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

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Text may not always be enough when giving written instructions

Consider illustrations to clarify, underscore message

Some say a picture is worth a thousand words. People in the field of patient education might add the word: "sometimes."

Drawings can help to clarify instructions, says **Christine Hess**, MEd, patient and family education coordinator at Wellspan Health in York, PA. Text may seem to give explicit instructions, but a line drawing will underscore the content to make sure the reader understands, she explains.

Line drawings may bolster comprehension, particularly for the person who is a visual learner, like Hess. She says she likes to be shown how to do something. "In my brain, the picture ties into the whole meaning," she explains.

Text, coupled with a drawing, reinforces the message, making it easier to recall, explains Hess.

Fran London, MS, RN, a health education specialist at The Emily Center at Phoenix (AZ) Children's Hospital, says she uses illustrations when she wants to reinforce or demonstrate a desired behavior, such as the angle at which to inject a medicine.

Frequently, she refers to the chapter on this topic in the book "Teaching Patients with Low Literacy Skills" by Len and Ceci Doak.[1] Now out of print, the book is available for free download from the Internet. (*To learn how to obtain information from this book, see Reference at the end of this article.*)

EXECUTIVE SUMMARY

Illustrations can greatly improve a reader's understanding of written materials if used properly. In this issue of *Patient Education Management*, we sought advice from those in the field about the selection and use of line drawings and photographs to enhance comprehension.

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The authors of this book advise the use of visuals "to give a sense of realism by helping the patient see the action recommended," says London.

According to the Doaks, illustrations are particularly useful when trying to communicate complex concepts. Visuals to show a step-by-step procedure can be logically grouped to make the sequence easier to learn than an explanation from text, say the Doaks.

Illustrations can serve as a guide for how to do an exercise, and they help "show" what the words intend, agrees **Diane Moyer**, BSN, MS, RN, program director for patient education at The Ohio State University Medical Center in Columbus.

"Any visual should add to or highlight a message in patient education materials," says Moyer. Photos or illustrations can be very important, but they should be thoughtfully added and tested to be sure the intended message is being conveyed by the visual.

Photos, line drawings, and sketches can increase understanding for patients with low literacy when used appropriately, says Moyer.

The sketch must be a general concept that is common knowledge, adds Hess. For example, a telephone is not visualized by all as a landline. Younger members of society may visualize a cell phone when thinking of such a communication tool. Therefore, when using illustrations, it is important to think of the cultural reference points and life experiences of the readers, she says.

London says that the type of illustration is important when trying to educate people with poor literacy skills. Computer clip art and stylized images are not readily identifiable by those with poor literacy skills, according to the Doaks. These authors recommend showing the text with pictures to a focus group to make sure the meaning of the illustration is clear.

To make sure the illustration depicts its intended message for all audiences, Hess uses a lay person review board at her health care institution to look at newly developed materials.

Moyer adds that a poor choice of illustrations can send the wrong message and be inappropriate.

"If you are illustrating what not to do, it is important to put a big X across the picture, so poor readers don't misunderstand that the picture shows what they should do," she warns.

Incorporating illustrations

When determining whether to use a photograph or drawing, consider the purpose of the illustration, advises Moyer. Photographs are often great for showing emotion and, if done well, can also show equipment and steps in a procedure. However, it is important to be sure the photographs are clear and to the point, she adds.

"A line drawing can keep the message simpler and less cluttered," says Moyer.

London agrees. Research shows line drawings eliminate unnecessary details, she explains. For example, in a photo, the reader may notice the red nail polish on the hand performing the task, rather

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than noticing the way the task is performed in the picture.

Digital cameras make it easy to take photos fairly inexpensively, says Moyer. But not everyone has the ability to edit the photos to adjust the shading and other features to make them work, she adds.

Also, if the written material will be printed in black and white, the photograph may not transfer well, says Moyer.

She says The Ohio State University Medical Center has no written policy on incorporating illustrations into written materials, but they are not used to make a piece look "pretty." "Illustrations are used to clarify or highlight the intended messages," says Moyer.

Illustrations may be added to show a piece of equipment to give the patient some idea of what to expect, to show exercises, and step-by-step instructions for things like giving injections or dressing changes. "We have mostly used simple line drawings," says Moyer.

Because line drawings require a skilled illustrator, they are often more costly than photos. Also, it can be difficult to find someone with the skills to do simple medical illustrations, she adds.

"We have been fortunate to have a contracted artist that we have used for many years. We have a fairly extensive inventory of illustrations that we are actually cataloging now, so that we are better able to know what we have and potentially may be able to make them available for others to use," says Moyer.

At Wellspan Health, the decision on whether to include illustrations with written materials is left to the patient education coordinator and the lay person review committee. While illustrations usually are used to enhance clarity, they also can be added for visual appeal if a document is too text-heavy, says Hess.

Illustrations are selected from basic, free clip art or licensed medical clip art that can be used for a fee. Also, Hess, who has studied art, will create a simple line drawing from a picture.

If the selected clip art is in color, Hess prints it out to see what it looks like in the gray color scale. "I tend to stick with black and white and the gray scale, because some of the documents are on a portal and can be printed on the unit," adds Hess.

Phoenix Children's Hospital uses line drawings of behaviors and includes captions. This policy is based on the Doaks' score for "Suitability Assessment of Materials," which includes criteria for illustrations. This assessment tool is in their book, says London.

The health care institution hires an artist to create its line drawings. London says the authors of the handout often take photos of the behaviors they want to reinforce, and the artist makes line drawings from the photos, showing only the essential features of the action.

To select an appropriate image, Moyer considers the message to be conveyed; the target audience, whether from a particular culture or age group; and the labels or captions needed to clarify the message of the illustration.

Moyer says that medical illustrations are often too complex and detailed to be good for patient education materials. She recommends keeping concepts simple. For example, when she wants to show a particular part of the body in an illustration, she uses the outline of the whole body and then pulls a second illustration from the body to show more detail, such as the location of the heart.

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Tailor education on heart disease to women

Teach prevention and how to advocate for good care

A one-size-fits-all education about heart disease is not a good strategy, according to **Holly**

EXECUTIVE SUMMARY

Women need information about heart disease. **Holly Andersen**, MD, discusses education strategies might be appropriate when preparing lessons for women.

Andersen, MD, director of education and outreach at the Ronald O. Perelman Heart Center at New York-Presbyterian Hospital Weill Cornell Medical Center in New York City.

Lessons for women should be different from those for men, because certain information is unique to females, she explains.

While heart disease is the number-one cause of death for both men and women in the United States, every year since 1984, more women have died of cardiovascular health problems than men, according to statistics tracked by the American Heart Association.

Heart disease is more deadly in women, says Andersen. Once a woman is diagnosed, she will be more likely to die from the disease than a man, she adds. Many factors contribute to this. Women are often diagnosed and treated later in the disease process. In addition, treatment methods have been proven in men but may not be as effective in women, she says. Women are treated less aggressively as well, she adds.

To help change the statistics, women need information about prevention; about risk factors that contribute to the development of heart disease; and about how to advocate for the best medical treatment.

"We are pretty good at treating heart attacks — but pretty bad as a profession about helping patients in our community practice prevention, which is so important," says Andersen.

Women usually go to gynecologists when they are of childbearing age and get their health care from this specialist. Therefore, Andersen, who is a cardiologist, is working to have gynecologists educate women about screening and prevention of cardiac disease. For example, one in two Hispanic girls will develop diabetes, which can lead to heart disease. So, when they reach childbearining age, they need to be taught about physical activity and diet, says Andersen. Learning ways to reduce stress and get enough sleep is also important.

"If you educate a woman about prevention, you educate a family," she adds.

In addition, heart disease can be addressed by pediatricians. Just because some young people look fine in spite of a poor diet doesn't mean their food choices are not doing damage, says Andersen.

She recommends that education go beyond the description of a good diet and teach people how to actually put the recommendations into practice. For example, a busy mother not only finds dinner at a fast food restaurant convenient, but inexpensive as well. Women need a solution to this predicament.

Teach risk factors

There are other factors that increase the risk of heart disease in addition to a poor diet, lack of exercise, and stress. Obesity and being overweight increase risk, as does smoking, high cholesterol, and diabetes.

Genetics can play a role, as well. It's important for women to know their family history and how that impacts their risk for heart disease. For example, risk is increased if there is a history of heart disease at a young age within a family, says Andersen.

Although genetics is important, lifestyle changes can improve risk factors. Those who smoke should stop; good, wholesome food should be consumed at mealtime; and physical activity should become a habit. Andersen says that studies show 20 minutes of exercise, five days a week, reduces premature death rates by 50% in both men and women.

Several risk factors are unique to women. For example, certain complications during pregnancy can be an indicator of future cardiovascular disease. Women who have had preeclampsia or gestational diabetes or hypertension should aggressively manage all risk factors for heart disease, says Andersen.

Smoking greatly increases the risk of heart attack for women under the age of 45. The combination of smoking and birth control pills increases a woman's risk by at least twenty-fold, she adds.

Women must become knowledgeable patients, tracking their cholesterol level, blood pressure, glucose level, sleep, and stress. Also, they must know their waist measurement, because a waistline is a good predictor of cardiovascular risk. The fat around the waist is metabolically active and will make a person more insulin resistant, which leads to diabetes. Ideally, women should have a waistline of 29 inches or less, but 33 or 34 inches is OK, says Andersen.

Some women should test for a "silent heart attack." This is a heart attack without pain, but it can cause permanent damage if it causes a long-term shortage of blood and oxygen flow to the heart. Women who are post-menopausal and have at least three risk factors for heart disease should ask their physician for a cardiac stress test, says Andersen.

It's also important for women to learn the warning signs of a heart attack, as well as symptoms leading up to one. Chest pain is the most common symptom for women, but only about 45% experience it. Other symptoms include jaw pain, back pain, sudden fatigue, perspiration, nausea, and indigestion. "The symptoms aren't really that subtle; you know something is going on. I would much rather have someone come in thinking they had a heart attack, and they had a bad case of indigestion, than miss a heart attack," says Andersen.

Yet often women do not call 911 right away when they think they are having a heart attack. In a survey conducted by the American Heart Association, 53% of women who think they are experiencing a heart attack call 911, which means that 47% do not make the call. Yet 88% of the women in the survey said they would call 911 if they thought someone else was having a heart attack.

Typically, people experience warning signs prior to their heart attack, such as a little tightness in the chest while climbing stairs, or feeling winded or more fatigued. Symptoms that come with exertion and go away with rest are heart disease until ruled out, says Andersen.

If a woman is taken by ambulance to the emergency department because she thinks she is having a heart attack, she should ask for an EKG test or an enzyme blood test to check for a heart attack if the medical team does not order one.

Women need to be active in their care, says Andersen. Medical professionals can miss heart attacks in women, so it is important that women know they can make their voice heard and get checked out, she says.

SOURCE

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Cancer education in the workplace

Lessons about diagnosis help co-workers respond

Education about a cancer diagnosis and the impact of treatment is not limited only to patients and family members treated at OhioHealth Cancer Services in Columbus, OH. Cancer education sometimes extends to patients' colleagues in their workplace

Staff can go into the workplace to educate colleagues of cancer patients who are returning to their job following an extended absence during treatment. Also, they can address the concerns of co-workers of cancer patients being treated while they continue to work.

The co-worker education program was initiated after cancer patients expressed concern about returning to the workforce, says **Mary Szczepanik**, RN, BSN, MS, a breast health specialist at OhioHealth Breast Health Institute.

"Our mission is to improve the lives of those who are touched by cancer," says Szczepanik.

While OhioHealth performs market research and follows national standards for cancer treatment and cancer survivorship, the staff listen to the individuals and groups in the community, who express their needs and opinions about how the health care institution can help, explains Szczepanik. For example, an employee of a large local bank died of breast cancer, and the administrators at this business asked for a series of classes for their staff.

Cancer diagnosis impacts not only close family members and friends of the patient, but also all who have a relationship with him or her, including co-workers, she adds.

Therefore, it is important to help cancer patients through the treatment process while in the work force or transitioning back into the workplace after time off, says Szczepanik. The diagnosis of cancer alone — hearing the words: "You have cancer" — is often devastating for an individual. While each person adapts to a cancer diagnosis

EXECUTIVE SUMMARY

Cancer patients can benefit when education is taken into the workplace, giving co-workers a better understanding of the disease, treatment, and recovery process.

differently, there are some consistent themes that can be discussed in classes.

People diagnosed with cancer often feel they have lost control over their lives, and the fear of recurrence is ever-present. They often express the desire to "get their lives back to normal" and want to be treated the same way they were before they were diagnosed.

At the same time, they may be experiencing some changes in their thoughts, feelings, and even physical abilities that they want others to understand. They don't want to be talking about cancer all the time, and yet they don't want others to be afraid to talk to them or ask questions, explains Szczepanik.

Tailor information to group

During a class, OhioHealth instructors suggest ways to introduce the subject of cancer; explain how to follow up on hints from the patient about whether to talk about the diagnosis; give tips on how to help the patient adapt if he or she does have a deficit, such as problems concentrating; and provide information on how colleagues can advocate for their co-worker.

The presentation should be tailored to the audience, says Szczepanik. This can be done by asking those attending the class what they want to know. The curriculum should also include basic information about the diagnosis and treatment for the type of cancer in which the audience expressed interest; psychosocial effects of a cancer diagnosis on the patient and family; cancer survivorship; and effective means by which individuals and groups can help a returning cancer patient.

The purpose of the lesson is, first, to educate the public, says Szczepanik. "We have found there is a general lack of accurate information about cancer circulating in the general public. It is often driven by the media or experiences of others who are being diagnosed or treated for cancer," she explains.

The lesson also provides reassurance to co-workers who are uncomfortable thinking about a colleague, who is often a friend, coming back to work. This reaction can be prompted by a personal experience with cancer or that of a family member or friend. In such cases, their impressions are at least partially based on the outcomes of that experience, such as whether the person survived or was physically changed. Or the co-worker may feel he or she failed a colleague with cancer in some way during diagnosis and treatment, notes Szczepanik.

A third purpose for the class is to assist the returning co-worker in the transition back to work. "A cancer survivor returning to the workplace can have an easier transition if his or her co-workers have a realistic idea of what to expect, how to interact with the individual, and what is most helpful," says Szczepanik.

The majority of employed patients at OhioHealth continue to work throughout treatment. Some can take certain days of the week or month off when they know symptoms and side effects will make it impossible to work, says Szczepanik. For example, they can take a day for chemotherapy treatment and the day after to help recover. With this form of treatment, they often have physical side effects and extreme fatigue, which affects their work, she adds.

Others, such as patients receiving external beam radiation therapy, often use their lunch break for therapy and return to work. These patients may have fewer side effects, theoretically making it easier to work during treatment, says Szczepanik.

"Keeping the work environment as normal as possible depends on the patient's response to treatment, both physically and mentally… [as well as] co-workers' level of anxiety and concern regarding their colleague," says Szczepanik.

It's easy for co-workers to understand that a person may have a hard time adjusting to changes in physical appearance, such as hair loss, loss of a body part, weight loss or gain, peripheral neuropathy, and pain. What most people don't understand is the fatigue that accompanies all types of cancer treatment, including surgery, chemotherapy, and radiation, explains Szczepanik.

The fatigue is not something that is resolved with a nap or a long night's sleep. Patients express significant frustration with this side effect, she adds.

Therefore, instructors in the classes not only talk about the obvious, but they also emphasize the invisible side effect of fatigue, says Szczepanik. Also, they talk about other physical and emotional side effects that may not be obvious to others.

Initiating a program

When setting up outreach classes to businesses who have employees undergoing treatment for cancer, choose a clinician with an education background to teach it, advises Szczepanik.

This instructor also should have good presen-

tation skills, good listening skills, and a broad knowledge of cancer. In addition, an oncology social worker or licensed counselor who works with cancer patients regularly is a great co-presenter, she says. This combination is especially helpful during question-and-answer periods.

The program can be promoted in many ways, says Szczepanik — for example, during face-to-face contact with individual patients, especially those who are seeing an oncology counselor or art therapist. A short description of the program can be included on print pieces describing services, which are mailed to patients and handed out at community events, presentations, classes, and support groups.

Patient education managers should not have a problem creating a curriculum and lesson plan, because the cancer-specific information provided in the workplace is relatively basic, says Szczepanik. However, there are budget considerations, as well. For example, class materials must be produced, and staff members are pulled out of their normal roles to conduct the programs. It is also helpful to have portable audio-visual equipment in case the business does not.

SOURCE

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Patient flow takes on new importance

Hospitals can't afford for patients to stay too long

As hospitals face cuts in reimbursement and patients who become insured under health care reform legislation seek care, moving patients safely and quickly through the continuum of care is going to become important, experts say.

"Hospitals are expensive places to be, and in today's reimbursement climate, hospitals need to reduce waste. Any time a patient is staying longer than necessary, he or she is utilizing services resulting in a waste of limited resources," says **Teresa Fugate**, RN, BBA, CCM, CPHQ, vice president, case management services for Covenant Health System.

Medicare payments are based on the geometric mean length of stay, which means that the hospital loses money on patients who stay longer than expected for their DRG, Fugate points out.

In addition, commercial payers are tightening their reimbursement, making it necessary for hospitals to ensure that patients get the care they need in a timely manner, she adds.

"Hospitals simply can't afford to have patients who do not need to be there. Health care is one of the most inefficient industries. Hospitals are going to have to become more efficient in order to survive," she says.

Any time a patient stays in the hospital, he or she is at an increased risk of infection, falls, and medical errors, Fugate points out.

"It's important for patients to be treated and discharged as quickly and efficiently as possible, not because of the hospital's bottom line, but from a standpoint of providing appropriate quality care," she says.

When hospitals have an increased length of stay and patients stay too long in the inpatient setting unnecessarily, it creates a bottleneck that results in overcrowded conditions in the emergency department. This adds additional time to the length of stay while patients wait for an inpatient bed and the emergency department ultimately runs the risk of going on diversion, adds **Roxanne Tackett**, RN, MBA, vice president of clinical services for Compirion Healthcare Solutions, a health care consulting firm based in Elk Grove, WI.

Reducing waits for beds in the emergency department improves patient satisfaction as well as improves quality and safety outcomes, which ultimately will improve the hospital's bottom line, Tackett points out.

"Patients shouldn't be on a stretcher for multiple hours waiting for an inpatient bed. Emergency department and post-anesthesia care unit [PACU] nurses are experts in stabilizing emergent patients, but they are not experts in providing ongoing critical care. Patients need to be transported to the appropriate inpatient bed as soon as possible in order to receive care from a particular unit that matches their treatment needs and so they can receive their medication in a timely manner," she says.

One way to help reduce the length of time admitted patients wait in the emergency department (ED) and eliminate boarding in the ED is to improve patient flow to the inpatient areas. It takes the entire team from throughout the organi-

zation working together to accomplish length-of-stay initiatives, she adds.

But improving patient flow doesn't just mean getting patients out of the emergency department and into a bed as quickly as possible, points out **Ann Kirby**, BA, BSN, MSN, MPA, managing director at Wellspring + Stockamp HuronHealthcare, a Chicago-based consulting firm.

"Good patient throughput is a balancing act. It's about getting patients into a bed where they can get the best care," she adds.

For instance, if a cardiac patient is placed on the orthopedic floor because that's the first bed that is available, it's not best for the patient, because the staff don't have the level of expertise to provide optimal care, she adds.

"It sounds like a great idea to get patients in the emergency department admitted to an inpatient bed as fast as you can. But, if hospital patients are placed in a bed on an appropriate unit, then being moved the next day, it creates a lot of extra work for the staff and adds to the length of stay," she says.

For instance, suppose there are two patients waiting for beds: an orthopedic patient who has been in the ED for an hour and a cardiac patient who has been there two hours.

"If there is a bed on the orthopedic unit available and the cardiac patient is stable, it would be better to admit the orthopedic patient to that bed, particularly if a cardiac bed is expected to open up soon," she says.

Addressing patient flow in a comprehensive manner is very important, Kirby says.

"Everybody knows that they need to improve flow, but it doesn't work well to tackle just one area at a time. Decisions on the unit or the department level don't necessarily make sense for the rest of the house," she says.

For instance, many hospitals focus on case management functions, but if people throughout the hospital are not involved, the initiative is likely to have limited impact, she adds.

"Capacity management no longer can be just the responsibility of care management. It requires collaboration between all disciplines to drive the flow from admission to discharge. Everybody who is involved with patient care has to work as a team to achieve timely patient flow," Fugate adds.

Hospitals in Covenant Health System's East Tennessee Region collaborated on improving efficiency and the quality of patient care by creating teamwork and ownership in bed capacity management, she says. *(For details on the initiative, see related article on page 93.)*

"The key for hospitals to survive in today's health care environment is for everyone who is directly or indirectly related to patient care to understand how what they do every day impacts patient flow and the ramifications for the hospital when patients stay longer than necessary and over-utilize resources," she says.

Kirby recommends developing a flow diagram that outlines all the processes that span the entire patient episode from the time a patient comes into the hospital until he or she leaves.

Look at how people are organized, how they are trained, the processes they use, and the tools that support them, Kirby recommends.

For instance, outline how the nursing supervisor helps facilitate getting patients to the unit, the roles of case management and social work, how the interdisciplinary team interacts, and how non-clinical staff such as housekeeping and transportation are involved in patient flow, she says.

"The patient flow process has a lot of moving parts. It's no wonder organizations are struggling to fix their flow," she says.

Look at the length of time it takes to place patients into a bed from the ED and how often the patient is placed on the most appropriate unit, she says.

Most hospitals need an automated bed board in order to effectively manage and measure patient flow performance, Kirby says.

The bed control staff have to have a good view of the beds available, who is ready to leave, and who is waiting to come into an inpatient bed in order to make the best decision for the patients.

In some hospitals, nurses approach housekeeping directly when there's a bed that needs to be cleaned. This process may impede patient flow because the housekeepers may be working on one unit when there are patients waiting for beds on another unit, she says.

"The people in the central bed hub should be the only ones to say a bed needs to be cleaned immediately. The nurse may see that her unit has four empty beds, but the most critical need for beds may be in another unit," Kirby points out.

Have good processes in place, so you automatically track your metrics and drill down to see the causes of the delays, she says.

"So often we see hospitals that have a lot of information, but they haven't set up a way to get

the team together to discuss information and set goals," she says.

For instance, if statistics show that housekeeping's response time is 25 minutes, and the goal is 15 minutes, the roadblock could be that the unit secretaries aren't entering discharges in a timely manner and are processing them all in a big group.

"All of the processes are interconnected, and everyone involved must be aware of the impact they have on patient flow," Kirby says.

When making changes in processes, it's important not to underestimate the length of time it takes to make the changes stick, Kirby says.

Some hospitals have invested in tools, such as a case management system or an automated bed board, but don't spend the time helping people transition through the new way of doing work or developing the metrics to monitor and recognize success and identify opportunities for improvement, she says.

It typically takes eight to 12 months for a hospital to determine what needs to be done -- and how to do it -- and to ingrain the behavior in the entire hospital staff, Kirby says.

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Communication key to improving throughput

Keep patients, family members in the loop

Improved communication, coordination, and collaboration among all members of the treatment team is the key to improving patient throughput, says **Roxanne Tackett**, RN, MBA, vice presidential of clinical services for Compirion Healthcare Solutions, a health care consulting firm with headquarters in Elk Grove, WI.

Case managers tend to be the owners of the throughput process, but all members of the unit have to take ownership to ensure that their patients get the care they need and are discharged in a timely manner, she says.

Everybody on the interdisciplinary treatment team needs to get together and talk about every patient every day, adds **Ann Kirby**, BA, BSN, MSN, MPA, managing director at Wellspring + Stockamp HuronHealthcare, a Chicago-based consulting firm.

"It is quite a challenge to get everybody together, but the payoff is huge," she adds.

Often, one team member thinks he or she is too busy, but once they start meeting, they realize how a short meeting can increase their efficiency, she says.

"The team can look at the plan of care for today, goals for the patient, barriers for discharge, and ways to resolve them. They don't spend time later trying to track each other down. Having everybody together can make the discharge process much smoother," she says.

The meetings should include a core group of people, including a physician or a physician representative, case managers, social workers, the bedside nurse, and other disciplines as needed. The charge nurse or unit leader should be the facilitator, she suggests.

The meetings should be short and focused on patients being discharged that day, as well as looking at patients who may be discharged in two or three days, and should address any barriers to discharge, Tackett says.

During the meeting, the staff should go over every patient on the unit, the anticipated discharge dates, potential barriers for discharge, current length of stay, and expected length of stay for that DRG, Tackett.

Having regular meetings alerts staff members to what they need to do before discharge. For instance, if a patient will be ready to go home the next day if he voids after his catheter is removed, the case manager knows to get his durable medical equipment or home health services lined up, Kirby adds.

"Patients should leave when they are medically ready and not have their stays extended because tests haven't been done or arrangements for post-discharge care or transportation haven't been made," she says.

If an anticipated discharge doesn't happen, the case manager should initiate an avoidable-day form to have a paper trail of the reasons for the delays, Tackett says.

Track avoidable days on a daily basis to determine if any trends are occurring, and take steps to

improve the process, Tackett suggests.

Analyze each avoidable day to determine the cause and whether it's hospital-related or community-related, she suggests.

For instance, the patient may have stayed an extra day because a skilled bed wasn't available, or the family couldn't pick him or her up.

Hospital-related causes may be that there was a delay in orders, the patient didn't get an antibiotic in a timely fashion, or the physical therapy assessment wasn't completed. Nursing needs to be aware of these causes and develop solutions to prevent them from recurring, Tackett says.

The avoidable-day form should be copied and given to the supervisor of the person or department responsible, she says.

When Tackett works with a hospital on patient flow initiatives, she suggests that the staff focus first on the noncomplicated discharges.

"I suggest that each floor try to get two of those easier patients discharged by 11 a.m., two out by noon, and two by 1 p.m. on a daily basis. This assists in reducing bottlenecks," she says.

The average discharge time in most hospitals is after 3 p.m., Tackett says. This is when the hospital typically has fewer resources, such as housekeeping and transportation ,and when the emergency department is beginning to experience peak volumes of patients who need to be admitted.

Lack of communication and coordination between members of the care team and between the care team and the family are the major reasons for delays in discharge, Kirby says.

In addition to verbally notifying the patient and family of when to expect discharge, Tackett suggests putting dry-erase boards in patient rooms and writing the anticipated discharge date along with treatment goals so the staff, the patient, and the family members are aware of when the discharge is likely to occur. ■

Don't violate patient privacy regs for *anyone*

Have you ever been put into the uncomfortable position of being asked for confidential health information about an employee by a senior leader or administrator? Be ready for this "sticky situation," as it may violate patient privacy regulations, says **Patricia B. Strasser**, PhD, RN, COHN-S/CM, FAAOHN, principal of Partners in BusinessHealth Solutions in Toledo, OH.

Managers may wrongly believe they don't need to comply with the Health Insurance Portability and Accountability Act (HIPAA) because it's a health insurance regulation. They may mistakenly think that the regulation doesn't apply to in-house occupational health.

However, maintaining confidentiality of health information extends beyond HIPAA. "Responsibility for preventing disclosure of health information does not rest exclusively with health care providers. Managers who are in receipt of medical information must also prevent inappropriate disclosure of the information," says Strasser. *(See related story on page 83 on penalties for violations.)*

Be prepared to make management aware of this fact, if they ask for inappropriate information. "Sometimes supervisors want more information than they need to have," says Strasser. "Occupational health nurses are frequently pressured to provide information such as an employee's diagnosis."

Human resources professionals are more likely to be aware of the regulations, and say, "Just tell me what I need to know." "Many don't want to even know the information or have the chance to be influenced by it," says Strasser. "There is more awareness because of the increase in legislation and lawsuits."

Managers may ask about a worker's condition, or why a potential employee didn't pass a post-offer evaluation. "The issue is not what the diagnosis is," says Strasser. "The issue is whether the person is capable of performing the job requirements with or without accommodation. Knowing that a person has had a myocardial infarction or has asthma is not important for the supervisor to know. What's important is what the person's physical capabilities are."

Don't give in to pressure

Don't ever disclose information you know is not appropriate to give. "Not only are you jeopardizing your professional ethical obligations, but there may be legal issues as well," says Strasser.

Instead, help the company managers understand that a specific diagnosis doesn't matter. "Medical conditions affect each person differently," says Strasser. "One person may be totally incapable of performing a job because of a certain condition.

Another person with the same diagnosis may be able to do the job without any difficulty."

Still, occupational health nurses/managers frequently find themselves torn between safeguarding employee health information and being responsive to their employers, says **Kathleen Liever**, an employment law associate at Fowler White Boggs in Tampa, FL.

"Privacy violations can arise as a result of pressure by human resources personnel or supervisors to reveal employee or applicant health information beyond that related to the particular job performed," says Liever.

During a disciplinary investigation, you may be asked to turn over a doctor's note submitted by an employee who has a history of absences. Similarly, an employer may require a fitness for duty certificate or doctor's note in order for an employee to return to work after an extended absence or leave. "These notes often state the employee's diagnosis, which is confidential," says Liever.

[For more information on compliance with patient privacy regulations, contact:

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COMING IN FUTURE MONTHS

- ■ Lessons cancer survivors need
- ■ Helping patients make educated choices
- ■ Making lasting lifestyle changes
- ■ Better teaching strategies for the elderly
- ■ Tying patient education into organizational initiatives

Know penalties for privacy reg violations

The unauthorized release of employee health information can result in civil, and some-

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.

Upon completion of this educational activity, participants should be able to:

- identify the management, clinical, educational and financial issues relevant to patient education
- explain the impact of the management, clinical, educational and financial issues relevant to patient education on health care educators and patients
- describe practical solutions to problems health care educators commonly encounter in their daily activities
- develop patient education programs based on existing programs.

CNE QUESTIONS

5. Illustrations added to text can do which of the following?
A. Demonstrate technique.
B. Clarify written instruction.
C. Increase understanding.
D. All of the above.

6. Illustrations added to text should be reviewed by lay persons to be sure the intended message is being conveyed by the visual.
A. True
B. False

7. Risk factors for heart disease unique to women include which of the following?
A. Poor diet.
B. Lack of physical activity.
C. Certain complications during pregnancy.
D. Stress

8. Offering outreach education to businesses that have an employee with cancer is helpful in which of the following ways?
A. Gives insight into fatigue from treatment.
B. Clears up misconceptions about cancer.
C. Gives coworkers tips on how to address disease with colleague.
D. All of the above.

Answers: 5. D; 6. A; 7. C; 8. D.

times criminal, liability under both federal and state laws. For example, covered individuals under the Health Insurance Portability and Accountability Act (HIPAA) face civil fines ranging from $100 to $25,000, depending on one's level of intent. Criminal penalties include fines ranging from $50,000 to $250,000 and imprisonment of up to 10 years.

"Personal liability may also arise under the Family and Medical Leave Act, depending on your jurisdiction, and give rise to state law claims for invasion of privacy, defamation, negligence, and breach of confidentiality," warns **Kathleen Liever**, an employment law associate at Fowler White Boggs in Tampa, FL.

Unauthorized disclosure could also result in disciplinary proceedings before licensing boards. "Likewise, employers may face civil and criminal liability under federal and state laws," says Liever.

Your first step is to become very familiar with federal and state laws and regulations addressing privacy and confidentiality issues, especially any limitations and exceptions to confidentiality. Next, educate management and human resources.

"You are in the best position to tell your employer how to safeguard employee health information," says Liever. "Get involved in the development or revision of policies and procedures, *before* you find yourself in a difficult position."

Your best bet is to keep your response simple. "Absent employee consent or the application of a limited exception, an occupational health nurse or manager is obliged to release health information only to the extent of advising the employer whether the employee is fit, unfit, or fit within limitations, to perform a particular job without endangering anyone else," explains. Liever.

Provide what information you can. Then, explain that anything beyond that is "confidential and protected by law from disclosure." "If that is not enough, try reminding management and human resource personnel that there are strong penalties for inappropriate disclosure," says Liever. ■