee meets once every other month. However, in between meetings patient advisors work on projects that interest them. One advisor is interested in helping identify funding sources, such as foundations, as well as developing a donor program. Others who are in wheelchairs like to be involved in accessibility issues, and others enjoy marketing the center and making sure waiting rooms throughout the medical center have a good supply of brochures.

Although members of the Resource Center Work Group are involved in all the decision-making processes, it is not a board of directors, but rather a means to provide checks and balances, explains Dotson.

"All the decisions go through our advisors, because the resource center is for our patients and families at the hospital, so we want to hear directly from them what will be beneficial," she says.

During work group meetings, all members have equal say, and matters are decided collectively. Dotson says all members are participating for the same reason — to make sure the resource center is sustained and grows.

The most recent meeting agenda covered several issues. Fund-raising is a current focus; therefore, there was a report from the parent advisor doing research on the topic, as well as brainstorming by the committee members.

A discussion over adding a sign to encourage visitors to the resource center to ask for help was also on the agenda. Dotson said the wording would be discussed, as well as why the sign was needed. Often, visitors don't realize staff can help them find more in-depth information.

How to add new information to the resource center brochure was discussed. Members talked through the wording to come to an agreement on what language was the friendliest.

Changes to the resource center survey were discussed, as well as why they were necessary. The center is evaluated on a quarterly basis, and improvements are made accordingly. Also discussed were all the evaluation data from the previous year.

Updates to the center's web site are always reviewed at meetings, and often committee members have suggestions on how to improve the site.

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Patient advisors are volunteers who have an advisory role. People who volunteer in this way can choose where they would like to serve. For example, those who have had an experience with premature birth may want to sit on the neonatal intensive care unit council. Or, if a family member was recently paralyzed, he or she may choose the rehab council, says Dotson.

To find patient advisors, information forums are held twice a quarter. These are open sessions where patients and their family members hear a presentation on what it means to become an advisor. ■

Make family members 'faculty' to orient staff

Clinicians view issues from a patient perspective

At The Children's Hospital of Philadelphia (PA), a group of 15 parents of chronically ill children treated at the institution are recognized as "family faculty."

These volunteers present their experiences to staff, discussing their challenges and providing input on ways to improve the delivery of family-centered care that works for both the hospital and the families, explains **Laura Bedrossian**, MS, a family consultant at The Children's Hospital of Philadelphia.

"There is a long list of opportunities for family

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To help staff see things from a patient perspective, select patients and family members for the role of family faculty. In this role, they teach staff in order to foster a patient- and family-centered care philosophy.

faculty to work with staff and bring their perspective," says Bedrossian.

Every other Monday, a member of the family faculty joins one of the family consultants to present at the new employee orientation, which includes all positions from housekeepers to physicians. The presentation includes the parent's personal story, a discussion of family-centered care, and information on how to incorporate family-centered care into the work each employee does.

In order for employees to apply family-centered care to their particular job, family faculty presenters must be able to give broad thoughts and suggestions on how to practice it in partnership.

Family faculty also can sit on the Family Advisory Council or take part in committee work such as the blood stream infection committee or rapid response committee. A family faculty member may be asked to provide input on a web site design or work with an architect to make sure a new building project has a family-centered environment.

Family faculty also teach by request, attending meetings to help departments address issues with which they struggle. For example, if wait times were increasing at a clinic, a member of the family faculty may be asked to discuss the waiting experience and how staff can be most effective in communication with families during unanticipated periods of waiting, says **Michele Lloyd**, senior vice president for Patient Care and Family Services at The Children's Hospital of Philadelphia.

Also, pediatric residents ask for feedback from the family faculty. For example, they may want education on how to deliver bad news to families. Family faculty provide a way for staff to dialogue and learn ways they can more effectively support and partner with families, says Lloyd.

It is important to note that family faculty are

recognized as teachers and are on equal footing with other faculty members. They have expertise and can teach staff, says Lloyd.

Skills identified

What makes a parent suited for the role of family faculty? Bedrossian says individuals who are articulate and outgoing make good faculty. Also helpful is an understanding of the health care system and an ability to think broadly, not only in terms of a parent's own challenges, but also some of the challenges the health care providers face.

"We look for individuals that are outgoing in that they are not afraid to speak up, and they want to share their story, because they want to make a difference. But they do so in a way that is constructive," says Bedrossian.

Families that have had a fair amount of experience with many different services — and have the ability to communicate with health care staff in a respectful way — are good faculty members.

"We are very flexible with our families as far as scheduling them, because we understand that their child is chronically ill, but we do ask that they are committed to being a part of our family faculty," says Bedrossian.

Before deciding to participate, family members must focus on commitment and understand that sometimes it is difficult for people to share their story in front of a large group. This type of sharing is very different from talking to a friend, says Bedrossian.

It also is important for families to know that a position on the faculty is not the same as joining a focus group. In a focus group, people focus on their child's diagnosis or situation, but as family faculty, they must think openly and be a good listener. In addition, family faculty must gain the confidence of health care providers for open, honest discussions, understanding that often what is discussed must stay in the room.

Family faculty do advocate for a family-centered approach to the delivery of health care but in partnership with the health care team, states Bedrossian.

Selections are made through an interview process. At that time, special attention is given to a person's listening skills, as well as his or her communication skills.

However, it is the training process that helps make a family faculty member successful. "We train them to think broadly in terms of helping an entire health system — not just focusing on their

SOURCE

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child's diagnosis or situation. In that way, what is shared is of value globally to our families, rather than what would be helpful in a support group," explains Bedrossian.

Family faculty members go through a two-hour formal training program. During this time, the faculty members learn about family-centered care, how to formally give a presentation, and the skills and guidelines for family faculty are reviewed. These include having a positive attitude, listening to all sides, and speaking concisely.

"To be effective as a family faculty member, parents must see the big picture, and to do that they need to step back from their personal situation and see what the needs are for members throughout the hospital," says Bedrossian. ■

DPs can address patients' adherence barriers

Understanding and behavioral are big ones

One key to discharge planning is understanding what might prevent your patient from following medication and other instructions.

Once you have an idea of what the patient's adherence barriers are, you can find solutions.

A substantial reason why continuity of care fails is that once patients are discharged, they're on their own with taking the medications they're given and following their discharge instructions, says **Alan J. Christensen, PhD**, a professor in the departments of psychology and internal medicine at the Carver College of Medicine of Iowa City, IA. Christensen also is a senior scientist with the

Veterans Administration Iowa City Health Care System.

Christensen describes the following potential barriers to discharge adherence:

- **Psychological:** "Does the patient understand the instructions?" Christensen says.

Patients' mental status and cognitive capacity should be assessed to make certain the patients are capable of following a complicated set of medication instructions, Christensen says.

"There are related issues like the division of attention during this stressful time period," Christensen notes. "I've never been in a hospital as a patient, but I know things are happening fast and furious, and a patient's attention is divided."

Patients already have extra cognitive demands, so it makes it difficult for them to concentrate when a discharge planner asks them to think about medication instructions, he adds.

"It's not only the demented patients who have trouble," Christensen says. "Most of us would have less than perfect memory, processing, and attention in that situation."

- **Behavioral barriers:** Cognitive barriers relate to understanding the instructions, and behavioral barriers relate to acting on what's taught, Christensen says.

Just because a patient understands what the discharge planner says doesn't mean the patient will follow instructions, he adds.

The reason is that it's difficult to remember to take one's medications at certain times of the day, Christensen explains.

"This overlaps with the cognitive, but we address it separately," he says. "We address the cognitive barriers by simplifying the instructions, and we address the behavioral barriers by giving people pill boxes and memory aides to use."

Discharge planners can provide patients with behavioral cues that will remind them of how and when to take their medications.

For instance, a discharge planner can show a patient how the medication is taken by having the patient demonstrate taking the pills, Christensen suggests.

"And we often talk about linking medication administration with other daily tasks that are habitual, such as brushing your teeth," he adds. "So, you tell a patient to take his medication when he brushes his teeth in the morning and when he eats dinner at night, instead of saying he should take the pills in the morning and at night."

- **Social barriers:** For some patients, such as

HIV-infected patients and diabetics, there might be a social stigma attached with taking medication or giving themselves injections, Christensen says.

"For younger, active patients there is a stigma associated with medication-taking, particularly if it involves having to give yourself an injection before a meal if you're a diabetic," he says.

There also are patients who don't like to take their medications during certain social situations or when other people are around, Christensen adds.

Another social barrier includes transportation problems, such as not having a way to go to the pharmacy and pick up the prescriptions, he says.

For these patients, the solution might be to have them use a mail-order pharmacy.

"But if they can't use a computer and are not that good on the telephone, then it might be an issue," Christensen says.

So part of the discharge planner's job is educating them about what options there are in terms of ordering prescriptions by mail and how to refill their prescriptions over the telephone or computer, he adds.

- **Financial barriers:** For some patients, the solution to financial barriers is to change their medication to generic forms, he says.

Other patients might need additional help, such as assistance from a hospital program that provides an initial supply of medications, Christensen says.

"But that depends more on the patient's long-term chronic regimen," he adds. "Because sending someone home with a seven-day sample of pills to get them started is not related to adherence over the long run." ■

Patient perceptions guide discharge education process

Patients often want more than what's allowed

Transitions in health care are changing more quickly than patients' expectations, which is why it's important to address these expectations head-on, an expert notes.

"That's been one of our greatest challenges — setting appropriate expectations," says **Pamela J. Tobichuk, RN, ONC**, a nurse case manager with the pre-admission orthopaedic total joint pro-

gram at Massachusetts General Hospital in Boston. Tobichuk spoke about using a pre-admission prediction tool to improve the discharge process at the 18th annual conference of the Case Management Society of America (CMSA), held June 17-20, 2008, in Orlando, FL.

Sometimes, patients will have a long lag time between when they are first told they will need elective joint therapy and when they actually schedule such therapy, Tobichuk says.

"They've had all this time before the surgery to build up expectations," Tobichuk says. "They might have a preconceived notion about what it is they'll do, and way back when they first met with the physician this was not part of the conversation or focus."

Another reason expectations might be different is that patients often have a friend, spouse, or neighbor who has been through similar therapy, and the way this other person's discharge was handled was different, she adds.

For example, it's possible the patient's husband had knee surgery a few years ago, and the spouse was discharged to an acute rehabilitation facility.

Now, because of payer and Medicare changes, this option is unavailable to the wife, and yet she expected that's precisely where she would go after discharge.

"Most times we ask the patient, 'What is your plan?' and the patient might answer, 'Oh, I'm going to Spaulding Rehab,' which is an acute rehab facility," Tobichuk says.

So, it's the discharge planner's/case manager's job to educate the patient about which options are available.

"I educate patients on the levels of care, home care, and even outpatient therapy," Tobichuk says. "We teach patients that they'll have some sort of therapy or rehabilitation, but we better define how this will be done."

For instance, low-risk patients who are highly motivated might be sent home and referred directly to outpatient therapy, she explains.

Mid-level risk patients might be sent home to receive home care, including therapy in the home, and high-risk patients might be discharged to a skilled nursing facility, where they receive physical therapy.

Occasionally, a patient will insist that a referral be made to acute rehabilitation.

In answer, the discharge planner can say, "Okay, I'll put the referral in, but I'm telling you this is unlikely," Tobichuk says.

The key is to engage the patient in the conversation, obtaining the patient's ownership of the discharge process.

Patients who feel that their opinions and concerns were heard and who are well-educated on what will happen to them post-discharge often report reduced anxiety about the discharge process.

"I try to explain that everyone's situation is different," Tobichuk says.

"We look at every case independently, and we try to give them an opportunity to be proactive in their own discharge plan, to empower them to make some decisions about what they're going to need." ■

LEP patients need solid translation services

Translation at discharge is crucial

Hospitals across the United States are seeing an increase in patients who have limited English proficiency (LEP), and this means discharge planners must plan accordingly.

A researcher who has studied the impact of having an enhanced interpreter service intervention says she conducted her study out of concern about LEP patients receiving substandard care.

"I was shocked as both a medical student and resident that patients who didn't speak English well didn't receive the standard of care," says **Elizabeth Jacobs**, MD, MPP, an associate professor of medicine in the collaborative research unit at the Stroger Hospital of Cook County and Rush University Medical Center in Chicago.

One of the most important facets of the standard of care is communication, and these LEP patients often lacked having a physician or discharge planner or other health professional who could communicate effectively with them, she notes.

"We need to understand what it is that patients need, what their conditions are like at home, and we need to give them adequate instructions about medications when they leave the hospital," Jacobs explains. "Or, they'll return to the hospital."

Language barriers are addressed inconsistently across the continuum of care, Jacobs says.

"The problems that arise come when there

are not people employed at the hospital who speak the language of LEP patients, including not having Spanish-speaking discharge planners," Jacobs says. "Interpreters can help overcome those barriers, but frequently those resources are not in place, and patients may not have access to video interpreters or telephone interpreters."

What happens instead is that hospitals rely on untrained bilingual staff or the patients' children, family members, or even the patient in the next bed to serve as ad hoc interpreters, Jacobs says.

This haphazard approach creates problems, especially since these ad hoc interpreters often would not test as truly bilingual, and they might not understand the medical terminology, she adds.

"So, a discharge planner is trying to communicate, but the message is not communicated, or it's miscommunicated, and the discharge planner might never find out that the patient was given incorrect information," Jacobs says.

For instance, a patient who has heart failure might need to be told to take a certain medication, to weigh himself every day and then to call the nurse or doctor if the weight goes up, she says.

"But if the patient doesn't understand the discharge instructions and doesn't take his medication correctly, then he won't be adequately treated and will go back into the hospital," Jacobs adds.

"I'm someone who feels very strongly that we should provide good interpretation or good communication in a language the patient can understand throughout the hospital encounter," Jacobs says.

But there are three crucial points where having a medical interpreter is essential, she notes.

"One is when you make a diagnosis, the second is when you have to obtain informed consent for procedures and are trying to communicate to patients how to make decisions about their care," Jacobs says. "And the third is when they are being discharged and are receiving discharge planning."

If a hospital must prioritize the expense of professional interpreter services, then it should at least have a medical interpreter available at these three junctures, Jacobs says.

"I advocate for having them available at all points of care, but if you must prioritize, then I'd prioritize those three time points," she adds.

Jacobs' research concluded that having an

enhanced interpreter service intervention did not significantly impact costs.¹

Having this interpreter service available did reduce return emergency department visits, however.¹

The study noted that the cost of having an enhanced interpreter service was \$234 per Spanish-speaking intervention patient, and it represented just 1.5% of the average hospital cost. But it was even more cost-effective to have a Spanish-speaking attending physician, and this also significantly increased the Spanish-speaking patients' satisfaction with the doctor and hospital.¹

"My research and other research have shown that if you provide adequate communication to a patient with LEP, then you have an opportunity to save on costs," Jacobs says.

"It's very inexpensive in the scheme of things compared with what we pay for in health care," she adds.

"For instance, in this study, I showed that providing the interpreter intervention represented just 1.5% of total hospital costs, which is incredibly small and represents the amount hospitals pay for an X-ray for hospitalized patients," Jacobs says.

Also, there are many costs that researchers have difficulty capturing, but they're still important for hospitals to think about, including the issues of malpractice, she adds.

"It only takes one million-dollar case to wipe out the cost of providing interpreter services over a three-to-five-year period in a hospital," Jacobs explains. "And there are health costs to the patient with not receiving adequate medical care."

In Stroger Hospital, there are interpreters who speak Spanish, Polish, Russian, and a couple of Chinese dialects, Jacobs says.

"The staff interpreters mostly are here during the week, but there's always somebody available 24 hours a day for Spanish," she says. "And there's always access to telephone interpretation services 24 hours a day, so we have 24/7 coverage, but it's just not all face-to-face interpreters."

Reference

1. Jacobs EA, Sadowski LS, Rathouz PJ. The impact of an enhanced interpreter service intervention on hospital costs and patient satisfaction. *J Gen Intern Med*. 2007;22 [Suppl 2]:306-311. ■

Family interpreters can cause harm

They might purposely misinterpret

When hospitals rely on a patient's family members to interpret medical news, they might be placing the patient at risk, an expert says.

Family members sometimes purposely misinterpret information because of their own biases or agenda, says **Elizabeth Jacobs**, MD, MPP, an associate professor of medicine in the collaborative research unit at the Stroger Hospital of Cook County and Rush University Medical Center in Chicago, IL. Jacobs recently studied the impact of having an enhanced interpretation service on Spanish-speaking patients' satisfaction and on hospital costs.

"When I ran the study, one of the things our interpreters did was introduce themselves to each Spanish-speaking patient, saying, 'My name is so and so. Here's my card, and you can keep it at the bedside and show to your doctor and family members,'" Jacobs says.

In one case, a family member told the interpreter, "No thank-you, we won't need your services," Jacobs recalls.

The interpreter told the family that the service was free, but the family still declined.

With a little investigation, the interpreter found that the family did not want the patient to know about her diagnosis, so the interpreter called Jacobs with this information.

"I told her I was glad she called me, and I called the attending and said, 'I want to make you aware of this situation,'" Jacobs says.

Jacobs advised the attending physician to be culturally sensitive, but to give the patient the option of refusing the interpreter services and relying on family members.

"I told him, 'You can get an interpreter to go in there and ask what the patient would like, saying the family would like to be the ones to give you all of the information, or we could have an interpreter in here to talk with you directly about your health,'" Jacobs recalls.

The doctor handled the case as Jacobs' recommended, and the patient chose to have a medical interpreter present, Jacobs says.

"In 80% to 90% of cases, the patient does want the information from an interpreter," she adds. "And that's an example of what happens if you use

an ad hoc interpreter."

Family members often will change the conversation or distort the doctor's words, often out of love and a misguided feeling that it's in the patient's best interest, Jacobs explains.

"So, the doctor could be treating a patient with chemotherapy and not know that the patient doesn't even know her diagnosis," Jacobs adds. ■

Medicare clarifies privacy of health info

When transferring private health information to potential post-acute providers, discharge planners need to be aware of some facts about the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

According to *MLN Matters*, published by the U.S. Department of Health and Human Services (HHS),

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provides a clarification about HIPAA's medical privacy rule, including the following:

- Discharge planners do not need to obtain signed consent forms from patients before sharing their medical information for treatment purposes.
- HHS adopted specific modifications to the rule in August 2002, which clarify that incidental disclosures do not violate the Privacy Rule when providers have common sense policies which reasonably safeguard and appropriately limit how protected health information is used and disclosed.
- Doctors and other providers, including discharge planners, can share needed information with patients' families, friends, or anyone else identified by patients as involved in their care as long as the patient agrees. ■

CNE instructions/objectives

Nurses and other patient education professionals participate in this continuing education program by reading the issue, using the provided references for further research, and studying the questions at the end of the issue.

Participants should select what they believe to be the correct answers, then refer to the list of correct answers to test their knowledge. To clarify confusion surrounding any questions answered incorrectly, please consult the source material. After completing this activity each semester, you must complete the evaluation form provided and return it in the reply envelope provided in order to receive a credit letter. When your evaluation is received, a credit letter will be mailed to you.

After reading *Patient Education Management*, health professionals will be able to:

- **identify** management, clinical, educational, and financial issues relevant to patient education;
- **explain** how those issues impact health care educators and patients;
- **describe** practical ways to solve problems that care providers commonly encounter in their daily activities;
- **develop** patient education programs based on existing programs from other facilities. ■

COMING IN FUTURE MONTHS

■ Using technology to improve patient teaching

■ Shaping materials via patient input

■ Best practice for selecting vendors

■ Education's role in demand management

■ Web sites that enhance teaching

CNE Questions

9. To make patient education fit the patient and family centered care philosophy, do which of the following?
 - A. Have patients sit on committees.
 - B. Present projects to the advisory council.
 - C. Use patients for continuous performance improvement review.
 - D. All of the above.
10. The philosophy of partnership is highly beneficial to patient education because patients and family are more likely to actively participate in the educational interventions when part of the health care team.
 - A. True
 - B. False
11. Family Faculty are used at The Children's Hospital of Philadelphia to teach other patients.
 - A. True
 - B. False
12. A parent suited for the role of Family Faculty has which of the following qualities?
 - A. Articulate and outgoing.
 - B. An ability to think broadly.
 - C. Experience with different services.
 - D. All of the above.

Answers: 9. D; 10. A; 11. B; 12. D.

Hospital-acquired conditions explained by CMS

Hospital providers need to be fully aware of the new steps taken by the Centers for Medicare & Medicaid Services (CMS) to report and prevent hospital-acquired conditions.

For more than one year, hospitals have been required to report on their Medicare claims whether any of eight selected conditions were present when patients were admitted to the hospital, and since Oct. 1, 2008, hospitals have had to report on additional conditions, as well.

These Present On Admission (POA) indicators

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must be completed for every diagnosis on an inpatient acute care hospital claim.

CMS defines POA as those conditions that are present at the time the order for inpatient admission occurs, including conditions that occur during an outpatient encounter, including emergency department, observation, or outpatient surgery.

If patients at discharge have any of the reportable conditions that were not identified as POA, then the condition is considered hospital-acquired, according to CMS.

The conditions CMS has selected as reasonably preventable include:

- Leaving a foreign object in a patient;
- Having an air embolism enter patient's blood stream;
- Giving patient wrong blood in transfusion;
- Falls and trauma;
- Fracture. ■